Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report (Announced)

The Grove Medical Centre, Swansea Bay University Health Board

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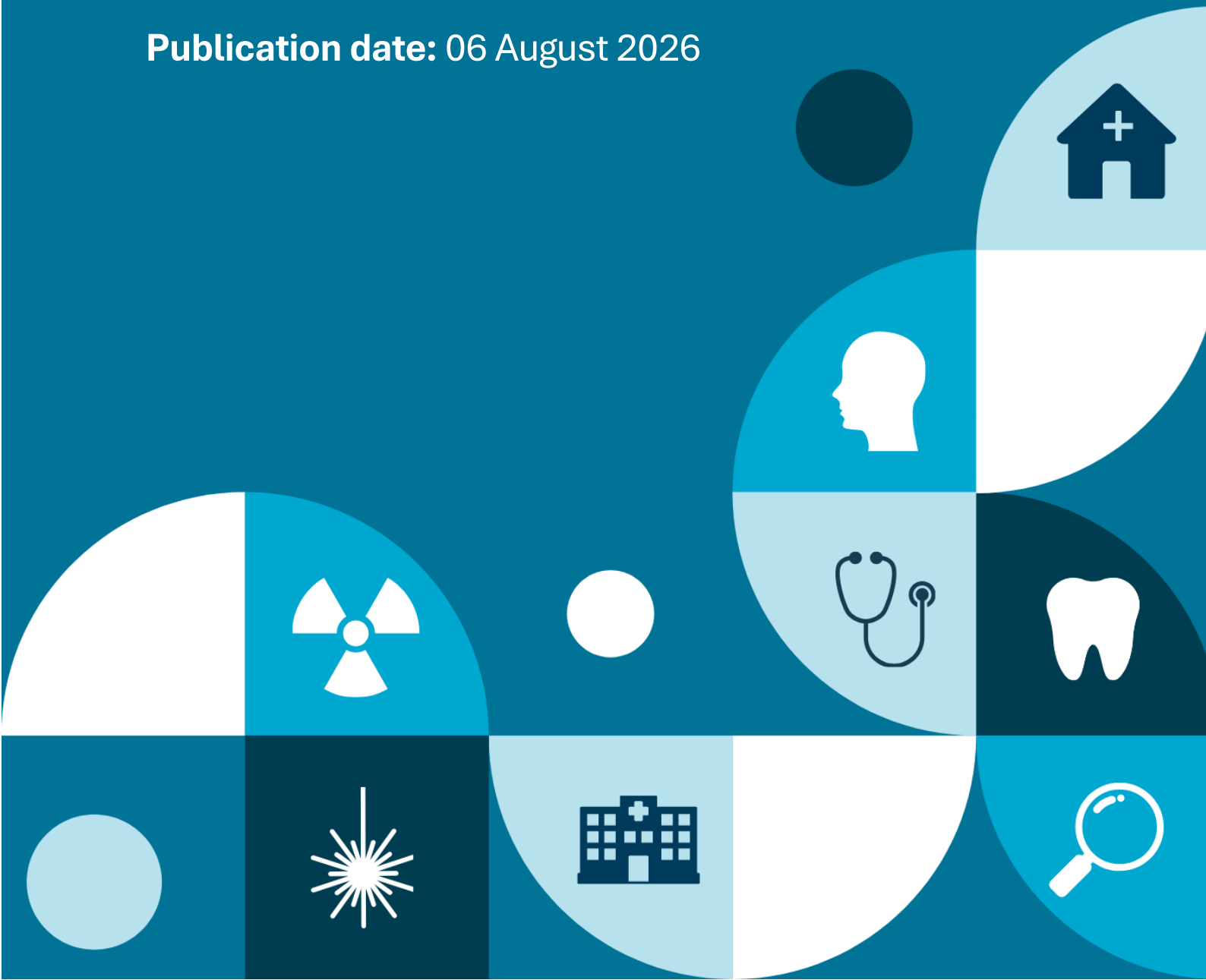

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Healthcare Inspectorate Wales (HIW) is the independent regulator and inspectorate of healthcare in Wales

Our Purpose

We check the safety and quality of healthcare across Wales.

Our Vision

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

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 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 The Grove Medical Centre Practice, Swansea Bay University Health Board on 06 May 2026.

Our team for the inspection comprised of one HIW healthcare inspector, 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 135 questionnaires were completed by patients or their carers and nine were completed by staff. Feedback and some of the comments we received appear throughout the report.

Where present, quotes in this publication may have been translated from their original language.

Note the inspection findings relate to the point in time that the inspection was undertaken.

2. Summary of inspection

Quality of Patient Experience

Overall summary:

We found that patients received a positive experience of care. Patient feedback was very positive, with most respondents reporting good access to the practice, positive experiences of care and high levels of satisfaction with the service received. Patients were particularly positive about opening hours, being able to contact the practice when needed, appointment choice, the cleanliness and accessibility of the premises, and the way staff treated them with dignity and respect. Patients also gave positive comments about the practice, describing staff as helpful and responsive.

We found that access was a strength of the practice. Patients could contact the practice online, by telephone, through the NHS app or in person, and the practice had clear systems to support timely appointment availability. The default appointment type was face-to-face, and the practice had processes to triage urgent needs, support patients in mental health crisis and ensure children were seen on the same day. The introduction of a new telephone system had reduced abandoned calls and allowed patients to request a call back while keeping their place in the queue. However, information about appointment options and alternative services was not displayed in the waiting room, which may make it harder for patients, particularly those without digital access, to understand the full range of options available.

Patients could access health promotion advice during consultations and new patient checks, and the practice worked with cluster and community services to support smoking cessation, mental health, social prescribing, chronic disease management, audiology, ear wax removal and targeted lifestyle programmes. Information was available through the website, printed resources and staff signposting, which helped support patients who were older or digitally excluded.

The practice had taken steps to support privacy in the reception area, including playing music near reception, providing a touch screen check-in system and offering a consulting room for confidential conversations on request. However, patient survey feedback identified privacy at reception as an area for improvement, with only around half of respondents saying they could speak to reception staff without being overheard. We also found that one clinical room had a privacy curtain placed on the examination couch rather than fitted and ready for use.

The practice had a chaperone policy and enough trained staff to provide male and female chaperones. The service was promoted in the practice and on the website. However, clinical records did not always show that the offer or use of a chaperone, or consent for intimate examinations, had been documented consistently.

The practice communicated with patients in a range of ways, including through the

website, practice leaflet, information boards, text messages, letters and direct contact with staff. Information was available in accessible formats, and the practice supported the Welsh language Active Offer through bilingual information and Welsh-speaking clinical staff. We also identified noteworthy practice in the use of tags in the AskmyGP application to support home visit requests and in task allocation for urgent suspected cancer referrals and cervical screening follow-up. However, the practice's received mail policy was dated September 2006 and required review.

The practice had taken steps to promote equality and support patients' rights, including maintaining an equality, diversity and inclusion policy, making reasonable adjustments for neurodivergent patients, and supporting transgender patients by recording preferred names, pronouns and correspondence preferences. However, not all staff had completed equality and diversity, autism awareness or learning disability training. We also identified physical accessibility issues, including baby changing facilities being located upstairs and the absence of an automatic entrance door, which may make access more difficult for wheelchair users, people with limited mobility and those attending with pushchairs.

This is what we recommend the service can improve:

- Ensure chaperone discussions and consent for intimate examinations are consistently documented in patient records
- Review physical accessibility of the premises, including access to the entrance and baby changing facilities, to identify and address barriers for patients
- Improve privacy at reception so patients can speak with staff confidentially and without being overheard.

This is what the service did well:

- Access to appointments was a strength
- The practice worked effectively with cluster and community services to support patients
- The practice used clinical system tags and task allocation effectively to support follow-up.

Delivery of Safe and Effective Care

Overall summary:

We found that the practice had suitable systems in place to support the delivery of safe and effective care, with some areas of noteworthy practice. There were appropriate arrangements for managing patient safety alerts, business continuity, staff absence, home visits, vaccine storage, emergency medicines, safeguarding training and patient records. Staff had completed resuscitation, infection prevention and control, and safeguarding training appropriate to their roles, and staff knew who to contact for safeguarding or infection control advice. Patient records were of good quality, with clear consultation notes that supported continuity of care.

The practice had effective arrangements for referrals, test results and urgent suspected cancer pathways. We identified noteworthy practice in the use of clinical system reminders to check that patients referred on urgent suspected cancer pathways had received their appointments. Mortality reviews were also a standing item at clinical meetings, which supported regular review and learning. The practice had systems to monitor patients who did not attend or were not brought to appointments, helping to identify potential safeguarding concerns.

Medicines management was generally well managed. Prescription pads were stored securely, and the practice maintained an audit trail for prescriptions collected from the practice, which we considered noteworthy practice. Vaccines were stored appropriately, fridge temperatures were checked, medicines were in date, and emergency drugs and equipment were checked weekly. However, staff involved in prescribing processes, including repeat prescriptions, had not all received formal medicines management training, and clinical staff had not completed BOC integrated valve medical gas cylinder training.

We identified several areas where safety arrangements needed strengthening. Some parts of the premises required repair or maintenance, including a damaged brick pillar at the car park exit, areas of disrepair in unused second-floor rooms, and a staff toilet requiring redecoration. The business continuity plan was up to date but did not specifically reference partnership risk. The practice also needed to review the accessibility of emergency equipment, as some consulting rooms were located on upper floors, which may affect the timely movement of emergency equipment during an incident.

Infection prevention and control arrangements were mostly appropriate, with an identified IPC lead, completed staff training, hand hygiene facilities, segregation arrangements and relevant policies in place. However, the IPC policy did not fully reflect current practice, daily cleaning records were not available for review, clinical waste bins were not fully secured, and we did not see evidence of an IPC audit.

The practice had processes for managing medical devices and equipment, and

equipment seen during the inspection appeared clean and in working order. However, a small vaccine refrigerator that was not in use and a pulse oximeter on the emergency trolley had missed their most recent calibration. This was addressed during the inspection.

Immediate assurances:

- Safeguarding arrangements were generally sound, with an identified safeguarding lead, an up-to-date safeguarding policy and access to the All-Wales Child Protection Procedures. However, clinical coding and household warnings for children at risk and looked-after children were not applied consistently.

This is what we recommend the service can improve:

- Strengthen infection prevention and control assurance arrangements
- Ensure all safety-critical training is completed
- Address environmental safety and maintenance risks.

This is what the service did well:

- Used clinical system reminders as an additional safety net to check that patients referred on urgent suspected cancer pathways had received their appointments
- Reviewed all deaths as a standing item at clinical meetings, supporting regular learning and oversight
- Commitment to learning and multidisciplinary working.

Quality of Management and Leadership

Overall summary:

We found that the practice was well led, with visible and approachable leaders and a positive staff culture. Staff told us they were clear about their roles, responsibilities and reporting lines, and that they understood the importance of working within their scope of practice. Staff survey responses were also positive, with all respondents agreeing that patient care was the practice's top priority, that the practice worked to keep staff and patients safe, and that they would recommend the practice as a good place to work.

The practice had clear communication and meeting structures in place. Clinical meetings were held twice a month, business meetings were held monthly, and reception meetings were held twice a year. Staff were able to contribute to meeting agendas, and clinical meeting minutes were shared with staff and stored on the shared drive. Leaders promoted an open-door culture, and staff described managers and doctors as accessible and supportive. The practice also had designated leads for key areas, including safeguarding, infection prevention and control, complaints and nursing.

The practice supported staff development and wellbeing. Staff had access to protected learning time sessions, clinical supervision and informal support from colleagues. There was evidence that staff were encouraged to develop within their roles, including a healthcare support worker who had been supported to complete nurse training and become a registered nurse. However, not all staff had received an appraisal or development review in the last 12 months, and not all staff records contained up-to-date job descriptions.

Governance arrangements were generally effective. Policies were accessible to staff and included a last reviewed date, and the practice had systems for sharing safety notices, learning from meetings and monitoring Quality Assurance and Improvement Framework requirements. However, policies did not include version control or review-due dates.

The practice had processes for managing recruitment and checking professional registrations. However, pre-employment health screening was not completed.

The practice encouraged feedback, learning and improvement. Complaints, incidents, mortality reviews and audit findings were discussed at meetings, and staff described an open culture where they could raise ideas and concerns. The practice also participated in cluster work and wider system meetings. However, improvements were needed in how complaints and patient feedback were monitored and communicated. The practice did not have a system to monitor complaint themes and trends, the complaints policy still referred to the Putting Things Right process, and we did not see evidence that changes made because of patient feedback were shared with patients.

Information governance arrangements were appropriate. The practice had an up-to-date information governance policy, clear data-handling processes, arrangements for external data submissions, and systems to monitor and report performance information. GP activity reports were made available to patients through the waiting room and the practice website.

This is what we recommend the service can improve:

- Strengthen workforce governance
- Improve policy and document control arrangements
- Strengthen complaints and feedback systems.

This is what the service did well:

- Strong leadership culture and staff engagement
- Well embedded learning and improvement culture.

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

Healthcare Inspectorate Wales reviewed patient feedback collected through a questionnaire issued to assess experiences at The Grove Medical Centre. A total of 135 responses were received. Overall, responses were positive, with most patients reporting good access to the practice, positive experiences of care, and high levels of satisfaction with the service received. Most respondents rated the service as very good, and most remaining respondents rated it as good.

All respondents were satisfied with the opening hours, and almost all said they were able to contact the practice when needed. Most patients also reported that they could access urgent and routine appointments when required.

Most patients said they were offered a choice of appointment type, and almost all said they were content with the type of appointment offered. Most appointments reported through the survey were in person at the practice, with a smaller number taking place by telephone.

Most respondents said the building was easily accessible, there were enough seats in the waiting area, and health promotion and patient information material was displayed. Most respondents also described the practice as clean.

Responses about privacy and dignity were mostly positive in relation to clinical care. Most patients said measures were taken to protect their privacy, and almost all said they were treated with dignity and respect. However, privacy at reception was a notable area of less positive feedback. Only around half of respondents said they were able to speak to reception staff without being overheard, while a significant minority disagreed.

The practice should review arrangements in the reception area to ensure patients are able to speak with staff confidentially and without being overheard. This should include considering how patients are made aware that they can request a private space for confidential discussions, and whether any additional measures are needed to improve privacy at the front desk.

Patients were positive about the quality of care they received. Most respondents said their appointment was on time, they were given enough time to explain their health needs, the GP explained things well and answered questions, they felt listened to, and they were involved in decisions about their healthcare as much as they wanted to be.

Feedback in relation to carers and service feedback suggested opportunities for improvement. Around half said they had been given details of organisations or support networks for carers. In relation to wider feedback, only a minority of respondents said they had previously been asked about their experience of the service, while many said

they had not.

The practice should:

- **strengthen arrangements for identifying and supporting carers, including ensuring carers are offered an assessment of their needs and are consistently signposted to relevant support organisations**
- **look for ways to improve patient awareness of the different ways they can provide feedback about the service.**

Patient comments included:

> "I feel very fortunate to be registered with a fantastic GP surgery. Always go above and beyond. Thank you"
>
> "Marvellous team at The Grove. They endeavour to see you as soon as they can and communication has always been great."
>
> "I think that this GP surgery is a good example of how a GP surgery should operate. I think that it is excellent"

Person-Centred

Health promotion

We found the practice had suitable arrangements in place to promote healthy lifestyles and support patients to access services aimed at preventing illness and improving wellbeing. Health promotion advice was provided opportunistically during consultations with clinical staff, including during new patient health checks undertaken by nursing staff.

The practice worked with a range of local services and wider cluster initiatives to improve access to care, support disease prevention and promote health. The practice offered seasonal flu and COVID-19 vaccinations as part of its winter vaccination programme. Respiratory Syncytial Virus (RSV) vaccinations were not delivered directly by the practice; however, the health board used a room within the premises to provide RSV clinics for patients from several local practices. The health board managed vaccination and immunisation promotion through written correspondence to eligible patients, with the practice providing follow-up text messages and telephone calls where required.

Patients could be referred to smoking cessation services, and mental health support was available through both practice and cluster-supported pathways. Access to the Swansea Wellbeing Centre was funded through a cluster initiative, enabling patients to access therapy services by following referral by a clinician. The practice also had

access to a social prescriber, to whom GPs could refer patients for support with non-clinical needs. The social prescriber signposted patients to appropriate services and referred them back to the GP where further clinical input was required.

Several additional cluster services were available to patients, including audiology and ear wax removal services, which reception staff were able to book directly. Two cluster pharmacists worked in the practice one day each week, supporting medicines-related care. A cluster chronic conditions nurse also attended the practice one day per week, with a role that included monitoring patients with long-term conditions, supporting housebound patients and seeing patients with acute issues where appropriate.

The practice also promoted access to targeted health improvement initiatives. This included FitJacks, delivered in partnership with Swansea Football Club, which provided a 12-week programme for men and women aged between 35 and 65 who met specific weight-related criteria.

Patients were informed about available health promotion and support services through the practice website, printed information displayed in the waiting room, and through signposting by trained care navigators and clinicians. We also saw a diabetes health promotion notice board in the waiting area, which provided patients with targeted information and advice. **We considered this to be noteworthy practice.** This helped to ensure that patients who were older or who did not have access to digital services could still receive information about relevant support.

The practice had arrangements in place to manage people who did not attend appointments. Instances of did not attend (DNA) were coded on patient records, and a recently updated policy outlined the use of text messages and letters following non-attendance. Staff explained that the “was not brought” process was highlighted within the safeguarding policy. Where appropriate, clinicians contacted patients to understand the reasons for non-attendance, and these cases were discussed at clinical meetings. The practice also had processes in place to monitor instances where patients did not attend hospital appointments.

Dignified and respectful care

The practice had arrangements in place to support patients to receive care in a dignified and respectful manner. Staff we spoke with demonstrated an understanding of the importance of treating patients sensitively and maintaining confidentiality when speaking with patients and when discussing patient information with colleagues.

Clinical rooms generally provided appropriate levels of privacy, with doors kept closed during consultations. However, we found that one clinical room upstairs, which staff told us was not used frequently, had a privacy curtain placed on the examination couch rather than hanging and ready for use.

The practice should ensure that privacy curtains in all clinical rooms, including

those used infrequently, are properly fitted, always maintained and ready for use.

The practice had taken steps to support confidentiality in the reception and waiting areas. Music was played near reception to reduce the risk of conversations being overheard, and patients were able to use a touch screen check-in system if they did not wish to speak directly to reception staff. Staff told us that, where a confidential conversation was required away from the waiting area, the consulting room nearest reception could be used. This was available to patients on request.

The practice had an up-to-date chaperone policy and offered both male and female chaperones. There were enough trained staff available to provide this service. The chaperone service was promoted through posters in reception and throughout the practice, and information was also available on the practice website. Patients were able to request a chaperone before their appointment, and this information was recorded on the appointment system.

Clinicians recorded verbal consent for intimate examinations and requests for chaperones in patients' medical records. However, this was not consistently reflected in the records we reviewed. In one patient record, the offer or use of a chaperone had not been documented. In another record, it was documented that the patient had declined a chaperone for an intimate examination, but the clinician had not recorded the patient's consent for the examination.

The practice must ensure that clinicians consistently document the offer of a chaperone, whether this was accepted or declined, and the identity of the chaperone when present. In addition, patient consent for intimate examinations should be clearly recorded in line with the practice policy and professional guidance.

Timely

Timely care

The practice had effective arrangements in place to support patients to access appointments and other appropriate services in a timely way. Patients were able to access information about appointments through the practice website, including how to request clinical advice or support from a healthcare professional. Care navigation arrangements also helped ensure patients could be directed to alternative services where appropriate, such as the Common Ailments Scheme, physiotherapy or other local support services. However, there was no information displayed in the waiting room explaining the different options available to patients for accessing appointments or alternative services. The practice had a comprehensive access policy in place.

The practice should make access information available in the waiting room, to ensure that patients who were digitally excluded, older people, or those who

preferred not to use online systems could still access appointments and advice.

Patients were encouraged to use the AskMyGP mobile application (app) to contact the practice, although this was not mandatory. Patients could also contact the practice by telephone, use the NHS app, or attend reception in person. The practice told us that AskMyGP was open for specified times and was not closed early. Staff told us this enabled the practice to plan capacity effectively and ensure demand was managed safely. **We found that access was a strength of the practice, with clear systems in place to support good appointment availability across the patient population.**

The practice had implemented a new telephone system in October 2025. Since its introduction, the number of abandoned calls had reduced. The system allowed patients to request a call back while keeping their place in the queue, which helped reduce the need for patients to remain on hold. The practice's GP activity data also showed positive performance in relation to calls answered within two minutes.

The practice gathered feedback from patients about the appointment system through an annual patient survey, which was kept open on a continuous basis. Patients could complete the survey using a QR code or by completing a paper form. This helped ensure the views of older people and those without digital access could be gathered effectively.

Reception staff and care navigators had clear pathways to support patients to access the most appropriate care. Care navigators had completed training through Health Education and Improvement Wales. The practice also had a triage policy which provided clear guidance for staff when signposting patients to appropriate services, including community pharmacy and other local services. Where care navigators were unsure about the most appropriate option for a patient, they could seek advice from clinical staff using the AskMyGP application, instant messaging through the clinical system, by telephone, or by speaking directly with a clinician.

The default appointment type offered by the practice was face-to-face. Telephone appointments were only provided where requested by the patient or where care navigation identified that the matter was suitable for a telephone consultation, such as pre-planned follow-up, test results, or fit notes. Patients were usually offered the next available appointment, which was often on the same day or the following day. Where a patient indicated that they needed to be seen sooner, the request was sent to the nominated duty doctor for clinical triage. This provided a clear process for identifying and responding to more urgent needs.

The practice had arrangements in place to support older people, vulnerable patients and those with communication difficulties. Individual needs were flagged on the clinical record, and the practice could accommodate patients at quieter times of the day, such as late morning, where this was beneficial. All children were seen on the same day.

Patients requiring urgent mental health support were offered face-to-face

appointments as the preferred option, although telephone appointments could be arranged where this was the patient's preference. Patients could be offered a same-day appointment, or where no appointment was available, their request would be sent to the duty doctor for triage.

The practice had processes for referring adults and children into secondary mental health services. Routine referrals were made electronically to the Primary Mental Health Support Service or the Community Mental Health Team, depending on the patient's risk assessment and clinical need. Urgent referrals were discussed with the Single Point of Access for mental health within the Community Mental Health Team. GPs also booked follow-up telephone appointments directly for patients to ensure they had a clear next point of contact.

Where patients were not accepted by secondary mental health services, the practice provided ongoing support. Staff told us that where a GP felt a patient required secondary care, they would escalate the referral through the appropriate channels and advocate for the patient to be offered an appointment. Where secondary care was not considered appropriate, patients were given advice about alternative support options, including GP-led care and voluntary sector services, with follow-up arranged by the GP as required.

The practice also had robust systems in place to identify when a patient had received crisis intervention for mental health needs, helping ensure appropriate follow-up and continuity of care.

Equitable

Communicating and language

We found that the practice used a range of methods to communicate information about services to patients. Information was provided through the practice website, practice leaflet, information boards in the premises and through direct contact with staff, including by telephone. Written information was available in accessible formats, including large print and braille, and the practice website could be translated into a range of languages.

The practice used a range of methods to keep patients informed of important changes. This included the use of a news banner on the practice website, posters displayed within the practice and text messages to patients. The practice maintained a list of patients who did not have a mobile telephone and told us these patients would be contacted by telephone where required. Letters were used for selected patients where other communication methods were not available.

Older people and those without digital access were supported to receive information about services through telephone contact with trained care navigators and by

accessing information displayed in waiting areas.

The practice had an up-to-date patient consent policy in place. This included the process to be followed where patients lacked capacity, and for patients who were regarded as minors.

The practice recorded all telephone calls. Patients were informed of this through the recorded message they heard when telephoning the surgery.

The practice supported patients to communicate in their preferred language. There was one Welsh-speaking GP and one Welsh-speaking nurse. Patients could contact reception to book an appointment with a Welsh-speaking clinician where available. Staff also had access to a language translation service.

The practice had arrangements in place to support the Welsh language Active Offer. Language requirements formed part of recruitment and workforce planning considerations. Bilingual signs, posters and reading material were available, and staff who spoke Welsh wore an 'Iaith Gwaith' badge or similar prompt to help patients, staff and visitors identify Welsh-speaking staff.

Rights and equality

We found that the practice promoted equality and diversity through an up-to-date Equality, Diversity and Inclusion (EDI) policy. Staff had access to relevant training resources, including the EDI Treat Me Fairly programme and autism awareness and learning disability training. However, on review of staff training records, we found that not all staff had completed equality and diversity training or autism awareness and learning disability training.

The practice should take steps to identify what rights and equality focused training should be completed by its staff and ensure records of this is maintained.

The practice had taken some steps to support accessibility for patients. There was an accessible toilet with an emergency pull bell, and patients were able to request a home visit where access to the practice was a barrier. The practice was also able to make reasonable adjustments for patients who required them. For example, neurodivergent patients could be booked towards the end of clinics, when the waiting area was quieter.

However, we identified some areas where accessibility could be improved. The room containing the baby changing facilities was located upstairs, which may make it difficult for patients or carers with babies, buggies or pushchairs to access. The entrance to the building did not have an automatic door, which may make access more difficult for patients using wheelchairs, those with limited mobility, or patients attending with children in pushchairs.

The practice should review the physical accessibility of the premises to identify and address barriers to improve accessibility for all patients.

The practice had processes in place to support the rights of transgender patients. Staff confirmed how patients wished to be addressed, including their preferred name and pronouns. Staff also confirmed patients' preferences for written correspondence.

Delivery of Safe and Effective Care

Safe

Risk management

During our inspection of the premises, including the external areas of the practice, we identified some areas requiring repair and maintenance. A brick pillar at the exit to the car park was damaged and appeared at risk of falling or becoming displaced. This presented a potential health and safety risk to patients, staff and visitors using the car park. We also found that some second-floor rooms, which were not currently in use, showed signs of disrepair, with evidence of black mould in one south-facing room. In addition, a staff toilet had paint peeling from the walls and needed redecoration.

The practice should arrange for the damaged brick pillar to be repaired or replaced promptly, and ensure the affected internal areas are repaired, treated where required, and redecorated. The practice should also consider whether any interim measures are needed to reduce risk until the required works are completed.

We reviewed the practice's business continuity plan and found this to be up to date and available electronically for staff to access. The plan included arrangements for responding to a significant health emergency and included consideration of GP incapacity. However, the plan did not specifically reference partnership risk.

The practice must update the business continuity plan to include a reference to partnership risk.

Staff told us that workforce planning and staff absence were managed using rotas. A GP partner was responsible for completing the GP rota, identifying any gaps and arranging locum cover where required. We were told that the practice generally used the same locum staff, which supported continuity of care.

The practice manager was aware of the Sustainability Framework and the associated escalation levels. We identified that resilience could be further strengthened by ensuring an additional named member of staff had access to this information in the event of a prolonged absence of the practice manager.

There were arrangements in place for managing patient safety alerts. The practice had dedicated staff responsible for receiving patient safety alerts, and more than one nominated person was able to access the relevant inbox if required.

The practice had a process for reviewing and discussing significant events, including patient safety incidents. When an incident was identified, a form was completed and the matter was added to the agenda for discussion at a team meeting. Events were reviewed, and minutes were shared with appropriate staff. The practice told us that a Datix report would be completed where necessary.

The practice had an induction process for new staff. Staff were given a tour of the

premises, including the branch site, introduced to colleagues and informed about relevant policies. An induction checklist was used. However, the checklist did not include a signature box to confirm that the staff member was satisfied that all required areas had been covered. There was also no induction pack for locum staff, although we were told this had not been required recently.

The practice should:

- **update the induction checklist to include a signed declaration confirming completion and understanding**
- **develop a standard induction pack for locum staff to support consistency and governance.**

The practice had arrangements in place for staff to request urgent help within the premises. The clinical system included a red button alert function. Emergency equipment was located centrally, and signage was available to show staff where emergency equipment and the spill kit were located. Staff told us that emergency drugs and equipment were stored in an office, with signage displayed around the practice.

Emergency equipment was stored on a trolley. However, some consulting rooms were located up one or more flights of stairs, which may have an impact on the timely movement of emergency equipment during an incident.

The practice should review the accessibility of emergency equipment, considering consulting rooms located on upper floors.

The practice had an up-to-date risk assessment in place for home visits, and we found appropriate processes were in place to support staff safety when undertaking visits.

Infection prevention and control (IPC) and decontamination

There was an appointed infection prevention and control lead, and staff were aware of who held this role. Staff we spoke with understood their responsibilities in maintaining infection prevention and control standards. Staff training records we reviewed showed that all staff had completed infection prevention and control training.

The practice had an infection prevention and control policy in place, which staff could access through the shared drive on the computer system. However, the policy included references to the decontamination of reusable invasive surgical instruments. Staff told us the practice used single-use equipment.

The practice should review and update its Infection Prevention and Control policy to ensure it accurately reflects current practice. References to the decontamination of reusable invasive surgical instruments should be removed where single-use equipment is exclusively used.

There was a cleaning contract in place for the practice site. We saw draft cleaning

schedules; however, daily cleaning records were not available for review. This made it difficult to verify whether routine environmental cleaning was being completed as intended.

The practice should ensure cleaning records are maintained and available to demonstrate that cleaning has been carried out in line with the agreed schedule.

The practice had suitable hand hygiene facilities available. Arrangements were in place to allow for the segregation of patients where required to reduce the risk of healthcare-associated infection. The practice had a designated isolation or high-risk room. Staff told us that patients could telephone from the car park and be admitted directly via an emergency exit adjacent to the room, avoiding the need to pass through the main surgery.

The practice had an up-to-date blood-borne virus policy and an up-to-date needlestick/ sharps injury policy. We identified that the needlestick policy could be further strengthened by the inclusion of a clear flow chart detailing reporting arrangements, including named contacts and telephone numbers for the local hospital or occupational health department.

The practice should strengthen its needlestick and sharps policy by including a clear and accessible flow chart outlining the actions to be taken following an incident.

The practice maintained a register of Hepatitis B immunisation status for relevant clinical staff, and records showed that all relevant staff had received Hepatitis B immunisations.

The practice had appropriate procedures for waste management, and the waste management policy was up to date. Clinical waste bins were stored outside in an enclosure, and the bins were locked. However, the bins were not secured to the enclosure, and the enclosure itself was not locked.

The practice should review the security arrangements for the external clinical waste storage area. Clinical waste bins should be appropriately secured, either by fixing them to the enclosure or by ensuring the enclosure itself is locked.

We did not see evidence of an infection prevention and control audit.

The practice should ensure that regular IPC audits are completed to monitor compliance with infection prevention and control standards and to identify any required improvements.

Medicines management

Prescription pads were stored securely and kept locked when not in use. The practice maintained a separate electronic log to provide an audit trail of where prescription pads

were kept. Although the practice had moved to electronic prescribing through the Electronic Prescription Service, it continued to maintain an audit log for prescriptions collected from the practice. This recorded each prescription collected and the number of items collected. **We considered this to be an area of noteworthy practice.**

Medication reviews were carried out by GPs and a cluster pharmacist. However, we found that staff involved in prescribing tasks, including those processing repeat prescriptions, had not all received formal medicines management training. Training needs related to prescribing were identified informally, for example through errors, staff requests or annual appraisals. There was no formal programme of medicines management training in place.

The practice should ensure that all staff involved in prescribing processes, including those responsible for processing repeat prescriptions, receive appropriate and up-to-date medicines management training.

The practice had appropriate arrangements in place for vaccine storage and cold chain management. There was an up-to-date cold chain policy available. We saw three dedicated clinical refrigerators, two of which were in use. Staff completed checks to ensure temperatures remained within guidelines. Vaccines were stored correctly, refrigerators were not overstocked, and vaccines checked during the inspection were in date.

A named person was responsible for checking drugs, and these checks were recorded. The practice ensured medicines did not exceed recommended storage temperatures, and the drugs we reviewed were in date. The practice did not hold controlled drugs on site.

The practice had arrangements in place for the management of emergency medicines and equipment. A named member of staff was responsible for checking emergency drugs and equipment, including the automated external defibrillator (AED). Weekly checks were carried out, and records were seen. The emergency drugs and equipment, including the AED, contained the necessary items to meet the minimum primary care standards outlined by Resuscitation Council UK.

Emergency medicines were stored in colour-coded bags on the emergency trolley. The bags had tamper-proof tags in place. Staff were aware of where the emergency trolley, AED and emergency medicines were kept. Signage was displayed around the building, including on and near the doors leading to the room where the emergency equipment was stored.

During the inspection, we found that the practice used BOC integrated valve medical gas cylinders. However, we did not see evidence that relevant staff had completed online BOC integrated valve portable oxygen cylinder training.

The practice must ensure BOC integrated valve medical gas cylinder training is completed by clinical staff.

Safeguarding of children and adults

We found that the practice had an identified safeguarding lead in place, and staff were aware of who to contact for safeguarding advice or concerns. An up-to-date safeguarding policy was available, and all staff had access to the All-Wales Child Protection Procedures.

The practice had systems in place to identify children who were on the child protection register or considered at risk. This included the maintenance of a safeguarding or at-risk register, supported using clinical codes and household warnings on the clinical system. However, we found that clinical coding for children at risk and looked-after children was not consistently recorded. This issue was addressed through our immediate assurance process and is detailed further in Appendix B of this report.

The practice monitored patients who did not attend appointments or who were not brought to appointments. Audits of "did not attend" and "was not brought" appointments were undertaken to check data quality and identify patients with frequent missed appointments, supporting early identification of potential safeguarding concerns. **We considered this to be an area of noteworthy practice.**

We found evidence of multi-agency and multi-professional working. Safeguarding was a standing agenda item at clinical meetings. Health visitors were invited to attend these meetings and did so when available. Palliative care discussions also formed part of these meetings, with the lead nurse attending.

A review of training records showed that staff had completed safeguarding training at a level appropriate to their role.

Management of medical devices and equipment

The practice had processes in place to support the safe use and management of medical devices and equipment. Staff told us the practice used single-use equipment wherever possible and did not use reusable equipment.

There were arrangements in place for checking medical devices and equipment to ensure they remained safe and suitable for use. A nurse was responsible for checking emergency equipment. Other equipment was checked by staff at the point of use. Equipment and devices we saw during the inspection appeared clean, in good condition and in working order.

The practice had contracts in place for the servicing and maintenance of medical devices and equipment. However, we found that a small vaccine refrigerator, which was not in use at the time of the inspection, and a pulse oximeter kept on the emergency trolley had missed the most recent calibration. This issue was addressed through the concerns resolved during inspection process, as detailed in Appendix A.

The practice also had a process in place for arranging emergency repair or replacement of equipment when required.

The practice should review and strengthen its systems for monitoring the servicing and calibration of medical devices to ensure that all equipment, including items not in regular use, receives calibration checks in line with manufacturer guidance.

Effective

Effective care

The practice had processes in place to support safe and effective treatment and care, with links to wider primary care services. The practice kept up to date with best practice, national and professional guidance and new ways of working through a range of routes. The practice manager attended practice manager meetings and cluster meetings. Staff also attended training where relevant and were expected to feedback and share learning with colleagues. New information was circulated to relevant staff by email through the clinical system. GPs discussed new National Institute for Health and Care Excellence (NICE) guidance at clinical meetings when required.

The practice had processes in place for urgent referrals, routine referrals and urgent suspected cancer referrals. Urgent suspected cancer referrals were completed by the doctor responsible for the patient's care. Doctors also set reminders for themselves on the clinical system to check that patients had received their appointment. **We considered this to be noteworthy practice**, as it provided an additional safety net for patients referred on an urgent cancer pathway. Referral rates were discussed within the practice and at cluster meetings, which helped the practice consider variation and identify any areas for review.

The practice had a process for reporting incidents. Staff told us when an incident was identified, a form was completed and the matter was added to the agenda for discussion at a clinical meeting. The form was then completed with the outcomes of the discussion. However, there was no significant event policy in place, and the practice did not have a clearly documented process for reviewing significant events and sharing learning with appropriate staff.

The practice must develop and implement a formal significant event policy. This should set out a clear and consistent process for the identification, review and documentation of significant events, including how learning and actions are shared with relevant staff.

The practice reviewed deaths in the community and hospital deaths where there was a primary care element. Death reviews were a standing item on the agenda for clinical meetings. All deaths were reviewed, and where concerns were identified, a significant event review would be completed. **We identified the routine inclusion of death**

reviews on clinical meeting agendas as noteworthy practice.

There were established processes for internal communication between staff. Clinical messages were sent through tasks on the clinical system and remained visible until actioned. Non-clinical messages were communicated through emails and instant messaging within the clinical system. The clinical system maintained an audit trail, which helped the practice monitor whether communications had been read and acted upon.

The practice had processes in place to manage incoming correspondence. Letters received by the practice, whether in paper or electronic form, were scanned, coded and forwarded to clinical staff for review. We found that the practice had a received mail policy; however, this was dated September 2006 and required review.

The practice should review and update its received mail/workflow policy to ensure clear guidance for staff on the management of out-of-hours and accident and emergency correspondence, including how this should be reviewed, recorded and escalated to clinicians where appropriate.

The practice had effective arrangements for processing requests for home visits. Housebound patients were tagged on the clinical system, and patients could also be tagged within AskMyGP to support easy identification when requests were submitted. We identified this as good practice, as the use of tags helped staff quickly identify patients who may be palliative, living with cancer, housebound, living in care homes, deceased, or requiring repeat prescription support.

The practice had processes in place to ensure patients who required further investigations or tests were appropriately followed up. We identified good practice in the use of clinical system task allocation for urgent suspected cancer referrals and cervical smear referrals. These were allocated to clinical staff to check that appropriate follow-up tests had been completed. This supported timely follow-up and reduced the risk of patients being missed.

Information received from secondary care was recorded and acted upon through established practice processes. The practice also had arrangements in place to provide patients with information about their condition, investigations and management options. Staff told us that information could be provided in ways that met patients' needs, including for older patients and those who were digitally excluded.

There was a process in place for ordering tests and relaying results to patients. Results could be provided to patients face-to-face or by telephone, which helped ensure older patients and those without digital access could receive information in an appropriate way. The practice also had an established process for following up and providing test results when the requesting clinician was not available.

The practice had arrangements to respond appropriately where patients contacted the practice about emergency care rather than calling 999. The telephone message advised

patients to call 999 in a medical emergency. Staff told us they also asked patients whether they had chest pain, and where shortness of breath was identified, patients were advised to contact 999. A review of training records showed that staff had completed resuscitation training.

Patient records

We reviewed a sample of eight patient records to assess the overall quality of record keeping. We found that patient records were of good overall quality. Consultation notes contained clear documentation and narrative, demonstrating the evidence and clinical reasoning behind decisions made relating to patient care. Records were easy to read and follow, and we found that they were sufficiently detailed to enable continuity of care by another clinician if required. However, our review identified that only one of the eight patient records included the patient's language preference.

The practice should ensure that patients' language preferences are consistently recorded within their medical records.

The practice operated a digital patient record system. Records were stored securely and in compliance with GDPR requirements. Access to the system was password protected, and staff used individual profiles to access records. Staff told us that only clinical staff coded information into patient records.

Efficient

Efficient

The practice had systems in place to support the efficient delivery of care and to help patients move through care and treatment pathways. Patients could be referred to external clinics where this was clinically appropriate, and self-referral options were available for a range of services.

We were told that the practice carried out annual reviews to monitor patients' ongoing health needs and support effective long-term condition management. Staff also signposted patients to other services where appropriate.

Staff also described systems for reporting and learning from significant events. This indicated a culture of continuous improvement and supported the practice to identify opportunities to improve the efficiency and safety of care delivery.

Quality of Management and Leadership

Staff Feedback

Healthcare Inspectorate Wales reviewed feedback collected through the staff survey at The Grove Medical Centre. Nine staff members responded.

Staff responses about patient care were very positive. All respondents agreed or strongly agreed that patients could access services in a timely way, that measures were taken to protect patient confidentiality, privacy and dignity.

All staff agreed or strongly agreed that patient care was the practice's top priority, that they were content with the practice's efforts to keep staff and patients safe, that they would recommend the practice as a good place to work, and that they would be happy with the standard of care provided for themselves, friends or family.

Most staff reported that they had received appropriate training for their role, with eight of the nine respondents answering "yes" and one answering "partially". Five respondents said they had received an appraisal, annual review or development review in the last 12 months, while four said they had not.

The practice should ensure that all staff receive a regular appraisal, annual review or development review.

Responses in relation to staff wellbeing were generally positive. All respondents agreed or strongly agreed that their job was not detrimental to their health, that the practice took positive action on health and wellbeing, and that they were aware of occupational health and wellbeing support. Most respondents felt their working pattern allowed for a good work-life balance.

Staff responses about Duty of Candour, incidents and safeguarding were also positive. All respondents agreed or strongly agreed that they understood the Duty of Candour, understood their role in meeting the standards, and felt the organisation encouraged staff to raise concerns when something had gone wrong and share this with patients. All respondents also agreed or strongly agreed that the organisation encouraged reporting of errors, near misses or incidents, treated staff fairly when involved in incidents, and took action to prevent recurrence.

The main area of less positive feedback related to infection prevention and control. While all respondents agreed or strongly agreed that appropriate PPE was supplied and used, and that the environment allowed for effective infection control, two respondents disagreed that the organisation implemented an effective infection control policy. Four respondents disagreed that there was an effective cleaning schedule in place.

The practice must review its infection prevention and control arrangements to ensure there is an effective cleaning schedule in place and that all staff are aware of, and work in line with, the practice's infection control policy.

Staff comments included:

> "I think the practice offers a good service to patients, offering various ways in which to make contact. Easier ways to order and obtain repeat prescriptions. The practice continually monitors the service we offer and will always seek to improve access for patients."
>
> "We have a mixed range of ages, cultures, religious beliefs at the practice and everyone is treated equally and with respect."

Leadership

Governance and leadership

Staff told us they were clear about their roles, responsibilities and reporting lines, and understood the importance of working within their scope of practice. There were designated leads for specific areas of practice, including safeguarding, infection prevention and control, complaints and nursing. Staff responsible for clinical oversight were also in place and available to provide advice where required.

Leaders were visible and approachable to the wider practice team. Staff described an open-door culture, with doctors and managers accessible to staff. The practice also used instant messaging to support timely communication between team members.

The practice had a range of meetings in place to support communication and shared learning. Clinical meetings were held twice a month, business meetings were held monthly, and reception staff meetings were held twice a year. Staff could contribute to meeting agendas by messaging the deputy manager with items for discussion. Clinical meetings were minuted, emailed to staff who were unable to attend, and saved on the shared drive so they could be accessed later. The practice also arranged occasional informal team-building activities.

We reviewed a sample of the practice's policies and procedures and found that they were clearly titled, relevant to the service and readily accessible to staff. All policies reviewed included a date of last review. However, we found that policies did not include version control or a review-due date.

The practice should ensure all policies and procedures include version control and a clearly defined review-due date.

Information, including changes to policies or procedures, was shared with staff by email through the clinical system. Lessons learned were discussed during clinical meetings, which were minuted and shared with relevant staff. The practice also had a robust process in place for implementing recommendations and sharing learning from safety notices, including those received from the Medicines and Healthcare products Regulatory Agency or Welsh Government.

We reviewed information relating to the Quality Assurance and Improvement Framework. The practice had documentation in place to show how it monitored and worked towards the framework requirements. Lessons learned were discussed during clinical meetings, which were minuted and shared with staff.

The practice participated in cluster projects and initiatives. Staff told us that cluster meetings were held quarterly and included external speakers, as well as discussion of projects and innovations.

Workforce

Skilled and enabled workforce

We found that the practice had an up-to-date recruitment policy in place, which set out the process for recruitment and pre-employment checks. The practice had a system in place to check that healthcare professionals remained registered with their regulatory body. The practice also carried out regular DBS checks, and we saw evidence of recently completed DBS checks. Staff told us the practice was working towards completing DBS checks every three years.

The practice should consider introducing annual DBS self-declaration as part of the appraisal process, to provide ongoing assurance that staff remain suitable to work for the service.

We found that pre-employment health screening was not completed.

The practice should ensure that pre-employment health screening is completed for all new staff, with appropriate risk assessments undertaken where health issues are identified.

Senior staff told us the practice encouraged training and development. Staff had access to protected learning time sessions, and professional registrations were checked where required. There was evidence that staff were supported to develop within their roles. For example, we were told that a healthcare support worker had been supported to complete nurse training and become a registered nurse.

We found evidence of clinical supervision. This included nurse meetings and regular informal discussions between staff, with staff describing a supportive team environment.

Rotas were used to identify staffing levels and absences at an early stage. Staff told us they were multi-skilled and able to cover one another where needed. Senior staff told us that increases in workload were monitored and used to identify when additional staffing was required.

We reviewed five staff recruitment records. Three of the five files contained an up-to-date job description. We were told that job descriptions were being rewritten for nursing

staff and the deputy practice manager.

The practice should ensure that all staff have an up-to-date job description that clearly outlines roles, responsibilities and scope of practice, and that a copy is retained within each staff file.

Culture

People engagement, feedback and learning

The practice had processes in place to receive, manage and respond to complaints and concerns. There was a named member of staff responsible for handling complaints, and we saw evidence that complaints were recorded and stored on the shared drive. The practice followed the Putting Things Right process, and we saw evidence that complaints and concerns had been managed in line with the practice's complaints arrangements.

Complaints and concerns were discussed at practice meetings, and learning was documented in meeting minutes. However, while complaints were recorded in files on the shared drive, the practice did not have a spreadsheet or other system to monitor the number and type of complaints received, or to identify themes and trends over time.

The practice should implement a suitable system to monitor complaints, concerns and outcomes, to support trend analysis and reporting.

The practice had an up-to-date complaints policy available. However, the policy still referred to the Putting Things Right process. Staff told us the practice was working towards the new NHS Listening to People process, and the new process was referenced on the practice website. Details of the NHS Listening to People procedure were displayed.

The practice should update its complaints policy to align with the NHS Listening to People process.

Patients could provide feedback through a link on the practice website or through the AskMyGP mobile application. Feedback and complaints were discussed in team meetings, and learning was recorded in meeting minutes. However, we did not see evidence that changes made because of patient feedback or survey responses were shared with patients.

The practice should introduce a suitable process to inform patients of actions taken in response to feedback, such as through the website, waiting room displays or a "you said, we did" approach.

Staff were encouraged to speak up and share ideas. Staff described an open environment where they could approach management, raise ideas during informal conversations such as lunchtime discussions, or contribute through meetings,

including under any other business. The practice had an up-to-date whistleblowing policy in place.

The practice also had an up-to-date Duty of Candour policy. We saw evidence that the Duty of Candour had been applied appropriately, with appropriate action taken. However, our review of five staff records found that only three staff had completed Duty of Candour training.

The practice should ensure that all staff complete Duty of Candour training appropriate to their role.

Information

Information governance and digital technology

There was an up-to-date information governance policy covering information processed by the practice. The practice's Data Protection Officer was Digital Health and Care Wales.

The practice had a clear process for handling data, and information about this was available on the practice website. Staff told us that audits were used to help ensure data was of a high quality and supported the delivery of safe and effective services to patients.

There were systems in place to monitor and report performance information. GP activity reports were made available to patients through the waiting room and the practice website.

The practice also had arrangements in place to submit data to external bodies where required. Shared agreements were in place, including agreements relating to cluster data sharing.

Learning, improvement and research

Quality improvement activities

The practice used complaints, incidents and reviews as opportunities to support learning and improvement. Complaints were a standing item on meeting agendas, and staff told us that all complaints were discussed and that any learning would be identified and shared.

The practice engaged in wider quality improvement activity through its involvement in the Bay Health Cluster and attendance at practice manager meetings.

The practice had a programme of clinical and internal audit to monitor quality. Audits were prepared and discussed in clinical meetings, with GPs presenting audit findings to colleagues.

Learning from internal and external reviews, including mortality reviews, incidents and complaints, was also discussed regularly at clinical meetings. These items formed part of the routine clinical meeting agenda.

Whole-systems approach

Partnership working and development

Staff told us that the practice followed agreed clinical pathways set by Swansea Bay University Health Board.

The practice engaged with system partners through a range of formal structures. These included cluster meetings, practice manager meetings and prescribing lead meetings. The practice also participated in multidisciplinary working with the chronic disease nurse, which supported coordinated care for patients with ongoing health needs.

Collaborative relationships with external partners were primarily developed through cluster working. Staff told us that the practice worked as part of the Bay Health Cluster and engaged in initiatives aimed at addressing shared challenges and meeting the needs of the local population. The practice also worked in partnership with the Swansea Wellbeing Centre, which supported access to wellbeing and support services beyond core general practice provision.

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
A pulse oximeter kept on the emergency trolley had missed the most recent calibration.	A pulse oximeter that has not been calibrated may give inaccurate oxygen saturation readings, which could affect timely clinical decision-making during an emergency.	Raised with the responsible clinician.	The pulse oximeter was replaced during the inspection.

Appendix B – Immediate improvement plan

Service: **The Grove Medical Centre**

Date of inspection: **06 May 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 1:	Although the practice holds a list of children on the safeguarding/at-risk register, and the practice uses clinical codes and household warnings, these were not being applied consistently. Checks found that clinical coding for children at risk and looked-after children was not consistently applied. In one foster care household, some children were correctly coded and flagged, while other children in the same foster home were not. Foster carers were also not consistently coded or manually flagged, and family members or siblings were not reliably identified within household records. This creates a risk that the practice does not have a complete or accurate picture of children and families requiring safeguarding oversight.		
Improvement needed		**Standard / Regulation**	
1.	The practice must ensure that coding and alerts are applied consistently not only to individual children but also through a household-level review process. Where one child in a household or foster placement is identified as looked after, in foster care, on the child protection register or otherwise at risk, the practice must review all linked household members to ensure relevant children, carers, foster carers, parents and siblings are appropriately coded or flagged.	Health & Care Quality Standards (2023): Safe, Effective, Person-centred, Equitable, Information, Learning, improvement and research. RCGP Safeguarding Standards Public Health Wales: Safeguarding Children and Adults at Risk in General Practice	
Service Action:		**Responsible officer**	**Timescale**

A search will be carried out for all currently registered patients with the codes 'child on protection register', 'looked after child', 'child in need', 'child at risk', 'child in foster care', 'is fostered', 'foster parent' and 'fostering medical examination'. The individual record of the whole household of any patient with one of these codes shall be reviewed and coding/alerts updated following the principles of the RCGP safeguarding toolkit which make recommendations on documenting safeguarding concerns and information. To ensure coding and alerts are constantly applied for households with child safeguarding concerns in future, we plan to update our new patient questionnaire and introduce a new three-step approach to coding safeguarding in children. Currently new patients who register with the practice will be identified as having potential safeguarding concerns within the household when their notes are summarised. To add an extra layer to this process and prevent coding/alerts being missed we will add a safeguarding section to our new patient questionnaire. We will ask if the new patient is known to social services or ever allocated a named social worker, as well as asking if the patient is a foster parent, or if they are under 18, are they or have they ever been fostered. When patients already registered with the practice are added to the child protection register or become 'looked after' this is usually identified from the child protection conference report. When any patient is now identified as potentially being a member of a household with child safeguarding concerns, either from new patient questionnaire, summarising, child protection case conference or any other means, there will now be a 3-step approach to ensure coding is not missed. 1. Firstly, the patient is highlighted to our assistant practice manager (or deputy) and also added to the agenda for the next safeguarding meeting (which is a standing agenda on our regular clinical meeting held at least twice monthly). The assistant practice manager (or deputy) will be the first nominated person to add the codes/alerts to all household members. 2. Secondly, when the patient is reviewed in the safeguarding meeting, the codes of all household members shall be reviewed and added if any have been missed in step one. 3. Thirdly, the document that identified the safeguarding concern will be work-flowed to a GP who will again review to check all codes have been added correctly to all household members. This robust approach should ensure a consistent and safe approach to coding and alerts for all household members of any patient with a child safeguarding concern.	Dr Jack Williams and other GP Partners	ASAP – Within two weeks

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: GP Partner

Name (print): Dr Jack Williams

Job role: GP Partner **Date:** 12-05-2026

Appendix C – Improvement plan

Service: **The Grove Medical Centre**

Date of inspection: **06 May 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.	Privacy at reception was a notable area of less positive feedback. Only around half of respondents said they were able to speak to reception staff without being overheard, while a significant minority disagreed.	The practice should review arrangements in the reception area to ensure patients are able to speak with staff confidentially and without being overheard. This should include considering how patients are made aware that they can request a private space for confidential discussions, and whether any additional measures are needed to improve privacy at the front desk.	Health & Care Quality Standards (2023) – Person-centred, Dignified, Safe.	We will ensure music at the front desk is sufficiently loud to best maintain patient confidentiality. We will also place a sign at the reception desk advising patients that we have a room available should they wish to speak in confidence. Longer term, we are going to move our medical records to the vacant room on the top floor of building and then reconfigure the reception / office space. We will use this opportunity to improve privacy within the reception area.	Steve Riley	1 – 2 weeks 12 – 18 months

2.	Feedback in relation to carers and service feedback suggested opportunities for improvement.	The practice should: • strengthen arrangements for identifying and supporting carers, including ensuring carers are offered an assessment of their needs and are consistently signposted to relevant support organisations • look for ways to improve patient awareness of the different ways they can provide feedback about the service.	Health & Care Quality Standards (2023) – Person- centred, Equitable, Effective.	Practice has a nominated carer's champion in place. We will monitor and update our EMIS register in respect of carers. We have carer packs which are available at reception at both sites. Our website is now updated with details of carer's needs assessment. Poster to be displayed in waiting room re having a carer's assessment	Carol Wilson	1 – 2 weeks
3.	We found that one clinical room upstairs, which staff told us was not used frequently, had a privacy curtain placed on the examination couch rather than hanging and ready for use.	The practice should ensure that privacy curtains in all clinical rooms, including those used infrequently, are properly fitted, maintained and ready for use at all times.	Health & Care Quality Standards (2023) – Person-centred.	Curtain now fitted in Consulting Room 7, post cleaning.	Steve Riley	Done 07/05/26

4.	In one patient record, the offer or use of a chaperone had not been documented. In another record, it was documented that the patient had declined a chaperone for an intimate examination, but the clinician had not recorded the patient's consent for the examination.	The practice must ensure that clinicians consistently document the offer of a chaperone, whether this was accepted or declined, and the identity of the chaperone when present. In addition, patient consent for intimate examinations should be clearly recorded in line with the practice policy and professional guidance.	Health & Care Quality Standards (2023) – Person-centred, Safe, Effective.	GPs to produce an EMIS template to ensure consistent chaperone recording across all consultations.	Steve Riley / GP Partners	3 – 4 weeks
5.	There was no information displayed in the waiting room explaining the different options available to patients for accessing appointments or alternative services.	The practice should make access information available in the waiting room, to ensure that patients who were digitally excluded, older people, or those who preferred not to use online systems could still access appointments and advice.	Health & Care Quality Standards (2023) – Person-centred, Equitable, Effective.	We create a new access poster for our waiting rooms to inform patients of the different ways they can make an appointment at the surgery	Carol Wilson	1 – 2 weeks
6.	On review of staff training records, we found that not all staff had completed equality and diversity training or autism awareness and learning disability training.	The practice should take steps to identify what rights and equality focused training should be completed by its staff and ensure records of this is maintained.	Health & Care Quality Standards (2023) – Workforce, Equitable, Safe, Person-centred.	All staff have now been provided with links to equity and diversity plus autism training via Learning@Wales and modules will be completed as a priority.	Carol Wilson	3 – 4 weeks (due to staff annual leave)

7.	The room containing the baby changing facilities was located upstairs. The entrance to the building did not have an automatic door, which may make access more difficult for patients using wheelchairs, those with limited mobility, or patients attending with children in pushchairs.	The practice should review the physical accessibility of the premises to identify and address barriers to improve accessibility for all patients.	Health & Care Quality Standards (2023) – Equitable, Person-centred, Safe.	We will install a doorbell at the front entrance so that patients can contact reception if they have difficulty accessing the building. We will install a baby changing unit in the toilet on the ground floor to aid patients with prams.	Steve Riley	3 – 4 weeks
8.	A brick pillar at the exit to the car park was damaged and appeared at risk of falling or becoming displaced. This presented a potential health and safety risk to patients, staff and visitors using the car park. We also found that some second-floor rooms, which were not currently in use, showed signs of disrepair, with evidence of black mould in one south-facing room. In addition, a staff toilet had paint peeling from the walls and needed redecoration.	The practice should arrange for the damaged brick pillar to be repaired or replaced promptly, and ensures the affected internal areas are repaired, treated where required, and redecorated. The practice should also consider whether any interim measures are needed to reduce risk until the required works are completed.	Health & Care Quality Standards (2023) – Safe.	We well engage a builder to repair the pillar at the exit of the surgery. Rooms and toilets upstairs will be redecorated in due course. These are not patient facing areas and will be given a low priority.	Steve Riley	1 – 2 weeks 6 – 12 months

9.	The business continuity plan did not specifically reference partnership risk.	The practice must update the business continuity plan to include a reference to partnership risk.	Health & Care Quality Standards (2023) – Safe, Effective, Efficient, Timely, Person-centred.	We will update the BCP to include a section on Partnership Risk.	Steve Riley	1 – 2 weeks
10.	The induction checklist did not include a signature box to confirm that the staff member was satisfied that all required areas had been covered. There was also no induction pack for locum staff.	The practice should: • update the induction checklist to include a signed declaration confirming completion and understanding • develop a standard induction pack for locum staff to support consistency and governance.	Health & Care Quality Standards (2023) – Safe, Effective, Leadership, Efficient.	The induction checklist has now been updated to include a signed declaration. We will develop a standard locum pack shortly. We have a pack for our GP Registrars which we will tweak accordingly.	Steve Riley	Completed 6 – 8 weeks
11.	Emergency equipment was stored on a trolley. However, some consulting rooms were located up one or more flights of stairs, which may have an impact on the timely movement of emergency equipment during an incident.	The practice should review the accessibility of emergency equipment, considering consulting rooms located on upper floors.	Health & Care Quality Standards (2023) – Safe, Effective, Efficient.	We will utilise our emergency bag to contain essentially supplies and use the emergency trolley to hold all other emergency stock. The bag will be replenished when it is used.	Steve Riley / Practice nurses	1 – 2 weeks

12.	The IPC policy included references to the decontamination of reusable invasive surgical instruments. Staff told us the practice used single-use equipment.	The practice should review and update its Infection Prevention and Control policy to ensure it accurately reflects current practice. References to the decontamination of reusable invasive surgical instruments should be removed where single-use equipment is exclusively used.	Health & Care Quality Standards (2023) – Safe, Effective, Leadership, Efficient.	Our IPC policy has now been updated to remove any reference to reusable surgical instruments.	Steve Riley / Kelly Di'iulio	Completed
13.	Daily cleaning records were not available for review. This made it difficult to verify whether routine environmental cleaning was being completed as intended.	The practice should ensure cleaning records are maintained and available to demonstrate that cleaning has been carried out in line with the agreed schedule.	Health & Care Quality Standards (2023) – Safe, Effective, Leadership, Information.	We will display daily cleaning sheets in each consulting room, kitchen and toilet for the cleaning staff to complete daily. Any issues identified by the cleaners will be written in a log book located in the reception office.	Steve Riley	1 – 2 weeks
14.	We identified that the needlestick policy could be further strengthened by the inclusion of a clear flow chart detailing reporting arrangements, including named contacts and telephone numbers for the local hospital or occupational health department.	The practice should strengthen its needlestick and sharps policy by including a clear and accessible flow chart outlining the actions to be taken following an incident.	Health & Care Quality Standards (2023) – Safe, Effective, Efficient.	Needlestick policy to be updated in due course to include a flow chart explaining reporting procedures.	Kelly Di'iulio	3 – 4 weeks

15.	The clinical waste bins were not secured to the enclosure, and the enclosure itself was not locked.	The practice should review the security arrangements for the external clinical waste storage area. Clinical waste bins should be appropriately secured, either by fixing them to the enclosure or by ensuring the enclosure itself is locked.	Health & Care Quality Standards (2023) – Safe, Effective, Efficient.	Bins are to be moved to a specially created concrete pad and secured to the wooden unit with large cable ties.	Carol Wilson	1 – 2 weeks
16.	We did not see evidence of an infection prevention and control audit.	The practice should ensure that regular IPC audits are completed to monitor compliance with infection prevention and control standards and to identify any required improvements.	Health & Care Quality Standards (2023) – Safe, Effective, Learning, improvement & research, Efficient.	The practice will conduct annual IPC audits as a minimum and mark areas for improvement.	Kelly Di'iulio / Steve Riley	3 – 4 weeks
17.	There was no formal programme of medicines management training in place.	The practice should ensure that all staff involved in prescribing processes, including those responsible for processing repeat prescriptions, receive appropriate and up-to-date medicines management training.	Health & Care Quality Standards (2023) – Safe, Effective, Workforce.	All staff to complete Medicines Administration Training as found on the HEIW website (Y Ty Dysgu)	Steve Riley	6 – 8 weeks
18.	We did not see evidence that relevant staff had completed online BOC integrated valve portable oxygen cylinder training.	The practice must ensure BOC integrated valve medical gas cylinder training is completed by clinical staff.	Health & Care Quality Standards (2023) – Safe.	3 remaining GPs to complete BOC oxygen training shortly	Steve Riley / GP Partners	1 – 2 weeks

19.	We found that a small vaccine refrigerator, which was not in use at the time of the inspection, and a pulse oximeter kept on the emergency trolley had missed the most recent calibration.	The practice should review and strengthen its systems for monitoring the servicing and calibration of medical devices to ensure that all equipment, including items not in regular use, receives calibration checks in line with manufacturer guidance	Health & Care Quality Standards (2023) – Safe, Effective, Leadership, Information.	A register of all medical equipment to be calibrated each year will be created and kept on file in readiness for the engineer's visit. Register will be updated when new equipment purchased.	Steve Riley / Practice nurses	3 – 4 weeks
20.	We found that the practice had a received mail policy; however, this was dated September 2006 and required review.	The practice should review and update its received mail/workflow policy to ensure clear guidance for staff on the management of out-of-hours and accident and emergency correspondence, including how this should be reviewed, recorded and escalated to clinicians where appropriate.	Health & Care Quality Standards (2023) – Safe, Effective, Efficient.	We will review and update the old 'received mail' policy to ensure it reflects current processes and procedures.	Carol Wilson / Steve Riley	3 – 4 weeks
21.	There was no significant event policy in place.	The practice must develop and implement a formal significant event policy. This should set out a clear and consistent process for the identification, review and documentation of significant events, including how learning and actions are shared with relevant staff.	Health & Care Quality Standards (2023) – Effective, Safe, Leadership.	Significant event policy to be updated and implemented.	Steve Riley	4 – 6 weeks

22.	Our review identified that only one of the eight patient records included the patient's language preference.	The practice should ensure that patients' language preferences are consistently recorded within their medical records.	Health & Care Quality Standards (2023) – Person-centred, Equitable, Information.	An internal email has been sent to all staff to ensure that patient's chosen language is entered into their notes at the registration stage. We will audit new patients each month to ensure this is happening.	Steve Riley	Change implemented but ongoing to ensure maintained.
23.	Five respondents said they had received an appraisal, annual review or development review in the last 12 months, while four said they had not.	The practice should ensure that all staff receive a regular appraisal, annual review or development review.	Health & Care Quality Standards (2023) – Effective, Workforce, Leadership.	Annual appraisals are ongoing and remaining staff will be appraised over the coming weeks.	Steve Riley	3 – 4 weeks
24.	Two respondents to the staff survey disagreed that the organisation implemented an effective infection control policy. Four respondents disagreed that there was an effective cleaning schedule in place.	The practice must review its infection prevention and control arrangements to ensure there is an effective cleaning schedule in place and that all staff are aware of, and work in line with, the practice's infection control policy.	Health & Care Quality Standards (2023) – Safe, Effective, Leadership, Workforce.	Cleaning schedules provided by supplier along with electronic copies of IPC policy to be shared with all practice staff.	Steve Riley	1 – 2 weeks

25.	We found that policies did not include version control or a review-due date.	The practice should ensure all policies and procedures include version control and a clearly defined review-due date.	Health & Care Quality Standards (2023) – Effective, Information, Learning, improvement & research.	All policies will be version controlled in future and an index of policies will be created and maintained as policies are updated.	Steve Riley	1 – 2 weeks
26.	Staff told us the practice was working towards completing DBS checks every three years.	The practice should consider introducing annual DBS self-declaration as part of the appraisal process, to provide ongoing assurance that staff remain suitable to work for the service.	Health & Care Quality Standards (2023) – Safe, Leadership, Workforce, Effective.	3 yearly DBS checks will be carried out on all staff and GPs to ensure they are suitable to work in practice.	Steve Riley	Completed for 2026 Diary note made for 2029
27.	We found that pre-employment health screening was not completed.	The practice should ensure that pre-employment health screening is completed for all new staff, with appropriate risk assessments undertaken where health issues are identified.	Health & Care Quality Standards (2023) – Workforce, Safe, Leadership.	Practice will develop a confidential questionnaire to be filled in by all new staff members as part of the induction process to identify any health needs.	Steve Riley	6 – 8 weeks

28.	Three of the five staff files reviewed contained an up-to-date job description.	The practice should ensure that all staff have an up-to-date job description that clearly outlines roles, responsibilities and scope of practice, and that a copy is retained within each staff file.	Health & Care Quality Standards (2023) – Person-centred, Effective, Leadership, Information, Workforce.	New job descriptions for admin, nurse and salaried doctors to be developed and updated in future where necessary	Steve Riley	8 – 12 weeks
29.	The practice did not have a spreadsheet or other system to monitor the number and type of complaints received, or to identify themes and trends over time.	The practice should implement a suitable system to monitor complaints, concerns and outcomes, to support trend analysis and reporting.	Health & Care Quality Standards (2023) – Learning, improvement & research, Information, Person-centred.	Spreadsheet to record and discuss all complaints to be developed to monitor all complaints received since 1 January 2026. Spreadsheet to be discussed annually to identify trends.	Steve Riley	1 – 2 weeks
30.	The complaints policy still referred to the Putting Things Right process.	The practice should update its complaints policy to align with the NHS Listening to People process.	Health & Care Quality Standards (2023) – Leadership, Information, Learning, improvement & research.	Our complaints policy will be updated to reflect the new Listening to People guidance	Steve Riley	1 – 2 weeks

31.	We did not see evidence that changes made because of patient feedback or survey responses were shared with patients.	The practice should introduce a suitable process to inform patients of actions taken in response to feedback, such as through the website, waiting room displays or a "you said, we did" approach.	Health & Care Quality Standards (2023) – Person-centred, Learning, improvement & research, Information.	We will create a poster each year based upon the finding of our patient experience survey and share both positive and negative feedback together with any resulting action we have taken. We will also include a section on our website which will display similar information.	Steve Riley	8 – 12 weeks
32.	Our review of five staff records found that only three staff had completed Duty of Candour training.	The practice should ensure that all staff complete Duty of Candour training appropriate to their role.	Health & Care Quality Standards (2023) – Workforce, Safe, Leadership, Learning, improvement & research.	All 13 members of the admin team have completed the Duty of Candour training. Nurses and GPs will be asked to complete as a priority.	Steve Riley	3 – 4 weeks (due to annual leave)

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): Steve Riley

Job role: Practice Manager **Date:** 24 June 2026