Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary

Haygarth Medical Centres

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Findings Record

Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Haygarth Medical Centres as part of its programme of assurance work. The Hay and Talgarth Group practice provides medical care to the towns of Hay-On-Wye and Talgarth, with their surrounding villages and hamlets covering an area of approximately 450 square miles of sparsely populated countryside. The practice was a General Practitioner (GP) / medical student training practice working from two purpose-built medical centres (Hay and Talgarth). Both were designed to accommodate the needs of the practice population and had fully equipped treatment rooms.

HIW's quality checks form part of a new tiered approach to assurance and are one of a number of ways in which it examines how healthcare services are meeting the Health and Care Standards 2015 (and other relevant regulations). Feedback is made available to service representatives at the end of the quality check, in a way which supports learning, development and improvement at both operational and strategic levels.

Quality Checks are a snapshot of the standards of care within healthcare settings. They are conducted entirely offsite and focus on three key areas; infection prevention and control, governance (specifically around staffing) and the environment of care. The work explores arrangements put in place to protect staff and patients from COVID 19, enabling us provide fast and supportive improvement advice on the safe operation of services during the pandemic. More information on our approach to inspections can be found here.

We spoke to the Practice Manager and one the practice partners on 1 December 2020 who provided us with information and evidence about their setting. We used the following key lines of enquiry:

- How has the practice and the services it provides, adapted during this period of COVID-19? What is the practice road map for returning to pre-COVID-19 levels of services?
- How effectively are you able to access wider primary care professionals and other services such as mental health teams, secondary care and out of hours currently?
- What changes have you implemented in light of COVID-19 to ensure infection prevention and control standards are maintained?
- How are you ensuring that patients (including vulnerable/at risk groups) are able to access services appropriately and safely?

Environment

During the quality check, we considered how the service has responded to the challenges presented by COVID-19. We questioned the practice on how they are making sure all patients have safe and appropriate access to services.

The following positive evidence was received:

The practice manager stated that a number of changes had been made to the environment. These included communications with staff and patients, as the practice believed this was important. This was done through a number of channels including social media. We were told that there was signage outside and inside the practice with permanent floor markers, to promote social distancing. The Medical Centres had been open throughout the pandemic lockdowns and that they found ways to ensure that their patients that need to be seen were seen whilst maintaining a safe working environment. The practice had adhered to the government guidelines in respect of COVID 19 and regularly sought advice to ensure that both patients and staff were safe.

The building was locked from the inside, and patients had to buzz to come in, on a pre-arranged appointment basis. There was alcohol hand gel available for both patients and staff. Screens had been installed to protect staff working in reception and consulting rooms.

Chairs had been removed from the reception area where possible and benches had restricted seating signage, all chairs and benches had vinyl surfaces that could be wiped clean. There were staggered breaks for staff to reduce contact and there were clinical and non-clinical rest rooms. Patients could only attend one of the practice sites to prevent cross infection. If the GP needed to examine patients, in addition to personal protective equipment (PPE), there were portable screens which could be used. Staff only attend one practice site during the day to prevent cross infection when possible

We were also told about the COVID-19 icon[1] on the personal computers of all staff. This kept them up to date with Welsh Government information, cases of COVID-19 and also included downloads to send to patients. This initiative was supplied by the NHS Wales Informatics Service (NWIS).

The changes to appointments and examinations were described. These included online consultations, face to face appointments and telephone consultations. The practice manager believed that the use of online and telephone consultations were embraced by patients. Where patients could not access or use these systems, patients were also allocated an appointment in the practice.

[1] In computing, an icon is a pictogram or ideogram displayed on a computer screen in order to help the user navigate a computer system.

The introduction of nurse triage, to facilitate on the day appointment requests, was described. This developed further with the cluster pilot of Total Nurse Triage[2] for urgent and routine appointments. Total Nurse Triage enabled the practice to increase appointment times from 10 to 15 minutes. The pilot had been very successful and had proved extremely beneficial during the pandemic. We were told that despite the funding for this having stopped, the practice made the decision to continue with Total Nurse Triage and fund this service within the practice.

There was also one practice nurse working on triage remotely, due to shielding. We were told that where triage was used by staff at the practice this would be within the agreed protocols. GPs also mentored staff involved in triage. The practice nurses had all attended a local ailment course at the local university and new practice nurses attend this course within the first year of employment with the practice.

We were also told of other initiatives such as staff being able to work remotely, with everything still recorded as required. All staff working at home completed the relevant health and safety assessments for the use of visual display units.

To reduce cross contamination, each member of staff worked on a nominated work station at the practice. The practice was also a dispensing practice and deliveries continued to pre-agreed drop off points, with appropriate PPE for the delivery staff. The practice manager stated that there were daily morning briefs with the practice staff. There were individual team meetings also scheduled within the practice. Additionally, the practice manager met weekly with other managers and a representative from the local health board also attended. Rotas were produced to reduce the number of staff working at any one time thus reducing footfall within the practice. Communal rooms had a capacity notice to ensure adherence to social distancing requirements.

We saw evidence of the environmental risk assessments completed for both sites. These appeared to be comprehensive and included identification of hazards, current controls, what further action was necessary and by whom.

We were told that some clinics were maintained, such as childhood immunisations and flu clinics. Patients who required a B12 injections[3], were reviewed and as appropriate changed to a tablet medication. The practice has returned to administering B12 injections to those who need this. These were continued with a patient flow system introduced to minimise footfall and contact within the practice. Patients would arrive and wait in the car park to limit time spent in the practice. Initially the practice stopped the cervical screening clinics, but these restarted as cleaning procedures were put in place and with portable screens. More time was allocated between patients. Additionally chronic disease clinics were stopped initially, but we were told that the interactive website now allowed patients to download

[2] https://www.redkiteltd.co.uk/totalnursetriage.html

[3] The treatment for vitamin B12 or folate deficiency anaemia depends on what's causing the condition. Most people can be easily treated with injections or tablets to replace the missing vitamins. Vitamin B12 deficiency anaemia is usually treated with injections of vitamin B12.

information for these clinics.

For patients who were unable to use telephones, they could still visit the practice but they would be screened prior to entering the practice. Some clinics were also arranged to coincide with busy days in the local town, such as market day for the flu clinic.

The medical information system used at the practice would alert staff of any patients who were at risk or extremely vulnerable, if they contacted the practice, we were told. Where required, home visits would be made, if this was the most clinically effective method. Home visits were risk assessed as to whether to visit or not. If a home visit was required, we were told that there was specific PPE allocated. In addition to the visit being risk assessed, the relevant member of staff had also been risk assessed. We also saw evidence of the form used to risk assess staff as to their risk and where they should work within the practice. In order to reduce the risk to staff, telephones were moved into other offices and rooms to enable staff who had a higher risk score to be able to segregate.

Care home visits and appointments continued, we were told, online initially, but the relevant staff would also visit if appropriate, dependant on a risk assessment. A Primary Care Specialist Nurse supported by a GP and Pharmacist covers the care homes within the practice.

No improvements were identified.

Infection prevention and control (IPC)

During this process, we reviewed infection control policies, cleaning schedules and staff training. We also questioned the setting about how the changes they had introduced to make sure appropriate infection control standards were maintained. We reviewed key systems including the use of PPE.

The following positive evidence was received:

The practice manager was in charge of ensuring that there was sufficient stock of PPE at the onset of the pandemic. An element of stock was supplied through the health board. Stock control was in place in respect of PPE. Whilst initially the supply of a specific type of antibacterial wipes had to be sourced elsewhere, there was no shortage of PPE noted.

We were told that the practice created videos to assist staff in the donning and doffing of PPE, which were available on the local computer drive. One of the GPs was allocated to check individuals when donning and doffing PPE, this reinforced staff confidence.

There were a number of posters displayed around the building, including those relating to hand washing, social distancing and donning and doffing PPE. Staff were encouraged not to leave the building during the working day to reduce the spread of any potential infection. There was also a shower for the staff to use should they wish.

The changes made to the cleaning routine were described, which included a deep clean every night. Additionally the screens introduced were cleaned during the day and at night. If there was any evidence of a patient attending with COVID-19 the building was closed and deep cleaned.

There were disposable curtains in the consulting rooms that were monitored regularly with a maximum of a six monthly replacement schedule in place. The changes made to the cleaning routine were described, which included a deep clean in every room, every night in the rooms where patients had been present. If there was any evidence of a suspected COVID-19 patient, the curtains were replaced. We saw evidence of the comprehensive cleaning schedules for both sites.

We also viewed the standard operating procedure for cleaning between patients, which aimed to ensure a high level of infection control was maintained in patient contact areas, for the safety of staff and patients during COVID-19.

We were told that clinicians who were required to carry out a home visit, after being risk assessed, were supplied with specific packs which included wipes, gel and masks. An oximeter, to take oxygen levels, together with waste bags in which to dispose of the contaminated waste were also included. Similar packs were also allocated to every consulting room together with an information sheet advising the patient as to what was happening. These packs were allocated to every consulting room

In order to reduce the possibility of patients visiting the surgery with suspected infectious illnesses, we were told that initially patients were triaged by phone. Then patients, where there was any doubt as to their infection status, were told to come into the surgery car park and a GP would don PPE and consult with them in the car, as necessary. Where there was still a doubt and the patient needed treatment, they would come into the treatment room directly from the outside, without going through the surgery. The PPE used was then double bagged for secure disposal and the room was deep cleaned.

We saw evidence of the Infection Control Inspection Checklist Audit carried out in November 2020 and the actions taken as a result of this internal check. There were a number of infection control documents used at the GP surgery, which were all in date, including the Infection Control Protocol and Infection Prevention Policy. This document set out the practice policy on infection control.

No improvements were identified.

Governance

As part of this standard, HIW reviewed policies and procedures for future pandemic emergencies. We also questioned the setting about how they have adapted their service in

light of the COVID-19 pandemic, how they are interfacing with wider primary care professionals and their risk management processes.

The following positive evidence was received:

We saw evidence of the adaptations that the practice made initially, in the form of an email at the beginning of the pandemic. This included stating that all routine appointments would be by telephone or video consultation. There was one triage list for both emergency and routine appointments, and routine bookable appointments were stopped. Regular communication continued throughout the pandemic advising staff of changes and developments and continue to do so regularly. Staff meetings were held virtually as a form of reassurance to staff.

The arrangements for clinics were made known, including contraceptive injections continuing and birth control pill prescribing was discussed over the telephone. Photographs when required for consultation were accepted through a secure online system. Information would be scanned and coded into the information system at the practice, even whilst remote working.

We were told that whilst chronic disease clinics were initially postponed, if needed the surgery would go through a triage process with the patient. If patients had a blood pressure machine, they were encouraged to post the information securely through the practice website. Also joint injections were postponed due to the risks involved. All services had now recommenced.

We saw evidence that the practice had engaged with an employee assistance programme, that assisted staff with personal problems or work-related problems that may impact their job performance, health, mental and emotional well-being. Staff were given flexibility in their work patters and all staff working that day had access to a virtual team meeting where the day was discussed and this assisted with communications.

Weekly partners meetings with the partners and management team. The daily team briefs in the morning also supported all our staff and keeps the staff fully informed and increases morale.

We were told that there was communication between the health board and the practice, this meant that the practice felt able to go to the health board if there were any issues that required health board involvement or assistance. The Powys practice managers held a monthly meeting, with a member of the health board in attendance.

The practice was part of the South Powys cluster[4] of four GP practices who formed a

[4] A cluster is a grouping of GPs working with other health and care professionals to plan and provide services locally. Clusters are determined by individual NHS Wales Local Health Boards (LHB's). GPs in the cluster play a key role in supporting the ongoing work of a Locality Network.

Community Interest Company[5] (CIC) called Red Kite Health Solutions in 2015, to deliver health and wellbeing services. They met regularly to look at services that could be facilitated for the benefit of their patients. We were told of the pandemic cluster initiative that looked at referral patterns, compared with the same period last year to ensure that the levels of activity were maintained, particularly in relation to cancer referrals. The four practices had a sharing agreement enabling the GPs and triage nurses to provide support if required.

We were told of the CIC application for National Lottery Funding to deliver a COVID 19 impact Service has been successful. This service would directly assist patients who had shielded or who are vulnerable through a telephone support during the next 12 months. The service would also increase and promote crucial health checks, in addition to signposting patients to available community support services when required. Additionally, this service would also target non-responder patients who were overdue cancer screening and other chronic health condition reviews.

Whilst we were told that opening times stayed the same during the majority of the pandemic, from October 2020, the reception area was closed on one site in the afternoons. The dispensary remained open and prescriptions were available throughout the afternoon, every day on both sites, patients could also still telephone the practice. Consultations would continue to take place but the reception was closed to enable the receptionist to complete other work. We were told that these changes were communicated through a number of channels including social media, the practice website, the practice newsletter, posters in the community and also via a local free magazine. Additionally, information in the form of a mini newsletter was also attached to all prescriptions. The GPs met with local councillors and there was also a newsletter on the practice website. The practice also met with the local Community Health Council[6] (CHC). We were told that if this happened outside the pandemic, there would also have been a public forum meeting.

We were provided with evidence of the current training data for all nursing staff in infection control, which showed that they were trained and in date at least to level 1.We were told that information relating to COVID-19 was accurately recorded and reported on a timely basis. All results were dealt with on the day received and reviewed twice daily and cascaded as necessary for clinician review. The practice manager checked the coding and scanning on a regular basis.

The access to the wider GP cluster was described, as was the out of hours (OOH) service called SHROPDOC[7]. This service was described as “excellent” by the practice manager. Initially when the pandemic started, this service supported patients with a management service online to

[5] A community interest company is a type of company introduced by the United Kingdom government in 2005 under the Companies Act 2004, designed for social enterprises that want to use their profits and assets for the public good.
[6] Community Health Councils (CHC) are the independent voice of people in Wales who use NHS services. They are made up of local volunteers who act as the eyes and ears of patients and the public.
[7] Shropdoc is a not-for-profit company established in 1996. We provide urgent medical services for patients when their GP surgery is closed and whose needs cannot safely wait until the surgery is next open. We work closely with NHS 111 to ensure urgent health needs are met as quickly as possible.

reduce the pressure on GPs. Arrangement and communication with out of hours services had continued, with any reports being downloaded onto the practice notes as were any visits or telephone calls for the attention of the duty doctor.

The systems of working with other agencies were described, such as the pharmacy and allied health professionals. The practice also worked with the Powys Association of Voluntary Organisations (PAVO)[8]. The optician near the surgeries would take referrals and perform a full assessment on eye problems including a Primary Eye-Care Assessment and Referral Service[9].

We were told that one hospital used by the practice had suspended routine operations, but they are now reverting to normal service. Also mental health services used to be based in the practice before the pandemic, and the practice would rather they were available in the practice to discuss any issues. We were told that there had not been any changes to patient discharge arrangements from secondary care.

No improvements were identified.

What next?

Where we have identified improvements during our check, which require the service to take action, these are detailed in the improvement plan below.

Where an improvement plan is required, it 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 Quality Check.

As a result of the findings from this quality check, 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.

[8] http://www.pavo.org.uk/

[9] The Primary Eyecare Acute Referral Scheme (PEARS) and the Welsh Eye Health Examination (WEHE) schemes are part of an all-encompassing Welsh Eye Care Initiative (WECI). The PEARS and WEHE schemes are intended, respectively, to facilitate the early assessment of acute ocular conditions and to case-find ocular disease in at-risk individuals.

Improvement plan

Setting: Haygarth Medical Centres

Date of activity: 1 December 2020

The table below includes improvements identified during the Tier 1 Quality Check, where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Please note, all actions are expected to be complete within three months of the Quality Check and the final version of the Improvement Plan is to be submitted via Objective Connect once complete.

Reference Number	Improvement needed	Standard/ Regulation	Service Action	Responsible Officer	Timescale
1	No improvements identified				