Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report (Announced)

Practice 3 Keir Hardie Health Park, Cwm Taf Morgannwg University Health Board

Inspection date: 05 March 2025
Publication date: 05 June 2025

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager
Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

Or via

Phone: 0300 062 8163
Email: hiw@gov.wales
Website: www.hiw.org.uk

Digital ISBN 978-1-83715-827-0

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 Practice 3, Keir Hardie Health Park, Cwm Taf Morgannwg University Health Board on 5 March 2025.

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

During the inspection we invited patients or their carers 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 17 questionnaires were completed by patients or their carers and five 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:
During our inspection we saw a wide range of health promotion information available for patients. The information was displayed in the patient waiting area, on the display screen and will be promoted through the new practice website. We saw health promotion information on a variety of topics including vaccinations, support groups and carers information. We were told that during consultations, specific information would be printed or sent electronically to patients.

Practice 3 is located within Keir Hardie Health Park and provides staff with access to various healthcare professionals. These included access to physiotherapy, mental health services, sexual health, dietetics and pharmacists. This unique set up within the health park enables patients to access help and support from other agencies in a timely manner and in one location.

We found patients were treated with dignity and respect throughout their patient journey. Clinical rooms provided patients with an appropriate level of privacy, with doors kept closed during consultations. Privacy curtains were also available.

Practice 3 shares a reception and waiting area with two other practices. Observations of this space on the day highlighted a busy area, with patients queuing to speak with the reception team. Whilst we saw reception staff welcoming patients in a professional and friendly manner, the levels of privacy offered by this arrangement were limited. However, floor markings, belt barriers and signage were in place to offer as much privacy as possible.

There were processes in place to ensure patients could access the right service at the right time and in a timely manner. Appointments could be made via telephone, e-consults and in-person appointments. Most respondents who answered our questionnaire were able to get a same-day appointment when they need to see a GP urgently (11/16) and said they could get routine appointments when they need them (12/16). The majority of respondents said they were not offered the option to choose the type of appointment they preferred.

The practice offered good access for patients. We noted that patient areas including treatment rooms, and an accessible toilet were located on the ground floor.

This is what we recommend the service can improve:

- Ensure the new website is accessible when searching for it online and for it to contain practice specific information, including how appointments can be accessed and the types available
- Implement a pathway process to support the care navigation process in place

This is what the service did well:

- Good patient access
- Access to translation services, including sign language as well as a hearing loop which support effective communication
- Good access to other services and healthcare professionals located within the health park

Delivery of Safe and Effective Care

Overall summary:
There were processes in place to protect the health, safety and wellbeing of all who used the service, including within clinical rooms. Overall, the practice was clean and tidy, free of clutter and in a good state of repair.

Practice 3 shares the building with two other GP surgeries and has good cluster cooperation. This arrangement could ensure patient care could continue in the event of an extreme situation. We recommend the practice's emergency plan is updated to reflect the arrangements in an extreme situation.

Overall, the IPC arrangements in place were appropriate. However, we did find areas that required improvement to ensure the practice upholds the required standards of IPC to maintain the safety of staff and patients. At the time of our visit staff referred to the local health board IPC policy, which was not site specific. However following our visit, an IPC policy specific to the practice was submitted.

Processes were in place to ensure the safe prescribing of medication. We saw prescriptions were kept in a locked cupboard and logged upon receipt. There were good records being maintained.

All the emergency drugs and equipment was in place and meets the standards of the resuscitation council guidelines. There was nominated staff responsible for checking these on a weekly basis and the checks are documented. The emergency drugs were kept in a locked cabinet, and we recommended they are not locked during the practices' opening hours. Consideration should be given to storing these in a tamper evident bag.

The patient records we reviewed were clear, written to a good standard and complete with appropriate information. They were contemporaneous and information was easy to understand for other clinicians reviewing the records.

The safeguarding procedures in place were satisfactory supported by a policy, which also highlighted the named safeguard leads. However, we found that the level of safeguarding training relevant to staff roles, and as listed in the policy, did not correlate with staff records.

This is what we recommend the service can improve:

- Ensure staff have the required level of safeguarding training as listed in the policy
- Update the business continuity plan to include partnership risk and the emergency plan to include the arrangements in place in the event of an extreme situation
- Ensure emergency drugs are not locked away but consider storing these in a tamper evident bag
- Ensure that safety alerts are circulated to all staff and where applicable action any advice.

This is what the service did well:

- Patient records were clear, written to a good standard and complete with appropriate information. They were contemporaneous and information was easy to understand for other clinicians reviewing the records
- The practice demonstrated good cluster cooperation to ensure patient care could continue in the event of an extreme situation
- Medical devices and equipment were in good condition, safe to use and had been appropriately checked.

Quality of Management and Leadership

Overall summary:
There were processes in place to support effective governance, leadership and accountability, to ensure a sustainable delivery of safe and effective care. There were suitable processes in place to share any information updates with staff.

Staff had access to an online training platform, and we found that whilst most staff had completed their mandatory training, some needed refresher training which needs completing promptly to ensure their skills and knowledge remain up to date. A training matrix was being developed, which will provide an overview of training compliance for all the staff at the practice.

Staff were clear about their roles, responsibilities, and reporting lines, and the importance of working within their scope of practice. Information sharing with staff was facilitated through a shared drive and message notifications about changes in policies or procedures. Some policies and procedures require updating so they are specific to the practice.

The practice had a complaints process aligned with the NHS Wales Putting Things Right process, with identified staff responsible for managing complaints. Compliance with the Duty of Candour is supported by a policy, although training is recommended to ensure staff are aware of their responsibilities.

There were good collaborative relationships in place with external partners and within the cluster. The practice worked within the local GP cluster 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.

This is what we recommend the service can improve:

- Policies and procedures need to be specific to the practice and version control information consistent
- All staff must complete their mandatory training at a level specific to their role
- The training matrix needs to be populated for all staff and monitored regularly to ensure staff skills and knowledge remain current
- Ensure that systems for obtaining patient feedback are made clear and where applicable, show how they used this for service improvement.

This is what the service did well:

- Staff were friendly and engaging
- Well managed complaints process with systems to identify themes
- There were good collaborative relationships in place with external partners and within the cluster.

3. What we found

Quality of Patient Experience

Person-centred

Health promotion

During our inspection we saw a wide range of health promotion information available for patients. The information was displayed in the patient waiting area, on the display screen and will be promoted through the new practice website. We saw health promotion information on a variety of topics including vaccinations, support groups and carers information. We were told that during consultations, specific information would be printed or sent electronically to patients.

Practice 3 is located within Keir Hardie Health Park and provides staff with access to various healthcare professionals. These included access to physiotherapy, mental health services, sexual health, dietetics and pharmacists. This unique set up within the health park enables patients to access help and support from other agencies in a timely manner, in one location.

Staff at the practice work closely with their patient group to ensure they receive the right care from the right services. To ensure vulnerable patients receive timely care, the practice uses their system to identify patients and make certain they have access to services specific to their needs.

A 'was not brought' procedure was included in the safeguarding policy. The process used by staff to monitor instances where people do not attend their appointments was described and includes letters being sent, including any children and cared for patients who do not attend their appointments.

The preparations used by the practice to manage their annual winter vaccination programme were suitable and included arrangements for vulnerable people and those without digital access.

All respondents to the HIW patient questionnaire told us there was health promotion information on display at the practice. Nine patients that answered the question told us they were offered healthy lifestyle advice. 13 out of 16 respondents agreed that their GP explained things well to them and answered their questions, said they felt listened to, and they were involved as much as they wanted to be in decisions about their healthcare.

Dignified and respectful care

We found patients were treated with dignity and respect throughout their patient journey. Clinical rooms provided patients with an appropriate level of privacy, with doors kept closed during consultations. Privacy curtains were also available.

All but two of the respondents who answered felt they were treated with dignity and respect (14/16) and all who answered said measures were taken to protect their privacy.

Practice 3 shares a reception and waiting area with two other practices. Observations of this space on the day highlighted a busy area, with patients queuing to speak with the reception team. Whilst we saw reception staff welcoming patients in a professional and friendly manner, the levels of privacy offered by this arrangement were limited. However, floor markings, belt barriers and signage were in place to offer as much privacy as possible.

Nine out of 15 patients who responded in the questionnaire regarding their ability to talk to reception staff without being overheard, agreed with this statement.

We saw notices displayed offering a chaperone service and a policy was also in place. All staff were trained on chaperoning, and the practice could offer male and female chaperones. The patients who responded to the question said they were offered a chaperone.

Timely

Timely care

There were processes in place to ensure patients could access the right service at the right time and in a timely manner. Appointments could be made via telephone, e-consults and in-person appointments. Most who answered the HIW survey were able to get a same-day appointment when they need to see a GP urgently and said they could get routine appointments when they need them. Very few respondents said they were offered the option to choose the type of appointment they preferred.

An access policy was in place, and we recommended that this is added to the new website to detail all the appointment types and how they can be accessed.

The practice must update their new website regarding accessing appointments, detailing how appointments can be accessed and the types available.

We were told if a patient requests to be seen, they will be given an appointment. If all appointments have been booked and there is a patient needing to be seen

urgently, they will be offered an appointment. Children requiring a face-to-face appointment are accommodated.

We found the care navigators were all trained, assigning patients to the most appropriate person or service. There was no specific pathway document/flowchart in place, and we recommend a pathway is implemented with input from clinical and non-clinical staff.

The practice must implement a pathway process document to support the care navigation process in place.

There were suitable processes in place to support patients in a mental health crisis. Where appropriate, patients are referred to primary care mental health team. Alternative support and signposting were also available for patients needing mental health support, including counselling and therapy services from third sector services.

In response to the HIW questionnaire:

- 15 out of 16 patients said they were satisfied with the opening hours of the practice
- 13 out of 16 patients said they were able to contact the practice when they need to by phone/online booking system.

Equitable

Communication and language

We found staff communicating in a clear manner and in a language appropriate to patient needs. They provided information in a way that enabled patients to make informed decisions about their care. The surgery had a hearing loop to support those hard of hearing and access to translation services which included sign language.

Patients are usually informed about the services offered at the practice through social media, text message service and a newsletter when there is something to communicate. The new website will offer another platform of keeping patients informed of any changes to the practice. Where patients are known not to have digital access, letters would be sent to individuals, and communication via telephone calls.

There were appropriate processes in place for the recording and action of information from secondary care. Letters and documents are scanned onto patient notes and directed to the correct health care practitioner to action as required.

The practice ensured messages were communicated internally to the appropriate people, by using the practices communication and technology (ICT) systems. External correspondence is scanned onto the system and actioned accordingly by the most appropriate person. Correspondence remains on the list until it is actioned appropriately and there are key staff responsible for this process.

Rights and equality

The practice offered good access for patients. We noted that patient areas including treatment rooms, and an accessible toilet were located on the ground floor.

All patients responding to our questionnaire thought the building was easily accessible.

We saw evidence of an equality and diversity policy in place, and staff had completed equality and diversity training. Three respondents who answered the question told us they feel they cannot access the right healthcare at the right time (3/16) and that they faced discrimination when accessing the service. The discrimination faced was on the grounds of age (2/15) and disability (1/15).

The rights of transgender patients were also upheld, staff confirmed that preferred pronouns and names were used from the outset of transition.

Delivery of Safe and Effective Care

Safe

Risk management
There were processes in place to protect the health, safety and wellbeing of all who used the service, including within clinical rooms. Overall, the practice was clean and tidy, free of clutter and in a good state of repair.

A business continuity plan (BCP) was in place and readily available for all staff. We found the BCP referred to the risk of any long-term staff absence/business partnership risk, however, it did not include how this would be addressed and recommended the policy is updated to include this. We found the BCP referred to a wider health board plan on how to deal with a significant health emergency, although this was not incorporated into the policy. We recommended the policy is updated to include information specific to the practice on how to deal with a health emergency.

The practice must update their business continuity plan to include business partnership risk and how the practice would deal with a significant health emergency.

Practice 3 shares the building with two other GP surgeries and has good cluster cooperation. This arrangement could ensure patient care could continue in the event of an extreme situation. We recommend the emergency plan is updated to reflect the arrangements in an extreme situation.

The practice must update their BCP/emergency plan to include the arrangements in place in the event of an extreme situation.

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

The emergency drugs and equipment were stored appropriately, and staff were able to locate this in an emergency.

We were told in the event of a patient facing a lengthy wait for an ambulance, doctors would assess the suitability of alternative transport against the urgency of the case.

Infection, prevention and control (IPC) and decontamination

Overall, the IPC arrangements in place were appropriate. However, we did find areas that required improvement to ensure the practice upholds the required standards of IPC to maintain the safety of staff and patients.

At the time of our visit staff referred to the local health board IPC policy, which was not site specific. However following our visit, an IPC policy specific to the practice was submitted.

The practice had appointed a new nurse, who was completing her transitioning to primary care training. While the IPC policy did not designate the nurse as the IPC lead, the practice-specific policy submitted subsequently did. This was recognised during our visit and the new policy has a named IPC lead for the practice. During discussions, we were reassured the nurse understood her role and responsibilities in upholding IPC standards.

We found staff had completed infection control training, but we recommended the nurse complete level 2 training for her role as the practice IPC lead. Public Health Wales advocate and advise that all patient facing staff undertake level 2 training which can be accessed via e-learning.

The practice must ensure that the practice nurse completes level 2 training to support her role as the IPC lead.

Discussions with staff confirmed all relevant clinical staff had Hepatitis B immunisations and flu vaccines were offered to staff.

A needlestick policy was in place. There were no needlestick advice posters displayed on the walls and we recommended these are displayed in each clinical room.

The practice must ensure that a needlestick advice poster is implemented and displayed in each clinical room.

Appropriate procedures were in place for the management and disposal of all waste. A generic NHS waste policy was in place but requires updating so it is specific to Practice 3. In addition, the review date for this policy was November 2024.

The practice must update the waste management policy in line with the review date and ensure it is specific to the practice.

From discussions with staff, we learned that during COVID, the practice shared an identified room with another practice to allow for segregation of people to reduce the risk of healthcare acquired infections. During our visit, some staff identified another room which potentially could be used for this purpose. The IPC policy has a link to guidance on this subject but does not clearly state how Practice 3 will segregate people with transmissible infections to reduce the risk of cross infection. Patients responding to the questionnaire agreed there were signs at the entrance explaining what to do if they had a contagious infection.

The practice must ensure the IPC policy is specific to Practice 3 and clearly identifies how they will segregate people with transmissible infections to reduce the risk of cross infection.

All the cleaning at the practice was managed by the building landlord. Staff were responsible for cleaning their own equipment and schedules were in place for this.

The patients responding to the questionnaire agreed that healthcare staff washed their hands before and after treating them, and those that answered the question said in their opinion the practice was clean or very clean.

Medicines management

Processes were in place to ensure the safe prescribing of medication. We saw prescriptions were kept in a locked cupboard and logged upon receipt. There were good records being maintained.

We were unable to locate a medication cold chain policy, and some staff told us there wasn't one in place. We were told that a member of staff receives the vaccine stock directly from the delivery and is placed immediately in the fridge. Twice daily temperature checks were completed and recorded. We found one refrigerator with some stock being kept on the fridge floor. This could impede the flow of air and maintain appropriate temperatures. We recommended the practice contact the fridge manufacturer to obtain the correct storage of stock so as to allow adequate circulation of air.

The practice must confirm they have or implement a cold chain policy and that it is specific to the practice.

The practice must contact the fridge manufacturer to ensure the storage of stock is appropriate and ensure appropriate cool air flow.

The practice had a nominated person responsible for checking the drugs on a weekly and monthly basis and the staff were aware of who this is.

All the emergency drugs and equipment were in place and met the standards of the resuscitation council guidelines. There was nominated staff responsible for checking these on a weekly basis and the checks were documented. The emergency drugs were kept in a locked cabinet, and we recommended they are not locked during the practices' opening hours. Consideration should be given to storing these in a tamper evident bag.

The practice must ensure emergency drugs are not locked away but consider storing these in a tamper evident bag.

An automated external defibrillator (AED) was in place and was fully charged. We found the AED had pads for both adults and children. All staff knew the location of the AED, and there was a sign on the door to specify the location.

We saw the oxygen cylinders had the appropriate stock levels and was checked on a weekly basis. However, a safety alert issued in September 2024 had not been actioned by staff and we recommended they obtain the alert and undertake the associated recommended training.

The practice must ensure safety alerts are circulated to all staff and where applicable action any advice.

Safeguarding of children and adults

We considered the safeguarding procedures in place at the practice and found a policy in place which included both adults and children. The policy referenced the national Wales safeguarding procedures and was available for all staff on the shared drive. The practice had named safeguarding leads which were recorded in the policy.

The safeguarding policy included the levels of training required for staff. We were provided with evidence of the safeguarding lead and some other staff. However, we did not see evidence that all staff had completed safeguarding training at the required level.

The practice must ensure all staff undertake the required level of safeguarding training (both children and adult) appropriate to their role, and a record should be kept to evidence this.

On review of patient records, we saw examples where people were appropriately flagged with any safeguarding concerns and followed a suitable safeguarding pathway.

Management of medical devices and equipment

We found medical devices and equipment were in good condition, safe to use and had been appropriately checked by a named person. Suitable contracts were in place for the repair or replacement of relevant equipment. Single use items were used where appropriate and disposed of correctly.

Effective

Effective care

Suitable processes were in place to support the safe, effective treatment and care for patients. We were told that any changes or new guidance is emailed and discussed with staff in meetings.

Appropriate processes were in place for reporting incidents, including discussions at internal meetings and Datix reporting, where appropriate. We noted minutes of meetings are not formally captured and recommend they are.

Patient referrals were managed to a good standard, including those which are urgent. Patient records contained investigation/ test results and had narrative as to why investigations were requested.

Patients in need of urgent medical help or those in a mental health crisis were provided with suitable support and information. The practice has access to the local mental health crisis team that are located in the same building.

Patient records

We reviewed ten electronic patient records which were stored securely and were password protected from unauthorised access. Overall, the records were clear, written to a good standard and complete with appropriate information. They were contemporaneous and information was easy to understand for other clinicians reviewing the records.

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 use of clinical read codes was being used consistently, which makes analysis and audit easier.

We found one record where consent was not recorded. This was discussed at the time and due to the nature of the intimate examination it was implied that consent was given, however, consent should always be recorded.

Efficient

Efficient

We found that services were arranged in an efficient manner and are person centred, to ensure people feel empowered in their healthcare journey.

The practice can refer to physiotherapy and mental health services and some services were located within the health park.

There are close working relationships with the cluster group and staff work across services to effectively coordinate care and promote best outcomes for patients.

Quality of Management and Leadership

Leadership

Governance and leadership

There were processes in place to support effective governance, leadership and accountability, to ensure a sustainable delivery of safe and effective care. Staff were clear about their roles, responsibilities and reporting lines and the importance of working within their scope of practice.

The practice had a process in place for sharing information with staff, such as changes in policies or procedures. All policies and procedures were on the shared drive and all staff would be told about any changes verbally and via messenger.

We found some inconsistencies with the document control on the polices we saw. Policies including the access policy and safeguarding policy had no version control information. We also identified polices that need updating so they are specific to the practice.

The practice must ensure all policies and procedures are specific to the practice and contain version control information.

We were told safety notices are received by the practice manager who shares them with staff. However, as identified in the medicines management section, we found staff had not implemented the recommendations from a safety notice in September 2024. The practice should consider having a system in place that confirms any actions from future alerts/notices are shared and documented.

We were told staff meetings do take place, however, some of these are not documented. We recommended minutes and actions are captured at all meetings.

The practice must document all meetings and any actions arising.

We were told staff have access to a confidential wellbeing programme and within the practice we saw designated leads for specific practice area that would be able to offer advice. The practice worked closely within the health board cluster group and worked collaboratively to lead projects, share learning and jointly manage initiatives.

Workforce

Skilled and enabled workforce

We spoke with staff across a range of roles. They all had sound knowledge of their roles and responsibilities, and each appeared committed to providing a quality service to patients.

Staff told us the process the practice uses for recruitment and conducting pre-employment checks, which included written references, evidence of registration with professional bodies and disclosure and barring (DBS) checks.

We found the system being used to check a healthcare's professional registration involved staff submitting a copy of their professional certificate for their staff file or checking the online professional register.

We were told the practice will ask staff to provide a self-declaration to confirm they remain suitable to work for the service and no changes have occurred since their last DBS check. Annual appraisals are undertaken for staff.

An induction process was available for new staff and a recruitment policy was in place. The contents of which included what we had been told.

There was no workforce plan in place, but we were told due to the limited staff numbers, staff leave is planned in advance so cover can be arranged. We were told there were no issues with the skill mix across the teams and this is reviewed regularly by the practice manager, ensuring staff numbers and clinical staff levels are maintained.

Generally, we found staff had completed their mandatory training, however, we identified some areas which need to be completed as soon as possible to ensure staff skills and knowledge are up to date. Safeguarding children and adults was an area that requires updating in line with the practices' policy.

The practice must ensure all staff are up to date with their mandatory training and complete the levels applicable to their role.

A training matrix was being developed which will provide an overview of training compliance for all the staff at the practice. All staff had access to an online training platform.

The practice must update the training matrix for all staff and ensure it is monitored regularly to ensure staff skills and knowledge remain current.

A review of staff records showed their files contained employment information specific to the requirements in the recruitment policy. This information included contracts of employment and references.

We were assured that staff would be supported to raise a concern should the need arise, and we were provided with the practice whistleblowing policy.

Staff results from the HIW questionnaire confirmed:

- All staff agreed they were able to meet all the conflicting demands on my time at work
- All agreed they had adequate materials, supplies and equipment to do their job
- All staff agreed there is an appropriate skill mix at the setting.

Culture

People engagement, feedback and learning

The practice had a comprehensive complaints process in place. A complaints procedure and policy were aligned to the NHS Wales Putting Things Right process. There were identified staff at the practice responsible for managing all complaints. This was clear within the complaints policy. Complaints/concerns are monitored to identify any themes and trends, and any actions for improvement are communicated to staff.

We were told that patient questionnaires are sent to collect feedback about the service. However, we found no evidence within the practice of how patients can make suggestions. Patients can verbally speak to staff, and they will ensure that they document their feedback and action accordingly. We recommended that systems for obtaining patient feedback are made clear and where applicable, the practice should show how they used this for service improvement.

The practice must have clear information available about how patient suggestions/feedback can be provided.

We spoke to staff about the arrangements in place regarding compliance with the Duty of Candour. A Duty of Candour policy was in place, but we were unable to find evidence that all staff had completed Duty of Candour training. We recommended training is undertaken to ensure staff are aware of their responsibilities as set out in the Duty of Candour Statutory guidance 2023.

Results from the HIW staff survey showed that all staff agreed that they know and understand the Duty of Candour; they understand their role in meeting the standards and they are encouraged to raise concerns when something has gone wrong and to share this with the patient.

The practice must confirm staff have completed Duty of Candour training.

Information

Information governance and digital technology

The practice understood its responsibility when processing information and demonstrated that data is managed in a safe and secure way. A current information governance policy was in place to support this.

The practice's policy for handling patient data was available on the shared drive. We recommend that this is added to the new website.

The practice must add their data handling policy to their new website.

Learning, improvement and research

Quality improvement activities

There was evidence of clinical and internal audit in place to monitor quality. We were told learning was shared across the practice to make improvements.

Whole-systems approach

Partnership working and development

The practice provided examples of how it, as a stakeholder in patient care, impacts on other parts of the healthcare system. This included following health board clinical pathways. The practice also interacts and engages with system partners at various multidisciplinary meetings, such as cluster meetings and practice manager meetings.

There were good collaborative relationships in place with external partners and within the cluster. The practice worked within the local GP cluster 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.

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
No immediate concerns were identified on this inspection			

Appendix B - Immediate improvement plan

Service: Practice 3, Keir Hardie Health Park

Date of inspection: 5 March 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.	No immediate assurances were identified on this inspection					
2.						

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 C - Improvement plan

Service: Practice 3, Keir Hardie Health Park

Date of inspection: 5 March 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.	We found the care navigators were all trained, assigning patients to the most appropriate person or service. There was no specific pathway document/flowchart in place, and recommended a pathway is implemented with input from clinical and non-clinical staff.	**The practice must implement a pathway process document to support the care navigation process in place.**	Health & Care Quality Standards - Information	Practice 3 have implemented a flow chart.	Practice Manager	Completed

2.	We found the BCP referred to the risk of any long-term staff absence/business partnership risk, however it did not include how this would be addressed and recommended the policy is updated to include this	**The practice must update their business continuity plan to include business partnership risk and how the practice would deal with a significant health emergency.**	Health & Care Quality Standards – Information	Practice 3 have updated their BCP to contain the information recommended.	Practice Manager	Completed
3.	Practice 3 shares the building with two other GP surgeries and has good cluster cooperation. This arrangement could ensure patient care could continue in the event of an extreme situation. We recommend the emergency plan is updated to reflect the arrangements in an extreme situation.	**The practice must update their BCP/emergency plan to include the arrangements in place in the event of an extreme situation.**	Health & Care Quality Standards – Information	Practice 3 have updated their BCP accordingly following the recommendation during our HIW visit.	Practice Manager	Completed

4.	We found staff had completed infection control training, but recommended the nurse compete level 2 training for her role as the practice IPC lead.	**The practice must ensure that the practice nurse completes level 2 training to support her role as the IPC lead.**	Health & Care Quality Standards – Information; Safe; Workforce	Practice 3 recruited a new part time nurse a few weeks prior to our HIW visit. IPC training was included at induction and listed on the training and development plan. Our new nurse is new to Primary Care and has a comprehensive plan with which she is working towards becoming a fully competent member of the team.	Practice Manager	July 2025
5.	There were no needlestick advice posters displayed on the walls and we recommended these are displayed in each clinical room.	**The practice must ensure that a needlestick advice poster is implemented and displayed in each clinical room.**	Health & Care Quality Standards – Information; Safe	Practice 3 have implemented this action on recommendation.	Practice Manager	Completed
6.	A generic NHS waste policy was in place but requires updating	**The practice must update the waste management policy in line with the**	Health & Care Quality Standards – Information	Practice 3 is located within Health Board premises and adheres	Practice Manager	Completed

	so it is specific to Practice 3.	**review date and ensure it is specific to the practice.**		to their waste management policy and waste segregation policy. Posters are displayed as a reminder to staff to dispose of all waste appropriately with an environmental (green) approach. A practice policy has been developed which includes links to Health Board policies to ensure they are viewed online to consider relevant updates which will not be distributed to the Practice.		
7.	From discussions with staff, we learned that during COVID, the practice shared an identified room with	**The practice must ensure the IPC policy is specific to Practice 3 and clearly identifies how they will segregate people with**	Health & Care Quality Standards – Information	Practice 3 have rewritten areas of our IPC policy following change recommendations	Practice Manager	Completed

	another practice to allow for segregation of people to reduce the risk of healthcare acquired infections. During our visit, some staff identified another room which potentially could be used for this purpose. The IPC policy has a link to guidance on this subject but does not clearly state how Practice 3 will segregate people with transmissible infections to reduce the risk of cross infection.	**transmissible infections to reduce the risk of cross infection.**		received. This coincidently was a few days after our HIW visit.		
8.	We were unable to locate a medication cold chain policy, and some staff told us there wasn't one in place.	**The practice must confirm they have or implement a cold chain policy and that it is specific to the practice.**	Health & Care Quality Standards – Information	Practice 3 confirm we have a specific cold chain policy. This was last updated in December 2024 prior to our HIW visit.	Practice Manager	Completed

9.	We found one refrigerator with some stock being kept on the fridge floor. This could impede the flow of air and maintain appropriate temperatures. We recommended the practice contact the fridge manufacturer to obtain the correct storage of stock so as to allow adequate circulation of air.	**The practice must contact the fridge manufacturer to ensure the storage of stock is appropriate and ensure appropriate cool air flow.**	Health & Care Quality Standards – Information; Safe	Practice 3 have acted on the comments. Anti – coagulation strips are no longer stored in the basket in the bottom of the fridge. We confirm air circulation continues in line with manufacturer's requirements.	Nursing Team	Completed
10.	The emergency drugs were kept in a locked cabinet, and we recommended they are not locked during the practices' opening hours. Consideration should be given to storing these in a tamper evident bag.	**The practice must ensure emergency drugs are not locked away but consider storing these in a tamper evident bag.**	Health & Care Quality Standards – Safe	Practice 3 have reviewed our storage of emergency drugs.	Clinical team	Completed

11.	A safety alert issued in September 2024 had not been actioned by staff and we recommended they obtain the alert and undertake the associated training recommended.	**The practice must ensure safety alerts are circulated to all staff and where applicable action any advice.**	Health & Care Quality Standards – Information	Practice 3 have undertaken the associated training	Clinical team	Completed by staff in P3. Staff on leave will complete on their return. April 2025
12.	We were provided with evidence of the safeguarding lead and some other staff, however, we did not see evidence that all staff had completed safeguarding training at the required level.	**The practice must ensure all staff undertake the required level of safeguarding training (both children and adult) appropriate to their role, and a record should be kept to evidence this.**	Health & Care Quality Standards – Information; Safe; Workforce	Practice 3 have obtained evidence of clinicians training.	Clinical team Practice Manager	Completed
13.	We found some inconsistencies with the document control on the polices we saw. Policies including the access policy and safeguarding policy had no version control information. We also	**The practice must ensure all policies and procedures are specific to the practice and contain version control information.**	Health & Care Quality Standards – Information	Practice 3 confirm an oversight with omission of the version number on a few policies and have updated these policies to correct this error.	Practice Manager	Completed

	identified polices that need updating so they are specific to the practice.			It should be noted that policies are reviewed annually. Policies are updated sooner to meet changes in procedures and legislation where applicable.		
14.	We were told staff meetings do take place, however some of these are not documented.	**The practice must document all meetings and any actions arising.**	Health & Care Quality Standards – Information	Practice 3 document all meetings with GP partners and staff. Practice 3 employ less than 10 part time staff and have a proactive approach to patient care. The practice manager will inform 2-3 staff of on-the-spot changes and/or updates during the day to ensure the smooth running of the Practice. This is also part of staff		Huddles are documented following HIW recommendations

				wellbeing and support, to address issues immediately. We refer to these informal gatherings as a 'huddle'.		
15.	Generally, we found staff had completed their mandatory training, however we identified some areas which need to be completed as soon as possible to ensure staff skills and knowledge are up to date.	**The practice must ensure all staff are up to date with their mandatory training and complete the levels applicable to their role.**	Health & Care Quality Standards – Workforce	We identified during our HIW visit that not all staff had completed Duty of Candour training. This is not mandatory for all staff but was recommended and training has been untaken. New staff have some outstanding training which had been added to their Personal Development Plan.	Practice Manager	Completed by some staff and planned for the remaining staff. July 2025
16.	A training matrix was being developed which will provide an overview of training	**The practice must update the training matrix for all staff and ensure it is monitored regularly to ensure staff skills and**	Health & Care Quality Standards – Information; Workforce	Practice 3 have developed a staff training matrix as an overview in addition to the individual	Practice Manager	Completed

	compliance for all the staff at the practice.	**knowledge remain current.**		training matrix held in staff HR records		
17.	We were told that patient questionnaires are sent to collect feedback about the service. However, we found no evidence within the practice of how patients can make suggestions. Patients can verbally speak to staff, and they will ensure that they document their feedback and action accordingly.	**The practice must have clear information available about how patient suggestions/feedback can be provided.**	Health & Care Quality Standards – Information; Culture	Practice 3 direct patients to our website to provide feedback. Patients who raise concern or make comments either over the telephone or when attending the practice are directed to the practice manager. We aim to resolve all matters as soon as practically possible. Practice 3 contact patients for their feedback and opinion when implementing a new process.	Practice Manager	Completed and ongoing as required.
18.	We were unable to find evidence that all staff had completed	**The practice must confirm staff have completed Duty of Candour training.**	Health & Care Quality Standards – Workforce	Practice 3 confirm this has been actioned with non - clinical staff.	Practice Manager	Completed Clinicians to complete as soon as possible.

	Duty of Candour training.					
19.	The practice's policy for handling patient data was available on the shared drive. We recommend that this is added to the new website.	**The practice must add their data handling policy to their new website**	Health & Care Quality Standards – Information	Practice 3 confirm actions	Practice Manager	Completed

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): Debbie Milton

Job role: Practice Manager

Date: 17th April 2025