Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report (Announced)

Pontardawe Health Centre, Swansea Bay University Health Board

Inspection date: 4 July 2023

Publication date: 4 October 2023

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

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

Digital ISBN 978-1-83504-768-2

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 Pontardawe Health Centre (the practice), Swansea Bay University Health Board on 4 July 2023.

Our team for the inspection comprised of a HIW Senior Healthcare Inspectors, two clinical peer reviewers and a practice manager. The inspection was led by a HIW Senior 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 six questionnaires were completed by patients or their carers and 16 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:
Patient responses received through HIW questionnaires were generally positive, with respondents rating the service as 'good' or 'very good'.

The practice had a good supply of health promotion information available and on display to patients. There were quick response (QR) posters, including one dedicated to youth issues, encouraging patients to view information through their smart phones.

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.

There were a number of Welsh speakers working at the practice, these were listed on posters in the reception area. However, we did not witness anyone wearing 'iaith gwaith' badges for patients to identify the Welsh speaking staff.

The process for monitoring and recording instances where patients did not attend (DNA) hospital appointments and where children did not attend appointments at the practice needs to be formalised.

This is what we recommend the service can improve:

- The DNA process needs to be formalised
- Ensure Welsh speaking staff wear the 'iaith gwaith' badge.

This is what the service did well:

- Displaying health promotion information
- Treating patients in a caring and friendly manner within surgeries that preserved their dignity
- Ensuring good facilities for patients with disabilities to access to the practice.

Delivery of Safe and Effective Care

Overall summary:
The team at the practice were 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 to describe the care and treatment.

Whilst areas of good practice were seen, we did identify a small number of issues in relation to infection prevention and control (IPC) audits and the need for weekly emergency equipment and emergency drug checks.

This is what we recommend the service can improve:

- Completing a programme of IPC audits
- Checking emergency drugs and equipment weekly
- Use of clinical Read coding.

This is what the service did well:

- Providing an environment that ensured safe and effective care
- Up to date risk assessment
- Recording of information on patient records.

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 were knowledgeable of their roles and responsibilities and committed to providing a quality service to patients.

Responses given by staff in the questionnaire were generally positive, a high number of respondents felt that they could make suggestions to improve services at the practice.

We identified improvements were needed in relation to aspects of the recruitment process and staff training compliance, which required immediate action by the practice.

Immediate assurances:

- All staff were out of date in training in the practical aspects of basic life support (BLS)
- Managers were unable to confirm what staff had completed what training in the areas of safeguarding and infection control

- Not all members of staff had completed Disclosure Barring Service (DBS) checks
- The hepatitis B register was not up to date as it did not reflect the status of all current staff at the practice.

This is what we recommend the service can improve:

- Implement a process to display outcomes of patient feedback that influenced improvements made at the practice
- Ensure staff complete and be up to date with all mandatory training as soon as possible.

This is what the service did well:

- We saw evidence of a clear management structure in place at the practice
- Good collaborative working within the local cluster.

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. In total, we received six responses from patients at this practice. As only six responses were completed, this low number needs to be borne in mind when considering the responses.

Responses received through HIW questionnaires were generally positive, with respondents rating the service as 'good' or 'very good' and all agreeing that the practice was clean. All patients said that the general practitioner (GP) explained things well and answered their questions, that they felt listened to and were treated with dignity and respect. However, the majority considered that if they needed to see a GP urgently, they could not arrange a same-day appointment and that they could not obtain routine appointments when they needed them. Additionally, they thought that they could not talk to reception staff without being overheard.

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 various noticeboards in the reception area. There were also quick response (QR) posters encouraging patients to view information through their smart phones. This included one QR poster dedicated to youth related issues. The practice were also advertising the use of the surgery application (app). The app allowed connection remotely with the GP surgery and had a number of features to manage an individual's health. The practice manager told us that approximately 25% of patient at the practice had uploaded the app.

A number of the signs and posters were bilingual in English and Welsh. There was also an informative practice website that allowed patients with digital access to request repeat prescriptions and gave guidance for accessing appointments at the practice. Information was also available on a range of different medical conditions with links to organisations to provide support and advice.

There was television screen in reception on a loop describing the app, child vaccinations and how to book a blood test.

The receptionists, we were told, follow up with parents or guardians for children who did not attend appointments. The process in place to monitor and record instances where patients did not attend hospital appointments involved a letter being generated but the patient would not be contacted directly. The practice manager acknowledged that this should be completed if the patient was a child or safeguarding or mental health issues may have affected the patient's ability to attend.

The practice needs to ensure that the process for monitoring and recording instances where patients did not attend hospital appointments and where children did not attend appointments at the practice is formalised. This must include an audit trail that allows the practice to ensure that the process includes follow up until a resolution is obtained.

We were told that the practice had offered the winter flu vaccination and COVID-19 vaccine to patients for the past two years and a range of vaccination clinics had been arranged for patients to attend for this.

All patients in the questionnaire agreed that there was health promotion and patient information material on display. All bar one member of staff in the questionnaire believed that they offered health promotion advice and information about chronic conditions to patients in a variety of medium.

Dignified and respectful care
Reception staff were seen welcoming patients in a friendly, professional and courteous manner. All telephone calls received into and made from the practice were done from the rooms located behind the reception desk area to ensure privacy and confidentiality. A room was available for private consultations should patients request this. Once the building work has finished there would also be a dedicated interview room that could be used. Patients queueing, waiting for a receptionist, normally waited a respectful distance from the patient at the reception desk. There was also a part of the reception desk that was lowered for patients in wheelchairs.

Consultation and treatment rooms were located away from the main waiting area and were well laid out. Doors to consulting rooms were always kept closed when in use and privacy curtains were present around examination couches to preserve patient dignity.

Senior practice staff informed us that both male and female chaperones (for intimate examinations or procedures) were available. These were usually members of the clinical team and the practice manager. Staff undertaking this role had received training through the e-learning provided by NHS Wales. A policy was in place that covered the use of chaperones at the practice that was in date. Patients were made aware of the chaperone service via several posters displayed at the practice.

Whilst the majority of patients believed that they could not talk to reception staff without being overheard, they stated that measures were taken to protect their privacy (e.g. curtains drawn, cover-up provided, private room used). All bar one member of staff stated that measures were taken to protect patient confidentiality and patient privacy and dignity.

Additionally, whilst the majority of patients said they did not know about the offer of a chaperone, there were signs on consulting room doors advising patients about chaperones. All staff in the survey stated that patients were offered chaperones when appropriate. The availability of chaperones should also be recorded on the patient website.

The practice should ensure that in addition to signage advertising the availability of chaperones, that patients are advised in advance of visiting the practice of the availability of chaperones.

Almost all staff felt that the care of patients was the practices' top priority and that they would be happy with the standard of care provided for themselves, friends and family. Furthermore, whilst 80% of staff were content with the efforts of this practice to keep staff and patients safe, 93% were satisfied with the quality of care and support they gave to patients.

Regarding feedback 80% of patients stated that they had not been asked by their GP practice about their experience of the service they provided. Whilst 75% of staff said that patient feedback was collected.

Timely

Timely Care

The arrangements for patients to access services was described. Patients were encouraged to contact the practice using the app (in place since September 2022). Appointments could also be made by telephone or, rarely, by turning up in person. All requests would be prioritised by reception care navigators and added to the list for same day contact, mainly by the on call doctor, supported by available clinicians. Those patients who needed to be seen face to face would be triaged to

the appropriate clinician. The duty doctor would see all those coming in for an appointment in the late afternoon. We were told that there always appeared to be adequate appointment slots available to meet demand on the day, as long as the patients accepted that this would not always be through a face to face meeting with a clinician. We were also told that there was a separate delayed list used for patients to send photographs to the practice, which we considered to be a noteworthy practice.

The practice had an access policy that was based on the requirements of the access standards. All staff had undertaken care navigation, but we were told that triage was undertaken by clinical staff.

The appointment system was not well advertised. The practice would benefit from including on their website and app an explanation of what the practice provides and that the practice review how they provide appointments. This was currently on the day appointments, but patients were ringing in early to try and arrange an appointment. This was evidenced by the figures for May 2023 which showed 5526 calls, 1254 abandoned, with only 1694 answered within two minutes.

The practice must advertise their appointment system to inform patients that they need not call first thing in the morning. The practice should also review the process of how they provided appointments to manage expectations of patients.

Regarding access to their GP all bar one of patients was satisfied with the opening hours of this practice and that they were able to contact their practice when they needed to. However, the majority stated that if they needed to see a GP urgently, they could not arrange a same-day appointment and that they could not arrange routine appointments when needed.

Half the patients in the questionnaire stated that they were offered the option to choose the type of appointment they preferred, whether that be in person, virtually by video or by telephone. All bar one patients were content with the type of appointment offered. The majority of patients with an ongoing medical condition were able to access the regular support needed and knew how to access out of hours services if they needed medical advice or an appointment that could not wait until GP opening hours.

The majority of staff believed that patients were able to access the services the practice provided in a timely way.

Equitable

Communication and language
A review of information from secondary care showed that letters were scanned and sent to general practitioners electronically when they were received by the practice. Test results were received by the practice electronically. Whilst we noted that the speed of response varied, there was no significant backlog noted. Any further actions required by the practice to take following discharge from secondary care would be agreed by the GPs as to whether to ask patients to attend for further actions, such as appointments or investigations, as appropriate.

The practice should audit the time for taking actions on correspondence or results of investigations to establish what the length of delay was and what delays there were.

We were provided with a demonstration of the new telephony system in use at the practice.

We were told that care homes were visited on a weekly basis and a nurse would complete a ward round. Acute visits were allocated via the on-call GP.

Clinical coders process incoming paper mail. Electronic information was imported automatically into the patient record, ie results and out of hours reports. Clinical coders were responsible for processing out of hours reports and these reports would be automatically entered into the patient record. There had been a backlog but the practice has employed external sources to catch up.

We were told of the different ways the practice would communicate 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.

There were a number of Welsh speakers working at the practice, these were listed on posters in the reception area. However, we did not witness any member of staff wearing 'iaith gwaith' badges for patients to identify the Welsh speaking staff. We asked the practice manager to ensure the relevant individuals wear these badges going forward. In responding to the questionnaire, three members of staff said they were Welsh speakers and they all confirmed they did not wear 'iaith gwaith' badges to identify them as Welsh speakers.

The practice is required to provide all Welsh speaking staff with 'iaith gwaith' badges.

All the patients who completed the questionnaire said their preferred language was English.

Whilst only 40% of patients agreed that their appointment was on time, they all agreed, where applicable, that their identity was checked. All patients agreed that their medical details were checked, such as allergies and long-term conditions, before medication was prescribed and that they were given enough time to explain their health needs. However, only 60% of patients knew how to complain about poor service, if they wanted to.

All bar one member of staff stated in the questionnaire that patients or their advocates were informed and involved in decisions about their care. Additionally, all bar one member of staff said that there were alerts on patient records that make them aware of any communication difficulties.

Rights and Equality
There was a formal equality and diversity policy in place which demonstrated how the practice would advance equality and make improvements in response to the information gathered. 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. Whilst the policy did not have a dated, completed, owner of the policy and date due review, there was a separate master list that listed these details.

The practice offered good access with a free car park and cars were also able to pull up near a ramp to the main doors to allow patients 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.

All bar one patient felt they could access the right healthcare at the right time. None of the patients said that they had faced discrimination when accessing or using the practice.

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

- The GP explained things well and answered their questions
- 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.

However, two patients of the five who answered the question strongly disagree that they were offered healthy lifestyle advice.

We also asked patients in the questionnaire about carer support. Only two patients said they provided care for someone with disabilities, long-term care needs or a terminal illness. One said they had been offered an assessment of their own needs as a carer. However, neither said that staff at the practice gave them details of organisations or support networks that could provide them with information and support as a carer. That being said, we did see several leaflets at the practice relating to carers and support available.

We were also told that the practice had a carers' champion who engaged with local carers' groups.

From a staff point of view, we asked them a series of questions about carer support:

- Whilst half of respondents agreed they maintained a register of carers, half of respondents answered that they were ‘not sure’

- Many respondents were unsure as to whether a dedicated ‘carers champion’ was in place at the practice

- Only two respondents stated that the centre offers an assessment of carers needs, whilst twelve did not know

- Only a few more signposted carers to support organisations (7/16), the remainder did not know.

The practice need to publicise to patients and staff the support available to carers.

Delivery of Safe and Effective Care

Safe

Risk Management
We found the practice premises to be generally clean, tidy and free from clutter. During the time of the inspection there was extensive building work being carried out on the practice that included moving the care navigation area from behind reception and providing additional consultation rooms.

The practice had a risk management policy that included arrangements for escalation and compliance. The practice had also appointed a third party company to partner with the practice, to assess and develop a new formulary of policies inclusive of risk assessments.

We were provided with a copy of the practice business continuity plan. This had been recently reviewed and contained all 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 patient safety alerts and significant events were dealt with appropriately and we were provided with policies for both that had been recently reviewed. Patient safety alerts would be sent electronically to all staff and new starters.

Staff were able to describe and were aware of the process to follow should they need to urgently call for help. This was achieved via a panic button in all consultation rooms as well as a call button in the practice software that would alert all users once pressed.

In relation to home visits, the triage doctor would contact patients to discuss the need for and urgency of the visit.

Most patients agreed the building was easily accessible. All patients said there were enough seats in the waiting area and that there were toilet and hand washing facilities that suited their needs. Additionally, all patients believed the practice was ‘child friendly’.

Infection, Prevention, Control (IPC) and Decontamination

The practice had an IPC policy in place that had been recently reviewed and was available to all staff via the practice intranet. The lead nurse at the practice was also the IPC lead, who also provided the IPC induction for all new staff.

The practice had maintained some precautions originally put in place because of the COVID-19 pandemic. These included a perspex screen at the reception desk and access to face masks and hand sanitiser for patients and their carers.

There was a blood borne virus policy, with posters in treatment rooms informing staff what to do in the event of a sharps or needlestick injury. Post exposure treatment would be provided by the local accident and emergency department.

A member of staff checked clinical waste bins in rooms and changed them if needed, these were placed in locked bins. They also checked sharps boxes and if full they would close the box and ensured they were disposed of appropriately. At the start of the inspection, we noted that the sharps bins were not labelled with the signature and date of the person starting the use of the bin. Additionally, clinical waste bins were noted in the corridor outside the consultation rooms, which was a system that started during COVID-19. The sharps bins were subsequently labelled and the waste bins removed into the treatment rooms during the inspection and are covered in Appendix A of this report.

In the consultation rooms, the curtains used to protect patients' dignity were cloth and there was no evidence of when they had been previously cleaned and there was no cleaning record available. We also noted two wheelchairs in the practice for use of patients. The cleaning of these was also not recorded on the IPC policy and who was responsible for cleaning these.

The practice must ensure that the cloth privacy curtains are regularly cleaned and a record of this cleaning kept available for inspection. Similarly, the wheelchairs must be cleaned before and after use and a record kept of this cleaning.

Additionally, there was no evidence of any IPC audits taking place at the practice. As a result there was not an annual healthcare waste audit, to evidence actions associated with any outcomes or areas of improvement highlighted as a result of audits.

The practice needs to ensure that regular IPC audits are conducted on a regular basis including the annual healthcare waste audit.

A series of questions were asked of patients relating to an invasive procedure, this included having bloods taken, injections and minor operations, four patients

answered yes to this. They all agreed that staff wore gloves during the procedure, that the syringe, needle or scalpel used was individually packaged or sanitised and that antibacterial wipes were used to clean the patients' skin before the procedure. All patients agreed that the practice was clean.

We also asked patients questions about IPC, they all agreed that there were signs at the practice explaining what to do if you are contagious and that hand sanitizers were available. However, one patient said that healthcare staff did not wash their hands before and after treating them.

The practice scored well across IPC areas with staff, all respondents stated that the organisation implemented an effective infection control policy and that the environment allowed for effective infection control. All bar one members of staff agreed that there was an effective cleaning schedule in place and that appropriate personal protective equipment (PPE) was supplied and used.

Whilst an external cleaning company were responsible for cleaning the premises, we did not see a Control of Substances Hazardous to Health (COSHH) risk assessment.

The practice must ensure that a COSHH risk assessment is available for the relevant substances in the premises.

Medicines Management
Requests for repeat prescriptions could be made online via 'my health online' on the practice website, the 'mysurgery app' or in person at the practice. There was also a team of pharmacy technicians and support staff working at the practice who would control the workload and prepare the scripts for patients that were on repeat medications for the GP to sign.

The pharmacy technicians were also trained to prevent overuse of medication by patients, that was supported by the prescribing GP lead. Patients requiring a review would only be reviewed by a GP. Medications no longer being by patients would be removed from the repeat prescribing list by the pharmacy technicians. The lead nurse was also a non-medical prescriber, working within an agreed scope of practice.

We were told that all clinical staff were aware of the yellow card reporting scheme for adverse effects. Patients' medical records would then be updated accordingly. Staff would follow the relevant guidelines in the event of a cold chain breach, that would be reported accordingly.

All the clinical refrigerators on site had their temperature monitored twice daily. These included appropriate vaccine refrigerators with back up thermometers in use. Vaccines were stored appropriately ensuring that they were not touching the sides of the refrigerators.

A member of the nursing team was responsible for checking the small amount of medicines kept on site. A log of stock was kept by the practice with expiry dates logged. All drugs reviewed were in date and regular stock takes taken and expired drugs, syringes and needles replaced as necessary. Weekly checks were made of the emergency kit, including expiry dates which were documented.

Safeguarding of Children and Adults
There was a comprehensive safeguarding policy in place at the practice. One of the practice GPs was appointed the safeguarding lead who was trained to level three in safeguarding. We noted that the nurses and the GPs worked well together on any safeguarding issues.

Safeguarding was a rolling agenda topic in the practice' weekly practice meeting, meaning any issues relating to policy, case studies or concerns were addressed weekly without fail, with any issues highlighted then investigated with change processes put in place.

We were told that the practice regularly reviewed their safeguarding systems and ensured they were consistent with national policy and best practice This included routinely submitting reports for all requests.

There was a vulnerable adults and children safeguarding policy in place. We were also told that the practice had recently completed the Identification and Referral to Improve Safety Service (IRIS) accreditation. IRIS is a collaboration between primary care and third sector organisations specialising in domestic violence and abuse.

The majority of staff stated they were up to date with adult and child safeguarding training. Many staff stated they knew how to report safeguarding concerns and also knew who the safeguarding lead for the practice was.

Management of Medical Devices and Equipment
Medical devices and equipment were checked by a health board contract, with calibration managed by the practice manager. All equipment inspected was in a good condition with the last calibration date in January 2023. The practice manager would arrange repairs needed for equipment. Only single use equipment was used in the practice

Resuscitation equipment was present within the practice on an emergency trolley in reception. There was an automatic external defibrillator (AED) available with age appropriate and in date pads. Emergency drugs were in line with Resuscitation Council UK guidance.

Monthly drugs and equipment checks were evidenced, these included expiry dates of drugs. These checks should be carried out weekly. The All Wales Clinical Governance Practice Self-Assessment Tool (CGPSAT) for the practice stated that the emergency trolley and defibrillator were checked on a weekly basis with a sign off sheet. The expiration dates of equipment, such as face masks, were not included in the checklist, although the equipment checked was all in date.

The practice must check all resuscitation drugs and equipment weekly and evidence these checks. The practice should add the expiration dates of all items in the emergency trolley to the weekly checklists.

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. Whilst practice meetings were held every Monday, clinical meetings for all clinical staff were not scheduled, these should be scheduled to discuss NICE updates, complaints, significant events and to provide support for registrars.

The practice must ensure that there are clinical meetings held for all clinical staff, GPs and nurses.

We were told that the practice engaged with other health board services, which were co-located with the practice. These included smoking cessation and pre diabetic clinics run by the health board as well as cluster services from the building. There was also cluster support initiatives such as occupational therapy, mental health through MIND, audiology and social prescribing.

Should patients contact the practice in crisis, the practice had a mental health support worker and also had access to a mental health crisis team, in addition the GPs would manage a mental health crisis.

Referrals reviewed were appropriate, these were sent via the Welsh Clinical Communications Gateway.

The physicians associate and pharmacy technicians were noted to have good access to GPs for support as required.

Patient records
We reviewed a sample of 10 electronic patient medical records. These were stored securely and protected from unauthorised access. Record keeping was found to be of good quality throughout our assessment. Entries relating to medicines management and the management of chronic disease (where applicable) were also clear and concise. The records were complete and contemporaneous apart from late home visits that were recorded at the next session in practice. Paper records were securely stored and electronic records were held centrally, protected to government information standards.

Whilst we considered there to be good individual record keeping, the clinical system, in our opinion did not encourage continuity of the record and needed to be actively interrogated for past episodes. Better read coding would help this, as the codes used were mainly admin codes, even when recording clinical information.

The practice need to introduce more clinical Read coding to describe the care and treatment given to patients, such as the signs, symptoms, treatments, investigations, occupations and diagnoses.

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. In total, we received 16 responses from staff at this practice. Some questions were skipped by some respondents, meaning not all questions had 16 responses.

Overall responses given by staff were generally positive, a high number of respondents felt that they could make suggestions to improve GP services at this practice (14/16). However, fewer felt they were involved in any decision making surrounding changes that may affect their work (10/16). Whilst the practice scored consistently well in patient care and incident reporting, the practice scored poorly in carer support. Staff comments included:

> *"Reception staff all work great together as a team and work to the best of their standards"*

Leadership

Governance and leadership
The practice is owned by the four GP partners and is a training GP practice set within the Upper Valleys Cluster of Swansea Bay University Health Board. The practice had approximately 13,400 registered patients. The practice has four full time GP partners, two salaried GP's, and a multi-disciplinary team including an advanced nurse practitioner.

It was evident that all staff were clear about their roles, responsibilities and there were clear lines of accountability in place at the practice. The new structure in the practice was described in the practice development plan, which defined a more specific role for each team lead with two main managers sitting beneath the Practice Manager. Those were the Operations Manager to ensure systems and procedures were functioning as intended and the Human Resource (HR) and Finance Manager to assist in the more organisational elements.

The practice had also created a series of line managers in each of the 4 key areas. a nurse lead, lead pharmacy technician, the admin team lead, who was also the HR and Finance Manager and the reception lead.

Formal practice meetings took place every Monday lunchtime. This was an agenda based meeting attended by all GP's, the practice manager, and relevant team

leads. The meeting was chaired by the practice manager with updates from all team leaders. Consistent themes such as complaints, safeguarding and compliance issues were rolling agenda points.

We saw that the practice had a range of policies and procedures in place that were available to all staff. The policies we reviewed during our visit, had all been recently reviewed and were up to date. 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 moved policies due for review into the second folder to show the reviewer they were due, whilst remaining accessible to staff.

Workforce

Skilled and enabled workforce
We spoke with staff across a range of roles working at the practice. It was clear that they were all knowledgeable of their roles and responsibilities and committed to providing a quality service to patients.

Nursing staff had extra specialist qualifications in respiratory and diabetes. Additionally, the lead nurse had additional contraceptive qualifications and hoped to start delivering long acting reversible contraceptives. Clinics were set up to match nurses specialist areas.

During our inspection we found evidence of the following issues that required immediate improvement to ensure the practice operated safely and effectively:

- Based on the training matrix and supporting information, all staff were out of date in training in the practical aspects of BLS. Additionally, the GPs and five of the nine nurses and healthcare support workers were not up to date with any training in BLS

- Managers were unable to confirm what staff had completed what training in the areas of safeguarding level two and three, and infection control level two and three for clinical staff. Management believed that the clinical staff had completed this training but were unable to provide the evidence to support this

- Not all members of staff had completed DBS checks

- The hepatitis B register was not up to date as it did not reflect the status of all current staff at the practice.

These were dealt with under our Immediate Assurance process.

Additionally, our review of the training matrix highlighted several other gaps in mandatory training for both clinical and non-clinical staff. This included fire safety, moving and handling and equality and diversity. We raised this with the practice manager and asked that all staff be fully compliant with mandatory training as soon as possible.

The practice must ensure that staff remain in date with all mandatory training.

We also checked a sample of staff files, these did not contain job descriptions or evidence of qualifications, this is particularly relevant to clinical work. Additionally, following a change to employee's role, this needs to be reflected in an updated job description.

The practice needs to ensure that all staff files contain the relevant information including up to date job descriptions, employee's contracts and evidence of qualifications. All new staff employed also need to have evidence on the file of the references required and a curriculum vitae.

We asked a series of questions of staff about their professional development, the majority of respondents felt they had appropriate training to undertake the role. However, staff commented that further computer training would be useful and that further appraisals were in progress. Almost all staff who answered the question said they had an appraisal, annual review or development review of their work in the last 12 months.

All bar one respondents felt that the practice took positive action on health and wellbeing and the majority believed that they could achieve a good work-life balance from their current working pattern. Almost all said that in general, their job was not detrimental to their health. The vast majority also said they were aware of the occupational health and wellbeing support available. We were told that staff had access to occupational health services and were able to use them. A HR company had been contracted to provide HR obligations, with back to work interviews for all staff and anyone off sick would be offered a counselling service.

Culture

People engagement, feedback and learning
The practice had in place an appropriate complaints policy and procedure. This was in line with the NHS Putting Things Right process and was available to patients on the practice website. However, Putting Things Right was not displayed at the practice.

The practice needs to display Putting Things Right at the practice in the reception area. Copies also needed to be available for patients on request.

A review of the complaints log showed that recent changes had been put into place to ensure that for 2023, copies of all the complaints and responses were held electronically. There was evidence to support the reasons why the complaints had been resolved or were still outstanding.

We were told that the practice had recently assessed patient views as part of the Quality Assurance and Improvement Framework (QAIF) and this fed into the equality impact assessment. This identified that the standard of care was good but level of access not as good. The outcomes of this assessment were not displayed in the reception to inform patients how the practice was acting on 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 has set up several groups on a business communication platform, such as diabetes, respiratory and nursing. Each group has a dedicated page to communicate and share information.

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.

We spoke with senior staff about the arrangements in place to ensure compliance with the duty of candour requirements. The practice had a duty of candour policy in place that met the requirements of the guidance. We were told that all staff had viewed the relevant video on the duty of candour. Regarding the duty, staff responded as follows:

- I know and understand the duty of candour – 88%
- I understand my role in meeting the duty of candour standards – 94%
- My organisation encouraged us to raise concerns when something had gone wrong and to share this with the patient – 88%

Staff were asked whether they faced discrimination at work within the last 12 months, none answered yes. Whilst only 69% of staff said they had fair and equal access to workplace opportunities, the remaining 31% preferred not to say.

Additionally, 88% of staff said they their workplace was supportive of equality, diversity and inclusion.

In relation to patient care, all bar one respondents felt there was an appropriate skill mix at the practice, whilst 75% felt they had the materials, supplies and equipment needed to do their job. Very few respondents felt there was enough staff employed at the centre to allow them to do their job properly (5/16). However, all bar one respondents were satisfied with the quality of care and support given to patient.

A total of 67% of staff said they were able to meet all the conflicting demands on their time at work, with 88% being able to access ICT systems they needed to provide good care and support for patients. Whilst only 63% of staff they were involved in deciding on changes introduced that affect their work, 88% said they were able to make suggestions to improve GP services and almost 94% said they would recommend this practice as a good place to work.

On the topic of incidents and concerns, all respondents stated that the organisation encourages them to report errors, near misses or incidents and that staff involved were treated fairly. All bar one respondent stated that the organisation took action to ensure that errors, near misses or incidents did not reoccur and that feedback was given in response to reported errors, near misses or incidents.

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.

A significant amount of information was available to patients through the practice website and the app, this included the practice activity data.

Learning, improvement and research

Quality improvement activities
During the inspection, building work was being carried out on an expansion to the building and renovation project which would allow for five more clinical rooms, also increasing the share of administrative space. The reception call centre, which was located within ear shot of patients was being moved to the first floor, negating any disruption and issues of data protection. The renovation would also enable the practice to modernise its building and future proof against further

continued growth. This would allow the practice to see more patients and house more clinicians and thereby improving the sustainability of the practice. There were significant challenges in room utilisation currently, meaning GPs had to work from home (triaging) on heavily staffed days.

The practice was an accredited research ready practice. We were told that due to staffing levels and the impact of the pandemic, alongside the re-engagement of QAIF, the practice had not been in a position to participate in any research projects recently.

We were told that as a training practice, the practice would work with any registrars in the completion of agreed Quality Improvement Activity (QIA) and Quality Improvement Projects (QIP)as part of their development which also helped drive forward performance within the practice.

Whole system approach

Partnership working and development
We were told that the practice worked closely within the GP cluster to build a shared understanding of challenges within the system and the needs of the population.

The GP clinicians together with the nurse lead met on a daily basis to discuss cases and concerns at lunchtime. All clinicians could attend and were encouraged to discuss problematic matters. The practice were attempting to create a culture where issues would be discussed openly and shared with a view to leaning on colleagues for assistance and guidance.

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
At the start of the inspection, we noted that the sharps bins were not labelled with the signature and date of the person starting the use of the bin. Additionally, clinical waste bins were noted in the corridor outside the consultation rooms, which was a system that started during COVID-19.	The labels warn everyone of where sharps and glass are stored. Sharps Container Labels ensure proper disposal and handling of hazardous sharps, protecting your employees and the environment. Patients could access the clinical waste bins in public areas.	We informed the practice manager and the practice nurse.	The sharps bins were subsequently labelled and the waste bins removed into the treatment rooms during the inspection.

Appendix B – Immediate improvement plan

Service: Pontardawe Health Centre

Date of inspection: 4 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
HIW were not assured that the management systems and procedures in place were sufficiently robust to ensure adequate governance of the practice. During our inspection HIW found evidence of the following issues that require immediate improvement to ensure the practice operates safely and effectively: • All staff were out of date in training in the	The practice must ensure that: • All clinical staff complete training relevant to their role, in resuscitation and managing emergency situations, ideally in immediate life support (ILS) training, and remain in date with this training • All staff complete the relevant mandatory training as relevant, including safeguarding level two / three and infection control level two / three for clinical staff and evidence of this is available on file	Having reviewed the practice mandatory training log, it has been identified that gaps in accurate logging were evident. Work has been done to address this and any completed training added to the log. This log has been uploaded for ease of reference as requested,. Should specific certificates confirming compliance be required, these can also be provided. You will note that there remain gaps in completion of	Owain Gimblett	1 month for completion of all outstanding mandatory training. With regard to BLS training, this is being arranged for September 2023 with confirmation awaited.

practical aspects of basic life support (BLS). Additionally, the general practitioners and five of the nine nurses and healthcare support workers were not up to date with any training in BLS • Managers were unable to confirm what staff had completed what training in the areas of safeguarding level two and three, and infection control level two and three for clinical staff. Management believed that the clinical staff had completed this training but were unable to provide the evidence to support this • Not all members of staff had completed Disclosure Barring Service (DBS) checks	• The training matrix is kept up to date to reflect the mandatory training completed and when due • Relevant DBS checks are completed for all staff, this should be carried out prior to employment, and evidence of this maintained on file • Staff annually confirm that the information on the DBS check remains accurate and that there have been no changes since this check • The hepatitis B register is kept up to date to reflect the status of all staff at the practice • Risk assessments are carried out on those staff who do not require a hepatitis B vaccine or do not respond to the hepatitis B vaccine.	mandatory training needs. These represent staff members who have been unable to complete their training thus far. To address this, now that the log is fully updated, it is clear where gaps appear in compliance training with these staff to complete asap. The updated DBS register is uploaded as evidence of current compliance. As can be seen, all new staff members have DBS checks in place. Long standing members of staff are outstanding. Assurance is given that applications have been made for all staff now and evidence of compliance can be given upon receipt of the outstanding DBS forms. We have uploaded the updated Hepatitis B staff	Owain Gimblett	Applications are under way for all outstanding DBS checks. These can take anywhere up to 12 weeks to be returned. Confirmation of outstanding evidence

• The hepatitis B register was not up to date as it did not reflect the status of all current staff at the practice.		register, which is fully up to date. Of those outstanding, we have been given assurance of their immunity but await sight of the evidence of this which they are seeking. Should this not be found, we will arrange for relevant blood tests and follow up where required.		within 1 month – blood tests thereafter.

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): **Owain Gimblett**

Job role: **Practice Manager**

Date: **11 July 2023**

Appendix C - Improvement plan

Service: Pontardawe Health Centre

Date of inspection: 4 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
The process in place to monitor and record instances where patients did not attend hospital appointments involved a letter being generated but the patient would not be contacted directly. The practice manager acknowledged that this should be completed if the patient was a child or safeguarding or mental health issues may have affected the patient's ability to attend.	The practice needs to ensure that the process for monitoring and recording instances where patients did not attend hospital appointments and where children did not attend appointments at the practice is formalised. This must include an audit trail that allows the practice to ensure that the process includes follow up until a resolution is obtained.	The practice is looking at finalising this new process where instances of non-attendance at hospital appointments are noted with an appropriate phone call made to ascertain the reason for non-attendance. Any safeguarding concerns will then be escalated to the safeguarding lead.	Rachel Topper	3 months

Patients were not advised in advance about the availability of chaperones.	The practice should ensure that in addition to signage advertising the availability of chaperones, that patients are advised in advance of visiting the practice of the availability of chaperones.	The practice feels we already offer this. However, an asterix will be added to our online forms highlighting the right for chaperones.	Owain Gimblett	1 month
The appointment system was not well advertised. This was currently on the day appointments, but patients were ringing in early to try and arrange an appointment.	The practice must advertise their appointment system to inform patients that they need not call first thing in the morning. The practice should also review the process of how they provided appointments to manage expectations of patients.	The practice is overhauling its appointment system with a view to launching this in October 2023. As part of this review, the way in which our appointment system is advertised is being re-written to ensure further clarity and making all available options better known to patients.	Owain Gimblett	3 months – in line with appointment/ access system overhaul
Test results were received by the practice electronically. We noted that the speed of response varied, there was no significant backlog noted.	The practice should audit the time for taking actions on correspondence or results of investigations to establish what the length of delay was and what delays there were.	The practice will look to conduct this audit and identify timescales – upon which the practice will act to improve turnover times if required.	Rachel Topper	1 month

We did not witness any member of staff wearing ‘iaith gwaith’ badges for patients to identify the Welsh speaking staff.	The practice is required to provide all Welsh speaking staff with ‘iaith gwaith’ badges.	Suitable lanyards have been ordered for Welsh speaking staff to wear, making them clearly identifiable to the public.	Owain Gimblett	Completed
We asked patients in the questionnaire about carer support. Two patients said they provided care for someone with disabilities, long-term care needs or a terminal illness, but neither said that staff at the practice gave them details of organisations or support networks that could provide them with information and support as a carer.	The practice need to publicise to patients and staff the support available to carers.	Our website has been amended to support this recommendation. A form online has been created called “tell us you’re a carer” where carers can inform us of their status more easily. There is also information the website about care support which is extensive.	Owain Gimblett	Completed
In the consultation rooms, the curtains used to protect patients’ dignity were cloth and there was no evidence of when they had been previously cleaned and there was no cleaning record available. We	The practice must ensure that the cloth privacy curtains are regularly cleaned and a record of this cleaning kept available for inspection. Similarly, the wheelchairs must be	A decision has been taken to remove the existing cloth curtains and replace with paper curtains. Orders are pending and all newly created rooms from the renovation project will also house paper	Nancy Davies	1 month – dependent on delivery timescales.

also noted two wheelchairs in the practice for use of patients. The cleaning of these was also not recorded on the IPC policy and who was responsible for cleaning these.	cleaned before and after use and a record kept of this cleaning.	curtains. These will be replaced regularly.		
There was no evidence of any IPC audits taking place at the practice. As a result, there was not an annual healthcare waste audit, to evidence actions associated with any outcomes or areas of improvement highlighted as a result of audits.	The practice needs to ensure that regular IPC audits are conducted on a regular basis including the annual healthcare waste audit.	The annual healthcare waste audit has been started and will shortly be completed and submitted to Stericycle. Likewise, an IPC audit is being developed which can be completed quarterly by the nursing team.	Owain Gimblett	1 month
Whilst an external cleaning company were responsible for cleaning the premises, we did not see a Control of Substances Hazardous to Health (COSHH) risk assessment, available to staff.	The practice must ensure that a COSHH risk assessment is available for the relevant substances in the premises.	This risk assessment is to be completed. Once completed, the practice will act on its outcomes.	Nancy Davies – Owain Gimblett	1 month

Monthly drugs and equipment checks were evidenced, these included expiry dates of drugs. These checks should be carried out weekly.	The practice must check all resuscitation drugs and equipment weekly and evidence these checks. The practice should add the expiration dates of all items in the emergency trolley to the weekly checklists.	This is already in place.	Nancy Davies	Completed
Practice meetings were held every Monday but clinical meetings for all clinical staff were not scheduled, these should be scheduled to discuss NICE updates, complaints, significant events and to provide support for registrars.	The practice must ensure that there are clinical meetings held for all clinical staff, GPs and nurses.	This is being adopted with a rota for clinical meetings being developed. Completion of the renovation is required first to allow the space to complete these meetings safely.	Dr Pat Wong	3 months
The clinical system on patient records in our opinion, did not encourage continuity of the record and needed to be actively interrogated for past episodes. Better read coding would help this, as the codes used were mainly admin codes,	The practice need to introduce more clinical read coding to describe the care and treatment given to patients, such as the signs, symptoms, treatments, investigations, occupations and diagnoses.	This is under review with a view to audits being completed to help inform what improvements are required. Once completed, the practice will act on its audit recommendations for better coding practices.	All GP Partners	6 months

even when recording clinical information.				
The review of the training matrix highlighted several gaps in mandatory training for both clinical and non-clinical staff. This included fire safety, moving and handling and equality and diversity.	The practice must ensure that staff remain in date with all mandatory training.	A catch up programme has been commenced with significant progress made to maintaining 100% completion.	Sharon Cockings	3 months
Putting Things Right was not displayed at the practice.	The practice needs to display Putting Things Right at the practice in the reception area. Copies also needed to be available for patients on request.	This has been completed.	Owain Gimblett	Completed
Patient views were assessed as part of the Quality Assurance and Improvement Framework (QAIF) The outcomes of this assessment were not displayed in the reception to inform patients how the practice was acting on 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 is developing this poster and this will be displayed in the waiting room as well as included on the website.	Owain Gimblett	1 month

The staff files checked did not contain job descriptions or evidence of qualifications. Additionally following any changes to an employee's role this needs to be reflected in an updated job description.	The practice needs to ensure that all staff files contain the relevant information including up to date job descriptions, employee's contracts and evidence of qualifications. All new staff employed also need to have evidence on the file of the references required and a curriculum vitae.	Staff files are maintained with Job descriptions and amendments already.	Sharon Cockings	Completed.

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): **Owain Gimblett**

Job role: **Practice Business Manager**

Date: **18/08/2023**