Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary
Princess Street Surgery
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Quality Check Summary

Our approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Princess Street Surgery, Gorseinion as part of its programme of assurance work. Princess Street Surgery forms part of GP services provided within the areas served by Swansea Bay University Health Board.

HIW's quality checks form part of a new tailored 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 services. 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 assurance and inspections can be found here.

We spoke to the Senior GP Partner and the Practice Manager on 16 June 2021, who provided us with information and evidence about their service. We used the following key lines of enquiry:

1. 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?

2. How effectively is the service able to access wider primary care professionals and other services such as mental health teams, secondary care and out of hours currently?

3. What changes have been made in light of COVID-19 to ensure infection prevention and control standards are maintained?

4. How is the service ensuring that patients (including vulnerable/at risk groups) are able to access services appropriately and safely in terms of the practice environment and accessing appointments.

Environment

During the quality check, we considered how the service has responded to the challenges presented by COVID-19 and how the service has designed and managed the environment of care to keep it as safe as possible for patients, staff and visitors.

The key documents we reviewed included:

- recent risk assessments;
- risk assessment policy;
- waste audit.

We also questioned the service representatives on the changes they have made to make sure patients continue to receive care and treatment according to their needs.

The following positive evidence was received:

We were told that, at the beginning of the COVID-19 pandemic, the practice remained closed to members of the public. The practice arranged for patients to receive consultations over the phone. All calls were handled by reception staff and triaged by a GP. Any patients who needed to see a clinician face to face, attended the practice by pre-booked appointment and were asked to wait in their car until they would be called.

In order to reduce the footfall to and inside the practice, we were told that the practice made use of an open window at the side of the building for staff to speak with and assist patients. Furthermore, the practice also erected two pop-up tents which were located in the car park. The use of the tents enabled the clinical team to see patients face to face without the need for them to enter the premises.

We found that some risk assessments have been conducted and policies and procedures have been updated to reflect the additional demands stemming from the COVID-19 pandemic.

We saw that the practice had recently reviewed the risk assessment which included assessments of the environment, lone working, fire, and the health, safety and well-being of staff and visitors to the practice.

We were told that the practice provides services to patients residing in care homes and visits have continued throughout the pandemic. We were told that GPs will follow the care home's procedures when entering the premises.

The Practice Manager told us that they monitor the environment on a daily basis. The Senior GP Partner and the Practice Manager both spoke very highly of the staff in how they have

responded to the needs of the practice, the patients and in supporting each other during the COVID-19 pandemic.

The following areas for improvement were identified:

We were told that home visits have continued throughout the pandemic. Each case is individually assessed and it was confirmed that ample personal protective equipment (PPE) is available. However, there is no written procedure or risk assessment in place.

The Practice Manager should ensure that a procedure for home visits is developed along with formal risk assessment.

During the quality check, we asked the Practice Manager if all staff have received a detailed COVID-19 risk assessment[1] to assess the personal risks of continuing to carry out their role during the COVID-19 pandemic. The Practice Manager confirmed that staff have not received a formal written risk assessment.

The Practice Manager should ensure that all staff receive a detailed COVID-19 risk assessment, which should be retained on staff files to evidence that these have been completed and reviewed as necessary.

Infection prevention and control

During the quality check, we considered how the service has responded to the challenges presented by COVID-19, and how well it manages and controls the risk of infection to help keep patients, visitors and staff safe.

The key documents we reviewed included:

- generic infection control and COVID-19 specific policies;
- handwashing and hand hygiene protocol;
- hand hygiene for staff leaflet;
- staff hand hygiene policy;
- employee handout: staff hand hygiene;
- PPE infection control protocol;

[1] 'This Risk Assessment Tool has been developed to help people working in the NHS and Social Care in Wales to see if they are at higher risk of developing more serious symptoms if they come into contact with the COVID-19 virus.

- PPE training;
- monthly infection control checklist audits;
- cleaning schedules / audits.

The following positive evidence was received:

We saw that a policy is in place for the prevention and control of infection and a specific COVID-19 policy. We were informed that the team received regular updates by email to ensure all staff were kept up to date with any changes in guidance or practice.

We were told that regular audits are undertaken to assess and manage the risk of infection. We saw evidence that an infection control audit had recently been completed with no actions or improvements identified.

The Practice Manager also confirmed that cleaning schedules have been increased and the use of personal protective equipment (PPE) has been optimised, with adequate stocks sourced and monitored on a regular basis.

We were told that one the practice nurses provided staff with training on infection control and the correct use of PPE, including donning, doffing and safe disposal of used equipment.

We were also told that the practice had a dedicated room, separate from the main patient area, to isolate patients if required, and a one way system was in place.

No areas for improvements were identified.

Governance / Staffing

As part of this standard, HIW questioned the service representatives about how, in the light of the impact of COVID-19, they have adapted their service. We explored how the service is working with other primary care teams (or services) and managing risks associated with Covid-19.

The key documents we reviewed included:

- business continuity plan;
- training requirements.

The following positive evidence was received:

We were told that staffing levels had been well managed during the pandemic and the Practice Manager confirmed that there are no vacancies. One of the GPs is currently on maternity leave and her sessions have been covered by two locum doctors.

We were told that regular cluster[2] meetings, which consists of four local practices, have continued during the pandemic. These meetings are conducted virtually using Microsoft Teams and are attended by one of the GPs and the Practice Manager.

We were told that the practice has had no issues accessing out of hours services during the pandemic. However, some concerns were raised with regards to accessing some secondary care services, such as metal health, with no linked consultant in place during the pandemic. Our concerns regarding this have been taken up directly with the health board.

The following areas for improvement were identified:

The Practice Manager confirmed that formal team meetings had been paused throughout the pandemic. Any further updates and changes to policies and procedures were e-mailed to staff.

The Practice Manager should ensure that formal team meetings are reinstated.

We saw evidence that the practice had reviewed and updated some key policies in light of the COVID-19 pandemic. We saw that the practice had updated their business continuity plan, pandemic management and infection prevention control policy. However, we found that the policies were not version controlled and did not contain a review date.

The Practice Manager should ensure that all policies and procedures contain a review date and are version controlled. The Practice Manager should also ensure they have a system in place to demonstrate that all staff have read and understood the policies and procedures.

The Senior GP told us that no formal Significant Event Analysis (SEA) meetings have been held during the pandemic. SEA meetings encourage the whole team involved in the case or the incident to have a supportive discussion with the aim to use the process to allow reflection and learning from those events to improve patient care. The senior GP agreed to reinstate these meeting immediately.

The Practice Manager should ensure that formal SEA meetings are now reinstated with immediate effect.

We were also informed by the Practice Manager that they are awaiting approval from the cluster group for e-learning to be provided through an approved training provider. The Practice Manager confirmed that any mandatory training for staff, which is due to be renewed, will be

[2] 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 **Clusters** play a key role in supporting the ongoing work of a Locality Network.

arranged promptly.

The Practice Manager must provide HIW with a copy of the updated mandatory training plan and, within three months of this quality check, provide HIW with a further update in relation to mandatory training completion rates.

What next?

Where we have identified areas for improvements during our quality check and require the service to tell us about the actions taken to address these, an improvement plan providing details will be provided at the end of this quality check summary.

Where an improvement plan is required, it should:

- 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 areas for improvements 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 the areas for improvements 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.

If no areas for improvement were identified during this quality check, an improvement plan will not be required, and only the quality check summary report will be published on HIW's website.

Improvement plan

Setting: Princess Street Surgery

Date of activity: 16 June 2021

The table below includes improvements identified during the 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	The Practice Manager should ensure that a procedure for home visits is developed along with formal risk assessment.	Safe and Clinically Effective Care	Risk assessment completed and circulated to GPs, paramedic and nurse to enable them to complete it on house visits	Michael Rimmer	Immediately
2	The Practice Manager should ensure that all staff receive a detailed COVID-19 risk assessment, which should be retained on staff files to evidence that these have been completed and reviewed as necessary.	Health Protection, Protection and Improvement	COVID 19 Risk Assessment has been completed and circulated to all staff via their email and requesting confirmation that the actions have been completed	Michael Rimmer	Immediately

3	The Practice Manager should ensure that formal team meetings are reinstated.	Governance	Weekly meetings with senior staff will be held on a weekly basis and relevant information will be circulated to all staff. Full staff meetings will commence when PLTS is reinstated.	Michael Rimmer	Immediately and approx. Sept
/4	The Practice Manager should ensure that all policies and procedures contain a review date and are version controlled. The Practice Manager should also ensure they have a system in place to demonstrate that all staff have read and understood the policies and procedures.	Governance	Protocols have been updated. The email system has a system which confirms that the staff have read their emails. I will monitor this regularly and contact those who have not read the information.		
5	The Practice Manager should ensure that formal SEA meetings are now reinstated with immediate effect.	Quality Improvement	This topic will be added to the partners monthly meeting agenda. SEAs were completed week commencing 12/7/2021	Michael Rimmer	Immediately
6	The Practice Manager must provide HIW with a copy of the updated mandatory training plan and, within three months of this quality check, provide HIW with a further update in relation to mandatory training completion rates.	Workforce	Attached is the training plan The weeks commencing 9/8,16/8,23/8 and 30/8/2021 have been greyed out due to staff annual leave. Staff are to advise me when they have completed the courses by giving me their certificate of completion which can be added to their staff file.	Michael Rimmer	Immediately

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.

Name: Michael Rimmer

Date: 26/07/2021