

# General Practice Inspection Report (Announced)

Foundry Town Clinic, Cwm Taf  
Morgannwg 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.



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# 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 Foundry Town Clinic, Cwm Taf Morgannwg University Health Board on 08 December 2025.

Our team for the inspection comprised of two HIW healthcare inspectors, two clinical peer reviewers, and a practice manager reviewer

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 33 questionnaires were completed by patients or their carers and 23 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:

The practice demonstrated a commitment to promoting healthy lifestyles and providing dignified and respectful care. Patients had access to a range of health information through consultations, leaflets, and signposting to external services including smoking cessation and mental health support.

Clinical areas maintained privacy, and staff were observed to be friendly and discreet. Confidential conversations were difficult within the reception area due to its layout; however, staff were able to explain processes to overcome this. A chaperone service was available with policies and procedures in place.

Processes were in place to support timely access to care, with multiple booking options and additional appointments offered when demand was high. However, there was no formal access policy in place. Communication was generally effective with bilingual information posters in waiting areas, however directional signage was not in place.

Equality and diversity principles were upheld, and reasonable adjustments supported patients with mobility and sensory needs. Systems were in place to respect patient rights, including transgender patients.

This is what we recommend the service can improve:

- Ensure the chaperone notices are available bilingually
- Introduce a system to inform patients of changes made following feedback
- Consolidate workflow documents into a single policy for clarity.

This is what the service did well:

- Maintained privacy in clinical areas with appropriate measures
- Promoted healthy lifestyles through varied resources
- Regular review appointments for patients with acute mental health needs.

### Delivery of Safe and Effective Care

Overall summary:

We found the practice had effective systems in place to deliver safe and high-quality care. Clinical areas were clean, well maintained, and supported by robust infection prevention and control measures, including annual audits, clear policies, and staff training. Medicines management arrangements were generally strong,

with secure storage, cold chain compliance, and regular checks of emergency drugs and equipment. However, improvements were needed in maintaining audit trails for controlled drugs.

Risk management processes were evident through business continuity planning, escalation reviews, and quarterly significant event meetings, although access to patient safety alerts was limited to one staff member. Safeguarding arrangements were appropriate, with policies, designated leads, and multi-disciplinary meetings in place; however, we noted Read coding was not being completed for vulnerable patients.

Patient records were mostly accurate and contemporaneous, though improvements were required in linking medication to diagnoses, recording language preferences, and applying clinical Read codes. Overall, the practice worked collaboratively to support efficient care pathways and demonstrated commitment to continuous improvement.

This is what we recommend the service can improve:

- Ensure multiple staff have access to patient safety and Welsh Government alerts
- Establish audit trails for controlled drug prescriptions
- Clinical staff to complete BOC oxygen cylinder training.

This is what the service did well:

- Appropriate medicines storage and cold chain compliance
- Robust process in place for managing test results and urgent referrals
- Reinstate room identification signage.

## **Quality of Management and Leadership**

Overall summary:

We found the practice had clear governance arrangements and systems to support effective leadership and accountability. Staff understood their roles and responsibilities, and the practice manager maintained an open-door policy, ensuring accessibility and support. Most policies and procedures were up to date, accessible in paper and digital formats, and regularly reviewed. Clinical oversight was provided by a named GP lead, with quality assurance responsibilities shared between GPs and the practice manager. Staff were supported through health board wellbeing initiatives and regular meetings, including protected learning time sessions.

Recruitment processes were robust, with appropriate pre-employment checks and annual appraisals in place. Mandatory training was monitored, and nurses held

specialist qualifications with access to Continuing Professional Development (CPD) opportunities. Workforce planning was supported by a multi-skilled team able to maintain service delivery during absences.

The practice had a complaints policy aligned with NHS Putting Things Right procedures; however, improvements were needed in logging and reviewing complaints to identify trends and learning. We found Duty of Candour processes were in place. Information governance arrangements were appropriate; however, the policy required review. The practice demonstrated commitment to quality improvement through audits, research participation, and collaborative working with system partners.

This is what we recommend the service can improve:

- Implement complaints log and review process
- Ensure all staff complete Duty of Candour training.

This is what the service did well:

- Accessible policies and regular staff communication
- Strong partnership working with cluster and third-sector organisations
- Clear governance and leadership arrangements.

## 3. What we found

# Quality of Patient Experience

### Patient feedback

HIW issued questionnaires to patients and carers who attend the practice to gather their views on the services provided. In total, we received 33 responses from patients at this setting. Some questions were skipped by some respondents, meaning not all questions had 33 responses. Responses were generally positive, with most respondents reporting they felt listened to and majority respondents reported they were treated with respect by staff.

Patient comments included:

*"Brilliant practice. Always professional and happy to help. Can always get an appointment. Really couldn't wish to have a better surgery."*

*"If you try to complain you are spoken down to at desk. I asked to speak with practice manager, he kept me waiting for 20mins while he was talking to staff cleaner."*

*"The staff at my GP surgery are always approachable, friendly and I feel they go above and beyond to help when needed..."*

*"I can never make a booking or send messages to the surgery via the online/NHS app ..."*

*"Excellent service staff and GP are very good"*

### Person-centred

#### Health promotion

The practice promoted healthy lifestyles through a range of accessible approaches. We were told information was provided during consultations and tailored to individual needs, with staff offering advice and leaflets relevant to specific conditions. A variety of printed resources were available in the reception area and on notice boards, with information such as smoking cessation, alcohol misuse, diabetes and grief support available. Whilst most information was up to date, we noted that one poster contained an incorrect contact number and advised the practice to replace it.

Patients without digital access were able to obtain information in printed form, and staff confirmed that materials could be provided in alternative formats if required. The practice also offered access to other healthcare professionals and services to support healthy lifestyles, diabetes education programmes, counselling and paediatric nursing support.

The practice worked with public health and voluntary agencies to improve access and promote health, including smoking cessation clinics and holistic therapies through cluster partnerships. The practice also has access to a pharmacy team, mental health practitioners and first contact physiotherapists through the cluster arrangement. We were told patients were signposted to these services by care navigators and clinicians.

The practice had commenced its winter vaccination programme, with letters issued to eligible patients. It was positive to note that weekend vaccination clinics were in place, which helps accessibility and uptake.

### **Dignified and respectful care**

We observed that clinical rooms provided patients with appropriate levels of privacy. Doors were kept closed during consultations, and conversations in treatment rooms could not be overheard. Privacy curtains were available in all treatment rooms, and windows were fitted with frosted glass to maintain confidentiality.

Reception staff were friendly, discreet and sensitive when speaking to patients; however, the layout of the reception area made it difficult to have confidential conversations without being overheard. To address this, patients were offered the option of moving to an empty treatment or consultation room for private discussions. Telephone conversations were conducted in an office away from reception, ensuring conversations could not be overheard. Of those that responded to the HIW questionnaire, 19 out of 28 agreed that they were able to talk to reception staff without being overheard.

The practice offered a chaperone service, with notices displayed around the practice and on the practice website; however, this information was only available in English.

### **The practice must ensure chaperone notices are available bi-lingually.**

Patients were able to request a chaperone at the time of booking or on arrival. While there was only one male chaperone available, we were told appointments would be rearranged if a male chaperone was required and not available. Some

staff had received chaperone training, with more staff scheduled to complete training soon. We found an up-to-date chaperone policy was in place, and clinicians recorded verbal consent and chaperone details in patients' medical records in line with GMC guidance. Where applicable, all respondents to the HIW questionnaire who answered the question said they were offered a chaperone for intimate examinations or procedures.

## Timely

### Timely care

We found that the practice had processes in place to help patients access care in a timely manner and with the most appropriate healthcare professional. Information about appointment options and services were available on the practice website, in patient leaflets and through staff signposting. We advised the practice manager to display details about access arrangements within the waiting area.

Patients could book appointments by telephone or in person and electronic consultations were available via eConsult, with plans to reintroduce online booking through the NHS Wales app. Staff confirmed that patients could access face-to-face consultations with GPs and other healthcare professionals when required. We found telephone calls were answered promptly on the day.

The majority of respondents to our survey told us they can obtain an urgent appointment and that they can access routine appointments. All but one respondent confirmed they were satisfied with the opening hours of the practice, and the most knew how to access out of hours services.

The practice had some documents relating to access arrangements; however, there was no specific practice access policy in place.

**The practice should develop and implement a formal access policy to clearly outline procedures for managing patient access to services.**

We found reception staff had completed care navigation training and followed a written pathway to signpost patients to appropriate services, including cluster-based and health board services. We saw a written Care Navigation policy was also in place. Staff were clear that they did not undertake clinical triage and could seek advice from the duty doctor if urgent support was needed.

Mental health support was provided through appointments at the practice, with urgent cases referred to crisis teams by telephone or same-day response. Patients not meeting secondary care thresholds were offered regular review appointments and signposted to third-sector services funded by the cluster. The practice

maintained processes for safety-netting and follow-up, including monitoring patients awaiting referral and ensuring continuity of care.

Requests for home visits were managed by telephone, with doctors contacting patients before attending where necessary. Out-of-hours interactions were recorded electronically into patients' records. We found appropriate processes in place to notify duty doctors or out-of-hours teams of patients receiving end of life care.

## **Equitable**

### **Communication and language**

The practice maintained an up-to-date website and a written patient information leaflet was available at the practice and on the practice website. Staff confirmed that information could be provided in alternative formats including large print, easy read and digital copies could be emailed to patients, to meet individual's needs. Patients without digital access were informed through notices displayed in the waiting areas.

Staff understood the importance of communicating with patients in their preferred language and the practice used appropriate interpreter services when required. We were told Welsh language training was available for staff who wished to learn. We saw bilingual information posters were available in the waiting area; however, there were no bilingual door or directional signs available. We were told no staff were Welsh speakers.

**The practice must work to ensure signage within the premises is available bilingually, within a reasonable timeframe.**

We were told patients were informed of changes to their care through telephone calls and written information was provided where required. Where appropriate, verbal explanations were supplemented by patient information leaflets during consultations to support understanding.

### **Rights and equality**

The practice had up to date policies in place for Equality and Diversity, and bullying and harassment, which had been reviewed in the last year. We noted staff had completed Equality, Diversity and inclusion training. Staff confirmed they understood the importance of applying the principles of equality and diversity in their work.

The practice was accessible to patients with mobility needs, with a ramp at the entrance, treatment rooms on one level and accessible toilet facilities with grab rails available.

Reasonable adjustments were made for patients where required, including the provision of a hearing loop at reception. We were told flexible appointment arrangements, such as scheduling quieter appointment times, were available if patients required. We found the practice had a digital tablet available at the entrance, allowing patients to check themselves in for appointments.

Systems were in place to uphold the rights of transgender patients. Staff recorded preferred pronouns and names in their systems and worked with gender specialists to ensure patients could access appropriate medication if refused elsewhere.

Of those who answered our questionnaire, most (28/30) told us they felt they could access the right healthcare at the right time. Of those who answered, most (28/30) respondents confirmed they had not faced discrimination when accessing the service due to various protected characteristics, with the remaining reporting discrimination based on age or pregnancy/maternity.

# Delivery of Safe and Effective Care

## Safe

### Risk management

The practice was clean, tidy and in a good state of repair. Clinical and treatment rooms were free from clutter and hazards. However, we noted one window ledge in a treatment room which required cleaning, this was addressed during the inspection. We noted room identification signage had not been reinstated following redecoration earlier in the year.

**The practice must implement signage within the practice to ensure patients can easily navigate the premises.**

The practice had an up-to-date Business Continuity Plan (BCP), which was available in paper and electronic formats. This included contingencies for health emergencies such as pandemics. However, we noted there was no information present on business partnership risks.

**The practice should include business partnership risks within the Business Continuity Plan (BCP).**

Processes were in place for managing patient safety alerts, however, we were told only one staff member currently had access to the information.

**The practice must ensure multiple staff members have access to patient safety alert information to ensure continuity in the event of a staff member not being present.**

Staff had use of portable emergency buttons in the event of help being required urgently. Staff were aware of the location of emergency drugs and equipment, which were stored in a clinical room. We advised the practice to relocate emergency drugs and equipment to a central location to ensure quick access during emergencies, as current storage could delay access during intimate examinations or if doors were locked.

**The practice should risk-assess and consider moving emergency drugs and equipment to a central location.**

### Infection, prevention and control (IPC) and decontamination

The practice had appropriate arrangements in place for infection prevention and control. There were no outstanding estates requests, and the premises was clean

and tidy. We were told cleaning was undertaken daily by an external contractor, and staff confirmed that the external cleaning team was responsible for most environmental cleaning tasks. We found cleaning schedules were available and displayed in treatment rooms. Of those who responded to the HIW questionnaire, all stated the practice was very clean or clean.

An IPC lead was in place, and staff were aware of who to contact regarding IPC matters. We found a practice specific IPC policy available, which was accessible both on paper and digitally. Staff demonstrated awareness of their responsibilities and were observed following good hand hygiene practices. Facilities included elbow-operated taps, foot operated bins and wipeable flooring and surfaces. Examination couches and chairs were wipeable, and clinical staff were bare below the elbows.

We saw evidence of an annual IPC audit, and staff completed annual IPC training. Waste management procedures were in place, supported by a policy and recent audit. In the event of needing to segregate people due to the risk of infection, staff advised spare rooms would be used due to space constraints.

We found a policy in place for blood-borne viruses; however, this was not practice specific.

**The practice must implement a practice specific blood-borne viruses' policy.**

We found an appropriate needlestick injuries policy in place, and staff were aware of the process for managing sharps injuries, including referral to occupational health. Posters outlining the procedure were displayed in accessible areas. Hepatitis B immunisation records were maintained for all relevant staff, including locums, and an ongoing vaccination programme for staff was in place. Sharps containers were present in all treatment rooms, correctly dated and not overfilled.

### **Medicines management**

We found the practice had appropriate arrangements in place for the safe management of medicines. We found prescription pads were appropriately stored in locked cupboards and locks were in place on all printers. We found the practice had a log in place which was maintained for prescriptions in use. No prescription pads were kept for individual GPs, and prescriptions for home visits were completed at the practice. However, there was no audit trail for Controlled Drug prescriptions that were collected from the practice by patients or carers. This limited the practice's ability to monitor and account for these prescriptions.

**The practice should establish a robust audit trail for Controlled Drug prescriptions collected by patients or carers.**

We were told medication reviews were carried out by the pharmacist or a GP, and prescribing clerks had completed online training and received support from clinicians. Repeat prescriptions were managed by dedicated staff, and any queries were referred to a GP before issuing. Any training needs were identified through appraisals and error monitoring.

We found vaccines were stored in a locked clinical fridge, with daily temperature checks recorded and a datalogger in place. A cold chain policy was available, and staff were aware of the protocol for managing temperature breaches. Stock rotation was observed, and all vaccines checked were in date. We noted appropriate signage was in place for emergency equipment, and emergency drugs and equipment, including an Automated External Defibrillator (AED) and oxygen cylinder, were available and met Resuscitation Council UK standards.

A named person was responsible for checking emergency drugs and equipment, and staff were aware of this role. We saw weekly checks were undertaken and recorded electronically, and expiry dates were monitored. Training in resuscitation was provided annually for clinicians and every three years for administrative staff. However, we noted BOC oxygen cylinder training had not been completed.

**The practice must ensure all clinical staff complete BOC integrated valve oxygen cylinder training.**

We found all medicines were stored securely at the practice, and checked confirmed items were in date. Expired drugs and sharps were disposed of in line with the policy, and adverse drug reactions were reported via the Yellow Card scheme, with audits completed by the pharmacist.

### **Safeguarding of children and adults**

We found the practice had an appropriate and up to date safeguarding policy in place which included guidance for vulnerable adults and children. There was a named safeguarding lead in place, with this role being temporarily covered by two other GPs during maternity leave. Staff were aware of who to contact in the event of a safeguarding concern.

Staff confirmed they had access to the All-Wales Child Protection Procedures, and safeguarding meetings were held quarterly with attendance from the safeguarding GP, health visitor, practice nurse and midwife. There was a process in place for monitoring A&E attendances and missed appointments, with an allocated GP and administrative staff responsible for managing safeguarding paperwork. Multi-disciplinary working was evident through safeguarding and palliative care

meetings, as well as cluster-funded initiatives such as an advanced nurse practitioner supporting nursing home patients.

We found safeguarding training was provided at levels appropriate to staff roles. However, we noted the practice manager did not have safeguarding level two in place.

**The practice manager must complete level two safeguarding training.**

We found systems were in place for identifying adults at risk through day-to-day interactions, home visits, and input from district nurses.

### **Management of medical devices and equipment**

All medical devices and equipment appeared to be in good condition, were stored appropriately and we observed that devices were clean and fit for purpose. We found that the practice used single-use equipment where possible. We were told three nurses shared responsibility for checking equipment, and we saw records of these checks were maintained in dedicated folders

We saw contracts were in place for the servicing and maintenance of medical devices through an external provider, and staff confirmed any urgent repairs or replacements were reported directly to the practice manager.

## **Effective**

### **Effective care**

We found that the practice had systems in place to keep up to date with best practice and national guidance. Clinical staff met quarterly for partner meetings and held regular journal club sessions to discuss National Institute for Health and Care Excellence (NICE) guideline updates and clinical developments. Information was also shared via a partners' WhatsApp group and during formal lunchtime meetings. We were told the practice manager attended cluster meetings, and external speakers were invited to share new approaches and innovations. Teams was the main platform for circulating updates to staff, supplemented by emails and notice boards.

A process was in place for reporting incidents, which involved completing a serious incident form and discussing these at quarterly meetings. Meetings were documented, and learning was shared among staff. Referrals were managed through the Welsh Clinical Communication Gateway (WCCG), with urgent cancer referrals being completed by the GP and tracked to ensure appointments were managed promptly. If an appointment was not received, the referral was returned

to the GP for follow-up. We were told locum GPs were provided with information of the referral process within their induction pack.

Reception staff demonstrated awareness of life-threatening emergencies and confirmed they would advise patients to call 999 or seek GP advice when appropriate. We were told the practice had adapted to recent changes to death certification legislation and that processes were working well. Mortality reviews were undertaken occasionally.

Test results were managed through a clear and robust process. Patients were asked to call the practice after one week, and GPs contacted patients directly if results were abnormal. Older patients and those without digital access were informed by telephone. We were told mental health support was available through counselling services and crisis team referrals, with GPs offering follow-up appointments and signposting to third sector services. Patients could self-refer for counselling, and letters from crisis intervention teams were received to enable continuity of care. We noted where referrals were not accepted or completed in the required timeframe, staff had processes in place to follow up with the patient. We were told staff complete mental health awareness training every three years.

Incoming mail was scanned, recorded into patients' notes where necessary by clinicians and tasks assigned to administrative staff. We found multiple documents were in place to describe the process to ensure information received was appropriately reviewed and recorded in patients' records. However, we noted that these could be brought together into one main workflow policy document.

**The practice should create a workflow policy from existing documents.**

### **Patient records**

We found the practice used Vision as its clinical system. We reviewed a sample of 10 patient records and found they were generally of good quality. Records reviewed were up to date and contemporaneous, with good planning information present. However, several areas required improvement. Medication was not consistently linked to the patient's presenting problem within their record; however, we noted the practice had limitations due to the clinical system used. This would be addressed when migrating to Egton Medical Information Systems (EMIS). Language preferences were not recorded in any of the records reviewed. Clinical Read codes were not applied for common conditions or new problems in nine out of ten records examined. In addition, indications for medication and reasons for discontinuation were not clearly stated in seven out of ten records.

**The practice must ensure the following:**

- Language preference is recorded in patient's records
- Clinical READ codes are used routinely
- Medication information is accurately recorded in patient's records.

## Efficient

### Efficient

We found that services were arranged in a way that supported efficient movement through care pathways and promoted person-centred care. Patients were able to self-refer to services such as physiotherapy, and staff could also book these appointments when required. Additional services were available within the practice or locally, including weekly baby clinics delivered by health visitors, retinal screening, and community-based diabetic nurse support.

Staff worked collaboratively across services to coordinate care and prevent unnecessary hospital admissions. Examples included hypertension monitoring and early intervention by nurses and GPs, spirometry referrals for patients with COPD, and access to paediatric nurse for diagnostic support. These arrangements helped ensure timely care and improved outcomes for patients.

# Quality of Management and Leadership

## Staff feedback

In total, we received 23 responses from staff at this setting. Some questions were skipped by some respondents, meaning not all questions had 23 responses. Overall, the responses from staff were positive. The majority of staff felt able to suggest improvements and involved in decisions.

Staff comments included:

*“Hard working staff who are a pleasure to work with, Staff try hard to accommodate patient needs and provide continuity”*

*“Patient centred, all staff are supported in all aspects of life e.g. work and home we have positive feedback in social media platforms from patients all GPs are supportive and encourage progression”*

*“During my time here at the practice I have progressed and with the help, training opportunities and development from management. This has allowed me to further my career within the setting and has allowed me to continue to develop my skills further. I have always felt supported in all aspects of my role(s) over the years and feel that I would confidently be able to discuss any issues if needed.”*

## Leadership

### Governance and leadership

We found that the practice had clear operational systems and processes in place to support effective governance, leadership, and accountability. Staff were clear about their roles, responsibilities, and reporting lines, and those spoken with confirmed they worked within their scope of practice. The practice manager was visible and approachable, maintaining an open-door policy and ensuring staff could contact her by phone when not on site.

Full practice meetings were held quarterly, and staff were encouraged to contribute to agendas. Minutes were recorded and shared with those unable to attend.

Changes to policies and procedures were communicated via email and discussed at meetings, with staff required to acknowledge receipt. Safety alerts from MHRA and Welsh Government were cascaded by the practice manager.

Policies and procedures were clear, accessible in both paper and digital formats, and regularly reviewed. Staff had access to wellbeing support through health board initiatives, including QR codes displayed on notice boards for counselling services. We saw evidence of staff being supported promptly when needed.

Clinical oversight was provided by a named GP lead, with overall management of the Quality Assurance and Improvement Framework (QAIF) shared between two GPs and the practice manager. Clinical information was shared through quarterly partner meetings and a WhatsApp group. The practice participated in cluster projects and governance processes, contributing to initiatives such as Vitality talking therapies.

The main challenge identified by the practice was meeting appointment demand, with mitigation put in place by the practice by adjusting the number of same-day appointments, and using GP hub support when required.

## Workforce

### Skilled and enabled workforce

We found that the practice had clear processes in place for recruitment and pre-employment checks. The practice had an up-to-date recruitment policy and induction programme in place. Vacancies were advertised via the NHS Jobs website, and checks included full employment history, proof of identity, references, health clearance, and Disclosure and Barring Service (DBS) verification. Professional registration was checked against relevant regulatory bodies, and annual appraisals were undertaken to confirm ongoing suitability for roles and identify training needs.

Staff were suitably trained and qualified for their roles, with mandatory training monitored and we were told staff were provided with protected time allocated for learning. We saw evidence of mandatory training being completed; however, some GP training certificates were not available. We were assured these had been completed as part of the GPs revalidation.

**The practice must ensure mandatory training certificates for all staff are obtained for practice records.**

Nurses held specialist qualifications in areas such as asthma, Chronic Obstructive Pulmonary Disease (COPD), and diabetes, and had access to Continuing Professional Development (CPD) opportunities. While there was no formal clinical supervision process, we found sufficient informal processes in place. We were told staff had access to GPs for advice and support, and regular meetings were held, including quarterly protected learning time sessions. Of those that answered the

question within the HIW questionnaire, the majority of respondents felt they had appropriate training for their roles.

Workforce planning was supported by a multi-skilled team able to cover absences and maintain service delivery. Appraisals were used to review skill mix and competencies, and additional staff were considered when workload pressures arose. The practice maintained indemnity cover for all staff and updated the workforce toolkit monthly.

Evidence of immunisation, training and health clearance was seen during the inspection. Responsibilities for management and reporting were understood by staff, and job descriptions were in place. Prescribing responsibilities were limited to GPs, and there was always a prescriber on site.

## Culture

### People engagement, feedback and learning

A feedback box was available within the waiting area and QR codes were available to ensure feedback could be gained from patients, including those without digital access. However, we noted there was no information for patients to inform them of changes made following feedback.

**The practice should introduce a system to ensure patients are informed of changes made following feedback.**

Of those who responded to the HIW questionnaire, 7 out of 32 said they had been asked by the practice about their experience of the service they provided, with 16 of 32 stating they had not been asked.

We found that the practice had an up-to-date complaints policy aligned with the NHS Putting Things Right procedures. Information about the policy and external contacts, including HIW and the Ombudsman, were displayed, and a complaints leaflet was available for patients. Details of Putting Things Right were clearly displayed on the notice board in the waiting area.

Complaints were stored securely in a dedicated folder and electronically, with copies of original complaints and response letters available. However, there was no central log or annual review of complaints, and concerns resolved immediately were not routinely recorded. As a result, themes and trends had not been identified. There was no formal process for documenting learning from complaints, although staff advised that issues would be discussed informally. Of the patients who responded to the HIW questionnaire, 20 out of 32 respondents stated they knew how to complain about poor service if required, with the remaining 12

stating they did not know how to complain.

**The practice must implement a complaints log with a review process to support identification of themes, as well as learning and improvement.**

The practice manager was responsible for handling complaints, with a GP partner taking the lead on more serious cases. On the day, staff confirmed they felt able to raise concerns and were aware of the whistleblowing policy, which was up to date. A Duty of Candour policy was in place, supported by flowcharts, and staff were aware of their responsibilities under the statutory guidance. Two out of five staff records reviewed showed evidence of completed Duty of Candour training

**The practice must ensure staff have completed Duty of Candour training.**

We saw documented evidence that the Duty of Candour process had been followed. Written communication was provided; an apology and an explanation were given. We were told that support was offered to the family. The incident was logged on DATIX, and senior managers were involved in the process. Of those who answered the question in the HIW questionnaire, 14 of 22 strongly agree and 7 of 22 agree that the organisation encourages staff to raise concerns.

## Information

### Information governance and digital technology

We found that the practice had an information governance policy in place; however, this was out of date and due for review in April 2024.

**The practice must ensure the information governance policy is kept under review.**

Paper records were stored in a secure room behind reception, which could be locked, and the room was clean and tidy. Electronic records were managed securely in compliance with GDPR. The practice used a health board-provided Data Protection Officer service, and staff were aware of this arrangement.

The practice used templates to maintain consistency in data entry and undertook audits to ensure data quality. GP activity data was published monthly on the website and displayed in the waiting room, providing transparency for patients. Data sharing agreements were in place with the cluster and other relevant bodies.

## Learning, improvement and research

### Quality improvement activities

We found that the practice engaged in activities to improve the quality of care. Partners met regularly to discuss innovation and service development. Clinical audits were undertaken, with examples including regular prescribing audits for Disease-Modifying Anti-Rheumatic Drugs (DMARDs). The practice also participated in research projects, such as the Sparrow project, which involved using C-reactive protein (CRP) testing in the practice to reduce unnecessary hospital admissions and improve patient outcomes.

Learning from significant events was shared during regular meetings, and minutes were circulated to staff who were unable to attend.

## **Whole-systems approach**

### **Partnership working and development**

The practice engaged in multi-disciplinary team (MDT) meetings, cluster meetings, and annual health board meetings to support collaborative working. Cluster working was well established, with external speakers attending meetings to share best practice and innovation. The practice maintained strong relationships with third-sector organisations, including Vitality talking therapies, which staff described as an excellent partnership.

These collaborative arrangements supported shared understanding of system challenges and patient needs, enabling the delivery of services that promoted continuity of care and reduced hospital admissions.

## 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 issues resolved during the inspection			

# Appendix B - Immediate improvement plan

**Service:** Foundry Town Clinic

**Date of inspection:** 08 December 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:** Foundry Town Clinic

**Date of inspection:** 08 December 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 practice offered a chaperone service, with notices displayed around the practice and on the practice website; however, this information was only available in English.	The practice must ensure chaperone notices are available bi-lingually.	Health and Care Quality Standards 2023 - Person Centred	Practice will ensure that all notices are displayed in both Welsh and English	Miss Hayley Rogers	Within 3 months
2. The practice had some documents relating to access arrangements; however, there was no specific practice access policy in place.	The practice should develop and implement a formal access policy to clearly outline procedures for managing patient access to services.	Health and Care Quality Standards 2023 - Timely	Practice will implement an access policy clearly outlining practice procedures so that patients have a better understanding of how to access services.	Miss Hayley Rogers	Within next 3 months

3.	We saw bilingual information posters were available in the waiting area; however, there were no bilingual door or directional signs available.	The practice must work to ensure signage within the premises is available bilingually, within a reasonable timeframe.	Health and Care Quality Standards 2023 - Equitable	Practice will ensure that bilingual directional and door signs will be in place as soon as possible	Miss Hayley Rogers	Within 1 Month
4.	Room identification signage had not been reinstated following redecoration earlier in the year.	The practice must implement signage within the practice to ensure patients can easily navigate the premises.	Health and Care Quality Standards 2023 - Safe	Signage has been ordered and will be in place as soon as possible	Miss Hayley Rogers	Within one Month
5.	We noted there was no information present on business partnership risks within the Business Continuity Plan.	The practice should include business partnership risks within the Business Continuity Plan (BCP).	Health and Care Quality Standards 2023 - Safe	The practice will ensure that we will update the BCP to include business partnership risks	Miss Hayley Rogers	Within 3 Month
6.	Processes were in place for managing patient safety alerts, however, we were told only one staff member currently had access to the information.	The practice must ensure multiple staff members have access to patient safety alert information to ensure continuity in the event of a staff member not being present.	Health and Care Quality Standards 2023 - Safe	Practice will increase access to patient safety alert information	Miss Hayley Rogers/Dr Niba Shah	Within 4 weeks

7.	We advised the practice to relocate emergency drugs and equipment to a central location to ensure quick access during emergencies, as current storage could delay access during intimate examinations or if doors were locked.	The practice should risk-assess and consider moving emergency drugs and equipment to a central location.	Health and Care Quality Standards 2023 - Safe	Consideration being taken to move emergency drugs and trolley to central location, practice is scoping out an ideal location for these currently	Mrs Gail Johnson	Within Four Weeks
8.	We found policies in place for blood-borne viruses; however, this was not practice specific.	The practice must implement a practice specific blood-borne viruses' policy.	Health and Care Quality Standards 2023 - Safe	Practice will implement practice specific Blood Borne Virus Policy	Mrs Gail Johnson	Within four weeks
9.	There was no audit trail for Controlled Drug prescriptions that were collected from the practice by patients or carers.	The practice should establish a robust audit trail for Controlled Drug prescriptions collected by patients or carers.	Health and Care Quality Standards 2023 - Safe	Practice is doing a scoping exercise to ensure safe delivery of controlled drugs and recording them and ensuring local chemists are signing for them. We are trying to see if an electronic or paper version would suit	Dr Niba Shah	Within 3 months

				better. With the implementation of electronic prescribing we hope that audit trailing will be better.		
10.	We noted BOC oxygen cylinder training had not been completed.	The practice must ensure all clinical staff complete BOC integrated valve oxygen cylinder training.	Health and Care Quality Standards 2023 - Safe	Necessary training will be completed for BOC Oxygen	Miss Hayley Rogers	Within 4 weeks
11.	We noted the practice manager did not have safeguarding level two in place.	The practice manager must complete level two safeguarding training.	Health and Care Quality Standards 2023 - Safe	Practice manager will attend level 2 safeguarding course and the relevant certificate will be stored in electronic files	Miss Hayley Rogers / Miss Tracey Felton	Within the next 3 months
12.	We found multiple documents were in place to describe the process to ensure information received was appropriately reviewed and recorded in patient's records. However, we noted that these could be brought together into one	The practice should create a workflow policy from existing documents.	Health and Care Quality Standards 2023 - Equitable	With migration to EMIS workflow may be managed differently, practice is awaiting Emis migration in may 2026 and then the workflow policy will be reviewed and the new comprehensive policy will be implemented	Miss Hayley Rogers / Dr Niba Shah / Miss Tracey Felton	Within the next 4-6 Months owing to migration

	main workflow policy document.					
13.	Language preferences were not recorded in any of the records reviewed. Clinical Read codes were not applied for common conditions or new problems in nine out of ten records examined. In addition, indications for medication and reasons for discontinuation were not clearly stated in seven out of ten records.	The practice must ensure the following: <ul style="list-style-type: none"> <li>• Language preference is recorded in patient's records</li> <li>• Clinical READ codes are used routinely</li> <li>• Medication information is accurately recorded in patient's records.</li> </ul>	Health and Care Quality Standards 2023 - Effective	The practice acknowledges that language preferences were not being recorded the practice has a new patient questionnaire which specifically asks for preferred language and language preferences being recorded for all new patients. We will also endeavour to start opportunistically update patients records as and when they have contact at the practice. Clinical read codes - all clinicians have been made aware of using appropriate clinical read codes whenever available and also with the introduction of SNOMED codes we hope	Dr Niba Shah	Continuous work but hoping to see improvement in the processes over the next 3 - 6 months

				<p>this will improve practice read coding. These will be reviewed consistently by the practice clinical team as well. Indications for medications all clinicians have been informed about linking medications to clinical problems, due to the vision set up some clinicians are not able to do this from their log ins, we hope to rectify this problem once we migrate to EMIS and this will be reiterated again with clinicians.</p>		
14.	<p>Some GP training certificates were not available. We were assured these had been completed as part of the GPs revalidation.</p>	<p>The practice must ensure mandatory training certificates for all staff are obtained for practice records.</p>	<p>Health and Care Quality Standards 2023 - Workforce</p>	<p>Practice will ensure all mandatory certificates are saved on files and these will be reviewed 6 monthly to ensure that these are updated.</p>	<p>Miss Hayley rogers / Miss Tracey Felton</p>	<p>Within 3 months</p>

15.	We noted there was no information for patients to inform them of changes made following feedback.	The practice should introduce a system to ensure patients are informed of changes made following feedback.	Health and Care Quality Standards 2023 - Timely	Practice will ensure that any changes made following feedback will be updated on the practice website as well as on notice board in the waiting room to inform the patients of changes made	Miss Hayley Rogers	Within the next 3 months
16.	There was no central log or annual review of complaints, and concerns resolved immediately were not routinely recorded.	The practice must implement a complaints log with a review process to support identification of themes, as well as learning and improvement.	Health and Care Quality Standards 2023 - Culture	Practice will ensure that the complaints procedure is more robust and all complaints will be recorded in the complaint files this will be stored on a central log these complaints will be discussed at significant event meetings quarterly	Miss Hayley Rogers / Dr Niba Shah	With immediate effect
17.	Two out of five staff records reviewed showed completed Duty of Candour training.	The practice must ensure staff have completed Duty of Candour training.	Health and Care Quality Standards 2023 - Culture	Practice will ensure that all staff have completed duty of candour training and add the completed	Miss Hayley Rogers	Within 3 months

				training certificated to their staff files		
18.	The information governance policy was out of date and required reviewing.	The practice must ensure the information governance policy is kept under review.	Health and Care Quality Standards 2023 - Information	Practice will review and update information governance policy on a regular basis	Miss Hayley Rogers	Within one month

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

**Service representative Dr Niba Shah / Miss Hayley Rogers**

**Name (print): Hayley Rogers**

**Job role: Practice manager**

**Date: 19/01/2026**