Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary

Service name: Nant Dowlais Health Centre, Cwmbran

Activity date: 05 October 2022

Publication date: 23 November 2022

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Digital ISBN 978-1-80535-054-5

Quality Check Summary

Our approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Nant Dowlais Health Centre as part of its programme of assurance work. Nant Dowlais Health Centre provides GP services to patients across Cwmbran on behalf of Aneurin Bevan University Health Board. The service operates from two sites and employs a large multidisciplinary clinical team, with a mix of general practitioner (GP) and advanced nurse practitioner (ANP) partners.

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.

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 on 05 October 2022 who provided us with information and evidence about their service. We used the following key lines of enquiry:

- How do you ensure there are appropriate arrangements in place that uphold current standards of IPC in order to protect patients, staff and visitors using the service?
- How are you ensuring that patients (including vulnerable/at risk groups) are able to access services appropriately and safely? In your answer please refer to both the practice environment and processes to enable patients to access appointments.
- How do you meet the needs of Welsh speaking patients when accessing healthcare services in the medium of Welsh?
- How do you ensure the practice maintains the expected quality of patient care and service delivery?
- How do you ensure that equality and a rights based approach are embedded across the service?
- How effectively are you able to access wider primary care professionals and other services? This may include mental health teams, secondary care and GP Out of Hours?

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. 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 key documents we requested included:

- The most recent environmental risk assessments / audits
- Fire safety policies/procedures, including fire safety risk assessment.

The following positive evidence was received:

We were told about the service changes that took place during the pandemic. Neither site closed at any point to the general public, but physical access was limited in line with social distancing requirements. While some virtual consultations were trialled, we were told that the majority of consultations with patients took place over the telephone. Patients were invited to attend the sites following the telephone discussion if deemed necessary by the clinicians.

In recent months, the practice has returned to undertaking more face-to-face appointments as standard, with telephone consultations also available if required. We were told that urgent appointments can only be booked by telephone. This helps to ensure patients without digital access are not disadvantaged, which we noted as a positive initiative.

The practice manager described the triage process which was the same for both sites. Care navigators are employed as the first point of contact for patients. Their role is to either direct patients to the most appropriate service if necessary or to schedule a face-to-face appointment. We were assured by the practice manager that care navigators would not offer clinical advice. On call doctors review the daily patient lists and allocates the most appropriate clinician according to the needs of the patients. This process helps to ensure that patients are seen by the right person, at the right time and at the right place.

We were told about the arrangements in place to help Welsh speakers access care in their first language. The website and social media channels are bilingual, and the practice telephone line was also bilingual. Inside the surgeries, all health board information is provided in both English and Welsh. We were told that two GPs were Welsh speakers and were therefore able to help Welsh speakers discuss care in the medium of Welsh. However, we were told that there were currently no Welsh speaking care navigators. We noted that there was currently one care navigator vacancy, and the practice may wish to consider whether employing a Welsh speaker would be beneficial to the practice and to patients.

We were told that the practice provides services to patients residing in two local care homes. An ANP partner undertakes weekly reviews of the patients remotely. Any concerns are either dealt with by the ANP or escalated to a GP who would undertake a visit to the care home. Staff would follow the care home's infection prevention and control procedures when entering the premises.

The following areas for improvement were identified:

We reviewed copies of previous fire risk assessments undertaken in February 2021 at the Fairwater Square and the Greenmeadow Way sites. The action plans for both fire risk assessments included a number of urgent and high priority recommendations for areas that needed to be addressed in order to reduce, or maintain, the fire risk at both sites to a tolerable level. Both fire risk assessments also stated that the suggested date for the next review by a competent fire expert was February 2022. During the quality check, the practice were unable to provide documented evidence of the actions taken to address the recommendations. The practice also confirmed that no review of the fire risk assessments had been carried out since February 2021.

As a result, we could not be assured that the health, safety and welfare of employees and people visiting both sites was being actively promoted and protected, or that identified fire safety risks were being monitored, reduced and/or prevented. Due to our concerns, we issued an Immediate Assurance letter. This is where we write to the service within two days of completion of the quality check with our findings requiring urgent remedial action. The Immediate Assurance issues, and the health board's response, are referred to in detail within Appendix A of this report.

We saw that a health and safety evaluation of the environment had been undertaken in September 2021 at the Fairwater Square site. While the standard of health and safety management was deemed generally satisfactory, recommendations were made to enhance standards. During the quality check, the practice were unable to provide documented evidence of the actions taken to address the recommendations. The practice must provide HIW with an updated action plan to highlight the actions taken in response to the health and safety evaluation.

Infection prevention and control

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 requested included:

- Generic infection prevention and 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:

We saw evidence of COVID-19 guidance and presentations that had been made available to staff that outlined the procedures for staff to follow during the pandemic. Some of the restrictions inside the practice have been relaxed with the move to the current COVID-19 alert level zero. Patients are now required to only wear masks when entering clinical areas. However, staff do actively check that there are not too many patients in the waiting room to adhere to social distancing.

We were told that all clinical staff received training regarding Personal Protective Equipment (PPE), which included advice on donning, doffing and the safe disposal of used equipment. Donning and doffing posters are also on display across the practice as a reminder to staff. Weekly stock checks of levels of PPE are undertaken and the practice manager confirmed that the practice has adequate stock.

We discussed the process for safely seeing patients with suspected infectious illnesses, including COVID-19. The practice has a designated clinical room near the entrance that is used for any patients that urgently need a face-to-face consultation who may be infectious. Patients are escorted directly into the clinical room to be assessed by staff wearing appropriate PPE. Following the consultation, the patient is escorted out of the building, and the clinical room would be deep cleaned by the clinician.

We saw that the practice had an infection prevention and control (IPC) policy in place. We were also provided with copies of recent cleaning schedules which were complete and up to date.

The following areas for improvement were identified:

We asked staff how the service monitored compliance with the IPC procedures in place at the practice. We were told that audits are not currently being undertaken but that work is currently ongoing to create a set of monitoring templates. We recommend that the

monitoring templates are finalised and implemented in a timely way to provide the service with assurance that IPC standards are being met.

We requested data for staff compliance with IPC training. We were provided with a spreadsheet that showed IPC training had been completed by some administrative and clinical staff members, but not all. The practice must provide assurance to HIW that all staff have completed their IPC training as required.

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 requested included:

- Mandatory training records for all staff
- Business continuity plans
- Recent staff meeting minutes
- HIW self-assessment.

The following positive evidence was received:

It was clear that the practice had worked hard throughout the pandemic to continue to meet the needs of its patients. There was an increase in remote working from staff and longer appointment times were allocated to ensure adequate time for effective cleaning between patients. A COVID-19 business continuity plan had been created to provide staff with guidance on working throughout the pandemic. We were told that the five GP practices in the South Torfaen Cluster had an agreement to share resources if, for example, one practice experienced a high number of staff absences due to COVID-19. We saw that a standard business continuity and recovery plan was in place that set out how the practice would be managed and operated under all other exceptional and adverse circumstances such as flooding.

We were told that staff worked well together during the pandemic to continue to meet the needs of the practice. However, the practice manager acknowledged the pressure this had placed on staff to cover roles during times of staff absences. The practice currently has a small number of vacancies and we were told that recruitment is ongoing to fill these places.

We saw evidence of monthly partnership meetings taking place between partners to discuss operational and management issues. We were told that senior staff across the cluster also meet regularly to discuss common issues and share learning.

We discussed the challenges faced by the practice over the previous 12 months. We were told that it has often been difficult to ensure the practice only undertakes its primary care work. There had been expectations during the pandemic from some secondary services for the practice to undertake work that was not in their remit. The practice has stood firm in only carrying out the work it is responsible for. Current challenges include the increase in business as usual work due to the backlog built up during COVID-19. For example, annual reviews took place via telephone during the pandemic wherever possible, but now the practice is undertaking work to ensure all patients are called in to receive a face-to-face annual review.

We were told that arrangements with the out-of-hours service and access to wider primary care professionals such children, adolescent and adult mental health teams was generally working well. However, patients are seeing an increase in referral times to be seen by secondary care professionals.

The following areas for improvement were identified:

We were told that weekly huddles took place among teams such as clinical staff, care navigators and administrators to share timely feedback and discuss practice issues. However, we were told that notes and minutes of these meetings are not taken. We recommend the practice records minutes of these meetings and distributes them to all staff to ensure those who couldn't attend the meeting are aware of what has been discussed.

We asked to see data on staff compliance with mandatory training and were provided with an incomplete spreadsheet. This meant it was difficult to determine which members of staff were compliant or not. The practice manager confirmed tracking mandatory training has been difficult due to inadequate electronic systems. We recommend the practice undertakes an exercise to check staff compliance with mandatory training to ensure that staff have the right knowledge and skills to carry out their duties. Furthermore, we recommend that a new system is implemented to help monitor staff compliance with mandatory training in future.

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.

Appendix A – Immediate improvement plan

Setting: Nant Dowlais Health Centre

Date of activity: 05 October 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
The practice must provide assurance to HIW on the actions that have been taken in response to the recommendations resulting from the fire risk assessments undertaken at both GP surgeries in February 2021.	2.1 Managing Risk and Promoting Health and Safety	I have contacted the relevant company to come next week to look at the needed improvements to the doors and to clear the areas that were highlighted as high risk. The work will then be carried out over the coming weekends to avoid disruption to patients.	Rachel Bentley	Within 1 month depending on the workforce ability to complete works around patient care.
The practice must subsequently arrange for another fire risk assessment to be undertaken at both GP surgeries by a competent person to provide assurance to HIW that the risk of fire has been managed to at least a tolerable level.	2.1 Managing Risk and Promoting Health and Safety	Once the above work has been carried out – we will contact the fire service to arrange a new fire risk assessment in line with their guidance.	Rachel Bentley	3/12 – depending on their availability

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): Rachel Bentley

Job role: Practice Manager

Date: 14 October 2022

Appendix B: Improvement plan

Setting: Nant Dowlais Health Centre

Date of activity: 05 October 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 provide HIW with an updated action plan to highlight the actions taken in response to the health and safety evaluation undertaken in September 2021.	Managing risk and health and safety	We reviewed our previous health and safety plan and have arranged for a new health and safety review to be done in the coming months; we are currently awaiting confirmation of a date.	Rachel Bentley	3 months
The practice must ensure IPC monitoring templates are finalised and implemented in a timely way to provide the service with assurance that IPC standards are being met.	Infection prevention and control (IPC) and decontamination	IPC monitoring templates are now in place and the nursing team oversee these. They will review these monthly and as a practice we will review the process annually or if any changes occur in legislation or within the practice.	Amanda Morgan/Rhonwen Davies-Keane/ Gemma Ramsahye	Immediately
The practice must provide assurance to HIW that all staff have completed their IPC training as required.	Infection prevention and control (IPC) and decontamination	All staff to provide certificates to management within the month as proof of IPC training being within compliance.	Rachel Bentley and Hayley Cooke	1 month

The practice must record minutes of staff meetings and distribute them to all staff to ensure those who couldn't attend the meeting are aware of what has been discussed.	Governance and accountability framework	It has been agreed that an administrator will sit in and take minutes. They will then type these up and disseminate to the relevant team. These will be kept in folders on our clinical system.	Amanda Morgan, Rachel Bentley and Hayley Cooke	With immediate effect.
The practice must check staff compliance with mandatory training to ensure that staff have the right knowledge and skills to carry out their duties.	Workforce planning, training and organisational development	Each line manager to check their team's compliance and allocate adequate time for them to complete the training ether within or outside of their working hours. Staff to provide certificates for the training so that the spreadsheet can be updated.	Amanda Morgan, Rachel Bentley and Hayley Cooke	Within 3 months
The practice must implement a new system to help monitor staff compliance with mandatory training in future.	Workforce planning, training and organisational development	As above it will be line managed and overseen by management, the current NHS system for GP practices is not sufficient so will ensure our own records are kept up to date and reminders sent to staff when due. I will pick this up with the E-Learning team.	Rachel Bentley	Within 3-6 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): Rachel Bentley

Job role: Practice Manager

Date: 08 November 2022