Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report
(Announced)
St Paul's Clinic, Aneurin Bevan University Health Board

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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

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 St Paul's Clinic, Aneurin Bevan University Health Board on 23 January 2025.

Our team for the inspection comprised of a HIW healthcare inspector and three clinical peer reviewers.

During the inspection we invited patients 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 11 questionnaires were completed by patients and 16 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.

2. Summary of inspection

Quality of Patient Experience

Overall summary:
Patients who completed a questionnaire provided positive feedback. All respondents rated the service as either 'very good' or 'good', and most said they could get routine appointments when needed, and a same-day appointment if urgent.

We observed friendly and caring interactions between staff and patients throughout the inspection. Patients could access information to help promote their health and wellbeing and lead a healthy lifestyle and received sufficient information to allow informed decisions to be made about their care.

A chaperone service was available where required, however, we noted that offers of a chaperone to patients were not always recorded within their medical records.

Staff demonstrated a willingness to accommodate known language or communication needs, particularly with a population whose first language was not English and Welsh. However, the language and communication needs of patients, and any actions taken to address any needs, should be routinely recorded within patient records. Equality and diversity was promoted through practice policies. However, we saw no evidence that staff had completed equality and diversity training.

The practice must improve its support offered to carers in terms of identifying needs and provision of relevant information. The practice should consider nominating a 'carer's champion' to help oversee this approach.

Delivery of Safe and Effective Care

Overall summary:
We found appropriate processes in place to protect the health, safety and wellbeing of patients and staff. The environment was generally well maintained; however, some doors had broken locks which needed to be repaired.

The clinical rooms were well stocked with clinical items and equipment. However, we identified aspects of the cold chain process that needed improving to maintain the efficacy of vaccines. Resuscitation equipment and emergency drugs were available to manage a patient emergency, and checks were being undertaken to

replace any expired resuscitation equipment and/or emergency drugs when required.

We saw a positive example of joint working among the practices in the Newport West cluster through the provision of a Psychological Health Practitioner to provide patients with mental health support. The Advanced Paramedic Practitioner at the practice was also a valuable resource to help deliver patient-focussed care.

We identified several areas of improvement that were needed to fully ensure the practice always upholds the required standards of infection prevention and control. These included ensuring that sharps containers are closed appropriately and always signed and dated and ensuring weekly cleaning schedules are implemented and maintained.

Patients were being directed to the most appropriate member of the practice team, or to other healthcare professionals in the community if necessary. However, we recommended that the practice reviews and updates its receptionists' triage policy to provide a more comprehensive guide for staff to follow in relation to specific care navigation pathways.

The patient records we reviewed were being maintained to a very good standard. Consultation narratives were well documented and there was evidence of shared decision making and appropriate investigations and referrals where required. Suitable processes were in place to ensure the safe prescribing of medication.

Administrative staff were responsible for summarising patient information and undertaking appropriate clinical coding. However, the practice should ensure administrative staff receive formal training in clinical coding and ensure regular audits of clinical coding are completed to monitor their accuracy.

Quality of Management and Leadership

Overall summary:
The GP partners were long serving staff who provided stability at the practice. We saw evidence of regular team and practice meetings, including use of various platforms for general and urgent communication between staff. A wide range of policies and procedures were in place to support the effective running of the practice.

Staff provided positive feedback in their HIW questionnaires. All respondents said that they would recommend the practice as a good place to work and would be happy with the standard of care provided by the practice for friends and family.

An area needing strengthening was ensuring that all staff receive an annual appraisal to discuss their performance, set annual objectives and identify any learning needs.

The practice told us about the challenges they faced in engaging with health visitors to support their child population. We have asked the health board to provide assurance to HIW on how it can improve the health visiting support to St Paul's Clinic to help families and children receive the help they need.

Immediate assurances:
During the inspection we could not determine whether staff had completed the required training to maintain the safety of patients, staff and visitors to the surgery. This is because the training matrix being maintained by the practice was incomplete in several areas. In addition, we were not assured that the processes in place to maintain safe recruitment of staff is robust. This is because during our review of staff personnel files we did not see evidence that all staff had suitable Disclosure Barring Service (DBS) certificates in place.

Details of our concerns and the immediate improvements and remedial actions taken by the practice are provided in Appendix B.

3. What we found

Quality of Patient Experience

Patient feedback

We received positive feedback from the 11 patients who completed a HIW questionnaire. All respondents rated the service provided by St Paul's Clinic as either 'very good' or 'good'. Each respondent also said that they were able to access regular support for their ongoing medical condition.

Patient comments included:

> *"I am always pleased when I am given the time to discuss my issues openly!"*

> *"Staff and doctors give an excellent service in all areas. Very caring and helpful practice. Highly recommended!"*

Person-centred

Health promotion
A wide range of health information leaflets and posters were available for patients in the reception area and by the front entrance. This included exercise referral schemes, pregnancy support and the family liaison service. A display screen in the waiting area informed patients about flu and COVID-19 vaccinations and signposted patients to other health services, such as opticians. All staff who completed a questionnaire agreed that the practice offered health promotion advice and information about chronic conditions to patients in a variety of mediums.

The practice was offering the winter flu vaccination service to patients. This service was promoted within the practice and on the practice website. We were told that patients are regularly reminded via text message, telephone or letter to encourage patients to attend.

We were told that practice staff contacted all registered patients aged 85 and over before Christmas to check on their welfare and identify any help they may require over the holiday season, which we noted as good practice.

Most staff who completed a questionnaire said that the practice maintained a register of carers and that they signposted carers to support organisations. However, the carers who completed a questionnaire were unclear on whether they had been offered an assessment of their needs as a carer and said that the practice had not provided them with details of organisations or support networks which provide information and support.

The practice must improve its support offered to carers in terms of identifying needs and provision of relevant information. The practice should consider nominating a 'carer's champion' to help oversee this approach.

Dignified and respectful care
We observed friendly and caring interactions between staff and patients during the inspection. All patients who completed a questionnaire felt they were treated with dignity and respect. The patients and staff who completed a questionnaire agreed that suitable measures were taken to protect the privacy and dignity of patients.

The consultation rooms had lockable doors and privacy curtains. One staff member suggested the following improvement in their questionnaire:

> *"New blinds on windows and pharmacy window, not paper."*

The practice must review its window covering provision to ensure it maintains patient privacy while also upholding infection prevention and control standards.

The waiting area was spacious and reception staff were located behind a glass partition wall. Music was being played in the waiting area which helped to prevent other patients from hearing private conversations between reception staff and patients. One patient provided the following comment in their questionnaire:

> *"Maybe a system where you check in for your appointment instead of waiting at the window."*

The practice may wish to consider whether this is a feasible option to further protect patient confidentiality.

Patients were advised through well-placed posters that they were welcome to have a chaperone present during their consultation. We confirmed that male and female staff were available. Five out of the seven patients who completed a questionnaire and attended the practice for their appointment said that they were offered a chaperone. However, none of the ten records we reviewed showed evidence of

verbal consent given for examination or that a chaperone had been offered. This included one instance where a patient had received a breast examination.

The practice must ensure that verbal consent for intimate examinations and offer of a chaperone is always recorded into patient medical records in accordance with General Medical Council (GMC) guidelines.

Timely

Timely care

There were processes in place to ensure patients could access the right service at the right time. Patients could book an appointment via telephone or in-person at the practice.

The responses to the HIW patient questionnaires indicated that care was being provided in a timely manner. All respondents said they were satisfied with the opening hours of the practice and were offered the option to choose the type of appointment they preferred. Most respondents said they could get routine appointments when they needed them and they were able to get a same-day appointment when they needed to see a GP urgently. All respondents to the staff questionnaire felt that patients were able to access the practice services in a timely way.

The practice was very busy during the inspection, with many patients attending at all times of the day. It appeared that patients did not have an excessive wait for their appointment. Nine of the eleven respondents to the patient questionnaire said that their appointment was on time.

All patients who completed a questionnaire said they knew how to access out of hours services if they needed medical advice or an appointment that could not wait until the practice reopened. However, we noted that the poster displaying the opening hours of the practice and the contact details for the out of hours service, was located inside the entrance but far away from the front door, which meant patients would be unable to read it when the practice was closed.

The practice must improve the signage at the front entrance to better inform patients of the opening hours and the contact details for the out of hours GP service when the practice is closed.

Equitable

Communication and language

We found that staff communicated with patients in a polite and clear manner. The patient records we reviewed evidenced that sufficient information was being provided to patients to allow informed decisions to be made about their care.

All respondents to the questionnaire felt their GP explained things well, answered their questions, and said that they felt listened to and involved in decisions about their healthcare.

A hearing loop was available to support those with hearing difficulties. The practice was in a multicultural area of Newport where English and Welsh was typically not the first language of patients. Despite this, staff demonstrated a willingness to accommodate known language or communication needs. The practice website had an accessibility widget which helped translate it into different languages as well as provide a range of other support, such as larger text. Alongside the use of Language Line, staff at the practice spoke 15 different languages between them which helped to ensure patients could engage in meaningful dialogue and make informed decisions about their care. One staff member told us:

> *"It is very difficult to manage most patients because they do not speak English. Despite this, right from reception to the consulting room, practice makes sure they are not disadvantaged."*

All staff who completed a questionnaire said there were alerts on the patient records to inform them of any communication difficulties patients may have. However, the language and communication needs of patients, and any actions taken to address any needs, was not recorded in any of the ten patient records we reviewed.

The practice must ensure that language and communication needs are routinely recorded within patient records

Rights and equality

We found all areas inside the practice to be accessible. All surgeries and patient facilities were located on the ground floor. An access ramp was available to the back entrance to assist patients with mobility needs. However, we noted that the back entrance doors were not automatic, which could hinder access to the building. Reception staff told us they review incoming appointments and help patients when required. Patients were also able to request a home visit if access to the practice was an issue. We were informed that the practice was going to

replace the back entrance doors with automatic doors to improve access for its patients. All patients who completed a questionnaire and attended the practice for their appointment said that the building is easily accessible, and that there were enough seats in the waiting area.

An up-to-date equality and diversity policy was in place. However, senior management were unable to confirm whether all staff had attended equality and diversity training.

The practice must ensure that mandatory training in equality and diversity takes place for all staff, and a log of training completion is kept.

One staff member who completed a questionnaire felt that they had faced discrimination at work and stated that this was “usually from service users and patients.” The practice must be mindful of this feedback and ensure staff can access appropriate wellbeing support when required.

Delivery of Safe and Effective Care

Safe

Risk management
We saw a suitable up-to-date business continuity and recovery plan in place which was available on the shared drive. This covered the procedures to take following a significant event, such as loss of computer system, pandemic and incapacity of key staff. The plan also included the contact details for key maintenance services.

The environment was generally well maintained; however, a few areas needed repair. For example, there was some missing plaster on the wall in the pharmacist's room, and some of the locks were not working on doors.

The practice must ensure that all doors have functioning locks and must review the environment to identify areas in need of repair and action accordingly.

We saw how patient safety alerts were received and disseminated through the practice and communicated in meetings. The process in place for managing patient safety alerts and significant incidents was robust.

An up-to-date home visit policy was in place which set out the procedures to follow to undertake home visits appropriately and safely. This included a list of accepted home visit justification criteria and the requirement to complete a risk assessment before attending.

Infection, prevention and control (IPC) and decontamination
The practice appeared visibly clean and was free of clutter in all areas. A nurse had been designated as the IPC lead for the practice. An up-to-date IPC policy and other supporting policies were available. All respondents to the questionnaire thought the practice was either 'very clean' or 'clean'.

One staff member suggested the following improvements in their questionnaire:

> *"Bottles of hand sanitiser in rooms and hand soap in patient toilet."*

We also identified several areas of improvement that were needed to fully ensure the practice always upholds the required standards of IPC to maintain the safety of staff and patients. These were:

- Some sharps containers were not closed appropriately which increased the risk of a needlestick or sharps injury

- Some sharps containers awaiting collection were not signed and dated
- The absence of posters or flowcharts displayed in clinical areas for staff to follow, should they receive a needlestick injury
- One clinical waste bin being stored outside the practice was empty and not in use, however the lid was cracked and the bin needed replacing
- Although the practice appeared clean, there was no evidence that weekly cleaning schedules were being maintained.

We also identified areas of concern that needed to be addressed immediately during the inspection. We found that the clinical waste bin being used outside the practice was unlocked. While we accept this may have been an isolated incident, we also noted that the clinical waste bin was unsecured, which meant patients or visitors could remove the bin should they wish to do so. During our tour of the practice, we also found the cleaning cupboard containing hazardous materials to be unlocked. We were told that this was because the lock was broken. We raised these issues with senior management staff and the actions taken to resolve our concerns are provided in Appendix A.

We saw that an IPC audit was completed in October 2024 which contained a recommendation for audits to be undertaken monthly. It did not appear that a subsequent audit had been carried out before our inspection.

The practice must:

- **Take improvement action to address all the areas relating to IPC listed above**
- **Strengthen its governance and oversight of the IPC processes considering the numerous issues we identified during the inspection. This should include more frequent IPC and clinical waste audits.**

Medicines management
Suitable processes were in place to ensure the safe prescribing of medication. Relevant policies were in place and prescribing clerks had access to regular training to ensure their skills and knowledge remain up to date. We saw that prescription pads were securely stored in a locked cupboard. We were told old prescription pads are shredded and disposed of appropriately when no longer in use.

We saw that vaccines were being stored in several clinical refrigerators at the practice. However, we found areas needing improvement, which include:

- Vaccines were being stored in plastic baskets within the refrigerators which could prevent effective circulation of cold air

- There were several gaps in the temperature monitoring forms for the clinical refrigerators containing the vaccines
- The refrigerator temperature monitoring form in the treatment room appeared to be for a catering refrigerator rather than a clinical refrigerator. This meant the guidance on the appropriate temperature range to store vaccines and when to take corrective action was incorrect
- We did not see evidence of clear instructions available for staff to follow in the event of a cold chain breach.

The practice must review and strengthen its cold chain storage and management processes which must include taking action to address the issues we have identified above.

We found robust procedures in place for the management of medical emergencies at the practice. The process was being effectively supervised by the Advanced Paramedic Practitioner. Appropriate resuscitation and emergency drugs were available, which met the primary care equipment standards as outlined by the Resuscitation Council UK guidance. We saw evidence that the checking of the emergency equipment and drugs was being recorded and completed weekly. Flowcharts were available which provided guidance on what to do in the event of several medical emergencies, such as cardiac arrest or a severe allergic reaction (anaphylaxis). We saw that oxygen cylinders were in date, with appropriate stock levels and arrangements were in place for reporting any incidents.

Notices were displayed throughout the practice to inform staff where the emergency equipment and defibrillator was located. We noted that access to the location was through a locked door that required a digital code. The practice may wish to consider whether the additional requirement to input a digital code to access the equipment in an emergency may prevent treatment from being provided in a timely manner.

Safeguarding of children and adults
The practice had a named safeguarding lead for adults and children. Staff had access to practice safeguarding policies and procedures which included contact details of designated leads. Staff described the challenges faced by the practice of identifying adults in their locality subject to other cultural risks, such as female genital mutilation or honour-based violence.

The practice had a 'Was not brought' policy to manage patients (including children) who did not attend for appointments. This included information on the process to follow should children or vulnerable adults not attend their hospital appointments.

We noted that not all staff had completed safeguarding training at the required level. The practice submitted documentation following the inspection which certified that all clinical staff had completed their relevant safeguarding training.

The electronic patient record system being used by the practice had a field to record children on the child protection register. The system provided an alert to notify the clinician during appointments that the patient was a child at risk. However, we saw instances where family members of children on the child protection register had not been flagged as potentially at risk within their own records. It is vital that all relevant family members are also assessed for potential risks to ensure a comprehensive approach to safeguarding the child and their family. Furthermore, it did not appear that safeguarding concerns were being regularly reviewed to evaluate whether the risk remained active.

The practice must:

- **Undertake an audit to ensure that all family members of children on the child protection register are also identified as potentially at risk**
- **Undertake regular reviews to determine whether safeguarding risks remain active to ensure patient records are accurate and contemporaneous.**

Management of medical devices and equipment
The practice had processes in place to safely maintain equipment. Single use disposable equipment was used whenever possible. There were contracts in place for maintenance and calibration of equipment as appropriate and for any emergency repairs and replacement. We found all equipment was in a good condition, well maintained with appropriate checks carried out.

Effective

Effective care
All respondents who completed a questionnaire agreed that during their appointment their identity and medical details were checked, and that they were given enough time to explain their health needs.

Staff described the processes in place to support the effective treatment and care of patients. This included processes to disseminate clinical updates, learning, and new guidance. However, staff were not aware of the recent regulation 28 report and Patient Safety Notice 041 reminder issued by Welsh Government, in relation to the correct operation of oxygen cylinders manufactured by BOC.

The practice must ensure:

- **All patient safety alerts are circulated to staff and that the actions identified in PSN 041 including training requirements are completed**
- **All relevant staff have received training to ensure they are competent in the use of setting up and using oxygen cylinders.**

Processes for reporting incidents through Datix were clear and understood by the practice staff. Referrals were being managed appropriately, including both standard and urgent referrals, such as suspected cancer. We were told that the practice did not undertake regular analysis of referral rates. The practice may wish to consider working with other practices in their cluster to compare referral rates and discuss potential reasons for any differences found.

Reception staff had received training in care navigation to help ensure patients could access the right service for their needs. Patients would be directed to the most appropriate member of the practice team or to other healthcare professionals in the community if necessary. However, we reviewed the receptionists' triage policy and felt it lacked sufficient detail and information in relation to specific care navigation pathways, to help reception staff direct patients accordingly, particularly in emergency situations.

The practice must review and update its receptionists' triage policy to provide a more comprehensive guide for staff to follow in relation to specific care navigation pathways in line with the British Medical Association's guidance document 'Care navigation and triage in general practice'.

Patient records

We reviewed ten patient records during the inspection which were being maintained to a very good standard. Consultation narratives were well documented with evidence of shared decision making and appropriate investigations and referrals where required. The patient records were contemporaneous and information was easy to understand for other clinicians reviewing the records.

We found there was a good and consistent use of clinical Read codes, which helped to make analysis and audit easier. The patient records where chronic disease was recorded contained a full summary of the condition/s, including all past and continuing problems as well as the medication being taken.

We found the continuity of care was effective, with close oversight and supervision of patients and patient records by all the GPs.

Administrative staff were responsible for summarising patient information and undertaking appropriate clinical coding. We spoke to one staff member who said

they had received support and advice in relation to clinical coding from a GP at the practice. However, there was no evidence that a clinical coding policy or guidance document was available to help staff to code correctly. We also saw no evidence that audits of the clinical coding and summaries were being undertaken to check the quality of the data entry.

The practice must:

- **Ensure administrative staff receive more formal training in clinical coding**
- **Develop a clinical coding policy or guidance document that describes the procedure for staff to undertake the clinical coding process consistently and correctly**
- **Ensure regular audits of clinical coding are completed to monitor their accuracy.**

Efficient

Efficient
Suitable processes were in place to help patients move efficiently through care and treatment pathways. We were told that a Psychological Health Practitioner (PHP) attends the practice every Friday to offer mental health assessments and signpost patients to appropriate support within the community or escalate and refer if required. The PHP provision was a Newport West cluster initiative which is a positive example of a co-ordinated approach towards improving the wellbeing of patients in the local community.

The Advanced Paramedic Practitioner at the practice was a valuable resource for helping deliver patient-focussed care. Their role included undertaking home visits to provide care for acutely unwell patients and managing chronic pain and disease reviews to help reduce hospital admissions in this cohort of patients.

Quality of Management and Leadership

Staff feedback

We received positive feedback from the 13 staff who completed a HIW questionnaire. All respondents said that they would recommend the practice as a good place to work, would be happy with the standard of care provided by the practice for friends and family, and that they were content with the efforts of the practice to keep staff and patients safe. One staff member commented:

> *"Surgery works well with us as a Place Based Care Team - both helping to provide support to patients when they need it and looking at individuals before they reach crisis point and supporting them to prevent hospital admission."*

Leadership

Governance and leadership
There appeared to be a clear management and leadership structure in place, and staff we spoke with were clear about their roles and responsibilities. The GP partners were long serving staff who provided stability at the practice. We saw evidence of regular team and practice meetings, including use of various platforms for general and urgent communication between staff.

A wide range of policies and procedures were in place to support the effective running of the practice. We saw they had been reviewed and updated regularly and were accessible to all staff via the shared drive. However, we noted examples where references to England were made, and not Wales.

The practice must ensure that all policies and procedures reflect the latest guidance for Wales where appropriate.

All staff who completed a questionnaire felt that they were able to make suggestions to improve services, and nine out of the thirteen staff said they were involved in deciding on changes introduced that affect their work.

Workforce

Skilled and enabled workforce
We spoke to staff across a range of roles throughout the inspection. Each had sound knowledge of their roles and responsibilities and appeared committed to providing a quality service to patients. Most staff who completed a questionnaire

said there are enough staff to allow them to do their job properly, and that there is an appropriate skill mix at the practice. Staff also felt able to meet all the conflicting demands on their time at work and they had adequate materials, supplies and equipment to do their job.

There were appropriate recruitment policies and procedures in place which described the required pre-employment checks for any new staff. This included checking of references and undertaking Disclosure and Barring Service (DBS) checks appropriate to their role. However, during our review of staff personnel files we did not see evidence to indicate that two administrative staff and three clinical staff members had suitable DBS certificates in place. We were also told that regular checks were not being completed to ensure DBS certificates for staff members remained accurate throughout their employment at the practice. This meant we were not assured that the processes in place to maintain safe recruitment of staff was robust.

In addition, during the inspection we also asked to review the training records of clinical and administrative staff working at the practice. We were informed that a training matrix had recently been created, and that management staff were in the process of requesting evidence of completed mandatory training from each member of staff. However, when we reviewed the training matrix, we found it was incomplete in several areas. This meant we could not determine that staff had completed the required training to maintain the safety of patients, staff and visitors to the surgery.

Our concerns in relation to DBS checks and training records were dealt with under our immediate assurance process. Details of the remedial actions taken by the service are provided in Appendix B.

We were told that all staff should receive an annual appraisal, however, two of the thirteen staff who completed a questionnaire said they had not received an appraisal or development review within the last 12 months. This was confirmed by senior management, who verified that not all staff had yet received their annual appraisal.

The practice must ensure that all staff receive an annual appraisal to discuss their performance, set annual objectives and identify any training needs.

All staff who completed a questionnaire said that in general, their job was not detrimental to their health, and felt they can achieve a good work-life balance from their current working pattern. Most staff said they were aware of the occupational health and wellbeing support available to them.

Culture

People engagement, feedback and learning
The practice had a patient complaints policy which was aligned to the NHS Wales Putting Things Right process. The senior partner was responsible for managing complaints and this was clear within the complaints policy. Complaints/concerns were being monitored to identify themes and trends, and any actions for improvement are communicated to staff.

We noted that the complaints policy was not displayed anywhere throughout the practice. A summary of the procedure was contained within the patient information leaflet. However, during the inspection the only patient information leaflets available in the front entrance were in Polish. We asked staff to ensure English and Welsh versions of the leaflet were printed and made available to patients. Despite this, all patients who completed a questionnaire said that they would know how to make a complaint about the service.

The practice had a duty of candour policy in place, and the staff responses to the questionnaire confirmed that they understood their responsibilities under the duty of candour, and were aware of the steps to follow should the duty apply.

Information

Information governance and digital technology
The practice understood its responsibility when processing information and demonstrated that electronic data is managed in a safe and secure way. An up-to-date information governance policy was in place to support this.

Patients could request repeat prescriptions using a form and box in the entrance area. However, the flap of the letterbox had broken off which meant the forms containing confidential information about patients, including their name, address and medical conditions could be accessed by other patients. We spoke with staff who immediately arranged for the box to be closed off and a sign displayed asking patients to hand their forms to reception staff.

The practice must implement a more secure way of managing requests for repeat prescriptions to maintain patient confidentiality at all times.

Learning, improvement and research

Quality improvement activities
All staff who completed a questionnaire said the practice encourages them to

report errors, near misses or incidents, and agreed that the organisation takes action to ensure they do not reoccur.

There was evidence of some clinical and internal audits in place to monitor quality. However, we have highlighted throughout this report some audits that require strengthening.

It was positive that the practice participated in research projects. Staff told us the practice had previously engaged in the Skills for Adolescent WELLbeing (SWELL) study, which aimed at preventing depression in young people who have a parent with a history of depression, and the ThinkCancer! study, which involved increasing awareness of potential cancer symptoms to help improve cancer diagnosis and referral rates.

Whole-systems approach

Partnership working and development
There appeared to be good collaborative relationships in place with external partners. We were told that the local GP cluster works together to build a shared understanding of the challenges and the needs of the local population, and to help integrate healthcare services for the wider area.

A member of staff had been designated as a homelessness champion whose role was to work closely with local homelessness services as this affected a large proportion of their patient group. This was a positive example of a proactive approach to providing good practice.

Staff told us that they are also working towards providing drug misuse services, which is another common issue in their locality. However, we were told of the challenges faced by the practice in engaging with health visitors to support their child population. The practice did not currently have a health visitor assigned to the practice, which meant it was difficult for practice staff to share information and work together with the service in the best interests of families.

The health board must provide assurance to HIW on how it can improve the health visiting support to St Paul's Clinic to help families and children receive the support they need.

We received three questionnaires from health professionals whose role was not based at the practice. It was positive that all three respondents said that the practice worked well with them to provide seamless patient care, that GP staff involved them in the patient's journey in a timely and appropriate way, and that the environment of the practice was suitable for them to perform their role.

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 summarises 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
We found the cleaning cupboard was unlocked. Staff informed us this was because the lock was broken.	The cleaning cupboard contained hazardous materials which could pose a danger to staff and patients.	We immediately raised this with senior management during the inspection.	Staff arranged for all hazardous materials to be removed from the cleaning cupboard and moved to a more secure location.
We found the clinical waste bin outside the practice was unlocked and not secured which meant it could be easily removed.	Patients, staff or visitors could have access to potentially hazardous clinical waste.	We immediately raised this with senior management during the inspection.	Staff arranged for the clinical waste bin to be immediately locked and assured us this was an isolated incident. Staff bought a chain and lock during the inspection to secure the clinical waste bin to a railing to ensure it could not be easily removed.
The flap of the letterbox containing repeat prescription forms had broken off.	This meant the forms containing confidential information about patients, including their name, address and medical conditions could be accessed by other patients.	We immediately raised this with senior management during the inspection.	Staff immediately arranged for the box to be closed off and a sign displayed asking patients to hand their forms to reception staff.

Appendix B – Immediate improvement plan

Service: St Paul's Clinic

Date of inspection: 23 January 2025

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	Standard / Regulation	Service action	Responsible officer	Timescale
1.	HIW was not assured that the management and oversight of mandatory training compliance was sufficiently robust to ensure all staff remained competent to perform their roles safely and appropriately. This is because we found the training matrix to be incomplete in several area. For example, the matrix indicated that five administrative staff and seven clinical staff members had not completed fire safety training and one administrative staff	The practice must ensure that: • All staff complete their mandatory training as required and evidence of their completion is documented • The training matrix is updated and monitored to establish staff compliance with mandatory training.	Workforce	All staff have been sent an individual training plan that they are required to complete within 2 weeks. New training matrix has been developed and Bright HR compliance software purchased to ensure future compliance.	Michele Richards	Two-Four weeks (Some staff on annual leave)

	and two clinical staff members had not completed safeguarding people training. This meant we could not determine that staff had completed the required training to maintain the safety of patients, staff and visitors to the surgery.					
2.	HIW was not assured that the processes in place to maintain safe recruitment of staff is robust. This is because there was no evidence available to indicate that two administrative staff and three clinical staff members had suitable Disclosure Barring Service (DBS) certificates in place. We were also told that regular checks were not being completed to ensure DBS certificates for staff members remained accurate throughout their employment at the practice.	The practice must ensure that: • All staff complete a DBS check relevant to their role • Staff confirm annually whether any new information has been added to their DBS certificate since previously issued • Staff are reminded that they should report any changes to their DBS certificate to their employer as they occur.	Workforce	DBS Checks for missing administrative staff members who were in post before this was a requirement. Bright HR compliance software will prompt staff and management to check this. DBS Policy disseminated to all staff with disclaimer and risk assessment. This will be further checked at Staff Annual Appraisal.	Michele Richards	1 month

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): **Michele Richards**

Job role: **Business Manager**

Date: **30 January 2025**

Appendix C - Improvement plan

Service: St Paul's Clinic

Date of inspection: 23 January 2025

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	Standard / Regulation	Service action	Responsible officer	Timescale
1.	Staff told us that the practice did not have a designated 'carer's champion'. The carers who completed a questionnaire were unclear on whether they had been offered an assessment of their needs as a carer and said that the practice had not given them information on services that can provide information and support.	The practice must improve its support offered to carers in terms of assessment, identifying needs and provision of relevant information. The practice should consider nominating a 'carer's champion' to help oversee this approach.	Health promotion	• Natalie Knott nominated as dedicated Carer's Champion. • Role clearly communicated to patients and staff through notices, practice website, and staff meetings. • Carers offered assessments routinely and provided with tailored support information. • Carers-specific training session arranged for the	Collette England	June 2025

				next staff CPD event (June 2025).		
2.	One staff member suggested that blinds should be used rather than paper as window coverings.	The practice must review its window covering provision to ensure it maintains patient privacy while also upholding infection prevention and control standards.	Dignified and respectful care	Blinds ordered from approved supplier to replace paper coverings, ensuring patient privacy and adherence to IPC standards.	Collette England	June 2025
3.	Five of the ten patient records we reviewed did not evidence that verbal consent and offer of a chaperone had been recorded.	The practice must ensure that verbal consent for intimate examinations and offer of a chaperone is always recorded into patient medical records in accordance with General Medical Council (GMC) guidelines.	Dignified and respectful care	• Chaperone training arranged for all staff (June 2025). • Chaperone and Consent policies reviewed and reinforced to staff. • Monthly audits initiated to monitor compliance with consent recording requirements.	Michele Richards	June 2025
4.	We noted that the poster displaying the opening hours of the practice and the contact details for the out of hours service was located far away	The practice must improve the signage at the front entrance to better inform patients of the opening hours and the contact details for the out of hours	Timely care	Sign displaying practice opening hours and out-of-hours service contact details clearly repositioned at the main entrance for improved visibility.	Jusna Begum	Complete

	from the front door which meant patients would be unable to read it when the practice was locked.	GP service when the practice is closed.				
5.	The language and communication needs of patients, and any actions taken to address any needs, was not recorded in any of the ten patient records we reviewed.	The practice must ensure that language and communication needs are routinely recorded within patient records.	Communication and language	• Patient registration and chronic disease templates updated to include mandatory language and communication need fields. • Monthly record audits introduced to ensure compliance.	Michele Richards	Complete
6.	There was no evidence to confirm whether all staff had attended equality and diversity training.	The practice must ensure that mandatory training in Equality and Diversity takes place for all staff, and a log of training completion is kept.	Rights and equality	• Mandatory Equality and Diversity training scheduled for all staff via compliance training platform. • Training compliance log maintained and reviewed monthly.	Michele Richards	Complete
7.	The environment was generally well maintained; however,	The practice must ensure that all doors have functioning locks and must review the environment to	Risk management	Comprehensive environmental review conducted, identifying all areas needing repairs	Collette England	June 2025

	a few areas needed repair.	identify areas in need of repair and action accordingly.		(including door locks). Repairs scheduled with immediate priority given to safety-critical areas.		
8.	We identified several areas of improvement that were needed to fully ensure the practice always upholds the required standards of IPC.	The practice must: • Take improvement action to address all the areas relating to IPC listed above • Strengthen its governance and oversight of the IPC processes considering the numerous issues we identified during the inspection. This should include more frequent IPC and clinical waste audits.	Infection, prevention and control (IPC) and decontamination	• Monthly IPC/Waste audits established. • Immediate action on sharps and clinical waste management improvements. • Quarterly trend analysis reports shared at governance meetings.	Collette England	Ongoing
9.	We identified aspects of the cold chain process that needed improving to ensure vaccine quality was maintained.	The practice must review and strengthen its cold chain storage and management processes which must include taking action to address the issues we have identified in the report.	Medicines management	• Cold chain protocols reviewed, updated, and reinforced through targeted staff training sessions. • Daily temperature logs implemented; monthly	Collette England	Complete

				compliance audits started immediately.		
10.	We saw instances where family members of children on the child protection register had not been flagged as potentially at risk within their own records. It also appeared that safeguarding concerns were not being regularly reviewed to evaluate whether the risk remained valid or could be removed.	The practice must: • Undertake an audit to ensure that all family members of children on the child protection register are also identified as potentially at risk • Undertake regular reviews to determine whether safeguarding risks remain active to ensure patient records are accurate and contemporaneous.	Safeguarding of children and adults	• Comprehensive audit initiated to flag all family members linked to child protection cases. • Safeguarding risks reviewed quarterly to ensure accuracy of patient records. • Level 3 Safeguarding training updates complete for clinical staff.	Michele Richards/Modupe Obilanade	Started Ongoing Complete
11.	Staff did not appear to be aware of the recent regulation 28 report and patient safety notice 041 reminder issued by the Welsh Government in relation to the correct operation of oxygen	The practice must ensure: • All patient safety alerts are circulated to staff and that the actions identified in PSN 041 including training requirements are completed	Effective care	• Patient Safety Notices (PSN 041) disseminated and discussed at staff meetings. • Competency-based oxygen cylinder training delivered to all relevant staff.	Aaron Lockitt	Complete

	cylinders manufactured by BOC.	• All relevant staff have received training to ensure they are competent in the use of setting up and using oxygen cylinders.				
12.	The receptionists' triage policy lacked sufficient detail and information in relation to specific care navigation pathways to help reception staff direct patients accordingly, particularly in emergency situations.	The practice must review and update its receptionists' triage policy to provide a more comprehensive guide for staff to follow in relation to specific care navigation pathways.	Effective care	• Triage policy comprehensively updated with specific care navigation guidance. • Staff briefed with policy updates; laminated copies placed at reception desks.	Michele Richards	Complete Ongoing
13.	Administrative staff had only received informal training on clinical coding. A clinical coding policy or guidance document was not available to support staff and regular audits of the clinical coding and summaries were not	The practice must: • Ensure administrative staff receive more formal training in clinical coding • Develop a clinical coding policy or guidance document that describes the procedure for staff to undertake the clinical	Patient records	• Formal clinical coding training sessions booked for administrative staff. • Clinical Coding Policy reviewed and disseminated. • Quarterly coding accuracy audits initiated.	Collette England Michele Richards Michele Richards	April 2025 Complete Ongoing

	being undertaken to check the quality of the data entry.	coding process consistently and correctly • Ensure regular audits of clinical coding are completed to monitor their accuracy.				
14.	We found examples of references made to England and not Wales in some practice policies.	The practice must ensure that all policies and procedures reflect the latest guidance for Wales where appropriate.	Governance and leadership	Comprehensive review of all policies completed, ensuring compliance with current Welsh guidelines, clearly stating where Welsh guidance aligns with English versions.	Michele Richards	Complete
15.	Staff members and senior management said that not all staff had received their annual appraisal.	The practice must ensure that all staff receive an annual appraisal to discuss their performance, set annual objectives and identify any training needs.	Skilled and enabled workforce	• Appraisals scheduled based on staff birth month to ensure timely completion. • Compliance monitored monthly and documented.	Collette England	Ongoing
16.	The flap of the letterbox containing repeat prescription forms had broken off which meant the forms containing confidential	The practice must implement a more secure way of managing requests for repeat prescriptions to maintain patient confidentiality at all times.	Information governance and digital technology	Secure, locked replacement prescription box installed immediately to ensure confidentiality.	Collette England	Complete

	information about patients could be accessed by other patients.					
17.	The practice faced challenges in engaging with health visitors to support their child population.	The health board must provide assurance to HIW on how it can improve the health visiting support to St Paul's Clinic to help families and children receive the support they need.	Partnership working and development	Formal request for support sent to Health Board.	Michele Richards	Complete

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): **Michele Richards**

Job role: **Business Manager**

Date: **24 March 2025**