Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report (Announced)

Taff's Well Medical Centre, Cwm Taff Morgannwg University Health Board

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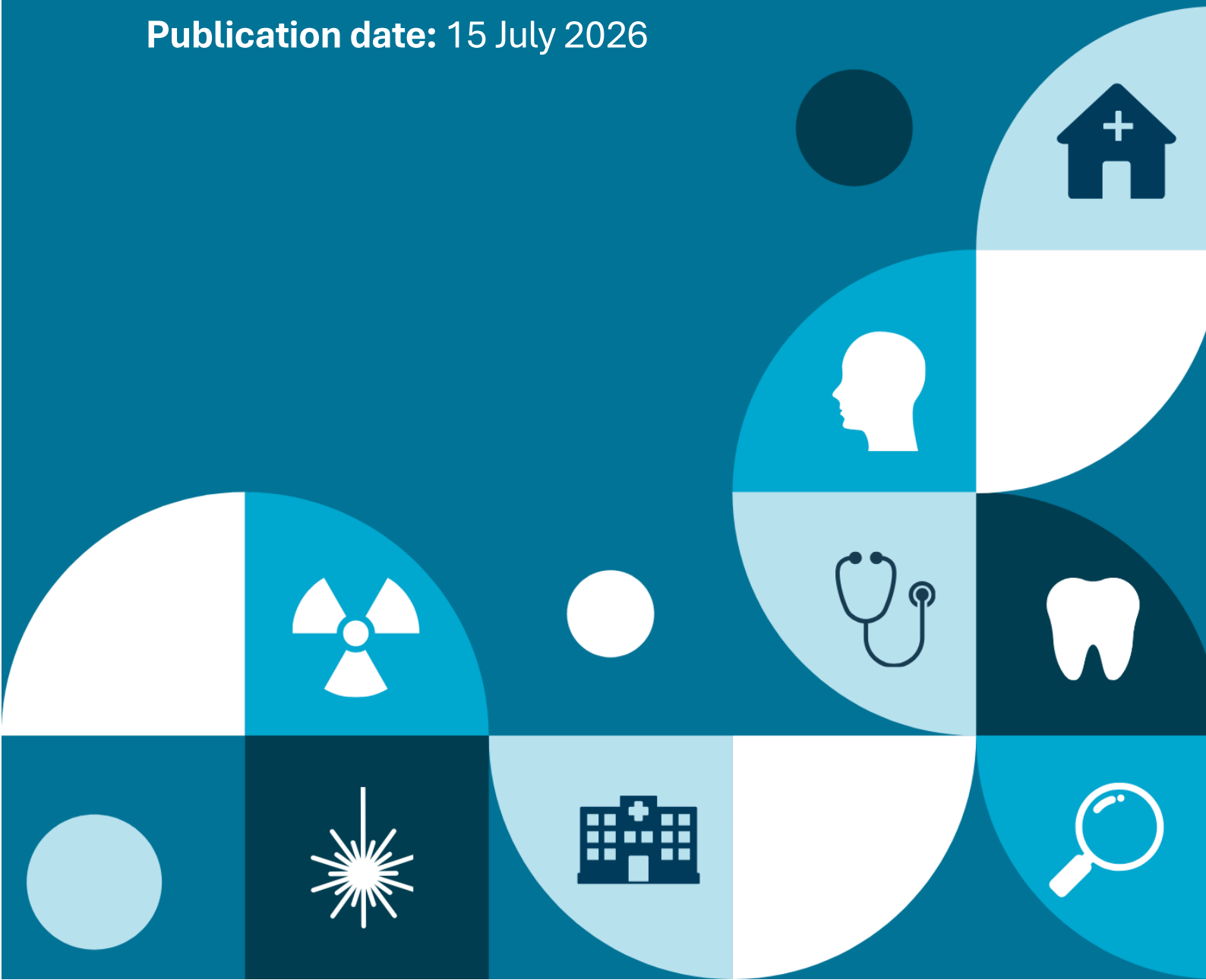

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Healthcare Inspectorate Wales (HIW) is the independent regulator and inspectorate of healthcare in Wales

Our Purpose

We check the safety and quality of healthcare across Wales.

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 Vision

A future where healthcare in Wales is safe, effective, and high-quality for everyone.

Our Priorities

Putting People First - We will focus on the biggest risks facing people and communities as they access healthcare services now and in the future.

Learning and Working Together - We will collaborate with partners to share learning and drive lasting improvements.

Investing in Our People - We will ensure our people feel supported, valued, and empowered.

Taking Action That Matters - We will take action to improve the quality and safety of healthcare for the future of Wales.

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 Taff's Well Medical Centre, Cwm Taff Morgannwg University Health Board on 14 April 2026.

Our team for the inspection comprised of one HIW healthcare inspector, and two clinical peer reviewers, and one practice manager peer 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 eleven questionnaires were completed by patients. There were none completed by staff. Feedback and some of the comments we received appear throughout the report.

2. Summary of inspection

Quality of Patient Experience

Overall summary:

We found the practice provided a caring and respectful service, with most patients rating the practice as good or very good. The waiting room was spacious and comfortable, and we saw that treatment doors were closed during consultations maintaining patient privacy and dignity.

Good cluster engagement supported access to a range of services, and the winter vaccination programme was well promoted using varied methods to reach a broad patient group.

Access to appointments remained a key pressure, with waits of several weeks for routine care reported, reflecting capacity challenges despite triage systems. The practice acknowledged this and have already appointed additional staff with the aim of resolving this.

We found appropriate arrangements to support patients with mental health issues, with good access to a variety of other mental health services available.

This is what we recommend the service can improve:

- Ensure that the offer of chaperones is displayed in clinical rooms so that patients are aware of the service
- Ensure a written patient information leaflet is available for patients who do not have digital access
- Install an emergency pull cord in the accessible toilet so that patients can summon help if they require assistance.

This is what the service did well:

- Award from the Wales Council for Deaf People in recognition of the high quality of support given to deaf patients
- Active offer of Welsh language with several Welsh speakers at the practice
- Disabled parking bays with ramp access to the practice entrance
- Knee-break chairs and hydraulic couches purchased to assist patients with mobility issues
- Quiet room available for neurodivergent and anxious patients, if required.

Delivery of Safe and Effective Care

Overall summary:

We found the practice provided care within a clean, clutter-free and generally well-maintained environment, with staff demonstrating a good understanding of infection prevention and control responsibilities. However, we found needlestick policies that needed to be merged, while cleaning schedules and infection control audits were not available for inspection.

Whilst medicines were largely well managed, storage arrangements needed some attention including the removal of keys from fridges and installation of a room thermometer. We discussed installing a data logger on both vaccine fridges to provide a more robust method of monitoring storage temperatures.

We found that improvements were required to strengthen governance systems with inconsistent policy documentation, such as safeguarding and prescribing, and limited evidence of oversight in areas such as IPC, equipment management and referrals.

Emergency preparedness required improvement, with gaps identified in equipment checks, accessibility and signage.

Patient records were of a high standard, and suitably coded. Records were appropriately protected from unauthorised access.

This is what we recommend the service can improve:

- Review their Business Continuity Plan to ensure it provides a framework for the practice to continue to operate under exceptional and adverse circumstances
- Arrange for a written record of drugs checks to be maintained
- To review and develop an appropriate safeguarding policy, with the correct contact details for the local safeguarding teams
- To record checks of non-emergency medical equipment
- To calibrate equipment in a timely manner
- To check emergency equipment on a weekly basis
- To display signs that indicate the location of emergency equipment.

This is what the service did well:

- Quality of patient records were very good
- Positive response to feedback with several issues resolved during the inspection
- Very clean practice

Quality of Management and Leadership

Overall summary:

We found a clear leadership structure at the practice, with defined roles for staff, an open and supportive culture, and strong team working supported by regular meetings. Staff were experienced, committed and up to date with most mandatory training, and information governance arrangements were robust.

However, governance systems lacked consistency. Policies were often incomplete, lacked version control and were not always easily accessible to staff. Workforce arrangements required significant improvement, with gaps identified in recruitment checks, absence of appraisals, and limited evidence of induction processes.

Training compliance was generally good, although oxygen cylinder training needed to be completed.

The practice demonstrated good engagement with the local cluster and wider partners, supporting service delivery and development. The practice described pressures relating to cross-boundary working which were impacting service delivery.

Immediate assurances:

- To ensure staff recruitment records are complete, accurate
- To ensure all clinical staff are in receipt of an enhanced DBS check, with a clear policy and rationale in place for when DBS checks are renewed
- To develop and implement a robust recruitment policy
- To ensure all relevant staff have appropriate health screening and that a up-to-date register is maintained.

This is what we recommend the service can improve:

- To ensure all policies contain appropriate version control
- To ensure all policies have sufficient detail to ensure staff are aware of the principles and scope of the policy, and that they are specific to the practice
- To ensure all staff have read and understood relevant policies
- To implement a structured induction process that is documented and signed off by a competent person at the practice
- To recommence annual staff appraisals
- To review the complaints procedure to align with the new Listening to People statutory guidance

- To display a copy of the complaint procedure where it can be easily seen
- To implement a structured programme of audits.

This is what the service did well:

- Evidence of staff development through further training and allocation of additional duties within scope of practice
- Open door policy with GPs and senior staff
- Good compliance with mandatory training.

Details of the concerns for patient's safety and the immediate improvements and remedial action required are provided in Appendix B.

3. What we found

Quality of Patient Experience

Patient feedback

In total, we received 11 responses from patients at this setting. Some questions were skipped by some respondents, meaning not all questions had 11 responses. Overall, 90% of patients rated the service as good or very good, with positive comments about staff responsiveness and care consistency. Concerns included long waiting times and limited appointment availability due to patient volume. Patient comments included:

> " Over the years the doctors and nurses at the practice have looked after my family very well... I am very happy and thank full for Taff's Well Medical staff."
>
> "The reception staff are brilliant, kind, considerate and always go over and above."
>
> "The staff at this practice are really good. The problem is waiting times for appointments, and appointments running late."
>
> "Appointments are very limited meaning long waits to see a preferred doctor. The online e-consult isn't as efficient anymore."

Person-Centred

Health promotion

During our inspection, we saw a limited range of relevant written health promotion information within the practice waiting areas. Staff informed us that a lot of leaflets had been removed during the Covid-19 pandemic and that now, relevant information would be provided during consultation with the GPs and clinicians. We saw information display screens in the waiting area although these were not in use at the time of the inspection. We also found the practice website contained some useful healthcare information, and we discussed the importance of keeping the website up to date to ensure this information remained relevant.

We were told that the practice was an active member of the Taff Ely healthcare cluster which funded several initiatives including Vitality mental health support and self-referral physiotherapy. The practice provided access to a range of other healthcare professionals including a cardio-vascular disease nurse, mental health practitioners and lifestyle counsellors, health visitors and midwives. Patients were signposted to these services through care navigation by practice staff or via the practice website. The practice may wish to consider how else they can promote these services to patients with limited digital access.

We were told that the winter vaccinations programme was well promoted using a variety of methods including posters, social media, letters and reminders on the bottom of prescriptions. This variety helped ensure patients without access to digital media were made aware of the programme resulting in a good response rate.

Whilst the practice manages instances where patients Did Not Attend (DNA) or Was Not Brought (WNB) to appointments, there was no policy describing this process and how the practice would consistently address this issue.

The practice should develop and implement an appropriate policy that describes how the practice manages patients that Did Not Attend or Was Not Brought to their appointments.

Dignified and respectful care

During the inspection, we observed reception staff welcoming patients in a respectful, friendly manner. The reception desk was separate from the patient waiting area providing a degree of privacy for patients when reporting to reception. We were told that telephone calls were handled by the reception staff. Most respondents who answered the HIW questionnaire felt that they were able to speak with a member of reception staff without being overheard by others in the patient waiting area, although four patients disagreed.

Treatment rooms doors were kept closed during consultations and privacy curtains were available to maintain patient privacy and dignity. There was a practice chaperone policy in place for intimate examinations although there were no notices displayed advertising this service to patients. Despite this our review of ten patient records indicated that the offer of chaperones had been recorded when appropriate. Whilst three respondents confirmed they were offered chaperones for intimate examinations or procedures, one respondent said that they were not.

The practice must ensure that the offer of chaperones is displayed in clinical rooms so that patients are aware of the service.

Most patients who answered the HIW questionnaire generally felt they were treated with dignity and respect with privacy protected during consultations. Similarly, most said the GP explained things well, felt listened to and were involved in decisions about their healthcare.

Timely

Timely care

The surgery was open between 8:00am and 6:00pm Monday to Friday with local health

board out-of-hours cover over evening and weekends. Patients were informed of options for accessing appointments and out of hours contact details via the practice website, telephone message and directly from staff. Information regarding the e-consult process was displayed in the entrance to the practice.

Appointments can be made by telephone, online and in-person. Appointments comprised of urgent on the day appointments or routine bookable appointments. We were told that patients were offered the next available appointments which had approximately three weeks wait at the time of the inspection. Urgent requests would be triaged by the on-call doctor, who would also decide on the most appropriate appointment format. We were told that e-consult was used every day although this was sometimes turned off once it had reached capacity.

Nearly two-thirds of the patients who answered the HIW questionnaire confirmed they were offered a choice of appointment type, and over 70% were content with the appointment type offered. Most appointments were in person, with one having a telephone consultation. Some dissatisfaction was linked to long waits, difficulties in obtaining same-day or routine appointments, and waiting times up to a month for medication reviews. Some patients commented:

> "You can always get to speak to a doctor or nurse if needed and will always get back to you quickly regarding triage calls. Sometimes within the hour."
>
> "Can't always get an appointment when you need it. Booked weeks in advance."
>
> "I have been waiting four weeks in pain for this appointment."

The practice recognised that access to GP's was an issue, and that they had recently been awarded funding for additional GP sessions and administrative capacity in the hope of improving this. We encourage the practice to monitor how this improves patient access and care.

Staff had completed care navigation pathway training with non-clinical navigators able to seek guidance from the on-call doctor if required. We saw care navigation flowcharts were available to guide staff in signposting patients to the most appropriate service.

There were appropriate processes in place to support patients in mental health crisis. Where appropriate, patients are referred to local mental health services for support, with safety netting in place as necessary. The practice also has access to other mental health services such as Valley Steps and MIND who hold a clinic once a week.

Equitable

Communicating and language

The practice informed patients about services and any changes primarily via the practice website, social media and notices displayed in the patient waiting areas. We

found that there were no practice information leaflets available for patients without digital access.

The practice should have a written patient information leaflet available for patients who do not have digital access.

We were told that staff would help with reading and filling in forms if patients had visual impairments. Despite a lack of British Sign Language provision available, we saw that the practice had received an award from the Wales Council for Deaf People in recognition of the high quality of support given to deaf patients.

We saw the Active Offer was displayed informing patients that treatment could be provided in the Welsh language. Several members of staff were able to speak Welsh. Lanyards had been supplied by the local health board to give a visual indication of which staff could provide care in Welsh, although several were having to be replaced with badges in accordance with the health board policy for clinical staff. We discussed adding the offer of consultations in Welsh on the practice website.

Rights and equality

The practice provided good access for patients with impaired mobility and wheelchair users with disabled parking bays and ramp access from the car park. The whole practice, including spacious waiting room and treatment rooms were in a single level building, with corridors and doorways wide enough to accommodate wheelchairs. Automatic doors were installed while assistive furniture had been purchased to support patients when attending the treatment rooms. A quiet room was available for neurodivergent and anxious patients. There was an accessible toilet available although this did not have an emergency pull cord fitted.

The practice should install an emergency pull cord so that patients can summon help if they require assistance.

We reviewed a sample of staff files and found that mandatory training had been completed in equality and diversity.

The practice was proactive in upholding the rights of transgender patients. We were told transgender patients were treated with preferred names and pronouns used as required.

All patients who responded to the HIW questionnaire confirmed they had not faced discrimination when accessing or using this health service. Most patients felt the practice was accessible although three patients disagreed but did not elaborate why.

Delivery of Safe and Effective Care

Safe

Risk management

We found the clinical treatment rooms were visibly clean, free of clutter and well-lit. Chairs in surgeries and waiting areas were in a good state of repair and upholstered with easily wipeable coverings.

We were provided with a copy of the practice Business Continuity Plan. However, this did not identify the steps to take in the event of an emergency event, nor did it contain contingencies for long term staff shortages. Furthermore, there was no plan detailing how it would cover a significant health emergency, such as the Covid-19 pandemic.

The practice should review their Business Continuity Plan to ensure it provides a framework for the practice to continue to operate under exceptional and adverse circumstances.

Staff were able to request emergency assistance from their individual clinical areas using the clinical software.

Senior staff described suitable processes for receiving and sharing patient safety alerts with relevant team members. Learning from significant event reviews was discussed at weekly team meetings and shared with the wider team via email, although we found logs of these events were not always retained.

The practice should ensure that record keeping in relation to significant events is further formalised.

While reviewing the fire safety arrangements we found exits were clear and signposted and that extinguishers had been serviced within the last 12 months. However, a floor plan of the practice indicating the location of oxygen cylinders was not displayed. Identifying the location of oxygen cylinders is critical for the safety of staff and the fire service in the event of a fire.

The practice must display emergency floor plans with the location of oxygen cylinders indicated.

We saw signage indicating the location of liquid nitrogen at the practice. However, we were told that treatments using liquid nitrogen were no longer offered and therefore no longer stored on site. We discussed removing this signage to avoid any confusion.

Infection prevention and control (IPC) and decontamination

The practice was visibly clean and largely clear of clutter. We saw appropriate handwash facilities available in surgeries and toilets. Cleaning of all areas was completed to a good standard. Sharps bins were suitably located and labelled.

The practice had an IPC lead appointed, and we found staff were aware of their roles and responsibilities in maintaining the necessary standards.

We found the practice had two needlestick policies in place. However, one was basic and lacked key details such as where to seek advice and treatment if a needlestick injury occurs. Also, the name of the needlestick injury lead was missing and there was no effective version control. The other was a generic health board policy that was out of date although this was version controlled and more comprehensive but not practice specific.

The practice should review the needlestick policy, considering merging the two policies to make one detailed, practice specific policy.

During our tour of the practice, we saw hand washing posters, needlestick injury flowcharts and waste segregation posters were displayed, but not in every relevant location. We discussed the benefit of having a consistent approach to displaying the infection control guidance throughout the practice.

We saw a third-party cleaning contract was in place. However, cleaning schedules and the latest IPC audit were not made available to us during the inspection.

The practice should:

- **Ensure cleaning schedules are used and made available for inspection**
- **Arrange to conduct an appropriate IPC audit and provide a copy to HIW when complete.**

All patients that answered the questionnaire said the practice was very clean. Most told us that hand sanitisers were always available for them in the practice and agreed that staff washed their hands before and after delivering care.

Medicines management

We reviewed how the practice safely managed prescribing of medicines. We found prescription pads appropriately stored and disposed of, while the collection of prescriptions was logged. Medication reviews were notified via the patient repeat prescription form when due. The practice had generic prescribing and cold chain policies in place, which were not practice specific. We discussed reviewing these documents to be more relevant to the practice.

Vaccines were stored within dedicated vaccine fridges which were subject to daily temperature checks. There was a data logger in one fridge only, and we discussed installing a data logger in both as a more robust method of monitoring temperatures. Both fridges were in a corridor with patient access. Whilst both were locked, we found the keys were left in the locks. Our concerns regarding this were dealt with at the time of the inspection. Further information on the issues we identified, and the actions taken by the service, are provided in Appendix A.

We found drugs were stored securely whilst expired drugs were taken to the local pharmacy to be destroyed. Adverse reactions were reported via the Yellow Card scheme. Whilst we were told that drugs were subject to checks by staff, there was no written record kept. Additionally, there was no room thermometer to ensure they remained at ambient temperature.

The practice should:

- **Arrange for a written record of drugs checks to be maintained**
- **Install a room thermometer in the room where drugs are stored to ensure they are stored at the relevant temperature.**

Safeguarding of children and adults

We inspected the safeguarding procedures in place at the practice. A process was in place to ensure the medical records of children and vulnerable adults with safeguarding status were identifiable to staff by way of an alert marker, although we were told they did not have patients on the safeguarding register at the time of the inspection. The practice is advised to ensure that its patient lists and registers are regularly reviewed. Any safeguarding issues formed part of the weekly management meeting agenda.

The practice had a safeguarding policy in place which included both adults and children. This was available to all staff via the practice IT system and contained the name of the practice safeguarding lead. However, the policy appeared to be a generic template and lacked any detail with no reference to the Wales Safeguarding Procedures. The contact telephone numbers for the local safeguarding teams differed to those in the Wales Safeguarding Procedures.

The practice should review and develop an appropriate safeguarding policy and ensure it contains the correct contact details for the local safeguarding teams.

We reviewed a sample of staff training records and found safeguarding training to have been completed at the required levels.

Management of medical devices and equipment

Medical devices and equipment were found to be in good working order. We were told that non-emergency equipment was checked at each use and where appropriate, calibrated once a year. However, there was no record of non-emergency equipment checks. Despite a third-party arrangement for calibration of medical equipment, the practice was unable to provide us with calibration documentation, while we found some calibration stickers on equipment that were out of date.

The practice should ensure:

- **Checks of non-emergency medical equipment are recorded**
- **Appropriate arrangements are in place to calibrate equipment in a timely manner.**

We inspected the emergency equipment and found only one oxygen cylinder in place, while some items were missing, some were out of date and others lacked required expiry dates. Our concerns regarding this were dealt with at the time of the inspection. Further information on the issues we identified, and the actions taken by the service, are provided in Appendix A.

We were told that the emergency equipment was checked monthly, rather than weekly. Whilst the location of the oxygen was signposted, there was nothing displayed to indicate the location of emergency drugs and equipment. We discussed options for moving the equipment from a treatment room which could hinder access in an emergency, to a more central location.

The practice should ensure that:

- **Emergency equipment is checked on a weekly basis in line with the Resuscitation Council guidelines**
- **Appropriate signage is displayed to indicate the location of emergency equipment**
- **Emergency equipment and drugs are always easily accessible to staff in the event of an emergency.**

Effective

Effective care

We found the practice had a dedicated team that worked hard to provide patients with effective and safe care. Updates in best practice and professional guidance was circulated to staff as appropriate, while incidents were reported using Significant Event Analysis forms for discussion during the weekly meetings.

Referrals to secondary care were managed via the Welsh Clinical Communications Gateway (WCCG). Referrals were suitably prioritised as routine, urgent and urgent suspected cancer. We were informed that whilst GP activity data was submitted, there was no current analysis to compare referral rates against other practices in the area.

The practice should consider implementing a review of referral rates to help highlight key themes and trends.

We found the process for referring deaths to the Medical Examiner Service (MES) and obtaining learning from the MES was embedded in the practice procedures.

The practice telephone answering service signposted callers with emergency

conditions to dial 999. Reception staff were aware of potential life-threatening conditions and the necessary action to take should a patient present with symptoms.

Senior staff described a suitable organised process for arranging tests and relaying the results to patients. We were told that cancer results would only be provided via face-to-face appointment.

A review of information from secondary care found effective handling of incoming documents which were scanned and coded by the clinical team. We also found appropriate systems for recording and monitoring the use of out-of-hours services, and for following up on tests and investigations.

Patient records

We reviewed a sample of seven patient medical records. These were stored securely and protected from unauthorised access. Overall, we considered the quality of patient records to be very good, with notes in line with the CARAT approach (Complete, Accurate, Relevant, Accessible and Timely) suitably summarised and Read Coded. We noted that examination findings were also Read Coded, which we considered good practice.

Chronic disease management was considered appropriate and reviewed in a timely manner.

Quality of Management and Leadership

Leadership

Governance and leadership

Taff's Well Medical Centre was operated by three GP partners and is an active member of the Taff-Ely Cluster of Cwm Taff Morgannwg University Health Board. The practice is a training practice that supports medical students, while providing a broad mix of services to support patient healthcare needs.

We found staff were clear about their roles and responsibilities and there were clear lines of accountability in place at the practice, with clinical oversight carried out by the senior partner. Management and staff alike confirmed there was an open-door policy with partners and senior staff available and approachable to all. Most staff at the practice were found to be long term employees.

The practice held quarterly staff meetings. Minutes of the meetings were shared with staff to ensure all were aware of the issues discussed. The practice clinical team also held meeting every Friday where issues such as safeguarding, palliative care and complaints would also be discussed.

The practice had a wide range of policies and procedures that were shared via email and available to all staff on the practice computer system. However, we noted that numerous policies lacked version control and review dates, while several policies including Access, Infection Control, Blood Borne Virus, Waste Management, and Equality and Diversity policies were extremely brief consisting of bullet points and lacking detail. Some policies, such as the Prescribing policy, were found to be third-party supplied, generic templates. Furthermore, some staff we spoke to were unable to find policies, such as Infection Control and the Cold Chain policies, when asked.

The practice should ensure that:

- **All policies contain appropriate version control including review dates and the name of the person responsible for drafting that policy**
- **All policies contain sufficient detail to establish the principles, scope and accountability of that policy, and are relevant to the practice**
- **All staff have read and understood relevant policies to ensure compliance with practice processes**
- **Ensure all staff can access relevant policies whenever they require them**
- **Provide HIW with evidence once completed.**

Due to the practice location near the border with two other health boards, we were told about the difficulties they experienced managing services for patients who may live within the area of another health board, especially when engaging with different district

nurse and palliative care teams, and referral pathways.

Workforce

Skilled and enabled workforce

We spoke with staff across a range of roles working at the practice. It was clear that staff were aware of their roles and responsibilities and appeared committed to providing a quality service to patients. We saw evidence of staff development through further training and additional duties within their scope of practice.

We reviewed a selection of staff records and found no evidence that identity checks, employee reference checks, or professional registration checks were being completed. There was only one Disclosure and Barring Service (DBS) certificate held on file, with no process in place to monitor the ongoing suitability of staff to remain employed at the practice. We also found limited evidence that pre-employment health screening was conducted with only one staff file containing documentation relating to Hepatitis B immunisation. Furthermore, the practice was unable to provide us with an up-to-date recruitment process policy.

Therefore, we were not assured that robust systems were in place to ensure that appropriate pre-employment and ongoing fitness to work checks would be completed. These issues were addressed under our immediate assurance process at Appendix B.

We were told that newly appointed staff were required to undergo an induction programme. However, there was no evidence provided to indicate that this was documented, or that the practice had a relevant policy to cover this process.

The practice should:

- **develop and implement an appropriate induction policy**
- **put in place an induction programme that is documented and signed off by a responsible competent person.**

We requested copies of staff annual appraisals. However, we were informed by senior managers that these had not been conducted, with staff confirming that they had not had an appraisal for a few years.

The practice should ensure that staff are provided with annual appraisals that are timely and appropriately documented.

We reviewed staff training records. Overall, compliance with mandatory training was good, with evidence of up-to-date annual resuscitation training and safeguarding training seen. However, we found that most staff had not completed the necessary training for the use of BOC oxygen cylinders.

The practice must ensure that staff complete the online BOC oxygen cylinder training.

Culture

People engagement, feedback and learning

The practice complaint procedure was available on request or on the practice website. We discussed reviewing this to align with the new Listening to People (LtP) statutory guidance, liaising with the health board primary care team to support its implementation.

The practice should:

- **Review the complaints procedure to align with the new Listening to People statutory guidance**
- **Display a copy of the complaint procedure in an area where it can be easily seen by patients**

We reviewed the practice complaints file and saw the process to be fully documented with responses in line with the policy timescales at that time. We were told that complaints would be discussed and considered in weekly partner meetings.

We found that patient feedback was sought through yearly NHS Wales Experience surveys, with the results analysed and discussed by senior management. However, only two respondents to the HIW questionnaire stated they had been asked to provide feedback on the service experience, while nearly half said they would not know how to complain about poor service if they wanted to do so.

We recommend the practice reflects on the issues raised in this feedback to improve patient awareness of how to make a complaint or provide feedback.

A whistleblowing policy was in place to support staff in raising concerns about the service. We were told that staff were happy to share any suggestions they might have to improve services, although there was no formal process in place. We discussed options for introducing a process for recording staff suggestions.

We saw an up-to-date Duty of Candour policy was in place that met the requirements of the guidance, and we saw evidence that staff had completed training on this topic. We were told that, to date there had been no incidents that had triggered this process.

Information

Information governance and digital technology

The practice understood its responsibility when processing information and demonstrated that data is managed in a safe and secure way. An information governance policy was in place with the Digital Health and Care Wales (DHCW) service fulfilling the data protection officer function. We found a confidentiality statement on

the practice website, while staff files indicated all staff had signed confidentiality agreements and had completed information governance training.

Appropriate systems were in place to ensure safe and effective sharing of information with external bodies.

Learning, improvement and research

Quality improvement activates

Learning from internal and external reviews, including incidents and complaints was shared across the practice via staff meetings and emails to make improvements. We found a limited scheme of audits carried out as part of the practice quality improvement activity, suggesting the practice was not always pro-active in this area.

The practice should consider implementing a structured programme of audits to ensure services and processes remain robust.

Whole-systems approach

Partnership working and development

We were told the practice had an effective working relationship with the local health board multi-disciplinary home service team to support the delivery of services. This helps in enabling patients to receive care at home, rather than admitting to hospital.

The practice appeared to have a good relationship with other practices within the local GP cluster, GP trainer network and local health board helping develop a shared understanding of the challenges and needs of the local area. We were told that cluster projects were managed by the collaborative rather than the practice.

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
Vaccine fridges were in a corridor with patient access. Whilst both were locked, we found the keys were left in the locks.	Patients could be at risk with unauthorised access to vaccines.	We raised this immediately with senior staff.	Keys were removed during the inspection.
We inspected the emergency equipment and found only one oxygen cylinder in place, while some items were missing, some were out of date and others lacked required expiry dates.	Patients or staff could be put at risk in the event of an emergency incident.	We raised this immediately with senior staff.	Replacements items were ordered during the inspection.

Appendix B – Immediate improvement plan

Service: **Taff's Well Medical Centre**

Date of inspection: **14 April 2026**

The table below includes any immediate non-compliance 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.

Findings	HIW is not assured that robust systems were in place to ensure that appropriate pre-employment and ongoing fitness to work checks had been completed. There was also a lack of complete and readily available recruitment records to review. During the inspection, we reviewed a sample of five staff records and found no evidence that identity checks, employee reference checks, or professional registration checks were being completed. There was only one Disclosure and Barring Service (DBS) certificate held on file, with no process in place to monitor the ongoing suitability of staff to remain employed at the practice. We also found limited evidence that pre-employment health screening was conducted with only one staff file containing documentation relating to Hepatitis B immunisation. The practice was unable to provide us with an up-to-date recruitment process policy

	Improvement needed	Standard / Regulation
	The practice must take immediate action to strengthen recruitment and staff training governance arrangements. This includes: • Ensuring staff recruitment records are complete, accurate, and readily available for review • Ensuring all clinical staff are in receipt of an enhanced DBS check, and to risk assess and have a clear policy and rationale in place for when DBS checks are renewed and when they are required for non-clinical staff, based on their roles and responsibilities • Developing and implementing a robust up-to-date recruitment policy Ensuring all relevant staff have been appropriately screened and that an up-to-date register is maintained. This includes adopting a documented, risk assessed approach for any staff who are 'non-responders' or who decline to participate.	Health and Care Quality Standards (2023) Eligibility for healthcare roles - GOV.UK Standard: UK Gov - Hepatitis B: the green book, chapter 18 Green Book Chapter 12: Immunisation of Healthcare Staff

Service Action:	Responsible officer	Timescale
A comprehensive Recruitment Policy must be developed, formally approved, and embedded within practice. This policy should outline all stages of the recruitment process, including pre-employment checks, selection procedures, and onboarding requirements. All staff must provide appropriate pre-employment documentation, including: • A valid Disclosure and Barring Service (DBS) certificate, where required for the role • Evidence of Hepatitis B (HepB) immunisation status or immunity, where applicable The practice must ensure: • DBS application forms are made available and processed for staff where required • Access to Occupational Health services is provided to support immunisation checks, health clearance, and fitness for work assessments Where applicable, staff must provide evidence of professional registration, including: • A valid and up-to-date Nursing and Midwifery Council (NMC) registration certificate Systems must be in place to verify, record, and regularly review all recruitment documentation to ensure ongoing compliance. 4 x DBS applications are processed, and further information is awaiting from current employed staff regarding Hepatitis B	Sarah Humphreys	Immediate – 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:

Name (print): Sarah Humphreys

Job role: Practice Manager **Date: 21 April 2026**

Appendix C – Improvement plan

Service: **Taff's Well Medical Centre**

Date of inspection: **14 April 2026**

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.	There was no policy describing the Did Not Attend or Was Not Brought process and how the practice would address this issue.	The practice should develop and implement an appropriate policy that describes how the practice manages patients that Did Not Attend or Was Not Brought to their appointments.	Health and Care Quality Standards – Person Centred	Policy to be put in place and regular coding of patient that do not or attend or not brought to appointments. Monthly audits for child not brought to be given to Safeguarding lead Dr A Bleasdale.	Sarah Humphreys	Ongoing 3 months
2.	There was a practice chaperone policy in place for intimate examinations although there were no notices displayed advertising this service to patients.	The practice must ensure that the offer of chaperones is displayed in clinical rooms so that patients are aware of the service.	Health and Care Quality Standards – Person Centred General Medical Council (GMC): Intimate examinations and chaperones	Display posters in waiting room and clinic room. Continue with documentation.	Sarah Humphreys	Completed

3.	There were no practice information leaflets available for patients without digital access.	The practice should have a written patient information leaflet available to ensure information is also available to patients who do not have digital access.	Health and Care Quality Standards – Equitable		Sarah Humphreys	3 months
4.	There was an accessible toilet available although this did not have an emergency pull cord fitted.	The practice should install an emergency pull cord so that patients can summon help if they require assistance.	Health and Care Quality Standards – Equitable	Pull chord in disabled toilet to be installed.	Sarah Humphreys	3 months
5.	The Business Continuity Plan did not identify the steps to take in the event of an emergency that affected service delivery, nor did it contain contingencies for long term staff shortages. Furthermore, there was no plan detailing how it would cover a significant health emergency, such as epidemics.	The practice should review their Business Continuity Plan to ensure it provides a framework for the practice to continue to operate under exceptional and adverse circumstances.	Health and Care Quality Standards – Safe; Risk Management	Review business continuity plan to include suggested items.	Sarah Humphreys	6 months

6.	Significant event reviews were discussed and shared with the wider team, although we found logs of these events were not always retained.	The practice should ensure that record keeping in relation to significant events is further formalised.	Health and Care Quality Standards – Safe; Risk Management	Individual significant event to be entered on to template and saved in Significant events folder on G Drive. Continue to discuss at weekly meetings.	Sarah Humphreys	Completed
7.	While reviewing the fire safety arrangements we noted that a floor plan of the practice, indicating the location of oxygen cylinders was not displayed	The practice must display emergency floor plans with the location of oxygen cylinders indicated.	Health and Care Quality Standards – Safe; Risk Management	Add oxygen cylinder to floor plan and display in reception office.	Sarah Humphreys	Completed
8.	We found the practice had two needlestick policies in place with varying information.	The practice should review the needlestick policy, considering merging the two policies to make one detailed, practice specific policy.	Health and Care Quality Standards – Safe; Infection Prevention and Control	Review policies and merge duplicates.	Sarah Humphreys	Completed

9.	Cleaning schedules and the latest IPC audit were not made available to us during the inspection.	The practice should: • Ensure cleaning schedules are used and made available for inspection • Arrange to conduct an appropriate IPC audit and provide a copy to HIW when complete.	Health and Care Quality Standards – Safe; Infection Prevention and Control	New company had recently taken over, and 3 months audits were not made available by contractor. Monthly copies of audits to be requested.	Sarah Humphreys	1 month
10.	Whilst drugs were subject to checks by staff, there was no written record kept. Additionally, there was no room thermometer to ensure they remained at ambient temperature.	The practice should: • Arrange for a written record of drugs checks to be maintained • Install a room thermometer in the room where drugs are stored to ensure they are stored at the relevant temperature.	Health and Care Quality Standards – Safe; Medicines Management	Practice Nurse to action.	Debbie Jones/Rachel Lewis	Completed

11.	The safeguarding policy appeared to be a generic template and lacked detail with no reference to the Wales Safeguarding Procedures. The contact telephone numbers for the local safeguarding teams differed to those in the Wales Safeguarding Procedures.	The practice should review and develop an appropriate safeguarding policy and ensure it contains the correct contact details for the local safeguarding teams.	Health and Care Quality Standards – Safe; Safeguarding Children and Adults	Review policy.	Dr Bleasdale	3 months
12.	There was no record of non-emergency equipment checks. The practice was unable to provide us with calibration documentation for some equipment, while we found some calibration stickers on equipment that were out of date.	The practice should ensure: • Checks of non-emergency medical equipment are recorded • Appropriate arrangements are in place to calibrate equipment in a timely manner.	Health and Care Quality Standards – Safe; Management of Medical Devices and Equipment	Williams Medical Supplies provide annual calibration checks and records kept. Next annual check due September 2026.	Sarah Humphreys	Documentation is available. Unsure who was asked for this information, was not Practice Manager. All staff now aware where the information can be found.

13.	The emergency equipment was checked monthly, rather than weekly. There were no signs displayed to indicate the location of emergency drugs and equipment. We discussed options for moving the emergency equipment to a more central location.	The practice should ensure that: • Emergency equipment is checked on a weekly basis in line with the Resuscitation Council guidelines • Appropriate signage is displayed to indicate the location of emergency equipment • Emergency equipment and drugs are always easily accessible to staff in the event of an emergency.	Health and Care Quality Standards – Safe; Medicines Management	Weekly checks to be put in place by Practice Nurse and recorded for audit purposes. Signage to be displayed on door. GP's in agreement equipment in easily accessible area and not to remove.	Debbie Jones/Rachel Lewis	Complete
14.	There was no current analysis to compare referral rates against other practices in the area.	The practice should consider implementing a review of referral rates to help highlight key themes and trends.	Health and Care Quality Standards – Effective Care	New clinical system in place so unsure how to do this currently.	Sarah Humphreys	Ongoing 6 months
15.	There was no formal mortality review process at the practice.	The practice should implement a formal mortality review process.	Health and Care Quality Standards – Effective Care	Will add to weekly meeting agenda and devise pro-forma for completion following every case.	GP Partners	Complete

16.	Numerous policies lacked version control and review dates, while several policies were extremely brief consisting of bullet points and lacking detail. Some staff we spoke to were unable to find certain policies when asked.	The practice should ensure that: • All policies contain appropriate version control including review dates and the name of the person responsible for drafting that policy • All policies contain sufficient detail to establish the principles, scope and accountability of that policy, and are relevant to the practice • All staff have read and understood relevant policies to ensure compliance with practice processes • Ensure all staff can access relevant policies whenever they require them • Provide HIW with evidence once completed.	Health and Care Quality Standards – Leadership	Review all policy folders and amend as necessary. Staff to be reminded how to access policies as some seem to have forgotten.	Sarah Humphreys	Ongoing process to be completed within 12 months

17.	There was no evidence provided to indicate that the induction process was documented, or that the practice had a policy to cover this process.	The practice should: • develop and implement an appropriate induction policy • put in place an induction programme that is documented and signed off by a responsible competent person.	Health and Care Quality Standards – Workforce	Induction programme to be put in place.	Sarah Humphreys	6 months
18.	We were informed that staff appraisals had not been conducted for a few years.	The practice should ensure that staff are provided with annual appraisals that are timely and appropriately documented.	Health and Care Quality Standards – Workforce	Annual appraisals to be resumed immediately and ongoing thereafter.	Sarah Humphreys GP Partners	Ongoing 6 months
19.	Most staff had not completed the necessary training for the use of BOC oxygen cylinders.	The practice must ensure that staff complete the online BOC oxygen cylinder training.	Health and Care Quality Standards – Workforce	Online BOC training has been arranged.	Sarah Humphreys	90% complete Outstanding Dr Painter – reminder sent for immediate action.

20.	The practice complaint procedure was available on request or on the practice website. We discussed reviewing this to align with the new Listening to People (LtP) statutory guidance.	The practice should: • Review the complaints procedure to align with the new Listening to People statutory guidance • Display a copy of the complaint procedure in an area where it can be easily seen by patients	Health and Care Quality Standards – Culture	Review policy & procedures, update as necessary. Display copy in patient waiting areas.	Sarah Humphreys	3 months
21.	Only two respondents to the HIW questionnaire stated they had been asked to provide feedback on the service experience, while nearly half said they would not know how to complain about poor service if they wanted to do so.	We recommend the practice reflects on the issues raised in this feedback to improve patient awareness of how to make a complaint or provide feedback.	Health and Care Quality Standards – Culture	Place suggestions box in patient areas. Already available via practice website. Display complaints procedure in all patient areas.	Sarah Humphreys	Completed
22.	We found a limited scheme of audits carried out as part of the practice quality improvement activity.	The practice should consider implementing a structured programme of audits to ensure services and processes remain robust.	Health and Care Quality Standards – Quality Improvement	Consider what audits could be necessary and action accordingly.	Sarah Humphreys Practice Nurses GP Partners	Ongoing process to be completed within 12 months

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

Service representative:

Name (print): **Sarah Humphreys**

Job role: **Practice Manager**

Date: **25 June 2026**