Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary
Pencoed Medical Centre
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Quality Check Summary

Our approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Pencoed Medical Centre as part of its programme of assurance work. This practice provides a range of primary care services over two sites, Pencoed in Bridgend is the main surgery and there is a branch surgery in Llanharan, Rhondda Cynon Taff. There are five general practitioner (GP) partners and the practice is an active training practice, with four GP registrars at various stages of their training journey.

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 NHS - 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. Quality checks allow us to explore how services are meeting the relevant standards in an agile way, enabling us to provide fast and supportive improvement advice on the safe operation of services. More information on our approach to assurance and inspections can be found here.

We spoke to the practice manager, who was joined by a GP partner during the call, on 14 September 2022, who provided us with information and evidence about their service. We used the following key lines of enquiry:

- How is the practice ensuring there are appropriate arrangements in place that uphold current standards of IPC in order to protect patients, staff and visitors using the service?
- How is the practice ensuring that patients (including vulnerable/at risk groups) are able to access services appropriately and safely?
- How is the practice meeting the needs of Welsh speaking patients when accessing healthcare services in the medium of Welsh?
- How is the practice ensuring it maintains the expected quality of patient care and service delivery?
- How is the practice ensuring that equality and a rights-based approach are embedded across the service?

- How effectively can the practice access wider primary care professionals and other services?

Environment

During the quality check, we considered 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:

- The most recent environmental risk assessments / audits
- legionella risk assessment
- fire safety risk assessment and fire safety check list.

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:

The practice manager stated that they had used specialist organisations to perform regular environmental risk assessments. We reviewed these documents complete with actions required to resolve any issues. We noted the fire risk assessment, dated May 21, did not have an update on actions taken. We have since received an updated action log, complete with dates and progress.

The practice manager described the extensive changes that were made to the practice environment at the start of the COVID-19 pandemic. These included restricting access to the practice, repurposing the waiting room and reception area into a nursing bay and laying wipe clean flooring. In addition, a gazebo outside the practice was assembled to allow for “drive through” appointments and minimising the time spent in the practice. Screens were used for the reception desk, hand gel stations were placed throughout the surgery and enhanced cleaning schedules were implemented. We were advised some of these changes had been risk assessed and scaled back in recent months, in line with the relaxation of COVID-19 guidelines and recommendations. We were provided with the risk assessment that was used when the waiting room area was re-opened and confirmed this was sufficiently completed.

We were told that patients were now able to use the waiting room and that the reception had re-opened to patients. The online check-in system was described whereby patients can check-in without contact with staff. All staff continue to wear masks and hand sanitising stations remain throughout the practice.

We were told of the systems in place to allow patients without digital access, including vulnerable patients and patients who did not understand English, to contact the practice. The GP partner described the links to a local nursing home, explaining they were telephoned

daily by the practice to check in on patients. A GP conducted virtual ward rounds with the nursing home on a fortnightly basis and every patient was reviewed by a GP at least once a month.

We were also told that risk assessments were carried out for home visits. A secure patient notes system was described whereby key information and potential risks were flagged to a GP prior to the visit to allow for any adjustments to be made. All staff had access to full personal protective equipment (PPE) for home visits.

We reviewed COVID-19 risk assessment documentation and were told of adjustments that had been made to the work environment to ensure that clinically vulnerable staff members and their families were protected during the height of the COVID-19 pandemic.

We were told that two practice GPs were fluent Welsh speakers and multiple staff members spoke Welsh. Patients were able to receive their healthcare through the medium of Welsh, should they wish. The practice telephone line was bilingual, in both English and Welsh.

No areas for improvements were identified

Infection prevention and control (IPC)

During the quality check, we considered how well the service manages and controls the risk of infection to help keep patients, visitors and staff safe.

The key documents we reviewed included:

- Generic infection control policies and COVID-19 specific policies
- Most recent infection control risk assessments / audits
- Cleaning schedules
- Training data for staff in infection prevention and control.

The following positive evidence was received:

The process used to ensure that there were sufficient supplies of PPE was described. We were told that the health board had supplied sufficient PPE and the practice had not experienced any difficulties in accessing stock. The practice manager described the stock control and re-order process for PPE.

We were told that that donning and doffing[1] guides were displayed throughout the practice for staff to refer to when using PPE. These described the process of donning and doffing safely to minimise the risk of infection. We were told that additional labelled bins were

[1] Donning – putting on personal protective equipment (PPE); Doffing – taking off personal protective equipment (PPE)

placed throughout the practice for used PPE and guidance was available for PPE used on home visits.

We saw the practice cleaning schedules and we were told of the additional cleaning of the practice during the highest COVID-19 restrictions. This included the clinical rooms being cleaned after each patient. We saw copies of the cleaning plans and processes carried out by the contracted cleaners.

We received a draft IPC policy. We noted this policy was not finalised, dated or signed. A final version of the IPC policy has now been submitted, dated September 2022 with a review date in place.

The following areas for improvement were identified:

We saw evidence of infection prevention and control training being completed for some administrative and some clinical staff members. The evidence received was limited to three staff members. We were informed that IPC training information was not routinely tracked, although a new system will be implemented imminently for the logging and tracking of mandatory training for all staff. The practice must ensure that a process is put in place to ensure staff training is kept up to date.

Governance / Staffing

As part of this standard, HIW questioned the service representatives about how they manage their services to support the delivery of high-quality healthcare. We explored how the service is working with other primary care teams (or services) and maintaining the quality of patient care.

The key documents we reviewed included:

- Business continuity plans
- Building hazards policy
- Health and safety policy
- The latest building maintenance documents – portable appliance test (PAT) certificates and fire servicing documentation
- Staff meeting minutes.

The following positive evidence was received:

During the quality check we were told of the changes that had been made to the appointments system during COVID-19 restrictions to ensure that patients continued to receive appropriate care. We were told that in person GP appointments were now available to book and that practice now offered patients a mixture of telephone and in-person appointments. The

practice manager confirmed that, whilst demand for in-person appointments remained high, there was a telephone triage system where patients were offered the most appropriate appointment in a timely manner.

The cluster[2] arrangements were described, the practice is part of the Bridgend East cluster. The cluster is made up of five practices in the surrounding area and recently also included a larger network of pharmacy, optometry, district nursing, health visiting and third sector organisations.

We were provided with evidence of team meetings, which were dated, minuted and included a list of attendees. The notes were themed and included solutions / actions where appropriate. We were told that these minutes were available to staff on the surgery systems.

The GP partner described the arrangements in place to ensure a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)[3] discussion and decision making was undertaken appropriately and sensitively. This included GPs having responsibility for the patient and family discussion. We were told that this discussion was documented in patient notes and shared with palliative care teams where appropriate. We were told that the practice used their links with Macmillan Cancer Support[4], to support their discussions in this area.

We were provided with a copy of the practice business continuity and recovery plan that was reviewed in July 2022. The purpose of this continuity plan was to provide both a response and framework under which the practice may be managed and continue to operate under exceptional and adverse circumstances.

A range of policy documents were reviewed including the buildings hazards policy and health and safety policy. These policies were comprehensive and dated.

We discussed with the GP how effectively the practice and patients were able to access wider primary care professionals and other services such as mental health teams, secondary care and out-of-hours. We were told that the practice was working at multiple levels with partners to ensure that services were accessible. Some challenges with capacity in some areas of secondary care were described. We were told that these challenges had been reported to health board leads.

The GP told us that adult patient access to mental health services was improving and patients were seen within a month. We were informed that the situation with child and adolescent mental health team referrals was more challenging and waiting lists were longer. The GP described the process of reporting incidents and concerns to the health board. All incidents

[2] A cluster is a grouping of GPs working with other health and care professionals to plan and provide services locally.

[3] https://www.nhs.uk/conditions/do-not-attempt-cardiopulmonary-resuscitation-dnacpr-decisions/

[4] Charity that provides specialist health care, information and financial support to people affected by cancer.

were reported via the Datix[5] Cymru reporting system.

No areas for improvements were identified.

What next?

Where we have identified areas for improvements and immediate concerns during our quality check and require the service to take action, these are detailed in the following ways within the appendices of this report:

- Appendix A: 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 B: Includes any other 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.

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.

[5] The Once for Wales Concerns Management System (Datix Cymru) provides a consistent Cloud based solution for incident reporting across NHS Wales

Appendix A – Immediate improvement plan

Setting: Pencoed Medical Centre

Date of activity: 14 September 2022

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

Immediate Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
No immediate Improvements required.				

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative:

Name (print):

Job role:

Date:

Appendix B: Improvement plan

Setting: Pencoed Medical Centre

Date of activity: 14 September 2022

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.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The practice must ensure that a process is put in place to ensure that the training of all staff, once the requirement is identified, is kept up to date.	Standard 2.4 Infection prevention and control Standard 7.1 Workforce	Workforce online training suite now in place for all staff, covering many mandatory and job-specific training, including infection control. Ongoing training will be monitored throughout the year, and specific infection control training will be completed within the required time frame.	Graeme Hunter, Business Manager	1 December 2022

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):	**Graeme Hunter**
Job role:	**Business Manager**
Date:	**11 October 2022**