Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report (Announced)

Roath House Surgery, Cardiff and Vale University Health Board

Inspection date: 23 April 2024

Publication date: 24 July 2024

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

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

In writing:

Communications Manager

Healthcare Inspectorate Wales
Welsh Government

Rhydycar Business Park

Merthyr Tydfil

CF48 1UZ

Or via

Phone: 0300 062 8163

Email: hiw@gov.wales
Website: www.hiw.org.uk

Digital ISBN 978-1-83625-431-7

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

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our values

We place people at the heart of what we do.
We are:

- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

Our goal

To be a trusted voice which influences and drives improvement in healthcare

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.

Contents

1. What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an announced inspection of Roath House Surgery, Cardiff and Vale University Health Board on 23 April 2024.

Our team for the inspection comprised of two HIW Healthcare Inspectors and two clinical peer reviewers. The inspection was led by a HIW Healthcare Inspector.

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 nine questionnaires were completed by patients or their carers, and nine questionnaires 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:

Staff worked hard to provide a caring and professional service for patients and the practice engaged positively as a member of the local healthcare cluster to ensure a collaborative approach to serving the community.

We found a good range of bilingual information available within the practice, although smoking cessation and healthy lifestyle advice was absent at the time of the inspection.

Patient feedback received through HIW questionnaires was mixed, with the main issues being about accessing the general practice / practitioner (GP) and arranging appointments. All patients felt that the GP explained things well to them and most felt involved in decisions about their healthcare.

There was ramp access into the premises from both the car park and street allowing patients with impaired mobility and wheelchair users access to facilities. The patient waiting room was clean and comfortable although this was limited in size due to recent refurbishment work that created additional treatment rooms. There was a separate room available for confidential discussions.

We saw a chaperone service was offered with relevant policies in place. Whilst chaperone training was not included as part of the induction for new staff, we were informed that the induction programme was currently under review.

This is what we recommend the service can improve:

- Implement a system for monitoring and reviewing instances where patients do not attend appointments
- Provide all carers with information and support as appropriate.

This is what the service did well:

- GP partners ran a Saturday vaccination clinic to cater for patients who were working Monday to Friday
- Care navigators were based with the duty doctor who provided guidance as necessary
- Welsh speaking members of staff helped to provide a bilingual service
- Held gender clinics with a gender clinical lead appointed.

Delivery of Safe and Effective Care

Overall summary:
The practice provided patients with safe and effective care in a clean and clutter-free environment. Our review of infection prevention and control measures found an adequate policy was in place with a lead appointed and recent audit conducted. All patients who answered the HIW questionnaire agreed the practice was clean.

Requests for repeat prescriptions could be made by various methods including email, in person or via the local pharmacy. The practice had arrangements for monitoring medication usage and conducting reviews to ensure patients had the most appropriate medication.

All equipment was well maintained and in good condition, with evidence of regular checks and servicing. Emergency equipment was available and well signposted to enable quick access for staff in the event of an emergency.

There was an up-to-date safeguarding policy that complied with the All Wales Safeguarding procedures. However, there was no evidence available to show that all staff had read and understood this update.

Patient records were stored securely and protected from unauthorised access. Overall, these records were clear, precise and had been completed to a good standard with investigations well documented and sufficient detail for any subsequent clinician to follow.

This is what we recommend the service can improve:

- Carry out weekly checks of emergency equipment and drugs
- Ensure all relevant staff have completed the necessary safeguarding training.

This is what the service did well:

- Good cluster cooperation with a ‘buddy’ practice, to ensure patient care could continue in the event of an extreme situation
- Data loggers monitored the temperatures of fridges to ensure drugs vaccines and drugs were stored at the correct temperatures
- Provision of an enhanced service for drug addiction.

Quality of Management and Leadership

Overall summary:

We found the practice had good leadership and clear lines of accountability. The staff team worked very well together and were committed to providing high quality healthcare for their patients. All staff who responded to the HIW questionnaire stated they would be happy with the standard of care provided by the practice for themselves, friends and family.

Team meetings were held on a weekly basis with evidence that minutes of these meetings were being recorded and shared with staff.

The practice had a comprehensive suite of policies available which were regularly reviewed and available to all staff via a shared drive. However, there was no register to indicate who had read the policies. Not all policies had version control including review dates and version history.

Staff files were readily available and included contracts of employment. However, we did identify several omissions within these records including incomplete references, an inaccurate job description for a nurse and disclosure and barring service (DBS) checks pending completion.

The practice manager was responsible for monitoring staff training compliance with most staff up to date with their mandatory requirements. Whilst there were several instances where training had not been recorded as completed, we were aware that the practice manager was on long term absence prior to and during our inspection.

The practice has established good relationships with the health board and other services to help meet the healthcare needs of the community.

This is what we recommend the service can improve:

- Update the name plaque on the outside of the practice to remove the names of the clinical staff no longer employed
- Ensure that all staff have an annual appraisal
- Ensure staff sign an annual declaration that there had not been any changes that affect their DBS status
- Implement a structured system of clinical audits to help improve quality of patient care.

This is what the service did well:

- Patient surveys conducted with results displayed in the practice waiting area
- Effective data governance processes with the Digital Health and Care Wales (DHCW) service to act as Data Protection Officer

- Positive response to patient feedback with a new appointment system implemented
- Building redesigned to provide additional clinical rooms to improve treatment capacity.

3. What we found

Quality of Patient Experience

Patient Feedback

Before our inspection we invited the practice to hand out HIW questionnaires to patients to obtain their views on the service provided at the practice. On the day of the inspection our inspectors also spoke with patients to find out about their experiences at the practice. Patient comments included the following:

> *"I find once you can get an appointment you generally get good care. But it's a minefield getting an appointment!"*
>
> *"Individual GPs, midwife etc are great… but overall, the whole picture isn't great."*
>
> *"The best practice in Cardiff."- (comment on the day of inspection)*

Person centred

Health Promotion
During our inspection we saw that the practice had a wide range of written health promotion information available for patients. The information was displayed in the patient waiting area, on the display screen and promoted through the practice Facebook page and website. However, there was an absence of information regarding smoking cessation or healthy lifestyle advice. We were advised these had been recently removed to make space for other notices but were reinstated during the course of the inspection.

We were told that the practice engaged in mental health promotion initiatives with signposting to MIND counsellors. We found the practice website also contained links to Rethink, a charity that seeks to improve the lives of people severely affected by mental illness through their networks of local groups and services, information and campaigns and Samaritans, a charity aimed at providing emotional support to anyone in emotional distress, struggling to cope or at risk of suicide.

The practice healthcare assistant (HCA) provided smoking cessation advice, with nurses proving diabetes advice as necessary. We were told the practice also held other clinics such as asthma, substance misuse and gender services.

Of the nine patients who completed the HIW questionnaire, eight agreed that there was health promotion information on display at the practice. Four patients agreed that they were offered healthier lifestyle advice, with four patients skipping the question.

We were told that the practice did not monitor data relating to patients who did not attend (DNA) appointments including medication reviews, children who were not brought and hospital appointments.

The practice should implement a system for monitoring and reviewing instances where patients do not attend appointments.

Two patients who answered the questionnaire told us they were carers. One said they had not been offered an assessment of their own needs as a carer nor been provided with details of carer support networks or organisations, whilst the other was not sure.

The practice should provide HIW with details of the action taken to ensure all patients with carer responsibilities are provided with information and support as appropriate.

The process in place to manage the winter vaccination programme was described. We were told that the GP partners ran a Saturday clinic to cater for patients who were working Monday to Friday.

Dignified and respectful care

Reception staff were observed welcoming patients in a professional and friendly manner. To protect confidentiality telephone calls were taken in the administration office, away from the reception desk. A room was also available to the rear of the reception for confidential conversations and we saw a notice asking patients to let the receptionist know if they wanted to speak in private. However, over half of the respondents to the HIW questionnaire felt that they were unable to speak with a member of reception staff without being overheard by other people in the patient waiting area.

The practice should consider this feedback to ensure that patients speaking at the reception desk are enabled to do so in a way that upholds their privacy and confidentiality.

During our tour of the practice we saw treatment rooms were closed when in use and that curtains were also available in the rooms to maintain patient's privacy and dignity. We saw notices displayed throughout the practice offering a chaperone service for intimate examinations. We were told that female and male

staff were trained as chaperones and were offered to patients as appropriate. However, this training did not form part of the induction training for new staff, although we were advised the induction programme was currently under review.

Additionally, two respondents to the patient questionnaire indicated they had not been offered a chaperone for intimate examinations or procedures.

We recommend that the practice:

- **Reflects on the issue raised in this feedback to ensure all patients are offered chaperones when appropriate, in line with the practice policy**
- **Add chaperone training to the induction programme for new staff employed at the practice.**

All but one of the patients who answered the HIW questionnaire felt they were treated with dignity and respect and said measures were taken to protect their privacy.

Timely

Timely Care

Roath House Surgery was open between 8:00am and 6:30pm Monday to Friday. Access to appointments was via a telephone booking. We were told that patients requesting urgent appointments would be triaged by a duty doctor.

Suitable arrangements for the assessment and referral to mental health services were described. The practice had a mental health liaison officer and offered mental health assessment via a nurse practitioner. The practice had access to mental health counselling services.

A flow chart was available for care navigators to help direct patients to the most appropriate person or service. The care navigators were based with the duty doctor who was available to provide guidance as necessary. We found the practice made good use of cluster-based support services.

We saw an analysis of access activity data which was communicated to patients via social media. We suggested that this could be added to the practice website and displayed in the waiting area to inform patients without social media or digital access. There was an up-to-date practice access policy available, however, this was a brief document and lacked detail.

We recommend the practice reviews and develops a comprehensive access policy and supply a copy to HIW once complete.

A third of the patients who responded to the questionnaires said they were able to get a same-day appointment when they needed to see a GP urgently, whilst less than half agreed they could get routine appointments when they needed them. Only one of the patients who answered said they were offered the option to choose the type of appointment they preferred, although almost all said they were content with the type of appointment they had.

Some comments we received about accessing the GP are below:

> *"Face to face was preferred and that's what I got at my last appointment."*
>
> *"It takes many times of phoning for appointment to get one. I only ask for appointment when it is really needed. It's frustrating to hang on phone for 45 minutes or more quite a few times to get an appointment in three weeks for something that's wrong now."*
>
> *"I can always get an appointment if I need to but getting one with the GP I would like is very difficult."*
>
> *"Only issue is being able to get appointments. If you ring at 2pm to book a non-urgent appointment, which would be for 3 weeks' time, you are in the queueing system for about 25 mins only to be told there are no appointments left. I have tried about five times over the last couple of weeks and haven't been able to book."*

We recommend the practice reflects on the issues raised in this feedback to ensure patients receive treatment in a timely manner.

Equitable

Communication and language
Staff informed us of the methods of communication used to convey information to patients. As well as face-to-face, the practice had a text reminder service and had a website with audio facility. Leaflets and forms were available in easy read and large print formats. We saw a practice leaflet providing useful information about the practice and services offered. This was also available in larger font and in Welsh. A hearing loop was installed for patients with impaired hearing.

We were provided with an up-to-date consent protocol. This ensured that all patients were able to give informed consent and those patients without capacity were appropriately protected. We were told the practice placed alerts on their

clinical notes system to notify staff if there were any issues regarding a patient's capacity to give consent.

There was a large amount of bilingual patient information in the practice and there was a translation service available. There were several staff that spoke Welsh and we saw 'Iaith Gwaith' badges and lanyards worn so patients could identify them as a Welsh speaker. However, we noted there were no signs in reception to inform patients that treatment in the medium of Welsh was available. We raised this with the assistant practice manager who installed signs in accordance with the 'Active Offer'.

The practice ensured messages were communicated to the appropriate people by using the practice information, communication and technology (ICT) systems with read receipts enabled for confirmation. There were appropriate workflow processes for letters and documents circulated in the practice, with paper documents scanned onto the practice ICT system and added to patient notes as required. Whilst workflow training was conducted in-house, the practice may benefit from reviewing the workflow process as part of the audit programme to ensure documents are directed to the appropriate staff.

We found information was shared with patients about their condition and care management options, with systems in place to follow up results.

All patients who answered the HIW questionnaire felt that the GP explained things well to them and answered all of their questions and most felt involved in decisions about their healthcare. Some comments we received about patient care were:

> *"I take advantage of the fact that there are now two doctors in the practice who speak Welsh. For years English was the only language of the doctors!"*

> *"I have a long-term health condition, but rarely need to consult my GP. When I do, it seems to be a different doctor each time, and I end up spending half the appointment explaining my medical history, rather than the specific matter for which I've made the appointment."*

Rights and Equality

The practice offered good access with a small dedicated free car park and on-street parking available. We noted that all patient areas including treatment rooms and accessible toilet were located on the ground floor. There was ramp access and handrails from street level, giving good accessibility for wheelchair users and patients with impaired mobility.

All except one patient who answered the HIW questionnaire thought the building was easily accessible.

We saw evidence of a comprehensive equality and diversity policy in place. 'Treat Me Fairly' training had been completed by most staff. All respondents who answered the question confirmed they had not faced discrimination when accessing or using this health service.

The practice must ensure all staff complete Treat Me Fairly training and provide HIW with evidence once complete.

The practice was proactive in upholding the rights of transgender patients. The practice provides gender clinics for Cardiff and Vale University Health Board and the Welsh Gender Service, with a dedicated gender clinical lead appointed. The practice provided initiation treatment and conducted annual reviews of transgender patients. We were told that transgender patients were treated with sensitivity, and it was confirmed that preferred pronouns and names were always used with records amended and merged accordingly.

Delivery of Safe and Effective Care

Safe

Risk Management
The premises appeared to be well maintained with evidence of recent alterations and refurbishment, although this has reduced the size of the patient waiting area.

We reviewed the practice business continuity plan which was up-to-date and contained all relevant information. The practice demonstrated good cluster cooperation with a cluster Covid agreement with a 'buddy' practice, to ensure patient care could continue in the event of an extreme situation. The business continuity plan was available to all staff via a shared drive.

Staff told us that they received patient safety alerts which were distributed appropriately amongst staff via email. These were incorporated into a locum pack to make sure any locums were also aware. We were told patient safety incidents and significant events would be shared and discussed at clinical meetings. Staff we spoke with confirmed this.

We were told that emergency assistance was via a designated call button built into the clinical ICT system that would alert all users once pressed. However, we were told this system was stopping shortly. The practice was in the process of sourcing a replacement system.

We discussed action taken when home visits were requested and found that they were triaged and risk assessed by the duty doctor. In the event of a patient facing a lengthy wait for an ambulance at home, the doctor would contact the surgery to rearrange clinics.

Infection, Prevention, Control (IPC) and Decontamination
During our tour of the practice we found the waiting and clinical areas were well lit, clean, tidy and free from unnecessary clutter with sharps bins securely stored. We found elbow operated taps and foot operated bins in clinical areas. Soap was available in both patient and staff toilets and hand washing posters were displayed. Sanitising hand gel was seen throughout patient areas. Personal protective equipment (PPE) was available for staff and a room was also earmarked for segregation of patients with infectious conditions.

We were provided with the practice Infection Prevention and Control Policy. This had been recently reviewed and was available to all staff via a shared drive and in

a policy folder. An IPC audit had been carried out recently by the practice lead and appropriate waste management procedures were in place.

There were appropriate protocols in place for needlestick injuries with flow charts in clinical rooms. A copy of the protocols was also available on the practice shared drive for all staff to access.

Our observations of the clinical environment found this to be good overall. Flooring and work surfaces were of a suitable wipe design, allowing for effective cleaning and appeared to be in a good condition. Cleaning of the practice was undertaken by an external company. However, we could not find an up-to-date cleaning contract, nor did we see evidence of completed cleaning schedules.

The practice must ensure that a current cleaning contract is in place and that cleaning schedules are used and kept on file. A copy of these cleaning schedules must be provided to HIW with evidence where completed.

All patients that responded to our questionnaire felt the practice was clean. Most confirmed that hand sanitiser was always available for them in the practice and agreed that staff washed their hands before and after treatments.

Six respondents indicated that they had attended for an invasive procedure. Most said that staff wore gloves during the procedure and used antibacterial wipes to clean their skin prior to the treatment, whilst one patient disagreed. Most agreed that the equipment used was individually packaged and appeared sanitised, whilst one patient was unsure.

The practice must reflect on the issues raised in this feedback to ensure appropriate infection control measures are always adhered to.

Medicines Management

We were told requests for repeat prescriptions could be made by various methods including via email, in person or via the local pharmacy. These would be processed within 48 hours if requested at the practice, or 72 hours if via the pharmacy. The requests would be managed by the practice pharmacist who would process them accordingly. To ensure patients continued to be prescribed the most appropriate medications, patients were required to undergo medication reviews. The trained prescribing clerk monitored medication usage to prevent overuse of medication. Appropriate prescribing and repeat medication policies were reviewed, although we noted version control data and review dates were missing.

Prescription pads were locked securely away from unauthorised access. In the event that a GP left the practice, relevant prescription pads were shredded to

prevent future use. We saw prescriptions collected from the practice were logged by reception.

We found vaccines were stored within dedicated vaccine fridges and had annual maintenance checks. An up-to-date cold chain protocol was in place to ensure safe storage of refrigerated medicines and we were assured that staff were aware of the action to take should there be a breach in the cold chain. Temperature checks were checked twice daily while we saw that data loggers were used to monitor temperatures over weekends and bank holidays or following a period of power outage.

Appropriate policies and arrangements were in place for the safe storage and handling of controlled drugs held at the practice. This was provided as part of an enhanced service for drug addiction.

Checks of drugs and medications was completed and logged by the nursing team. Our review of medication found all to be securely stored and in date.

Management of Medical Devices and Equipment
The practice manager had responsibility for arranging annual checks and calibration of devices and equipment, with staff reporting any emergency repairs or replacements required. We saw current contracts in place for the maintenance and repair of equipment. On the day of our visit we found that all were well maintained and in a good condition.

Emergency equipment including oxygen and a defibrillator were available and signposted to ensure staff knew where to find them in an emergency. Whilst checks on the defibrillator were conducted daily, we were told that the emergency equipment and drugs were checked monthly.

We recommend emergency equipment and drugs are checked weekly.

Safeguarding of Children and Adults
We saw evidence of up-to-date safeguarding policy that complied with the All Wales Safeguarding procedures. This included contact details for the local safeguarding team and the policy clearly identified the safeguarding lead and deputy at the practice. Whilst the policy was up to date, we did not see evidence that the updated policy had been read by staff.

We recommend the practice ensures staff sign the safeguarding policy whenever it is reviewed, to confirm they have read and understood any updates.

We saw evidence of alerts on the practice systems for identifying children at risk and looked after children. There was also an appropriate process for removing these when no longer at risk.

We were also provided with evidence of effective multi-disciplinary team (MDT) working. This included liaison with the ambulance service and the police as part of monitoring attendances.

We were provided with a training matrix to demonstrate compliance with appropriate levels of training in safeguarding. However, we found that up to date training had not been completed by several staff. Although all staff who responded to the HIW questionnaire said that they would know how to report a safeguarding concern, one said they were unaware who the safeguarding lead was at the practice.

The practice must ensure all relevant staff have completed the necessary safeguarding training and are aware of the practice leads when dealing with a safeguarding concern.

Effective

Effective Care

It was apparent that the practice had a dedicated team that worked hard to provide patients with safe and effective care. The practice manager kept staff up to date with the latest best practice and national guidelines by circulating emails and clinical meetings.

Senior staff informed us of the practice procedure for patient referrals. Referrals were appropriately categorized as routine, urgent and urgent suspected cancer. We were told referral rates were reviewed and found that the procedure was explained within a locum pack, to ensure locum GPs were aware of the practice process.

The practice telephone answering service directed callers with emergency conditions to dial 999 and also suggested attending a pharmacy for minor issues.

There was an organised process for ordering tests and relaying results to patients with overdue tasks monitored and referred to the duty GP as necessary.

We were told that contact from patients in crisis would be triaged with the majority brought to the surgery. Whilst the practice had access to mental health support, they found that demand outstrips capacity, resulting in patients sometimes being directed to Emergency Departments (ED). The practice received

reports from the ED whenever a patient had received intervention care. This was forwarded to the clinician responsible who created an appropriate action plan.

Patient records
We reviewed a sample of ten electronic patient medical records. These were stored securely and protected from unauthorised access in compliance with relevant legislation.

Overall, our review indicated patient records were clear, precise and of a good standard. We saw evidence that these were made in a timely manner with sufficient detail for the next clinician to follow. Any investigations arranged were well documented, with evidence of reasoning and decision making. We found good use of Read codes and medications clearly linked to conditions. The standard was consistent for all clinicians reviewed although some were more detailed than others.

There were a significant number of paper patient records relating to transferred-in patients that not been summarised to the practice electronic records system due to the volume and workload involved.

We recommend that the practice ensure patient notes are summarised for transferred-in patients, without delay.

Quality of Management and Leadership

Staff feedback

Before our inspection we invited the practice staff to complete an online questionnaire to obtain their views of working for the practice. In total, we received nine responses from staff at this practice. Some questions were skipped by some respondents, meaning not all questions had nine responses.

The response to the staff survey was generally positive. All respondents agreed that they were satisfied with the quality of care and would be happy with the standard of care provided by the practice for themselves, friends and family. Staff comments included the following:

> *"I have been employed by the surgery since January and have been supported to make some changes as and when needed and they are a brilliant supportive team."*

Leadership

Governance and leadership
Roath House Surgery was operated by four GP partners and is a GP training practice set within the Cardiff North Cluster of Cardiff and Vale University Health Board. The practice has approximately 14,000 registered patients. In addition to the GP partners, we were told there were five salaried GPs, three nurses and several attached staff including a district nurse and a pharmacist. Whilst it was evident there were clear lines of accountability in place at the practice, we were told that a senior member of staff was on long term absence which was being covered by a colleague. We noted that the plaque outside the practice displayed the name of a retired GP.

We recommend the practice update the name plaque to remove the names of the clinical staff no longer employed at the practice.

We were told that team meetings were held on a weekly basis, on alternating days to ensure all staff could attend at least fortnightly. We saw evidence that minutes of these meetings were being recorded and disseminated. Appropriate methods were described for sharing information, including policy and procedural changes, with staff.

The practice had a comprehensive suite of policies and procedures held on their ICT system. Generally, we found the policies were reviewed on a regular basis with staff having easy access to them via a shared drive. However, we found there was no register to confirm if staff had read and understood the policies, some policies lacked review dates and many policies were missing any form of version control.

The practice must ensure that:

- **All staff have read and understood relevant practice policies to ensure compliance with practice processes**
- **Provide HIW with evidence once completed**
- **All policies contain version history, review dates and person responsible for reviewing the procedure.**

At the time of our visit we were told the main challenge faced by the practice was the demand for continued professional education training (CPET) sessions for staff and the financial pressures of running and modernising an older property. We were told the practice was on a waiting list with the health board for purpose built premises.

Workforce

Skilled and enabled workforce
We spoke with staff across a range of roles working at the practice. They all had sound knowledge of their roles and responsibilities and were committed to providing a quality service to patients. Staff felt workload allocation was appropriate and within their scope of practice.

Our review of staff files found contracts of employment in place. However, there was no job description on file to accurately reflect the role of the nursing staff and evidence of relevant references was missing for some staff. Furthermore, it appeared that several staff had not had appraisals for several years, with six staff who responded to the questionnaire confirming they had not had an appraisal in the last 12 months.

The practice must ensure that:

- **All staff have up-to-date job descriptions retained in their personnel files, and that these include the scope of competence of the staff member**
- **Relevant references are obtained for all new staff employed and that evidence of the references is kept on file**

- **All staff have an annual appraisal and a process is put in place to ensure these occur in a timely manner.**

We saw that whilst some staff had Disclosure and Barring Service (DBS) checks in place, there were others at various stages of completion. There was no evidence of a DBS check for a member of clinical staff.

The practice must ensure that:

- **DBS checks are carried out on all new staff before starting work and evidence kept on file**
- **The contracts of employment should include a section on having to inform management if there had been any changes (i.e. criminal convictions or cautions etc) that would affect their DBS status**
- **Staff are required to complete and sign an annual declaration that there had not been any changes (i.e. criminal convictions or cautions etc) that would affect their DBS status.**

We found an induction and onboarding process in place for newly appointed staff, trainees and medical students. This would be documented and signed off by the practice manager or appointed staff member. The practice should consider whether to add DBS and employment reference confirmation checks to this document as an additional layer of assurance that the necessary information has been obtained.

We were told that the practice used the practice development plan and audits to identify and review staff training needs. The practice manager was responsible for monitoring the staff training matrix. It was noted that the training matrix indicated the same training refresher timescales for clinical and administrative staff, although for some courses this was different. This was raised with the assistant practice manager who arranged for the matrix to be appropriately divided to reflect the different refresher training periods. We were provided with a copy shortly following the inspection.

Whilst most staff had up to date mandatory training, our review of records highlighted several gaps for both clinical and non-clinical staff including information governance and safeguarding training missing or out of date for some and we saw no evidence that level two IPC training was being recorded or monitored.

The practice must ensure staff are fully compliant with mandatory training and provide HIW with evidence when completed.

We found the hepatitis B immunisation status was on file for 12 of the 13 clinical staff checked. We were told that the practice was waiting for confirmation from a previous employer for one member of staff.

The practice must ensure that all relevant staff have the appropriate hepatitis B immunisation status and a copy kept on file.

We were assured that staff would be supported in raising a concern should the need arise and we were provided with the practice whistleblowing policy. Further guidance of the process was available to all staff via the staff manual.

All nine staff who completed the HIW questionnaire said they had not faced discrimination within the last 12 months and that they had fair and equal access to workplace opportunities. Additionally, eight said their workplace was supportive of equality, diversity and inclusion, with the remainder preferring not to say.

In relation to patient care, all said they had access to the ICT systems they needed to provide good care and support for patients. All bar one respondents felt there was an appropriate skill mix at the practice and felt they had the materials, supplies and equipment needed to do their job. However, three respondents felt there was not enough staff employed at the centre to allow them to do their job properly, whilst two disagreed that they were able to meet all the conflicting demands on their time at work.

Culture

People engagement, feedback and learning

The practice had in place an appropriate complaints policy and procedure which was recently reviewed and in line with the NHS 'Putting Things Right' process. We noted that the policy contained a timescale for response and a named member of staff responsible for investigating the complaint and details of how the complaint could be escalated should a resolution not be found. However, there was no Putting Things Right poster displayed in the waiting area. We raised this with the practice staff who rectified this during the inspection.

We reviewed the practice complaints folder, however we noted that the paper records were not all kept in the same place. Additionally, themes were not identified and the initial complaint itself was sometimes missing from the notes.

The practice must ensure that all complaints received are filed in accordance with practice policy, with full details of the complaint, investigation and resolution recorded, and themes identified where possible.

The practice gathered feedback via patient surveys with the results including analysis and responses displayed in the practice waiting area. Analysis of this feedback identified that appointment times was an issue. This resulted in several changes including adjusting the time that routine appointments become available, additional care navigation training for staff and increased provision for same day appointments. The practice had recently undergone a building redesign to provide additional clinical rooms to improve treatment capacity.

Of the staff who responded to the HIW questionnaire all except one said they were able to make suggestions to improve GP services, whilst 75% said they were involved in deciding on changes introduced that affected their work.

We spoke to senior staff about the arrangements in place to ensure compliance with the Duty of Candour requirements. The practice did not have a Duty of Candour policy in place and staff had not completed online training on the subject.

The practice must:

- **Develop a Duty of Candour policy in line with the guidance and ensure all staff have read and understood this policy**
- **Ensure staff complete appropriate Duty of Candour training and provide HIW with evidence when completed.**

In total 67% of the staff who responded to the HIW questionnaire said they knew about and understood their role in relation to the Duty of Candour. All except one agreed that the practice encouraged them to raise concerns when something had gone wrong and to share this with the patient.

Information

Information governance and digital technology
We saw evidence of systems in place to ensure the effective collection, sharing and reporting of data and information. There were notices in the waiting area explaining how the practice collected, used and shared patient information and patient rights in relation to this. The practice had use of industry recognised software and reported incident data to the local health board via appropriate systems.

We were informed that the practice was using the Digital Health and Care Wales (DHCW) service to act as Data Protection Officer for the practice. DHCW dealt with any information requests received to ensure compliance with Data Protection regulations. The practice had numerous up to date policies to help ensure the

accuracy of information and how it was securely handled within national standards.

Learning, improvement and research

Quality improvement activities
Senior staff told us that they aimed to conduct annual reviews including that of significant events and complaints, as part of their commitment to improving the service. We were told that the practice enabled shared learning via practice meetings or via digital channels, often involving multi-disciplinary teams. However, we could not see any evidence that learning from significant events was disseminated to staff.

We recommend that:

- **The practice conducts reviews of significant events on a more regular basis**
- **Any learning from reviews is discussed formally and suitably documented and disseminated.**

We were provided with evidence of audits including diabetes, IPC and waste management that had been completed to demonstrate quality improvement activities undertaken by the practice. However, we did not see a structured system of audit to ensure compliance with practice policies and procedures.

The practice must implement a structured system of clinical audits to help improve quality of patient care.

As a result of patient feedback and from participating in the Quality Improvement Project regarding access, the practice has implemented a new appointment system, which involved the Duty Doctor triaging 'urgent' appointments prior to offering an appointment with the most appropriate service. The practice also played an active role in the Urgent Primary Care Centre in their cluster to help facilitate increased access to GP appointments. The effectiveness of these interventions would be monitored and assessed going forward.

Whole system approach

Partnership working and development
We were told that the practice worked closely within the local GP collaborative/ cluster to build a shared understanding of the challenges and the needs of the

local population and to help integrate healthcare services for the wider Cardiff area.

The practice had established a good relationship with the local health board and other services including the Welsh Gender Service, the Welsh Ambulance University Services NHS Trust, care homes and community support services. This helped to achieve reliable, and sustainable outcomes that met the evolving needs of the community.

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 summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns Identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns were identified on this inspection.			

Appendix B - Immediate improvement plan

Service: Roath House Surgery

Date of inspection: 23 April 2024

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Risk/finding/issue	Improvement needed	Service action	Responsible officer	Timescale
No immediate improvements were identified on this inspection.				

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.

Appendix C - Improvement plan

Service: Roath House Surgery

Date of inspection: 23 April 2024

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	Service action	Responsible officer	Timescale
We were told that the practice did not monitor data relating to patients who did not attend (DNA) appointments including medication reviews, children who were not brought and hospital appointments.	The practice should implement a system for monitoring and reviewing instances where patients do not attend appointments.	Management will re-introduce the system for monitoring and reviewing DNAs, and then a nominated member of the admin team will be tasked with checking DNAs daily and giving the figures to the management team to discuss at the Practice Team meeting. To ensure this is regularly discussed it will be a permanent feature on the Team meeting agenda.	GP Partners	Complete and ongoing.

Two patients who answered the questionnaire told us they were carers. One said they had not been offered an assessment of their own needs as a carer nor been provided with details of carer support networks or organisations, whilst the other was not sure	The practice should provide HIW with details of the action taken to ensure all patients with carer responsibilities are provided with information and support as appropriate.	Following staff appraisals a new Carer's champion, has been appointed. Management will review the current list of carers on the clinical system and run a data cleansing exercise to check everyone on the list is still a current carer. The Office Manager is currently looking into relevant training and resources. The Carer's Champion will then have protected scheduled time every week to run a patient search to check if any new carers have been identified and to also contact existing carers and offer support.	GP Partners	Completed and protected time to contact carers and for training is ongoing
Over half of the respondents to the HIW questionnaire felt that they were unable to speak with	The practice should consider this feedback to ensure that patients speaking at the reception desk are	We appreciate constructive feedback from our patients, and management have	GP Partners	Completed

a member of reception staff without being overheard by other people in the patient waiting area.	enabled to do so in a way that upholds their privacy and confidentiality.	discussed this. We are restricted by the size and shape of the reception and waiting room area, and have previously tried a different seating configuration, however this didn't help with this matter, which is why the current layout is being used. Whilst we do already have a room available for private conversations, we will aim to improve patient awareness that they can request to speak to reception staff privately, through additional signage in the waiting area and information on our practice website.		
Chaperone training did not form part of the induction training for new staff. Two respondents to the patient questionnaire indicated they had not been offered a	We recommend that the practice: • Add chaperone training to the induction programme for new staff employed at the practice	Following the inspection, in-house chaperone training has already been added to our induction checklist to ensure all new relevant staff receive the training.	GP Partners	Completed

chaperone for intimate examinations or procedures.	• Reflects on the issue raised in this feedback to ensure all patients are offered chaperones when appropriate, in line with the practice policy.	Regarding the issue of patients not being offered a chaperone, this will be discussed in the next Practice team meeting, and all clinicians will be sent a reminder via Microsoft Teams, to ask patients if they would like a chaperone before intimate examinations or procedures. Clinicians will be asked to acknowledge the reminder. We will also add information regarding the availability of chaperones to the practice website, under the information section for routine appointments.		
There was an up-to-date practice access policy available, however, this was a brief document and lacked detail.	We recommend the practice reviews and develops a comprehensive access policy and supply a copy to HIW once complete.	Management will review this policy within the next month and amend it accordingly for submission back to HIW.	GP Partners	26/7/2024

Patients expressed numerous negative comments about accessing the GP.	We recommend the practice reflects on the issues raised in this feedback to ensure patients receive treatment in a timely manner.	This feedback has been added to the next team meeting agenda to be reflected on by the practice team. Management are currently in the process of reviewing options for a new telephone system which should enable better management of incoming calls and reduce waiting times on the phonelines. There are currently three companies being reviewed on our shortlist.	GP Partners	18/7/2024
'Treat Me Fairly' training had been completed by most (not all) staff.	The practice must ensure all staff complete Treat Me Fairly training and provide HIW with evidence once complete.	There is currently only one staff member who is yet to complete this module as she is currently away from the office and training will be scheduled in upon her return. A copy of the certificate will be forwarded to HIW on completion.	GP Partners	Completed

Cleaning of the practice was undertaken by an external company. However, we could not find an up-to-date cleaning contract, nor did we see evidence of completed cleaning schedules.	The practice must ensure that a current cleaning contract is in place and that cleaning schedules are used and kept on file. A copy of these cleaning schedules must be provided to HIW with evidence where completed.	We have a rolling contract with a local cleaning company. Cleaning schedules will be implemented immediately and once completed sent to HIW.	GP Partners	Meeting with the cleaning company scheduled for 17/7/24 and ongoing for schedules
One patient disagreed that staff wore gloves during an invasive procedure and used antibacterial wipes to clean their skin prior to treatment.	The practice must reflect on the issues raised in this feedback to ensure appropriate infection control measures are always adhered to.	Reflecting on this feedback, all staff will be sent a Microsoft TEAMS message by Management asking them to acknowledge the reminder that they follow our Infection Protection Control policy (the policy will be attached for their attention).	GP Partners	Completed
We were told that the emergency equipment and drugs were checked monthly.	We recommend emergency equipment and drugs are checked weekly.	This has already been actioned following the HIW inspection and is now checked weekly.	Practice Nursing Team	Completed
We did not see evidence that the updated safeguarding policy had been read by staff.	We recommend the practice ensures staff sign the safeguarding policy whenever it is reviewed, to confirm	We are in the process of getting all staff to sign to confirm that they have read	GP Partners	3 months – 12/10/2024

	they have read and understood any updates.	the policy and understand the contents.		
We found that up to date safeguarding training had not been completed by several staff. One staff member said they were unaware who the safeguarding lead was at the practice.	The practice must ensure all relevant staff have completed the necessary safeguarding training and are aware of the practice leads when dealing with a safeguarding concern.	We have one member of staff who is outstanding their safeguarding training however we have scheduled time for them to complete this by 12/9/2024. Management will send a TEAMS message to all staff with a flow chart diagram of how to deal with a safeguarding concern and a hard copy of this will also be available in the kitchen area noticeboard.	GP Partners	2 Months – 12/9/2024
There were a significant number of paper patient records relating to transferred-in patients that not been summarised to the practice electronic records system due to the volume and workload involved.	We recommend that the practice ensure patient notes are summarised for transferred-in patients, without delay.	The Partners have proactively employed additional staff on a fixed term contract to focus on summarising the records.	GP Partners	Completed

We noted that the plaque outside the practice displayed the name of a retired GP.	We recommend the practice update the name plaque to remove the names of the clinical staff no longer employed at the practice.	This has already been actioned. New signage has been ordered and will be installed on Monday 15th July 2024.	GP Partners	Completed
We found there was no register to confirm if staff had read and understood the policies, some policies lacked review dates and many policies were missing any form of version control.	The practice must ensure that: • All staff have read and understood relevant practice policies to ensure compliance with practice processes • Provide HIW with evidence once completed • All policies contain version history, review dates and person responsible for reviewing the procedure.	We are in the process of getting all staff to sign to confirm that they have read the policy and understand the contents. Management will also ensure all policies contain the version history, review dates and person responsible for reviewing the procedure.	GP Partners	3 months – 12/10/2024
Our review of staff files found there was no job description on file to accurately reflect the role of the nursing staff and evidence of relevant references was missing for some staff.	The practice must ensure that: • All staff have up-to-date job descriptions retained in their personnel files, and that these include the scope of	• All non-clinical staff have had an up-to-date job description as part of their annual appraisal.	GP Partners	2 Months – 12/9/2024

Furthermore, it appeared that several staff had not had appraisals for several years.	competence of the staff member • Relevant references are obtained for all new staff employed and that evidence of the references is kept on file • All staff have an annual appraisal and a process is put in place to ensure these occur in a timely manner.	• Clinical staff job descriptions – Management are in the process of reviewing these and will be providing an up-to-date job description, where appropriate. • Checking references have been received is now on the onboarding checklist used by management when a new member of staff is joining the surgery. Once received these are added to the staff member's personnel file. • All clinical staff and non-clinical staff have now had an annual appraisal, except for the management team, whose appraisals are	

		currently being scheduled.		
We saw that whilst some staff had Disclosure and Barring Service (DBS) checks in place, there were others at various stages of completion. There was no evidence of a DBS check for a member of clinical staff.	The practice must ensure that: • DBS checks are carried out on all new staff before starting work and evidence kept on file • The contracts of employment should include a section on having to inform management if there had been any changes (i.e. criminal convictions or cautions etc) that would affect their DBS status • Staff are required to complete and sign an annual declaration that there had not been any changes (i.e. criminal convictions or cautions etc) that would affect their DBS status.	All relevant staff have now received their DBS or had it requested and are just awaiting the document. Our onboarding checklist has been updated to ensure that DBS checks are requested in good time. Management will develop a section for the contracts of employment regarding informing us of any changes that would affect a staff member's DBS status. Part of the reviewed appraisal process, following the inspection, is that staff will be asked to sign an annual declaration to confirm there have been no changes to their DBS status.	GP Partners	Completed and ongoing for any new staff.

Whilst most staff had up to date mandatory training, our review of records highlighted several gaps including information governance and safeguarding training missing or out of date for some and we saw no evidence that level two IPC training was being recorded or monitored.	The practice must ensure staff are fully compliant with mandatory training and provide HIW with evidence when completed.	The Management team are currently scheduling time for staff to complete/update any outstanding mandatory training modules. Going forward, the management team have diarised time to check the staff training log once a month and arrange any necessary training as appropriate.	GP Partners	3 months – 12/10/2024
We found the hepatitis B immunisation status was on file for 12 of the 13 clinical staff checked. We were told that the practice was waiting for confirmation from a previous employer for one member of staff.	The practice must ensure that all relevant staff have the appropriate hepatitis B immunisation status and a copy kept on file.	Management to ensure copies of existing evidence of hepatitis B immunisation status are on all individual staff files. Hepatitis B status is already discussed as part of the induction process, and anyone who wants to be vaccinated will be offered a time with the Practice nurse. The staff handbook will be amended to	GP Partners	1 month – 12/8/2024

		state that staff need to inform management when they have been vaccinated.		
We reviewed the practice complaints folder, however we noted that the paper records were not all kept in the same place. Additionally, themes were not identified and the initial complaint itself was sometimes missing from the notes.	The practice must ensure that all complaints received are filed in accordance with practice policy, with full details of the complaint, investigation and resolution recorded, and themes identified where possible.	Our complaints process has now been reviewed and changes implemented. The complaints team are now keeping hard copies of all aspects of the complaint and themes will be reviewed quarterly. Discussing complaints has been permanently added to the agenda for team meetings, so these will be discussed at practice level regularly.	Senior GP Partner/Complaints Lead	Completed
The practice did not have a Duty of Candour policy in place and staff had not completed online training on the subject.	The practice must: • Develop a Duty of Candour policy in line with the guidance and ensure all staff have read and understood this policy	The management team will develop a duty of candour policy, and then ask all staff to read and sign to confirm they understand the policy. Protected training time will be scheduled for the 5 staff	GP Partners	3 months – 12/10/2024

	• Ensure staff complete appropriate Duty of Candour training and provide HIW with evidence when completed.	members outstanding their training.		
We could not see any evidence that learning from significant events was disseminated to staff.	We recommend that: • The practice conducts reviews of significant events on a more regular basis • Any learning from reviews is discussed formally and suitably documented and disseminated.	Reviews of significant events has been added as a permanent topic on our team meeting agenda, which means it will be discussed at every team meeting and any learning will be available in the team minutes, which are available to all staff via the TEAMS channels.	GP Partners	Completed and ongoing
We did not see a structured system of audit to ensure compliance with practice policies and procedures.	The practice must implement a structured system of clinical audits to help improve quality of patient care.	Each quarter, one team meeting will be dedicated to reviewing quality improvement projects and clinical audits (approximately 2 per quarter). The information will be saved to the shared drive, so it is available for all staff.	GP Partners	3 months – 12/10/2024

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

Service representative:

Name (print): Dr Simon Lawson

Job role: GP Partner

Date: 10/07/2024