Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report (Announced)

Cardiff Bay Surgery, Butetown, Cardiff and Vale University Health Board

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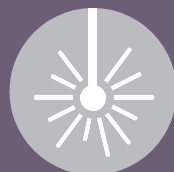

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

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

Our values

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

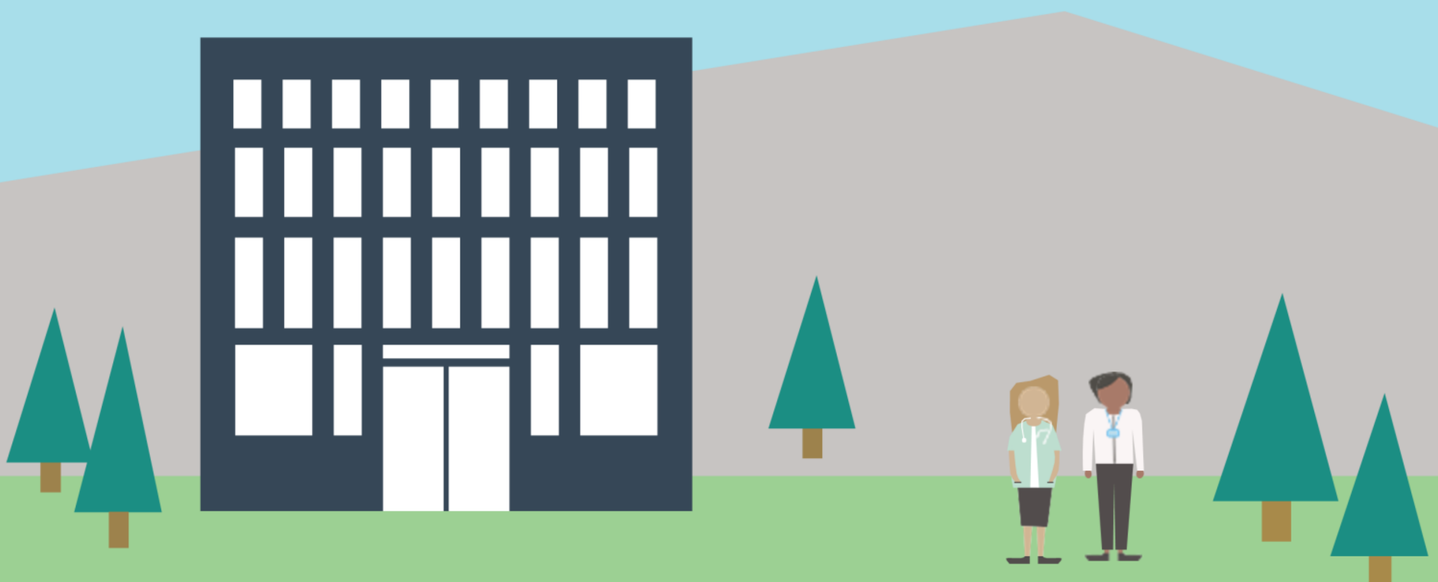
- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and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

Our goal

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

Our priorities

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



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1. What we did

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

Healthcare Inspectorate Wales (HIW) completed an announced inspection of Cardiff Bay Surgery, Butetown Branch, Cardiff and Vale University Health Board on 05 November 2024.

Our team for the inspection comprised of two HIW healthcare inspectors and three clinical peer reviewers.

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of 12 questionnaires were completed by patients or their carers and none were completed by staff. Feedback and some of the comments from patients appear throughout the report.

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

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

2. Summary of inspection

Quality of Patient Experience

Overall summary:

The patient feedback about Cardiff Bay Surgery, Butetown practice, gathered through a questionnaire, was largely positive. Most rated the service as 'very good' or 'good'. Patients praised the helpfulness and politeness of the receptionists and doctors. The practice promotes health through various initiatives and provides accessible facilities for self-monitoring health metrics. Efforts to engage with the local community, including health sessions in mosques, were noted positively.

Patients felt respected and their privacy maintained, with chaperones available when needed. While most patients could get timely appointments, some expressed dissatisfaction with appointment access and communication. The practice was advised to address these concerns.

Communication was clear, with information available in multiple languages, though the practice was urged to update its accessibility information and promote bilingual services for Welsh speakers. Equality and diversity policies were in place, but mandatory training for staff needed improvement. The practice was accessible to patients with mobility needs.

This is what we recommend the service can improve:

- The practice must review and update the accessibility information on the practice website
- Take action to improve the experience of patients calling for appointments
- Ensure that the active offer of Welsh is promoted to patients.

This is what the service did well:

- Supporting self-monitoring of health (weight and blood pressure)
- Engaging with the local community around health promotion
- Kind and caring staff.

Delivery of Safe and Effective Care

Overall summary:
The practice is clean, modern, and well-maintained, with processes in place to protect health, safety, and wellbeing. However, infection prevention and control (IPC) governance and training needed improvement. Some safe prescribing processes were in place, but there was no policy or process in place for managing blank prescription forms. Safeguarding policies needed formalisation, and not all

staff had completed required training. Expired clinical items were found in clinical areas, therefore governance around this needs strengthening. Effective processes support safe and effective care, with good examples of patient-centred decision-making. Regular audits and systems for learning from significant events are in place. Patient records are secure and well-maintained, but there are inconsistencies in Read coding.

Immediate assurances:

- Safeguarding policies and processes including mandatory training compliance
- Management of expired items within the clinical areas
- Safety and management of blank prescriptions.

This is what we recommend the service can improve:

- Formalisation of supervision of non-medical prescribers
- Review IPC training levels and arrangements
- Audit patient records.

This is what the service did well:

- Well maintained, clean and modern building
- Learning from incidents.

Quality of Management and Leadership

Overall summary:
A new leadership team was established following the retirement of longstanding staff members. Most staff felt supported and able to approach leaders with concerns. However, meeting minutes lacked a comprehensive action log, and policies and procedures needed better document control and regular updates to match the practice's specific needs.

The practice serves 9,000 patients across two sites, but leaders were challenged with staffing levels and recruitment. There was no system to monitor mandatory training compliance, and recruitment policies were limited, with inconsistent DBS checks posing potential risks.

Patient feedback was regularly sought, but there was a need for more transparency on actions taken from this feedback. An effective complaints process was in place. The practice adhered to GDPR, ensuring patient information is stored securely. Staff engaged in quality improvement activities and cluster-wide projects, demonstrating innovation in care delivery.

Partnership working was evident through collaboration within a GP cluster, and there were opportunities to deepen community links. Recommendations included adding an action log to meeting minutes, strengthening document control, reviewing staffing levels, implementing a system for monitoring training compliance, ensuring consistent DBS checks, increasing transparency on patient feedback actions, and improving links with co-located agencies.

Immediate assurances:

- Consistent completion and logging of Disclosure and Barring Service (DBS) checks for all staff.

This is what we recommend the service can improve:

- Review and improve meeting minutes
- Strengthen document control systems
- Review staffing levels
- Review mandatory training compliance and implement a system for monitoring.

This is what the service did well:

- Comprehensive complaints monitoring system
- Information governance.

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

HIW issued a questionnaire to obtain patient views on the care at Cardiff Bay Surgery, Butetown practice. In total, we received 12 responses, which were mostly positive across all areas, and rated the service as 'very good' or 'good'.

Patient comments included:

> *"The Receptionist was always helpful and served kindly."*

> *"The receptionist at Cardiff Bay Surgery and the group of doctors have always been very polite, well-mannered and respectful of my needs, they have always listened to my concerns and have addressed them appropriately."*

Person-centred

Health promotion

Information relating to health and wellbeing was available at the practice. Notice boards and the information screen within reception displayed a wide range of health promotion initiatives, which included smoking cessation, alcohol reduction and healthy eating.

Responses to our patient questionnaire confirmed that health promotion and patient information material was on display at the practice. Additionally, staff told us that the practice offered health promotion advice and information about chronic conditions to patients.

A room was available next to reception where patients were able to use the weighing scales and blood pressure machine, their results are then passed to reception staff to record in their records. This is an area of noteworthy practice, since patients can access this anytime the surgery is open. Patients would benefit from increased awareness of this service and a notice with clear instructions.

We were told about a range of initiatives undertaken by the GP to engage actively with the local diverse community. Health promotion sessions were delivered in local mosques around many health issues, including men's mental health. **This was viewed as notable good practice.**

Dignified and respectful care

There were suitable arrangements in place to maintain patient privacy and dignity. We noted staff maintaining this by closing or locking doors, and staff were treating patients with courtesy, respect, and kindness.

In our questionnaire, most respondents agreed that:

- Staff treated them with dignity and respect
- Measures were taken to protect their privacy
- Staff listened to them.

The practice offered chaperones in all appropriate circumstances, we reviewed training records that confirmed staff were trained, and there was a sign displayed on the screen regarding the availability of chaperones.

Timely

Timely care

There were processes in place to ensure patients could access care in a timely manner, and with the most appropriate person.

Staff described the arrangements for patients to access services and confirmed that if appropriate, appointments may be available in the main practice if there none were available in the Butetown branch.

We saw evidence of the practice manager monitoring patient satisfaction levels with appointment access and timely care. This highlighted that some patients were unhappy with access to appointments and included actions for improving patient access. Many respondents to the patient questionnaire confirmed that they were able to get a same-day appointment if urgent, and all but two said they could get routine appointments when needed.

Some patients commented on access to appointments, these included:

> *"Need longer opening hours closes at 1pm."*
>
> *"They lack coordination and communication. It has two branches, but their online appointments don't specify which branch."*
>
> *"I called on the phone for a GP appointment. I was offered a ten minute call two weeks later."*

The practice must consider the patient comments we received and where necessary, take action to improve the experience of patients calling for appointments.

Equitable

Communication and language
We found that staff communicated in a clear manner and in language appropriate to patient needs. They also provided information in a way that enabled patients to make informed decisions about their care.

Patients were usually informed about the services offered at the practice through the website and by sharing information and updates via a text messaging service. Whilst the website was available in many different languages, there was accessibility information on the practice website that had not been updated.

The practice must review and update the accessibility information on the practice website.

Where patients were known not to have a mobile phone, letters would be sent to individuals, and communication through telephone calls.

The practice serves a diverse community and staff confirmed that language and translation support were used as needed, to support patients to communicate effectively.

We were told that there were very few Welsh speaking patients and no staff who spoke Welsh. As part of the "active offer" for Welsh patients, all practice information and signs should be bilingual. We saw that some signs and posters were available in Welsh, however, the practice information leaflet was available in English only.

The practice manager should ensure that the active offer of Welsh is promoted to patients.

Rights and equality
Equality and diversity were promoted through both Antidiscrimination and Equal Opportunities policies.

We were told that mandatory Equality and Diversity training was not in place for all staff at the time of inspection, and staff were not able to confirm who, if any had attended this training.

The practice must ensure that staff are supported to complete Equality and Diversity training, and that a record is kept to evidence completion.

The practice was accessible to patients with a range of mobility and access needs. The practice and consulting rooms were accessed via a lift from the ground floor. There were wide doorways in place to support wheelchair access, and the patient self service check-in facility was available in multiple languages.

Delivery of Safe and Effective Care

Safe

Risk management
The practice was clean and tidy, modern, free of clutter and in a good state of repair. There were also processes in place to protect the health, safety and wellbeing of all who used the practice services.

We reviewed the practice business continuity plan dated March 2024. This covered the business partnership risk, pandemic risk and appropriately detailed contingencies for long-term sickness absence.

Infection, prevention and control (IPC) and decontamination
There were some policies and procedures in place in to protect patients, staff and visitors at the practice. Whilst no specific IPC concerns were seen, there were some areas where IPC governance and training could be further strengthened.

There was an IPC lead in place at the practice, however they had not completed the two-day IPC course and was not responsible for all IPC issues.
There was no record maintained of staff who had completed IPC training or when it required updating.

The practice must ensure all staff are supported to complete IPC training relevant to their role, and that a record is kept to evidence completion.

We reviewed an IPC audit and found improvements could be made to make it clearer and more effective.

The IPC audit template must be reviewed and updated to ensure it includes all areas within the practice. In addition, areas for improvement should be recorded and include action points and dates for completion.

We found a record was in place to evidence that clinical staff had received their Hepatitis B vaccinations and immunity response.

We reviewed cleaning schedules, and these were appropriate and up to date.

Medicines management
Processes were in place to ensure the safe prescribing of medication. The process for patients requesting repeat medication was clear, and this could be done via my health online, through nominated pharmacy repeat prescription requests, and personal requests at the practice. Patient medication review audits were undertaken, and medications no longer taken by a patient were removed from their repeat prescription list.

We reviewed the processes in place for the security of blank prescription forms. Practice leaders confirmed there was no process in place to monitor the allocation of prescription pads to prescribers, nor did they record the serial numbers of blank prescription forms. In addition, there was no formal process or policy in place to support the management of blank prescription forms. The issues around blank prescription forms were addressed under our immediate assurance process at Appendix B.

We reviewed the prescribing arrangements in place for the pharmacist who was a non-medical prescriber. Whilst leaders confirmed that regular meetings were in place to review these arrangements, the process was not formalised and there was no formal review and audit process to monitor non-medical prescribers.

The practice must implement a formal process to review and support the prescribing practices of all non-medical prescribers.

Safeguarding of children and adults
We considered the processes in place for safeguarding children and vulnerable adults, however, these were informal and not robust.

During the inspection, practice leaders were unable to provide evidence to confirm that all staff had completed safeguarding training relevant to their role. Additionally, the safeguarding policy did not identify the designated safeguarding lead, and some staff we spoke with were not able to confirm who the designated safeguarding lead at the practice was. This posed a potential risk to the safety and wellbeing of patients.

The issues we identified with safeguarding were addressed under our immediate assurance process, highlighted in Appendix B.

There was a process in place for following up on children not brought to appointments, however children at risk/looked after children were not appropriately Read coded on the electronic care record system, to immediately identify those at risk. We were also told that regular safeguarding meetings had not taken place in recent months.

The practice must ensure:

- **Safeguarding policies and procedures are robust and align to the Wales Safeguarding Procedures**
- **Safeguarding meetings should be held regularly**
- **Read codes are used appropriately to identify children at risk and care experienced children.**

Management of medical devices and equipment
The practice had some processes in place to safely maintain medical devices and equipment.

This included maintenance contracts in place for maintenance and calibration of equipment as appropriate, and for emergency repairs or equipment replacement.

There were appropriate resuscitation equipment and emergency drugs in place to manage a patient emergency, such as cardiac arrest. These met the primary care equipment standards as outlined by the Resuscitation Council UK guidance. We reviewed processes in place for checking and replacement of all resuscitation equipment, and relevant emergency drugs, and portable oxygen. The checks were completed and recorded regularly.

It was not evident where emergency equipment is stored within the practice, which poses a risk if using locum staff.

The practice manager should consider placing a notice in the relevant storage area of emergency equipment, to ensure it is swiftly located in a patient emergency.

We found clinical items which had passed their expiry dates within clinical areas, such as bandages, syringes, gloves, stitch cutters/removers and needles. This posed and infection risk if unsterile items are used to treat patients. This issue was dealt with under our immediate assurance process highlighted in Appendix B.

Effective

Effective care
Processes were in place to promote safe and effective care, and included the provision of treatment or care at the main GP surgery when the branch surgery had no capacity or is closed. We found good examples of acute and chronic illness management, and a clear narrative with evidence of patient centred decision making.

Staff also described appropriate systems for reporting and leaning from significant events and from audit activity, such as improving practice following antibiotic audits.

Clinical staff confirmed during interviews that a comprehensive process was in place to share and receive new evidence-based practice and updated or new NICE guidance.

Patient records

At the time of inspection, preparations were being made to migrate the patient IT system to a new system.

We reviewed a sample of ten electronic patient records. These were stored securely and were password protected from unauthorised access. The records were clear, written to a good standard and completed with appropriate information. Record entries were contemporaneous and were easy to understand by other clinicians. Read codes were mostly used well and were appropriate for a patient's clinical condition, although some inconsistencies were seen in the way that different clinicians Read coded.

The practice must audit patient records and Read coding use, to ensure a consistent approach in recording information.

Quality of Management and Leadership

Leadership

Governance and leadership
A relatively new leadership team was in place, following the retirement of some longstanding members of staff.

Most staff we spoke with felt supported and able to approach leaders with any concerns and felt these would be addressed appropriately. Leaders confirmed that an open-door policy was in place to enable staff to share concerns and ideas for the practice.

The practice manager provided us with minutes and information following staff meetings and informed us that these can be accessed through their emails or the shared drive. The meeting minutes we reviewed did not include a record of actions, where applicable, to enable action owners to understand what was required of them.

The practice should consider including an action log on meeting minutes to effectively allocate and monitor actions appropriately.

We reviewed the recently updated policies and procedures, and were told they were accessible to all staff. There were, however, limited document control systems in place, and some policies had not been implemented to align with the specific needs of the practice.

The practice must strengthen governance arrangements to include robust document control and review process, to ensure all policies and procedures are in date, reviewed regularly, are available to staff and relevant to the practice.

Workforce

Skilled and enabled workforce
The practice was busy with 9,000 patients across two sites. Staff told us that they had struggled to recruit clinical staff and were actively recruiting to practice nurse vacancies. We noted that a receptionist had commenced training as a Healthcare Assistant, which demonstrated a commitment to staff development and retention. Staffing levels appeared low for the patient population, and increased staffing levels would allow for greater delegation of duties.

The practice should review the staff establishment to ensure staff numbers are appropriate to manage the volume of patients and is in line best practice/ guidance.

There was no process in place to monitor staff compliance with mandatory training. Implementing a training matrix would easily identify training compliance and those due to complete update training. Therefore, during inspection, it was not possible to confirm staff training compliance during the inspection.

The practice must ensure staff are supported to attend mandatory training and should implement a system to record compliance.

There were limited recruitment policies and procedures in place neither was there evidence recorded to confirm that Disclosure and Barring Service (DBS) checks had been completed at the required level for all practice staff. This posed a potential risk to the safety and wellbeing of patients. The DBS completion and monitoring requirement for staff was addressed under our immediate assurance process at Appendix B.

Culture

People engagement, feedback and learning
The practice regularly sought patient feedback, and we found examples where action and learning took place. Information was displayed in all areas detailing how people could feedback on their experiences. There was no information available detailing how concerns and comments from people have been used to develop and improve the service.

The practice should consider adding a "You said, we did" information board/ poster, for patients to demonstrate actions taken as a result of feedback received.

An effective complaints process and tracking system was in place to monitor, review and resolve complaints and feedback. This was aligned to the NHS Wales Putting Things Right process.

Information

Information governance and digital technology
The inspection team considered the arrangements for maintaining patient confidentiality and adherence to Information Governance and the General Data Protection Regulations (GDPR) 2018 at the practice. We saw evidence of patient information being stored securely.

Learning, improvement and research

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

Whole-systems approach

Partnership working and development
We found evidence of partnership working with the practice's collaboration within the GP cluster. Medical staff attended cluster meetings and provided services on a cluster wide basis.

The practice is located in the heart of the community with a wide variety of other services located within the same building. Therefore, additional opportunities are present for the practice to strengthen its links with the community.

The practice should consider how it can improve links with other agencies or services co-located on the same site.

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 resolved during this inspection			

Appendix B - Immediate improvement plan

Service: Cardiff Bay Surgery, Butetown Branch

Date of inspection: 5 November 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	Standard / Regulation	Service action	Responsible officer	Timescale
1.	During our inspection, we reviewed staff files, processes and documentation. There was no evidence available to confirm that Disclosure and Barring Service (DBS) checks were in place for all practice staff. This poses a potential risk to the safety and wellbeing of patients.	A robust system must be implemented in relation to the completion and monitoring of DBS checks for all staff. • Relevant DBS checks must be completed for all staff and maintained on file • DBS checks must be completed prior to employment, and evidence of this maintained on file Staff must annually confirm that the information on the DBS check remains accurate and that there have been no changes since this check.	Health and Care Quality Standards - Safe	• Applications for DBS checks have been submitted for staff members needing renewal or initial checks. • Staff files updated with DBS status. • DBS log created to review status expiry dates. Annual appraisal form updated with DBS status and confirmation of accurate DBS information and that	Practice Manager	Completed

				there have been no changes since this check.		
2.	During the inspection, practice leaders were unable to provide evidence to confirm that all staff had completed safeguarding training at the required levels. Additionally, the safeguarding policy in place at the practice did not identify the designated safeguarding lead, and some staff members that we spoke with were not able to confirm who the designated safeguarding lead at the practice was. This poses a potential risk to the safety and wellbeing of patients.	The practice must: • Review, update and communicate safeguarding policies and processes with all staff to ensure all are aware of how to raise a safeguarding concern • Ensure that all staff complete the relevant mandatory safeguarding training. • Implement a robust system for the monitoring of training compliance.	Health and Care Quality Standards - Safe	• Safeguarding policies have been reviewed, updated and published to ensure staff are aware of the safeguarding lead and how to raise a safeguarding concern. • All staff have now completed relevant mandatory safeguarding trainings. • A training matrix has been created, listing expired, required and completed trainings. • The following documents have been created/modified to ensure training compliance:	Practice Manager and GP partner	Completed

				Annual Appraisal Form Training Matrix Induction Programme		
3.	During the inspection HIW found expired items present within clinical areas that had not been removed from use. Expired items included: bandages, syringes, gloves, stitch removers and needles. If equipment is out-of-date, it may be unsafe. There is a risk to patient and staff safety if expired equipment is used.	The practice must: • Ensure all expired items are removed from clinical areas and disposed of in an appropriate manner • Develop, implement and maintain a robust system for the management of sterile materials	Health and Care Quality Standards – Safe (Devices)	• I can confirm that all expired items from clinical areas have been removed and disposed of in an appropriate manner. • Weekly checklists for clinical rooms for sterile items have been created and persons have been nominated (Reception staff SB & Practice Nurse in the absence of nominated staff) to complete the checklist once a week (Wednesday).	Practice nurse and practice manager	Completed

4.	During the inspection HIW reviewed processes in place to ensure the security of blank prescription forms. There was no process or policy in place related to the management of blank prescription forms. Practice leaders confirmed that they did not have a system in place to control and record prescription form movement. There was no routine system in place for the recording of serial numbers of blank prescription forms. Without sufficient measures in place, there is a risk of prescription form theft, fraud and misuse.	The practice must implement a robust and safe system and policy to ensure the security of blank prescription forms. This must include details of how the practice will • Prevent theft and misuse through secure storage • Develop an organisational policy outlining roles and responsibilities • Develop local action protocols outlining what actions to take in the case of loss, theft or missing prescription forms/paper Control and record prescription form movement, including recording serial numbers.	Health and Care Quality Standards – Safe	• A Prescription Security Protocol has been created and published to ensure the safety of blank prescription forms and pad. • The document includes the following details: Secure storage to prevent theft and misuse of prescriptions forms. Actions to take in the case of loss, theft or missing prescriptions or pad. • A prescription log has been created to record the following: Ordering and receiving of prescription forms. Serial numbers of prescription forms. Movement of prescription forms. Persons (KZ & SB, NH in absence of nominated persons) nominated for prescription	Practice manager and GP partner	Completed

			ordering, receipt and movement. • Old prescription pads from all clinicians have been taken and destroyed. • A new prescription pad has been requested which will be used when required.		

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): Abeeda Taj

Job role: **Abeeda Taj**

Date: **14 November 2024**

Appendix C - Improvement plan

Service: Cardiff Bay Surgery, Butetown Branch

Date of inspection: 5 November 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	Standard / Regulation	Service action	Responsible officer	Timescale
1.	Some patients told us that they had a poor experience when calling for appointments	The practice must consider the patient comments we received and where necessary, take action to improve the experience of patients calling for appointments	Health and Care Quality Standards - Timely	• To reduce wait times, we have recently introduced a callback feature for patients in the call queue. • To accommodate more patients, we have recently increased the number of appointments per day. We are currently organising customer service training for all	AT	April 2025

				staff to further enhance patient service.		
2.	The accessibility area of the practice website had not been updated	The practice must review and update the accessibility information on the practice website	Health and Care Quality Standards - Equitable	• We are reviewing the accessibility section of our website and will update it promptly.	EA	March 2025
3.	The active offer of Welsh for patients was not consistently promoted	The practice manager should ensure that the active offer of Welsh is promoted to patients	Health and Care Quality Standards - Equitable	• We are currently reviewing and updating our website to improve access to Welsh language content for users. • We are in the process of implementing a policy to make Welsh-speaking staff easily identifiable, such as by wearing a badge.	EA	March 2025

4.	Staff had not received Equality and Diversity training	The practice must ensure that mandatory training in Equality and Diversity takes place for all staff and a log of training completion is kept	Health and Care Quality Standards - Equitable	• Equality and Diversity training has been arranged for all staff. A training log has been created and will be regularly updated to track progress.	AT	February 2025
5.	The IPC lead has not received the 2 day IPC training	The practice must review and update mandatory IPC training requirements to ensure that all staff are trained at the appropriate level	Health and Care Quality Standards - Safe	• We are in the process of organising mandatory IPC training sessions for all staff.	AT	April 2025
6.	IPC audit reviewed lacked clarify	The IPC audit template must be reviewed and updated to ensure that it is practice wide, comprehensive and includes action points and dates	Health and Care Quality Standards - Safe	We are reviewing and updating our IPC audit templates to improve thoroughness, incorporating action points and deadlines/dates.	AT	April 2025
7.	Non-medical prescribers did not have a formal review	The practice must implement a formal process to review the prescribing practices of all non-medical prescribers	Health and Care Quality Standards - Safe	A formal review of non-medical prescriber has been scheduled and a process will be	AT	March 2025

				introduced shortly for regular reviews.		
8.	The practice has paused safeguarding meetings and were not Read coding children at risk / looked after children	The practice must review and improve all safeguarding policies and procedures including - reintroducing regular, minuted safeguarding meetings - Ensuring that children at risk and looked after children are appropriately Read coded	Health and Care Quality Standards - Safe	• Safeguarding policies and procedures will be reviewed and updated to ensure: Minuted safeguarding meetings are held regularly. Clinical notes for children at risk and looked-after children are Read coded appropriately.	All clinicians/AT	March 2025
9.	Emergency equipment location was not clearly signposted on the door	The practice manager should consider adding a sign to indicate where emergency equipment is kept ensuring it can be swiftly located in a patient emergency.	Health and Care Quality Standards - Safe	• Emergency equipment/ trolly locations are clearly marked with signs, ensuring swift identification and access during patient emergencies.	AT	Completed

10.	Inconsistencies between clinician Read coding was seen in some patient records	The practice must audit patient records and Read coding to ensure a consistent approach in recording	Health and Care Quality Standards - Safe	Regular audits of patient records will be conducted to ensure a consistent approach in Read coding.	EA/MAN/AAN	March 2025
11.	Meeting minutes did not include action logs	The practice should consider including an action log on meeting minutes to effectively track and allocate meeting actions appropriately	Health and Care Quality Standards - Effective	Already in place	AT	Completed
12.	Document control processes were inconsistent and not all policies and procedures were up to date and practice specific	The practice must strengthen governance arrangements to include sufficient document control and review process that ensures that all policies and procedures are up to date, reviewed regularly, available to staff and relevant to the practice	Health and Care Quality Standards - Effective	• An annual review of document control processes, training needs, and policies will be conducted each April to ensure that all policies and procedures are up-to-date, accessible to staff, and relevant to our practice.	AT	April 2025

13.	On review of staffing levels, these appeared low for the patient population served	The practice should review staffing levels with a view to ensuring staffing levels are in line best practice / guidance	Health and Care Quality Standards - Effective	• The in house HCA will begin training in Feb 2025. Aiming to hire a new practice nurse.	MAN/AAN/EA/AT	April 2025
14.	No system in place for the logging and monitoring of mandatory training courses	The practice must review and update the mandatory training courses for all staff and implement a system to ensure that mandatory training compliance can be reviewed, monitored and improved where necessary	Health and Care Quality Standards - Effective	A training log has been created and will be regularly updated to ensure continuous compliance with mandatory training requirements.	AT	Completed
15.	No information displayed on what the practice have done with complaints / comments received	The practice should consider adding "You said, we did" information for patients to demonstrate actions taken as a result of feedback received	Health and Care Quality Standards - Effective	We are in the process of creating a dedicated space on the website and in the waiting area to highlight the improvements made in response to patient feedback.	AT/EA	April 2025
16.	The practice is collocated with a range of health and social care services	The practice should consider improving links with other agencies co-located on the same site	Health and Care Quality Standards - Effective	In process of arranging meetings with co-located services	AT	April 2025

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

Service representative

Name (print): **Abeeda Taj**

Job role: **Practice Manager**

Date: **21st January 2025**