Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

# General Practice Inspection Report
(Announced)

## Dewi Sant Branch Practice, Taff Vale Practice, Cwm Taf Morganwg 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 Dewi Sant Branch Practice, Taff Vale Practice, Cwm Taf Morgannwg University Health Board on 10 April 2025.

Our team for the inspection comprised of two HIW healthcare inspectors 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 six questionnaires were completed by patients or their carers 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:
We received a limited number of responses to our patient questionnaire, which may not fully represent the entire cohort. However, the feedback was predominantly negative, but the sentiment was strong regarding accessing appointments and the process for this. Despite this, our inspection revealed several processes in place to ensure timely and appropriate access to care.

Information was displayed on health promotion and there were monthly displays that focussed on specific health topics.

Respiratory syncytial virus immunisation clinics were held at various locations within the practice catchment area, with staff contacting patients via telephone, texts, and letters.

Clinical rooms had lockable doors and privacy curtains. Chaperones were available for patients, with trained staff of both genders.

Mental health support included referrals to child and adolescent mental health services (CAMHS), primary mental health services and crisis intervention.

Communication was clear and accessible, with translation services available. Equality and diversity was promoted through policies and training, with specific support for transgender patients.

This is what we recommend the service can improve:

- Review patient feedback regarding access to appointments.

This is what the service did well:

- Displaying information to help staff maintain their own health
- Respiratory syncytial virus immunisation clinics
- Clinical rooms to ensure patient dignity and privacy.

## Delivery of Safe and Effective Care

Overall summary:
Overall, the practice demonstrated a commitment to maintaining a safe, clean, and well-organised environment, ensuring high standards of patient care and staff wellbeing.

There was a business continuity plan (BCP) which covered emergencies, including pandemics. Staff were aware of the BCP, which was accessible both on-site and off-site. Safety alerts and significant events were communicated to staff through meetings and electronic messaging.

The practice has sufficient GP partners and salaried GPs, reducing the need for locums. There were regular safeguarding meetings ensuring effective multi-agency cooperation.

An infection prevention and control (IPC) policy was in place, with a designated lead nurse. Sharps bins were appropriately managed and staff were aware of needlestick policies. The practice maintained records of staff immunisations and followed a blood-borne virus policy.

Overall, processes ensured the safe prescribing and management of medications. A pharmacist conducted medication reviews and the cold chain for vaccines was maintained.

Emergency drugs and equipment, including oxygen and defibrillators, were available and regularly checked. All staff were aware of the location of emergency drugs and equipment.

Both paper and digital systems were used for patient records, ensuring clear and accurate documentation, summarising and coding of records were regularly reviewed for quality.

The practice supported patient access to various services, including mental health and physiotherapy. Initiatives were in place to reduce emergency department visits and support frequent attenders.

This is what we recommend the service can improve:

- Implement a process for the safety of lone workers during home appointments
- Oxygen cylinders are appropriately stored
- The use of a chaperone during treatment is appropriately documented.

This is what the service did well:

- A commitment to maintaining a safe, clean and well-organised environment
- The practice maintained records of staff immunisations
- Patient records were concise and clear.

## Quality of Management and Leadership

Overall summary:
Overall, the practice demonstrated a commitment to effective governance, staff wellbeing, continuous improvement and patient-centred care. There were clear roles, responsibilities and reporting lines for staff and managers. Policies and procedures were version-controlled and accessible on the shared drive. There were regular team meetings and clinical meetings to discuss updates and share information.

Positive actions were taken to support staff health and wellbeing, with most staff achieving a good work-life balance.

There were gaps in mandatory training for some staff, including equality and diversity, safeguarding and health and safety. Whilst there were regular appraisals for nursing staff, there were delays for salaried GPs and administrative staff.

A recruitment policy and induction process was in place, but there were gaps in maintaining a full employment history and DBS checks, including no self-declarations of DBS status.

Monitoring and documentation of complaints was generally good, with processes to identify themes and trends, this could be strengthened by implementing a designated complaints lead. The practice participated in the NHS Annual Survey with positive patient feedback.

The practice engaged in cluster-wide projects and audits to improve care delivery.

This is what we recommend the service can improve:

- Compliance with the recruitment policy
- Completing DBS checks before staff commence employment
- Ensure all staff complete mandatory training at the required level
- Complete annual appraisals for all staff in a timely manner.

This is what the service did well:

- A commitment to effective governance and continuous improvement
- Policies and procedures were version-controlled and accessible
- Monitoring and documentation of complaints was generally good
- The practice engaged in cluster-wide projects and audits to improve care delivery.

# 3. What we found

# Quality of Patient Experience

## Patient feedback

HIW issued a questionnaire to obtain patient views on the service provided at the practice. There were six patient surveys completed, and the results were not all positive, including all six saying they could not get routine appointments when they needed them and they could not easily access regular support for ongoing medical conditions. They also said they could not talk at reception without being overheard and their appointment was not on time. However, five of the six patients said they were treated with dignity and respect and the GP explained things well and answered their questions.

It is pertinent to note that the number of responses is a very small percentage of people for the catchment area and therefore may not fully reflect the patient cohort overall. However, any patient feedback is important, and the sentiment was strong in most patient comments, which highlighted frustrations with accessing appointments and the process for this:

> ***"…appointments are impossible unless you are a friend to one of them or have been with them a long time. They (not doctors) decide if you're ill enough to see a GP. Prescriptions are constantly lost and they don't care.***
>
> ***" …Call backs don't happen, then they say it's your fault. I would like to leave them however they are my closest GP. Six weeks waiting for blood results now told to wait another two weeks…."***
>
> ***"Automated appointment system is next to useless No one answers the phone. Doctors are so rushed that they have no time to care for me."***
>
> ***"There is a practice on the estate I live but always have to travel to another location which includes bus services as I don't drive but I do have mobility issues "***
>
> ***"We, as a fortunate family are astounded at the lack of care given by this establishment. Our choice was to live rural, which apparently means making the choice for far below par care. My [redacted] have conditions that are largely ignored and brushed off. Including me having***

*to pay a private GP to get the necessary diagnosis to seek treatment privately.*

*"Getting past the receptionist is a skill unto itself… their job is not to diagnose a condition over the phone, their job is to listen and seek an appropriately times appointment.*

*"Try getting an appointment urgently is near impossible also, if you're lucky enough… you MIGHT be offered an appointment in 2 weeks' time, which for a serious illness is purely unacceptable."*

The above comments were concerning, particularly regarding the ability to access the service in a timely manner and navigating the process to request an appointment.

**The practice must consider the patient comments and inform HIW of the actions it will take to address these issues.**

We received another comment in response to our questionnaire, relating to alleged missing prescriptions (which allegedly included controlled drugs), as follows:

*"On two occasions recently, my prescription was sent to pharmacies in the RCT area. I never asked for this and feel like it goes against GDPR to just give my information, without my permission to a third party. My prescription at the desk has been lost on several occasions and I take controlled medication. The staff who answer the telephone are extremely rude."*

**The practice must review the prescription process, including issuing and collection of these, to maintain the security of patient data and of prescriptions.**

## Person-centred

### Health promotion

The practice had a range of written health promotion information available that was displayed on notice boards and on the practice website. This included smoking cessation, mental health, dementia support, weight management and healthy eating advice. The website also had information and links providing advice and support relating to health and wellbeing, as well as self-care for certain illnesses and conditions. We also noted one set of posters, which were known as posters of the month, which were change monthly. For April, the posters were about cancers

and self-help to reduce stress. **This is a noteworthy initiative to raise a focussed awareness on certain health topics.**

There was a display screen in the practice waiting area, but this was not working at the time of the inspection. We were told information relating to health promotion would also be displayed on this display screen.

We were told that new patients were provided with a 'new patient pack' including a practice leaflet and information relating to healthy living, smoking cessation and weight management, in addition to a patient questionnaire. The practice information leaflet was also available on the practice website. A large print copy was also available on request.

Staff told us the recent influenza vaccination clinics were arranged at each site and two were on a Saturday morning near the closed former branches in Cilfynydd and Ynysybwl. Staff told us they printed lists of those patients due a vaccination and in addition to calling the patients, staff also sent text messages and letters.

All staff in the questionnaire agreed the practice offered health promotion advice and information about chronic conditions to patients in a variety of mediums.

The process used by the practice to manage patients who did not attend or were not brought to their appointment, complied with the 'was not brought' policy, which was current and up to date. This policy set out what staff would do if children, young people or adults were not brought to an appointment.

All staff in the questionnaire agreed the practice offered health promotion advice and information about chronic conditions to patients in a variety of mediums.

**Dignified and respectful care**
The environment supported the rights of patients to be treated with dignity and respect. The clinical rooms provided appropriate levels of privacy, with lockable doors. There were also disposable privacy curtains within the examination rooms. The external windows had curtains to maintain privacy.

In contrast to the patient comments highlighted earlier we observed reception staff welcoming patients in a professional and friendly manner. The practice respected the confidentiality and privacy of people.

Most telephone calls would be taken or made in the room behind the reception desk. Whilst some telephone conversations could be overheard in reception, we were told that no patient identifiable information would be discussed. The reception desk was located opposite the waiting area, which offered some level of

privacy from those waiting. Rooms were also available to maintain discreet conversations between patients and staff next to the reception area.

Chaperones were all trained in house and there were both male and female staff available. Patients were informed of the availability of chaperones through signs on each clinical room door.

All staff in the questionnaire stated that patients were offered chaperones when appropriate and measures are taken to protect patient confidentiality and patient privacy and dignity.

## Timely

**Timely care**
Processes were in place to ensure people could access care via the appropriate channel and with the most appropriate person in a timely manner, however, some patient survey comments contradicted this. There was information on the practice website to signpost patients to the different options available to them to access appointments and advice from a health care professional. There were also notices in the practice on access standards. This included appropriate support and signposting for people that presented in mental health crisis or with poor mental health.

The practice had an up-to-date practice access policy. There were arrangements in place for older people or other vulnerable groups who may need a face-to-face appointment and children would be seen in person when they needed to see a GP.

We noted the appointment system had been adapted to the patient population. Longer appointment times were available for routine appointments where appropriate to account for the patient population with a higher percentage of co-morbidity and deprivation. Separate slots were allocated to give test results with shorter appointment times. Staff also had systems in place to care navigate to other services.

There was a system to respond to urgent home care requests which were triaged by the on-call GP. The GP would call the patient prior to visiting the patient. Patients who were housebound or disabled were flagged on the patient medical record system.

We were told all staff had completed care navigation training with Health Education and Improvement Wales (HEIW) and that clinical staff were readily available to provide support if staff were unsure of the best options for a patient.

A triage process known as 'Prioritisation of patients: A guide to urgency for non-clinical staff' (POPGUNS) was used to identify urgent cases.

The on-call doctor would triage patients and those with urgent problems would receive a face-to-face appointment if appropriate. Care navigators could also redirect to the common ailments scheme at the pharmacy, first contact physiotherapist, optician and dentist.

There were various services available to support patients with mental health problems. Services were provided by the third sector or by service level agreement via cluster initiatives. Talking therapies was a cluster initiative in Taff Ely, Men's Sheds were cluster initiative but are now provided by the third sector, following the initial set up. There were also processes for the safety netting and follow up of patients after they had been seen by other services.

Where a patient required urgent mental health support, or they were in crisis and needed an urgent mental health assessment, they would be assessed by the duty doctor. Patients would also be signposted to NHS 111 Wales, option 2 (mental health support line), as required. Children with mental health issues would have an urgent Child and Adolescent Mental Health Services (CAMHS) referral and could also contact NHS 111 Wales, option 2.

Mental health practitioners were also available through the primary mental health services, which were a single point of access and would navigate patients to suitable services. Additionally, the Taff Ely Cluster had also funded additional practitioners to work in practice. The practice was made aware when a patient had received crisis intervention for mental health needs, by letter, and the GP would action and follow up appropriately.

## Equitable

**Communication and language**
The practice provided information to patients and communicated in a way that was clear, accessible and in a language and manner appropriate to their individual needs. Staff also provided information in a way that enabled patients to make informed decisions about their care.

We were told that information about the services offered by the practice, such as when the branch surgeries in Cilfynydd and Ynysybwl were closed, was made known by letter to every patient at both branches. The practice also held meetings with the community about the closures. Patients were usually informed about the services offered at the practice through the website, social media and by sharing information and updates via a text messaging service. Where patients were known

not to have digital access, letters would be sent to individuals, or they were called by telephone.

There was a notice in the reception window advising patients that consultations in Welsh were available. The practice website identified the several Welsh speaking staff at the practice and Welsh speaking staff wore a lanyard to highlight they were happy to communicate in Welsh. The practice had used translation services to support patients who required services in a different language, other than Welsh or English. **They also had access to a British Sign Language electronic tablet, which is noteworthy**.

The practice recorded telephone calls and patients were informed of this on the recorded message when they called the surgery, before they spoke to a member of staff.

Messages would be communicated internally by a variety of methods including face to face, telephone and online systems for instant messages, emails and the medical record system used. Where a communication needed to be evidenced, an email would be sent with an urgent flag and requiring a read receipt.

There were good processes for the flow of patient documents and patient letters circulated around the practice. Information, such as inpatient hospital discharge letters, outpatient letters and patient results from secondary care were recorded and acted upon appropriately. There was a clear flow of information to clinicians of incoming correspondence, supported by a current workflow policy. Hospital letters and discharge summaries were Read coded. GPs would review the workflow and give actions to administrative staff who contacted the patients by text or letter. If urgent, the GP would call the patient themselves.

All staff in the questionnaire said there were alerts on patients records that made them aware of any communication difficulties.

**Rights and equality**

The practice was located on the second floor of the health park, with level access to the building and lift access to the second floor. Although there was free parking at the health park, this was limited during the day, due to the number of other healthcare services accessed at the health park. There were wide corridors to the practice and all patient areas including treatment rooms and the accessible toilet, were available for those with mobility issues or wheelchair users.

The practice culture and processes supported an approach that recognised the diversity and rights of individuals. Equality and diversity were promoted through

practice policies and staff training. Training was available for all staff to complete on equality and diversity through NHS elearning.

Staff we spoke with said they treated everyone equally and fairly. Senior staff also said that allowances had been made for staff to work flexibly and for staff to observe any religious requirements.

The practice ensured that the records of transgender patients were updated to reflect their change of names, gender and title. The rights of transgender patients were also upheld, staff confirmed preferred pronouns and names were used from the outset of transition. The practice also held a clinic for transgender patients.

# Delivery of Safe and Effective Care

## Safe

**Risk management**
Arrangements were in place to help maintain the health, safety and wellbeing of staff and people visiting the practice. The practice was clean and tidy, free of clutter and in a good state of repair. We noted a pleasant, modern and safe environment for patients to receive healthcare, in a calm surrounding with good clinical areas.

A business continuity plan (BCP) was in place and included the contingencies for any long-term staff absence and business partnership risk. The BCP covered a range of emergencies including pandemic and epidemic emergencies. We were told staff knew where to find the BCP on the shared drive and the practice manager had a copy of the plan at their home, if they could not access the practice premises.

There were nominated members of staff responsible for receiving national patient safety alerts. We were told patient safety alerts and significant event notifications were shared with staff through face-to-face discussions or through electronic messaging. Significant events were also discussed at the multidisciplinary team meeting and information would then be shared in team meetings with the team leaders.

The practice was fortunate in that they did not need to use locums as there were eight GP partners and three salaried GPs to cover for other medical staff absences.

There were mechanisms in place should staff need urgent help, with emergency call buttons in the consultation and treatment rooms, there was also a red button on the healthcare software screen, to call for help.

There was a current home visits policy in place and we were told patients reviewed at home were generally known to the practice. Where a history of violence or aggression was known at these locations, this was flagged on the patient notes. Whilst the practice was aware when a GP was reviewing a patient at home, there was no process in place to confirm the safety of the lone worker, particularly if they travelled elsewhere following the home appointment.

**The practice must ensure there is robust a process in place to monitor the safety of lone workers attending patient homes.**

**Infection, prevention and control (IPC) and decontamination**
There was an infection control policy in place and the practice had a designated nurse as the lead for IPC.

Staff we spoke with understood their roles and responsibilities in upholding IPC standards. Nursing staff also understood their responsibilities including identifying and managing potential IPC risks for patients and staff.

The sharps bins at the practice were appropriately marked and stored appropriately. The practice had a needlestick injury policy and any incidents would be reported to the health board occupational health department.

Nursing staff maintained full records of staff immunisations including hepatitis B immunisations and immunity levels for all relevant clinical staff and the blood borne virus policy was current.

All staff who completed the HIW questionnaire stated the organisation implemented an effective infection control policy and there was an effective cleaning schedule in place. They also all agreed the environment allowed for effective infection control and appropriate personal protective equipment (PPE) was supplied and used.

The overall arrangements in place generally upheld the standards of IPC and protected staff, patients and visitors using the service.

**Medicines management**
Processes were in place to ensure the safe prescribing of medication, aside from the issue highlighted earlier relating to alleged lost prescriptions. We were told repeat prescriptions would not normally be actioned at the branch but would go through the main practice site and managed by two prescribing clerks. The practices employed a Pharmacist and Pharmacy Technician to support medicines management within the practice.

We were told the practice required patients and pharmacies to sign for prescriptions when collected, where there were controlled drugs prescribed.

The staff ensured they maintained the cold chain for all applicable vaccinations and immunisations. There was a current cold chain policy in place and reception staff monitored clinical fridge temperatures. Records evidenced that fridge temperatures were recorded daily.

All the medication at the practice was in date and regularly checked by the practice nurses. The practice nurses were also responsible for checking and

ordering stocks of medical supplies and medication at the surgery. Expired drugs, syringes and needles were disposed of in accordance with the medication management policy.

Emergency drugs and equipment including oxygen and a defibrillator were available and met the basic primary care equipment standards as outlined by the Resuscitation Council UK guidelines. Staff were aware of their location and appropriate signs were present on the doors of their location. Records evidenced that regular checks were completed on the equipment and drugs.

The practice kept three small oxygen cylinders on site, however, none of the staff had completed oxygen cylinder training. Additionally, the oxygen cylinders were not stored appropriately within upright cradles.

**The practice must ensure that:**

- **Oxygen cylinder training is carried out by all personal involved in the use of oxygen**

- **Oxygen warning labels are displayed on all doors containing oxygen**

- **Oxygen cylinders are secured safely in appropriate housings or cradles.**

**Safeguarding of children and adults**
We found evidence of good documentation relating to safeguarding, including effective multi-agency and multi-professional working for safeguarding adults and children. This included health visitors and district nurses in addition to the practice clinical staff. Safeguarding meetings were conducted as appropriate and minutes were documented and distributed to relevant staff.

A cluster initiative had recently been implemented to review frequent attenders at accident and emergency departments. A doctor would review the patient's details, then review them to discuss their frequent ED attendances, to help reduce the frequency of the visits. In addition, the practice were looking at high users of their services as well as proactively looking at newly diagnosed palliative care patients who could become high users. The safeguarding leads would also review the reasons for these frequent attenders.

The practice had two safeguarding leads, one GP partner was responsible for safeguarding of children and one GP partner was responsible for safeguarding adults. We were told staff knew who the safeguarding leads were. The safeguarding policy reviewed was up to date and there was also a was not brought to appointment policy.

The patient records we reviewed evidenced appropriate safeguarding information. The systems in place ensured children on the child protection register, together with their parents or carers and siblings could be identified from their family records and were appropriately coded. Alerts were added to practice notes and any patient safeguarding referrals were saved in relevant clinical records. Details of the safeguarding meetings were also scanned onto patient records. There was also a process in place to identify when a child was no longer present on the child protection register and were told the alert would remain on the patient record to highlight a previous concern. Care experienced children were also appropriately coded on the patient records.

Any child who did not attend an appointment at the practice or for a hospital appointment, were appropriately followed up by a GP. In addition, attendances of children at an ED were also followed up by the practice. These would also be discussed at safeguarding meetings.

All staff who responded to the questionnaire stated they were up to date with adult and child safeguarding training, that they knew how to report safeguarding concerns and knew the safeguarding leads for the practice.

**Management of medical devices and equipment**
There was evidence of a systematic approach to the management and maintenance of relevant equipment. Contracts were in place for the maintenance and calibration of equipment as appropriate which also accounted for emergency repairs and replacement. Single use disposable equipment was used whenever possible.

All equipment was in a good condition, well maintained with good systems for stock control and maintenance. The checks were kept on an inventory, which was kept on the practice shared drive. The practice used an appropriate retailer for repair or replacement.

The arrangements for the checking of clinical bags for home visits were discussed. The nursing team assisted in equipping the clinical bags used by the GPs.

## Effective

**Effective care**
There were processes in place to support safe and effective care and the practice also had links with the wider primary care services. This included processes to disseminate clinical updates, learning, and new guidance and was supported

through quality improvement initiatives, multidisciplinary team (MDT) meetings and cluster working arrangements.

Most patient referrals to specialist services were submitted via the Welsh Clinical Communications Gateway (WCCG). Referrals were being managed appropriately, including both standard and urgent referrals. We were told the practice currently did not undertake analysis of referral rates to identify whether referrals were higher or lower than other practitioners in the local area. 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.

All respondents who completed our questionnaire agreed that care of patients was the practice's top priority and they would be happy with the standard of care provided for themselves, friends and family. Overall, all staff were content with the efforts of the practice to keep staff and patients safe.

Additionally, summaries were sent to the practice pharmacist for medication reconciliation and letters were sent to the GP if any action was needed.

**Patient records**
The patient medical records we reviewed were clear and provided the reasoning for decisions made relating to patient care. Records were complete and contemporaneous. There were robust processes in place for summarising and coding records, with regular reviews carried out of the quality of summarising. Read coding was generally good, but there were some gaps with coding of problems and reasons for discontinuing medications, which were not always recorded. The practice had a current consent policy in place and there was evidence of obtaining verbal consent for examinations and offering or use of a chaperone during examinations. However, the language preferences of patients were not generally recorded.

**The practice must ensure that:**

- **The reasons for discontinuing medication are appropriately documented and Read coded**

- **Chronic conditions must be appropriately Read coded**

- **Patient language preferences are recorded.**

There was a current chaperone policy available, which stated that the chaperone should annotate the patient notes that they attended as a chaperone. However, our records review identified that this did not always occur. For example, whilst

there was a chaperone present during insertion of intrauterine devices (IUD), this was not documented in the clinical records. There may be value in revising the IUD consent form to capture this information.

**The practice must ensure that *w*here a chaperone is used, they annotate the patient notes that they attended as a chaperone.**

## Efficient

**Efficient**
Services were arranged in an efficient manner and were person centred, to ensure people felt empowered in their healthcare journey. The co-location of the practice at the health park enabled the ease of contact with health and wellbeing services. All staff worked across the various branches of the practice.

Patients could access care through self-referral to a physiotherapist and mental health practitioners. There were several other initiatives available to patients, such as Pwysau Iach Plant Yng Nghymru (PIPYN), meaning Healthy Children Healthy Weight in Wales, to support children aged 3-7 and their families with healthy choices. There were also community care co-ordinators available via a cluster initiative.

Patients could also access eConsult, which allowed patients to quickly and safely request help and advice from their practice online, if their concern was of a routine, clinical or administrative nature.

# Quality of Management and Leadership

## Staff feedback

We issued a staff questionnaire to obtain their views on the care at the practice. In total, we received 16 responses. Some questions were skipped by some respondents, meaning not all questions had 16 responses. Responses given by staff were mostly positive, most respondents felt they could make suggestions to improve GP services and felt they were involved in any decision-making surrounding changes that may affect their work. The following comments were received:

> ***"Everyone at the practice is friendly and supportive. Patients seem to be extremely demanding, but the practice works hard to support all requests (unlike my own GP practice). Access to appointments is good, again better than my own experience and all clinical staff care. More walk in services would be good and later blood sessions, but these are restricted by the Trust collection schedules. This affects patient access meaning they may need two (sometimes three) appointments for their annual reviews. Virtual reviews are good for patients."***
>
> ***"Main cause of stress is when the {name suppled} IT connection fails, or printer settings fail and need frequent support from IT help desk."***
>
> ***"Patients do tell me it is difficult to get through to the surgery to get an appointment, often making them wait many weeks for their concerns. They however are understanding of the pressures on GP's and the health service."***

## Leadership

### Governance and leadership

There were operational systems and processes in place to support effective governance, leadership and accountability to ensure sustainable delivery of safe and effective care.

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

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 staff would be told about any changes via email, requiring an acknowledgement of the receipt of the email. Staff were also encouraged to speak to a team leader if they did not understand the changes.

The policies and procedures at the practice were all version controlled and included a date reviewed, date due review, who completed the review and who approved the review.

Staff could access health board initiatives if they were feeling stressed as well as being able to speak to practice management.

All but two members of staff said they were aware of the occupational health and wellbeing support available. All staff felt the practice took positive action on health and wellbeing and all but one felt they could achieve a good work-life balance from their current working pattern.

We were told that the main challenges and pressures being faced by the practice were the expectations of patients. The practice said they did their best to meet these expectations, but occasionally some patients felt this was not good enough.

There were designated leads for specific practice areas who were able to provide advice, such as safeguarding leads, a clinical lead and Quality Improvement Framework lead. Clinical information was shared in the practice through the MDT, as well as an online application for sharing clinical guidelines.

The lead nurse was methodical and systematic, demonstrating a commendable level of detail with all systems in date and accessible by anyone. Clinical systems were good and consultations well managed. Tests were ordered using the GP test result (GPTR) system, an electronic test requesting system.

We saw that team meetings were held monthly and we saw evidence of regular clinical meeting minutes.

All staff in the questionnaire agreed that:

- They were able to access the ICT systems needed to provide good care and support for patients
- Patients were able to access the services this GP practice provided in a timely way
- They would recommend the practice as a good place to work

- Their job was not detrimental to their health
- Patients or their advocates were informed and involved in decisions about their care.

## Workforce

**Skilled and enabled workforce**
There was an appropriate recruitment policy and an induction policy in place. However, this was not being followed since there was an absence of written employment references and employment history records were not kept on file. There was evidence that disclosure barring service (DBS) checks had been completed for four out of the five members of staff we checked, the other was in the process of being actioned. Additionally, job descriptions were available for the sample checked.

There were processes in place for the induction of new staff. We saw evidence of the induction check sheet completed for all new staff.

We were told that annual checks were made of healthcare professional's registration with their regulatory body. However, there were no checks made to ensure a person remained suitable to work for the practice, such as self-declarations by staff to confirm there had been no change in their DBS status.

**The practice must ensure that:**

- **The recruitment policy is followed**
- **Relevant documentation such as written references and full employment histories are requested for new staff and kept on file**
- **DBS checks at the appropriate level are carried out before staff commence employment or an appropriate risk assessment is carried out before the DBS is received**
- **All staff are required to complete an annual certification to confirm there has not been a change that would affect their DBS status.**

We reviewed the mandatory training of five members of staff and noted that there were compliance issues for all which included:

- Only two of the five staff had completed training in equality diversity and human rights, safeguarding adults and children, and duty of candour

- Only one staff had completed training in health and safety at work, control of substances hazardous to health and IPC

- No staff had completed portable oxygen cylinder training.

It was however positive to see that all staff had completed the training on information governance, fire safety awareness, moving and handling and resuscitation.

**The practice must ensure that all staff complete mandatory training at the required level. This should include level two for clinical staff in IPC and safeguarding.**

In the staff questionnaire, all but one felt they had appropriate training to undertake the role.

We spoke to senior staff about appraisal compliance and noted that all the nursing team had received an annual appraisal. However, these had not been completed for salaried GPs and half the administrative and reception staff were awaiting an appraisal date. We were also told that the practice had several staff within their first year of contract and that GPs, the management team and health care assistants were the groups needing appraisals. However, all staff in the questionnaire said they had received an appraisal in the last 12 months.

**The practice must ensure that staff annual appraisals are completed in a timely manner.**

Senior staff told us there was always and appropriate capacity and skill mix of staff available when required. Rotas for non-clinical staff were completed six weeks ahead using the 'floating' capacity within administrative and reception staff.

For those who responded, all staff felt there was an appropriate skill mix at the setting and they had the materials, supplies and equipment needed to do their job. All felt there were enough staff employed to allow them to do their job properly and were satisfied with the quality of care and support given to patients.

All nurses had the relevant experience and qualifications relevant to nursing in general practice, such as an Advanced Nurse Practitioner degree. We also found an example of continuous professional development (CPD), where one nurse was undertaking a university based respiratory course, the overall team were well

supported in maintaining CPD. There were patient group directions in place for all relevant medications managed by the nursing team.

All staff in the questionnaire said they had fair and equal access to workplace opportunities and that the workplace was supportive of equality, diversity and inclusion. All but one felt they were able to meet all the conflicting demands on their time at work.

## Culture

**People engagement, feedback and learning**
The practice had a process in pace to manage and monitor concerns. Senior staff explained the process and the records kept. There were 64 complaints in the year 2024/25, with two complaints still not resolved, with further action needed to resolve these. Complaints and concerns were monitored to identify any themes and trends and any actions for improvement were communicated to staff.

The complaints policy in place aligned to the NHS Wales Putting Things Right process, however, there was no designated complaints lead in place. This was because doctors were paired with other doctors to resolve complaints and other team leaders were responsible for resolving complaints for other staff. However, for consistency, the practice should consider delegating an individual, such as the practice manager, to manage and monitor the overall process. We were informed subsequently by the practice that although GPs have buddies to work with on complaints, the practice had an overall complaints lead, one of the GP partners was named, and this was discussed on the day. Whilst the deputy practice manager took the administrative lead, the named GP partner was the overall concerns lead.

Whilst the complaints procedure was displayed in the practice reception area, details of the NHS ‘Putting Things Right’ procedure was not displayed.

**The practice must ensure that:**

- **A designated person is identified to manage and monitor the overall complaints process to maintain consistency**

- **Information is available to monitor for both closed and current complaints, such as 3-day acknowledgment letter, 30-day response letter and all relevant information relating to the complaint**

- **The NHS Putting Things right process is clearly displayed at the practice.**

The practice participated in the recent NHS Annual Survey with mainly positive results. This included over 80% of patients saying they were always or usually, listened to, well cared for, understood what was happening in their care and were involved as much as they wanted to be in decision about their care. The overall rating was eight out of ten. However, there was no feedback mechanism in place, such as a 'you said, we did' notice to inform patients of the results, or any action taken following the survey.

**The practice must ensure the results of patient surveys or feedback are available to patients.**

A Duty of Candour policy was in place which had been recently reviewed. All staff who responded to the questionnaire said they knew and understood the Duty of Candour and their obligation in line with the Duty of Candour.

In our questionnaire, staff felt that the practice encouraged them to report errors, near misses or incidents, they were treated fairly if involved, that action was taken to minimise recurrence and that feedback was given following incidents.

## Information

**Information governance and digital technology**
The practice used the Digital Health and Care Wales (DHCW) service to support the data protection officer, the information governance lead. The practice process for handling data was available for patients to see on the internet, there was also a notice in the waiting room to advise patients.

We considered the arrangements in place for patient confidentiality and compliance with information governance and the General Data Protection Regulations (GDPR) 2018. We saw evidence of patient information being stored securely. A current information governance policy was in place to support this.

Secure and effective sharing arrangements were in place to ensure patient data or key notifications were submitted to external bodies as required. This included using the Secure Anonymised Information Linkage (SAIL) Databank.

## Learning, improvement and research

**Quality improvement activities**
We found that staff engaged with quality improvement by developing and implementing innovative ways of delivering care. This included the involvement in cluster wide projects.

We were told lessons learnt from concerns and complaints and mortality reviews were shared among the team. We were told shared learning involved staff from both sites, as part of their commitment to improving the entire service.

The practice completed audits to learn and improve, which were discussed at the MDT meetings.

## Whole-systems approach

**Partnership working and development**
The practice was an active member of the Taff Ely Primary Care Cluster and the practice manager was the non-clinical cluster lead. One of the GP partners was the nominated GP cluster representative.

There were several cluster initiatives described, such as dementia care and the work on the frequent attenders at the ED, in addition, the 'talking therapies' were funded by the cluster.

We were told the practice engaged with several agencies to improve access to various healthcare professionals via their cluster group. These included access to physiotherapy, mental health services and pharmacists. This enabled patients to access help and support from other agencies in a timely manner.

# 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. | | | |
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# Appendix B - Immediate improvement plan

## Service: Dewi Sant Health Park, Taff Vale Practice

## Date of inspection: 10 April 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 assurance issues identified. | | | | | |

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: Dewi Sant Health Park, Taff Vale Practice

## Date of inspection: 10 April 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. | The patients' comments were concerning, in particular about patient ability to access the service in a timely manner and navigating the process to request an appointment. | The practice must consider the patient comments and inform HIW of the actions they will take to address these issues. | Health and Care Quality Standard – Timely Care | Comments and feedback will be discussed with all members of staff via team meetings.<br><br>Where needed, training will be provided regarding confidentiality.<br><br>Current notices regarding access will be reviewed for clarity. | June Hunt | August 2025 |

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| | | | | Increased social media posts will be made regarding “how to access” and “care navigation” | | |
| **2.** | We received another comment in response to our questionnaire, relating to alleged missing prescriptions (which allegedly included controlled drugs). | The practice must review the prescription process, including issuing and collection of these, to maintain the security of patient data and of prescriptions. | Health and Care Quality Standard – Medicines Management | A review of concerns relating to prescriptions will be undertaken to look for themes.<br><br>Outcomes of the review will be considered and where Medicines Management and repeat prescribing policy will be updated. | Simon Povey | September 2025 |
| **3.** | Whilst the practice was aware when a GP was reviewing a patient at home, there was no process in place to confirm the | The practice must ensure there is robust a process in place to monitor the safety of lone workers attending patient homes. | Health and Care Quality Standard – Risk Management | Policy to be reviewed by author. Addition to be made to ensure reporting responsibility of GP | Dr Lara D’Arcy | August 2025 |

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| | safety of the lone worker, particularly if they travelled elsewhere following the home appointment. | | | undertaking Home visit to the oncall GP for that day. | | |
| **4.** | The practice kept three small oxygen cylinders on site, however, none of the staff had completed oxygen cylinder training. Additionally, the oxygen cylinders were not stored appropriately within upright cradles. | The practice must ensure that:<br>• Oxygen cylinder training is carried out by all personal involved in the use of oxygen<br>• Oxygen warning labels are displayed on all doors containing oxygen<br>• Oxygen cylinders are secured safely in appropriate housings or cradles. | Health and Care Quality Standard – Medicines Management | Training to be sourced and undertaken by relevant staff.<br>Oxygen labels to be purchased and displayed where relevant.<br>Cylinder stands to be sourced and purchased. | Sr Nurse Claire Ghuman | October 2025 |
| 5. | Read coding was generally good, but there were some | The practice must ensure that: | | Discussion to be held with all prescribers | Dr Kathryn Scullion | October 2025 |

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| | gaps with coding of problems and reasons for discontinuing medications, which were not always recorded. The practice had a current consent policy in place and there was evidence of obtaining verbal consent for examinations and offering or use of a chaperone during examinations. However, the language preferences of patients were not generally recorded. | • The reasons for discontinuing medication are appropriately documented and Read coded<br><br>• Chronic conditions must be appropriately Read coded | Health and Care Quality Standard – Patient records | and medicines management team to ensure understanding on the importance of ensuring a reason for discontinuation is recorded. We will work with IT to review how to extract this data from Vision.<br><br>We are aware of historic issues with coding (coding changes, QoF QAIF, QiF, practice merge). Staff to be updated on importance of coding and use of Vision templates for accuracy.<br><br>Data Tidy up work will be undertaken to review all disease areas. | | July 2025 |

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| | | • Patient language preferences are recorded. | | Patient language preference is included in our new patient questionnaire.<br><br>Language choice to be added to our ethnicity questionnaire and made available to receptionists for patient completion at time of attendance<br><br>Language choice to be added to consent forms. | Jayne Taylor-Lloyd | |
| **6.** | Whilst there was a chaperone present during insertion of intrauterine devices (IUD), this was not documented in the clinical records. There may be value in revising the IUD consent form to capture this information. | The practice must ensure that where a chaperone is used, they annotate the patient notes that they attended as a chaperone. | Health and Care Quality Standard – Patient records | IUD and other consent forms where chaperone is automatically present will be updated to record chaperone in attendance. | Jayne Taylor-Lloyd | July 2025 |

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| 7. | There was an absence of written employment references and employment history records were not kept on file.<br><br>There were no checks made to ensure a person remained suitable to work for the practice, such as self-declarations by staff to confirm there had been no change in their DBS status. | The practice must ensure that:<br><br>• The recruitment policy is followed<br><br>• Relevant documentation such as written references and full employment histories are requested for new staff and kept on file<br><br>• DBS checks at the appropriate level are carried out before staff commence employment or an appropriate risk assessment is carried out before the DBS is received<br><br>• All staff are required to complete an annual certification to | Health and Care Quality Standard – Workforce | Recruitment policy has been shared with all team leaders to ensure compliance moving forward.<br><br>Start dates not to be progressed until all documentation is received and recorded.<br><br>DBS checks now in place for long standing staff and policy is being followed for new recruitment.<br><br>Certification template has been prepared ready for annual | Jayne Taylor-Lloyd | June 2025 |

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| | | confirm there has not been a change that would affect their DBS status. | | certification which will commence January 2026 | | |
| **8.** | We reviewed the mandatory training of five members of staff and noted that there were compliance issues for all. | The practice must ensure that all staff complete mandatory training at the required level. This should include level two for clinical staff in IPC and safeguarding. | Health and Care Quality Standard – Workforce | All staff with outstanding mandatory training will be sent a reminder with a deadline for completion | June Hunt | October 2025 |
| 9. | Appraisals had not been completed for salaried GPs and half the administrative and reception staff were awaiting an appraisal date. | The practice must ensure that staff annual appraisals are completed in a timely manner. | Health and Care Quality Standard – Workforce | All team leaders will be requested to book outstanding appraisals with priority.<br><br>All team leaders will be reminded of the need for ensuring set up of annual appraisal process as routine in line with appraisal policy. | Jayne Taylor-Lloyd | September 2025 |

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| **10.** | The practice should consider delegating an individual, such as the practice manager, to manage and monitor the overall process.<br><br>Whilst the complaints procedure was displayed in the practice reception area, details of the NHS 'Putting Things Right' procedure was not displayed. | The practice must ensure that:<br><br>• A designated person is identified to manage and monitor the overall complaints process to maintain consistency<br><br>• Information is available to monitor for both closed and current complaints, such as 3-day acknowledgment letter, 30-day response letter and all relevant information relating to the complaint<br><br>• The NHS Putting Things right process is | Health and Care Quality Standard – Culture | Mrs June Hunt is designated person to ensure administrative compliance. Dr Jonathan Finnegan is designated Complaints lead which includes audit and theme reviews.<br><br>Current spreadsheets to be amalgamated to ensure all data is available on one spreadsheet for easier review.<br><br>Poster to be displayed in waiting area. | Dr Jonathan Finnegan | July 2025 |

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| | | clearly displayed at the practice. | | | | |
| 11. | There was no feedback mechanism in place, such as a 'you said, we did' notice to inform patients of the results, or any action taken following the survey. | The practice must ensure the results of patient surveys or feedback are available to patients. | Health and Care Quality Standard – Culture | Change current process of displaying for 1 month post survey to dedicated long term section within display boards/area | June Hunt | August 2025 |

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):** **Dr Kathryn Scullion**

**Job role:** **GP Partner**

**Date:** **18 June 2025**