Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report (Announced)

SA1 Medical Centre, Swansea Bay University Health Board

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

In writing:

Communications Manager

Healthcare Inspectorate Wales
Welsh Government

Rhydycar Business Park

Merthyr Tydfil

CF48 1UZ

Or via

Phone: 0300 062 8163

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

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

Our purpose

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

Our values

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

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

Our goal

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

Our priorities

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

Contents

1. What we did 5

2. Summary of inspection 6

3. What we found 9

- Quality of Patient Experience 9
- Delivery of Safe and Effective Care 15
- Quality of Management and Leadership 19

4. Next steps 24

Appendix A – Summary of concerns resolved during the inspection 25

Appendix B – Immediate improvement plan 26

Appendix C – Improvement plan 31

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 SA1 Medical Centre, Swansea Bay University Health Board on 29 June 2023.

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

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

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

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

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

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

2. Summary of inspection

Quality of Patient Experience

Overall summary:
We found SA1 Medical Centre was committed to providing a positive experience to patients. Patient responses received through the HIW questionnaire were generally positive. All respondents rated the practice as 'very good' or 'good'.

Health promotion information was available to patients in all waiting areas, some of which was bilingual. Patients could also access this information digitally.

There was level access to the practice allowing wheelchair users or those with mobility issues to access the facilities easily. The waiting rooms were spacious and the treatment areas were situated on the ground floor or first floor accessible via a lift.

There were Welsh speaking staff available at the practice, however these staff did not wear 'Iaith Gwaith' badges to identify them as Welsh speakers. There was also a receptionist that was fluent in sign language for patients who were deaf or hard of hearing. A hearing loop was also in place.

Issues were identified relating to the reception area and implementing a care navigation process.

This is what we recommend the service can improve:

- Ensure the privacy and confidentiality of patients is maintained in the reception area
- Update policies to reflect changes
- Implement a written process to ensure a clear pathway of care navigation.

This is what the service did well:

- Availability of health promotion information both written and digitally
- Treating patients in a caring and friendly manner within surgeries that preserved their dignity
- Good facilities for patients with disabilities to the practice.

Delivery of Safe and Effective Care

Overall summary:

Overall, we found SA1 Medical Centre staff to be dedicated and committed to providing patients with safe and effective care. The practice was mostly clean and clutter free. All treatment rooms were well equipped and of a good size.

Whilst areas of good practice were noted, we did identify a small number of issues in relation to medical items and equipment checks. We also found various issues in regard to infection, prevention and control. These issues were dealt with under HIW's Immediate Assurance process.

Medical records reviewed were found to be of a good standard, however some improvements were required in relation to Read codes.

Immediate assurances:

- Checklist required for the equipment in the emergency bag
- Practice specific resuscitation procedure required
- Infection, prevention and control audits required
- Ensure compliance with cleaning schedules
- Decluttering of all treatment rooms to allow for adequate cleaning
- Repair or replace damaged chairs in waiting rooms.

This is what we recommend the service can improve:

- Ensure staff complete the level of safeguarding training relevant to their role
- Managers to ensure staff are aware of their roles and responsibilities
- Improve Read coding on medical records.

This is what the service did well:

- Adherence to cold chain storage procedures
- Up to date risk assessments
- Business continuity arrangements.

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.

There was evidence of a comprehensive induction process, followed by regular supervision and annual appraisals. However, on review we found gaps present in mandatory training compliance.

Team meetings were taking place with the relevant team leads, however full practice meetings were not taking place. We recommended the development of a formal process for team meetings that were minuted and disseminated accordingly.

Immediate assurances:

- Ensure staff receive the appropriate training in IPC dependant on their role
- Develop and implement a mandatory training schedule
- Ensure all mandatory training is completed in a timely manner
- Develop and implement a full audit schedule for the practice, to include annual IPC and hand hygiene audits.

This is what we recommend the service can improve:

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

This is what the service did well:

- Clear management structure in place at the practice
- Good collaborative working with cluster and secondary care
- Access to training to allow for continued professional development

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

3. What we found

Quality of Patient Experience

Patient Feedback

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

> *"Always receive exceptional care from this practice for both myself and my family."*
>
> *"Amazing reception staff."*
>
> *"I have used SA1 Surgery since 2006 and I have to say I have always received great service and support from all the GPs in this practice... I've noticed in my work in social care sector that surgeries generally in recent years are struggling with greater numbers of patients and less resources. This no doubt is true for SA1 Surgery too but however that surgery team is managed, however it operates, it could be/should be used as a model for other surgeries on how to do/cope with the best one can with the limited resources available."*

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

> *"Bring back booking online as the queue system is very long winded."*
>
> *"Sometimes hard to get through on phone. Then told emergencies only."*
>
> *"Would be easier to use the online booking system."*

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

Person centred

Health Promotion
During our inspection we saw that the practice had health promotion information available to patients, displayed on various noticeboards in the waiting room areas on both floors of the practice.

We saw a variety of health promotion information on the practice website, the text size for which could be enlarged for the visually impaired. We were also advised that general practitioners (GPs) and nurses were able to print health promotion advice during a patient's consultation where required.

The practice had a mental health associate that patients could be referred to and offered an in-practice counselling service. There was a cluster pharmacist who attended the practice and also a cluster paramedic who carried out home visits. They were described as an asset to the practice.

All patients who completed the specific question in the questionnaire told us that they 'agreed' or 'strongly agreed' that health promotion material was accessible. All staff in the questionnaire agreed that a variety of health promotion advice was readily available to patients.

We were told that the practice had organised winter influenza vaccination clinics for patients. Timings of the clinics are agreed when vaccines are received, usually arranged as walk in clinics late afternoons and evenings.

There were processes in place for monitoring, following up and recording instances where patients did not attend (DNA) their appointments, both at the practice and hospital appointments. This process included contacting the parents or guardians of children under the age of sixteen.

Dignified and respectful care
We observed reception staff welcoming patients in a friendly and professional manner. Telephone calls received into and made from the practice were carried out from the upstairs offices in the staff area or rear office room behind the reception desk area to attempt to ensure privacy and confidentiality. However, there is a shared reception with another GP practice, so confidentiality cannot be maintained. This is reflected in the patient questionnaire where four patients 'disagreed' or 'strongly disagreed' that they were able to talk to the reception staff without being overheard.

The practice must ensure that measures are taken, so far as reasonably practicable, to preserve the privacy and confidentiality of patients.

We saw consultation room doors were kept closed during appointments and privacy curtains and/or locks were used when required to preserve patient dignity. Chaperones were available at the practice and this was very well advertised throughout the practice. All staff used as chaperones were trained appropriately. Patients were offered a private room if they wished to discuss anything in confidence to respect their privacy.

All the patients that completed the questionnaire and felt this was applicable said they felt they were treated with dignity and respect, and that measures were taken to protect their privacy. All the members of staff that completed the questionnaire agreed that measures were in place to protect patient privacy and dignity of patients, this included the use of chaperones.

Timely

Timely Care
Patients accessed appointments in person, via the telephone or on the practice website. We were advised that phones could be very busy and more phone lines or a queueing system would be helpful. We were shown that there was a new telephony system in place.

The practice must update their access policy to reflect the recent changes.

The practice manager was in the process of creating a comprehensive list of presenting complaints and who would deal with those. This was to ensure the reception staff were able to triage patients and navigate care, signposting to other services where required. The onsite doctors were responsible for triaging all patients at the time of the inspection. Urgent appointments could be opened at the discretion of the on-call doctor. Whilst we are advised there is usually adequate in-house capacity, help for acute problems could also be accessed from the Health Board Urgent Care Service. All patients under the age of 16 would be seen the same day. All patients, regardless of age were given safety netting advice on when to re-contact practice or secondary care services if their condition does not improve or deteriorates.

The practice must ensure that the written process is implemented as soon as possible to ensure receptionists have a clear pathway of care navigation.

All the patients that completed the questionnaire and felt this question was applicable said they were able to get a same-day appointment when they need to see a GP urgently. All patients who answered were content with the type of

appointment offered and almost all of the patients said they could book routine appointments when needed.

We were advised that a doctor would complete a telephone triage for anyone presenting with mental health concerns and a referral for mental health team assessment would be made where required. We reviewed notes of a patient presenting with urgent mental health problems and found the process was being followed as explained. Where a referral was made for a patient who did not meet the secondary care mental health threshold, there would re-referral for re-assessment with escalation to consultant level where required. Staff also knew how to signpost to various third sector counselling services where relevant.

When answering questions on patient care, all staff agreed that patients were able to access GP services in a timely way.

Equitable

Communication and language
We reviewed how information from secondary care was recorded and acted upon. We found that this information was collated by the administrative staff who would scan documents received in hard copy. These would be sent electronically to either the named doctor or the partners. Urgent problems would be highlighted for same day action otherwise these would be worked through gradually. Whilst response times varied, no significant backlog was noted.

An examination of ten patient records showed that all letters appearing in the clinical system had actions recorded against them. We were advised that verbal information was given to patients regarding their health condition where relevant and this was supplemented by a patient information leaflet (PIL). This was currently not Read coded. Where a patient was discharged from secondary care the practice would contact the patient by telephone or text message.

We recommend the practice add Read codes to clinical records when a PIL is issued.

The practice described suitable ways of communication 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 NHS mail, tasks and yellow messages in the patient information system.

There was a process being followed to ensure clinical staff were aware of any new diagnosis or changes to a patient's condition, and this appeared to work well. However, there was not a policy or protocol to specify what to send where or when. We were advised that medication changes were sent to the pharmacist and everything else went via the GP or filed if no further action was required. Evidence from the records reviewed showed that Read coding was not always used correctly when recording letters.

The practice must ensure a policy and protocol is put in place to ensure that all staff are fully informed of the correct process of where and when to send information on medical changes for a patient. This must include correct use of Read codes.

There were some Welsh speaking staff at the practice. However, we did not witness any wearing 'Iaith Gwaith' badges for patients to identify Welsh speaking staff. Bilingual material was available throughout the practice and we were advised that "easy read" literature was also available. Where this was not available, it was offered. Translations services could be accessed by the practice where required via the Health Board. All the patients who completed the questionnaire said their preferred language was English.

The practice is required to provide all Welsh speaking staff with 'Iaith Gwaith' badges and ensure patients are offered the 'Active Offer'.

Where a patient had hearing difficulties and needed to lip read, the practice manager informed us that if personal protective equipment (PPE) was required, the staff would wear clear visors in place of face masks. We also spoke with one receptionist who was fluent in sign language. Noteworthy practice was found whereby alerts on the electronic system indicated various situations, including hearing or sight issues to inform staff. There was also a hidden hearing loop installed.

Rights and Equality

There was a suitable equality and diversity policy in place that had been recently reviewed. This policy demonstrated how the practice would uphold the rights of an individual and how they would drive equality. This area of practice was overseen by four GPs who ensured that all were treated fairly. All staff were in date with their mandatory equality and diversity training.

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

There was level access to the practice allowing wheelchair users or those with mobility issues to access the facilities easily. There was also a lift in place if the appointment was to take place in any of the first floor treatment rooms. The two waiting room areas were spacious, as were the treatment rooms viewed. Toilets were also wheelchair accessible.

To ensure equality of access, GPs or the cluster paramedic would attend home visits. There was also a care home supported by the practice. We were told that occasionally double appointment slots were booked for those patients requiring extra assistance.

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

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

We also asked patients in the questionnaire about carer support. Only three patients said they provided care for someone with disabilities, long-term care needs or a terminal illness. Two answered that they had been offered an assessment of their own needs as a carer. However, all three answered that staff at the practice had given them details of organisations or support networks that could provide them with information and support as a carer.

Over half of the staff members who responded to our questionnaire were unaware that the practice kept a register of their patients who were carers and also did not know that carers should be offered an assessment of their needs. Similarly, just over half of the respondents knew to signpost carers to support organisations. Most staff were unsure if the practice had a carer's champion.

The practice must ensure that staff are aware of their roles and responsibilities for providing assessment of need for carers, and to ensure they are providing support, advice and guidance as necessary.

Delivery of Safe and Effective Care

Safe

Risk Management
We found the practice to be generally clean and tidy. During the inspection, we viewed up to date environmental risk assessments and a health and safety risk assessment for the practice.

Sharps bins were in each treatment room, in a safe location. However, one sharps bin was found in the reception area accessible to anyone. This was discussed with the practice and safely removed from the area during the inspection. The area in which clinical waste bins were stored had adequate signage to warn staff, patients and visitors of the relevant hazard.

The practice provided a copy of their Business Continuity Plan which contained the relevant information required. There was a "buddying" arrangement in place with a neighbouring practice within the cluster to ensure cover in extreme situations.

The GP and cluster paramedic undertook home visits when required. The request for home visits would be risk assessed and facilitated where required with all necessary precautions put in place.

Discussions were held with the practice manager around the processes in place for the recording and management of significant events and patient safety alerts. These appeared to be dealt with appropriately and learning shared amongst staff. Up to date policies were in place.

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

Infection, Prevention, Control (IPC) and Decontamination
Several treatment rooms were inspected at the practice. We found the flooring was durable and intact. Both the floor and surfaces were 'wipe clean', allowing for thorough cleaning to take place. However, whilst some treatment rooms were generally clean and tidy, in others we found a lot of clutter on work surfaces and shelves which would prevent adequate cleaning. In one clinical treatment room the frame of the bed was visibly not clean, the floor under the treatment bed and above the privacy curtain rail were also dusty and not clean. Several vinyl covered chairs in the reception area were excessively worn and this would not allow for adequate cleaning and would therefore pose an unnecessary IPC risk to patients.

HIW were not assured that appropriately robust procedures were in place to ensure that IPC was always maintained at the medical practice and therefore issued an Immediate Assurance to the practice.

There were no practice Control of Substances Hazardous to Health (COSHH) records and the practice did not have access to the full COSHH documents. This related to all cleaning substances used on the premises for health and safety purposes.

The practice is to ensure that there are copies of the COSHH records available to staff at the premises.

Contracted cleaners were in place and cleaning schedules were viewed. As bed frames and curtain rails form part of those schedules, the practice confirmed that contact had been made with the contractors to ensure compliance.

We saw that the practice had an IPC policy in place that had been recently reviewed and was available to all staff. The lead nurse was the IPC lead however, the nurse advised that they were unaware they held this responsibility. As a result, IPC audits had not been undertaken. This formed part of the Immediate Assurance issued to the practice. We saw evidence of a recently completely healthcare waste audit that was site specific.

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

All sinks in clinical areas had taps which were elbow operated. Additionally, all rooms had foot operated bins. Sinks throughout the practice had signage showing patients, staff and visitors how to wash their hands correctly.

We observed unlabelled urine specimens on the desk at reception. We were told that a nurse would be called to collect this and would be told the patient's name, verbally, by a member of reception. If they received two specimens then they would add names to the specimens. This could lead to the wrong name being given to the nurse. If urine samples have to be left at reception, then they should be labelled with patients' name and date of birth.

The practice is to ensure that where urine specimens have to be left at the reception desk, they should be clearly marked with the patient's name and date of birth.

Medicines Management
During the inspection we viewed the cold chain policy, the process for which the nurse was able to explain clearly. The fridge temperature logs were also viewed and were recorded twice a day. Fridges were subject to portable appliance testing, calibrated regularly and alarmed. The fridges were clean and uncluttered. Older flu vaccines were being stored separately ready to be collected and disposed of safely.

Only a small amount of non-emergency drugs were kept on site which were kept in a locked cupboard. Spot checks on medications and drugs kept on site were undertaken by the nursing team. We reviewed a recent spot check that showed all were in date.

Appropriate arrangements were in place to ensure prescription pads were stored securely at the practice.

Safeguarding of Children and Adults
We saw the practice had safeguarding policies in place which had been recently reviewed. We also saw flow charts in place to assist staff in identifying an individual at risk. The practice was reviewing the system in place to monitor patients who did not attend appointments.

We were told that staff could easily access the safeguarding team and safeguarding meetings would be attended where required. There were good links between the practice and health visitors, palliative care and district nurses.

We viewed certificates showing most staff had undertaken training in safeguarding to levels appropriate to their positions.

The practice must ensure staff complete the level of safeguarding training relevant to their role.

Staff we spoke to limited knowledge of Gillick Competency and the Fraser Guidelines, legal judgements that set out the 'rules' around when a child was deemed to be competent to make their own decisions.

The practice needs to ensure that staff, particularly those staff involved with children under 18 years of age are fully aware of Gillick Competency and the Fraser Guidelines.

Management of Medical Devices and Equipment
The practice manager advised that the practice nurse held responsibility for checking devices and equipment.

Annual checks are being carried out on all equipment at the practice and this was last carried out in September 2022. Spot checks on equipment showed no issues. Checklists were in place for monthly checks on emergency drugs but not equipment. When we checked the emergency equipment, we noted there were no paediatric defibrillator pads within the emergency equipment bag. There was also no risk assessment in place for the omission of such. This was dealt with under HIW's Immediate Assurance process.

Effective

Effective Care

It was evident that the practice had a caring and dedicated team who provided patients with safe and effective care.

The referrals process reviewed was appropriate. We were advised that the GPs would either complete their own referrals via the Welsh Clinical Communications Gateway, or they would dictate a referral for the medical secretaries to complete. All urgent suspected cancers were referred within 24 hours.

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

There was a mental health (MH) worker who attended the practice regularly. The practice triaged those patients requiring a review. In addition, a psychological wellbeing practitioner attended the practice frequently. A crisis worker could be accessed when required.

Patient records

We reviewed a sample of 10 electronic patient medical records. These were stored securely and protected from unauthorised access. We found that the two-layer authentication for access to patient records to be very effective in protecting patients' details.

Record keeping was of a good standard. However, we found there was inconsistent use of Read codes with no evidence of local subsets and only sporadic linking to allow a problem orientated consultation. It was not always easy to read back on patient records.

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

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 seven responses from staff at this practice. Overall responses given by staff were generally positive.

All but one of the respondents answered that they felt able to meet the conflicting demands of their time at work, however all agreed they had the appropriate materials and equipment to carry out their duties. All staff bar one agreed there were enough staff members working at the practice to do their job properly. However, all agreed that the skill mix was appropriate.

A high number of respondents indicated that they were able to make suggestions to improve GP services and were involved in decision on changes introduced that affected their work.

All respondents also felt satisfied with the quality of care and support they give to their patients.

Staff comments included the following:

"Patient care is our top priority"

"Good supportive team and management."

Leadership

Governance and leadership

SA1 Medical Centre was owned by four GP partners. It was a training GP practice within the Swansea Bay University Health Board area. The practice had approximately 8500 patients registered patients.

The practice employed several clinical and non-clinical staff, including salaried GP's, nurse practitioners and healthcare support workers. The practice was further supported by a team of administrative staff. It was evident that all staff at the practice were clear about their roles and responsibilities and there were clear lines of accountability in place.

Team meetings took place between the relevant team leads and their staff. The GP partners would meet bi-monthly and the notes disseminated. However, no whole practice meetings took place.

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

The practice had a range of policies and procedures in place that were available to staff. However, some were overdue for review. Where information needed to be shared amongst staff, such as a policy or procedural change, this was communicated to staff promptly.

The practice manager informed us of the staff engagement and wellbeing programmes for staff. All staff could access Occupational Health via the Health Board.

Workforce

Skilled and enabled workforce

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

Some nursing staff had additional qualifications in areas such as respiratory conditions. Clinics were set up to match nurses specialist areas.

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

- Lack of mandatory training in fire safety, manual handling, health and safety, IPC, and data protection

- Managers were unable to confirm what staff had completed what training, without going through individual staff files.

Furthermore, when asked to produce copies of any recent audits at the practice, for example annual healthcare waste audit, audit of concerns or serious incidents and hand hygiene audit, we were advised these have not been conducted for some time. Therefore, HIW were not assured that management were effectively auditing the practice and its clinical practices. These were dealt with under HIW's Immediate Assurance process.

Whilst reviewing staff records we noted that all staff had an appropriate Disclosure Barring Service (DBS) check. We were informed that all new starters were required to undertake an enhanced DBS before taking up post.

Continuous professional development (CPD) was supported for all staff and the practice manager appeared keen to support the progression of the workforce. Administrative staff were also offered support to develop and enhance their skillset. There was an induction process in place for new starters, however this did not include locums working at the practice.

We asked a series of questions of staff about their professional development, all bar one respondent felt they had appropriate training to undertake their role. However, staff commented that more in-depth computer training would be useful. Only half of the 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 respondent said that in general, their job was not detrimental to their health. All felt that the practice took positive action on health and wellbeing and the felt their work pattern allowed for a good work-life balance. All were aware of the occupational health and wellbeing support available to them.

Culture

People engagement, feedback and learning
There appeared to be appropriate processes in place for reporting and responding to concerns. However, there was no policy or procedure in place. The Putting Things Right (PTR) processes in the NHS was not mentioned or displayed at the practice.

The practice must create and implement a complaints policy and display Putting Things Right information for patients in the waiting rooms. Copies also need to be available for patients on request.

The practice complaints were reviewed, these contained copies of complaints and responses. We saw that complaints were dealt with in a timely manner.

We saw suggestions boxes in the reception area and in the staff room. Suggestions would be discussed in meetings and would be put into action where appropriate. However, we were told that whilst feedback was encouraged, there was no process to inform patients of the results of this feedback.

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

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 and this was available to all staff.

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

- I know and understand the duty of candour – 100%
- I understand my role in meeting the duty of candour standards – 100%
- My organisation encouraged us to raise concerns when something had gone wrong and to share this with the patient – 100%

When answering on the topic of incidents and concerns, all respondents stated that the organisation encouraged them to report errors, near misses or incidents and that staff involved were treated fairly. All stated that their organisation took action to ensure that errors, near misses or incidents did not reoccur. All bar one agreed 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 a GP partner was the dedicated Data Protection Officer for the practice.

Information was available to patients through the practice website, this included the practice activity data.

All staff answering the HIW questionnaire agreed that they could access ICT systems they needed, to provide good care and support for patients.

Learning, improvement and research

Quality improvement activities
From discussions with staff, improvements that were identified from audit activity were not formally discussed and shared with staff.

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

Whole system approach

Partnership working and development
Staff informed us that some multi-disciplinary meetings took place. This ensured effective interaction and engagement with healthcare partners. We were told that the practice engaged well with the GP cluster to build a shared understanding of challenges within the system and the needs of the population. However, staff felt that the outcomes of such meetings were not shared.

The practice must devise a process for shared learning amongst staff.

We were also informed of good arrangements between the practice and secondary care, and third sector organisations.

4. Next steps

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

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

The improvement plans should:

- Clearly state how the findings identified will be addressed
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

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

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

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

Appendix A – Summary of concerns resolved during the inspection

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

Immediate concerns Identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved

Appendix B – Immediate improvement plan

Service: SA1 Medical Practice

Date of inspection: 29 June 2023

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

Risk/finding/issue	Improvement needed	Service action	Responsible officer	Timescale
HIW were not assured that the practice had in place a suitably robust system to ensure that all equipment required in the event of an emergency was available.	• Ensure paediatric defibrillator pads are available in the event of an emergency or carry out and document a risk assessment as to whether these are required	These have now been ordered and received by the surgery and put with defib machine in emergency cupboard in nurses room.	Jayne Rees	Done
During the inspection HIW found that there were no paediatric defibrillator pads in the emergency equipment and whilst logs were in place to check the expiration of emergency medication, no checks were being undertaken on the availability of	• Ensure there are sufficient processes in place to check equipment levels and expiration dates of this equipment. • Implement a practice specific a resuscitation procedure.	We have updated our emergency checking system to include our emergency equipment. We have now implemented a practice specific resuscitation procedure using the resuscitation council	Jayne Rees Dr E Howells	July 2023 July 202323

equipment. Furthermore, the practice did not have a resuscitation policy or procedure.		guidelines		
HIW were not assured that appropriately robust procedures were in place to ensure that infection prevention and control (IPC) was always maintained at the medical practice. During our observations of the practice, we found some treatment rooms were cluttered which would prevent adequate cleaning. In one clinical treatment room the frame of the bed was visibly not clean, the floor under the treatment bed and above the privacy curtain rail were also dusty and not clean.	• Provide the lead IPC nurse with an appropriate training programme • Ensure all staff receive the appropriate in date training for IPC dependant on their role • Undertaken annual IPC audits • Undertake regular hand hygiene audits • Ensure the cleaning schedule is amended to include bed frames, curtain rails and all other relevant areas	Nurse has done eLearning on IPC level 2 completed. All other staff will be completing this to the appropriate level for their position. These will be undertaken by Jayne Rees & Mandy Clarke As above We have contacted and heard back from the cleaning company via email to update their cleaning schedule which did include bed frames and curtain rails. This is being sent out to all cleaning staff, to ensure compliance.	Jayne Rees Anne Simons	4 July 2023 July 2023

Several leather chairs in the reception area were excessively worn and this would not allow for adequate cleaning and would therefore pose an unnecessary IPC risk to patients. IPC audits had not been completed including hand hygiene audits. There was no evidence of appropriate training for the IPC lead and the other staff at the practice.	• Declutter all treatment rooms to allow for adequate cleaning • Repair or replace the damaged chairs in the reception area.	De cluttering was done on 29.6.23 but after you had visited the room Mace Upholstery is attending w/c 10.7.23 to remove and recover all necessary chairs	Joanne Lewis Anne Simons	29 June 2023 July 2023
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	• Develop, implement and maintain a mandatory training schedule to ensure staff are up-to-date with the requirements • Maintain a training matrix to identify what staff had completed what mandatory training and whether they were up to date with this	We have implemented a training matrix for all staff for mandatory training using excel spreadsheet and Blue Stream Academy. This will be monitored frequently to ensure compliance with all training and kept up to date.	Anne Simons	4 July 2023

issues that require immediate improvement to ensure the practice operates safely and effectively: • Lack of mandatory training in fire safety, manual handling, health and safety, IPC, and data protection • Managers were unable to confirm what staff had completed what training, without going through individual staff files. Furthermore, when asked to produce copies of any recent audits at the practice, for example annual healthcare waste audit, audit of concerns or serious incidents, and hand hygiene audit, we were advised these have not been conducted for some time. Therefore, HIW	training • Develop and implement a full audit schedule for the practice.	Audits are being developed for annual healthcare waste audit, hand hygiene audit, room restocking, and infection control audits, and spreadsheet developed to ensure always up to date.	Anne Simons/ Jayne Rees	July 23

were not assured that management were effectively auditing the practice and its clinical practices.				

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.

SA1 Medical Practice Representative:

Name (print): **Anne Simons**

Job role: **Practice Manager**

Date: **06 July 2023**

Appendix C - Improvement plan

Service: SA1 Medical Practice

Date of inspection: 29 June 2023

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

Risk/finding/issue	Improvement needed	Service action	Responsible officer	Timescale
Some comments were made by patients relating to access to appointments and the inability to book appointments online.	We recommend that the practice considers the comments and responses received from patients to improve patient access to appointments to ensure patients can access appointments in a timely manner.	Online booking is being discussed. Also, with the new app (once live) patients will be able to book online	Anne Simons	Six months
The reception area and booking desk was shared with another GP practice which meant that confidentiality could not be maintained.	The practice must ensure that measures are taken, so far as reasonably practicable, to preserve the privacy and confidentiality of patients.	This will have to be discussed with other practice and Landlord to examine what changes we can make	Anne Simons	12 months
During the inspection we were shown that a new telephony	The practice must update their access policy to reflect the recent	Policy has been updated	Anne Simons	Yearly

system was in place at the practice to assist with demand.	changes.			
We noted that the practice manager was in the process of creating a comprehensive list of presenting complaints and who would deal with those, to ensure reception staff were able to triage patients and navigate care appropriately.	The practice must ensure that the written process is implemented as soon as possible to ensure receptionists have a clear pathway of care navigation.	This will continue to be updated over the next few months	Anne Simons	As required
There were no practice Control of Substances Hazardous to Health (COSHH) records and the practice did not have access to the full COSHH documents. This related to all cleaning substances used on the premises for health and safety purposes.	The practice is to ensure that there are copies of the COSHH records available to staff at the premises.	There are paper copies of these reports in the cleaners cupboard. We now have access to their portal with all new information added to that.	Anne Simons	Reviewed as and when new information is added and notified by cleaning company
We observed unlabelled urine specimens on the desk at reception. We were told that a nurse would be called to collect this and would be told the	The practice is to ensure that where urine specimens have to be left at the reception desk, they should be clearly marked with the patient's name and date of birth.	This has been addressed and no urine is to be left in reception unlabelled	Anne Simons	Reviewed regularly

patient's name, verbally, by a member of reception. If they received two specimens then they would add names to the specimens. This could lead to the wrong name being given to the nurse.				
Staff we spoke to limited knowledge of Gillick Competency and the Fraser Guidelines, legal judgements that set out the 'rules' around when a child was deemed to be competent to make their own decisions.	The practice needs to ensure that staff, particularly those staff involved with children under 18 years of age are fully aware of Gillick Competency and the Fraser Guidelines.	Information is given to all relevant staff as appropriate	Eleri Howells	3 months
From an examination of patient records, it became clear that there were no Read codes for when patients were issued with a patient information leaflet for their condition and/or diagnosis.	We recommend the practice add Read codes to clinical records when a patient information leaflet is issued.	This will be discussed with all clinical staff and implemented	Eleri Howells	3 months
We found that whilst a process was being followed to ensure	The practice must ensure a policy and protocol is put in place to	This will be discussed with all clinical staff and implemented	Eleri Howells	3 months

clinical staff were aware of new diagnosis or changes to a patients' condition, there was no formal policy or protocol.	ensure that all staff are fully informed of the correct process of where and when to send information on medical changes for a patient. This must include correct use of Read codes.			
Some staff members at the practice were Welsh speaking, however none wore 'Iaith Gwaith' badges to inform patients of this.	The practice is required to provide all Welsh speaking staff with 'Iaith Gwaith' badges and ensure patients are offered the 'Active Offer'.	Staff are now wearing lanyards and badges	Anne Simons	12 months – as new staff are employed
Over half of the staff members who responded to our questionnaire were unaware that the practice kept a register of their patients who were carers and also did not know that carers should be offered an assessment of their needs.	The practice must ensure that staff are aware of their roles and responsibilities for providing assessment of need for carers, and to ensure they are providing support, advice, and guidance as necessary.	Care register in place, staff have been reminded of this and will be discussed in next meeting. Leaflets have been requested from Carers Centre in Swansea to be displayed in reception.	Anne Simons	3 months
We viewed certificates showing most staff had undertaken training in safeguarding to levels appropriate to their	The practice must ensure staff complete the level of safeguarding training relevant to their role.	Training matrix is now in place and any outstanding training is being completed	Anne Simons	On going

positions. However, some had not.				
Record keeping was found to be good standard throughout our assessment. However, we found there was inconsistent use of Read codes with no evidence of local subsets, only sporadic linking to allow problem orientated consultation. It was not always easy to read back on patient records.	The practice needs to introduce more clinical Read coding to describe the care and treatment given to patients, such as the signs, symptoms, treatments, investigations, occupations, diagnoses and drugs and appliances.	Will be discussed with all clinical staff	Eleri Howells	6 months
We found that whilst team meetings took place between the relevant team leads and their staff, there were no whole practice meetings taking place.	The practice must develop a formal process for team meetings. These should be formally recorded and minutes disseminated to all staff to allow for whole team discussion and information sharing.	Meetings are now being formally monitored and carried out regularly	Anne Simons	On going
There appeared to be appropriate processes in place for reporting and responding to concerns. However, there was no policy or procedure in place. Putting Things Right (PTR)	The practice must create and implement a complaints policy and display Putting Things Right information for patients in the waiting rooms. Copies also need to be available for patients on request.	Policy in place and posters on order for reception	Anne Simons	6 months

processes for NHS patients was not mentioned or displayed at the practice.				
We found that whilst the practice engaged well with the GP cluster to build a shared understanding of challenges within the system and the needs of the population. However, staff felt that the outcomes of such meetings were not shared.	The practice must devise a process for shared learning amongst staff.	Any relevant staff that need to know details from Cluster meeting will be informed via email after every meeting	Eleri Howells	3 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): **Anne Simons**

Job role: **Practice Manager**

Date: **21st September 2023**