Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report
(Announced)

Dinas Powys Medical Centre, Cardiff & Vale Health Board

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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

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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.

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 Dinas Powys Medical Centre, Cardiff and Vale Health Board on 08 January 2025.

Our team for the inspection comprised of one 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 two questionnaires were completed by patients or their carers and two were completed by staff. Feedback and some of the comments we received appear throughout the report.

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

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

2. Summary of inspection

Quality of Patient Experience

Overall summary:
The findings from our patient questionnaires confirmed patients felt they were treated with dignity and respect, and all rated the service as ‘very good’ or ‘good’. During our inspection we witnessed staff speaking to patients and their carers in a polite and positive manner.

There were processes in place that enabled patients to access the right service at the right time. The practice ensured vulnerable patients receive timely care. This was supported by the Dinas Powys Voluntary Concern, which can provide transport and practice information to patients via their magazine. We recognised this as good practice.

There was good access into the premises allowing patients with impaired mobility and wheelchair users to easily access the facilities. The environment was clean and well maintained. The different types of chairs available in the waiting area is good practice as well as the dedicated ambulance access.

The service provided good patient access and had well-equipped waiting area facilities, including various seating options and blood pressure monitoring equipment. The staff ensured that patients felt they were treated with dignity and respect and the service maintained a strong relationship with the Dinas Powys Voluntary Concern group, which offers transport and practice information through their magazine.

The chaperone policy should be updated to ensure that all tasks required to be completed by the chaperone, are being properly recorded. Additionally, an access policy should be introduced, providing more detailed information about the types of appointments available and how these can be accessed. A patient pathway policy should also be implemented to support the current care navigation process in place.

Delivery of Safe and Effective Care

Overall summary:
Our findings demonstrated a dedicated and enthusiastic clinical team who worked hard to provide patients with safe and effective care.

There were processes in place to protect the health, safety and wellbeing of all who used the service, including within clinical rooms. The practice was clean and tidy, free of clutter and in a good state of repair.

The practice demonstrated good cluster cooperation to ensure patient care could continue in the event of an extreme situation.

There was an appropriate mechanism in place should help be urgently required within the practice. The emergency drugs and equipment were stored appropriately, and staff were able to locate this in an emergency. All the emergency drugs and equipment in place meets the standards of the resuscitation council UK guidelines. A named person is responsible for checking these on a weekly basis and the checks are documented.

The IPC arrangements in place were appropriate. The procedures in place ensured the practice upholds the required standards of IPC to maintain the safety of staff and patients. We found staff understood their roles and responsibilities in upholding IPC standards and nursing staff were up to date with their training.

Daily temperature checks were taking place for medicines that require refrigeration. The fridges we checked had good air circulation due to the appropriate storage of the medicines as per the manufacturer’s guidelines.

The safeguarding procedures in place were satisfactory with a policy in place and named safeguard leads at the practice. We found that the level of safeguarding training appropriate to staff roles, and as listed in the policy, did not match the staff training records.

The patient medical notes were clear, written to a good standard and complete with appropriate information. We found there were a lack of management plans in the records we looked at and the use of clinical Read codes were not being used consistently.

Responses from staff who completed the questionnaire were positive. All staff felt that the care of patients was this practice's top priority, and they all were content with the efforts of the practice to keep staff and patients safe.

Quality of Management and Leadership

Overall summary:
There were processes in place to support effective governance, leadership and accountability, to ensure a sustainable delivery of safe and effective care. Staff

were clear about their roles, responsibilities and reporting lines and the importance of working within their scope of practice.

The practice had a suite of relevant policies and procedures and there were processes in place to share any information updates with staff.

We found there was an appropriate skill mix across the teams to deliver the services required and the practice had a process in place for ensuring staff numbers and clinical staff levels are maintained.

A review of staff training highlighted that a training matrix should be developed and maintained to have an overall picture of training compliance. We found that staff records had to be searched to identify compliance with mandatory training. We were told that due to GP appraisals and revalidations, doctors keep their certificates and therefore limited evidence was available in their files. A training matrix will enable the practice to ensure compliance can be monitored effectively and to ensure staff skills and knowledge are up to date in line with their role.

We were assured that staff would be supported to raise a concern should the need arise, and we were provided with the practice whistleblowing policy.

Staff members were friendly and engaged well with both patients and each other. The practice demonstrated a strong understanding of their responsibilities in processing information, ensuring that data was managed in a safe and secure manner. Additionally, there were commendable collaborative relationships established with external partners and within the cluster.

3. What we found

Quality of Patient Experience

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 website. We saw health promotion information on a variety of topics including vaccinations, screenings, support groups and carers information.

The waiting area had a blood pressure monitor and weighing scales which patients can use without the need for an appointment. Print out results from the blood pressure monitor can be taken to reception for the information to be added to the patients record. The area was protected by a privacy screen and instructions and antibacterial wipes were available.

We were told the practice engaged with several agencies to improve access to various healthcare professionals via their cluster group and the Dinas Powys voluntary concern. In addition to access to physiotherapy, mental health services and pharmacists, we recognised the voluntary group provided an excellent service to patients in the area, by providing transport to those who have none. We were told they played an important role in the recent flu vaccination programme, by promoting and assisting patients to the surgery for their vaccinations. This enables patients to access help and support from other agencies in a timely manner.

The process and preparations by the practice to manage the annual winter vaccination programme were suitable and included arrangements for vulnerable and care home residents and those without digital access. The assistance of the Dinas Powys voluntary concerns group ensured patients without transport were able to attend appointments.

Staff at the practice work closely with their patient group to ensure they receive the right care from the right services. To ensure vulnerable patients receive timely care, the practice has a home care provision; ensuring patients with chronic diseases and housebound patients receive appropriate health checks and vaccinations specific to their needs. We recognised the home care service as going an extra mile for this patient group.

The ‘was not brought’ procedure was included within the ‘did not attend’ policy. Staff confirmed that any person who misses two appointments receives a letter, including any children who do not attend their appointments in the practice or at the local hospital. The policy and system in place to manage these patients was appropriate.

The respondents to the HIW patient questionnaire told us there was health promotion information on display at the practice and told us they were offered healthy lifestyle advice. All patients agreed that their GP explained things well to them and answered their questions. All patients said they felt listened to and they were involved as much as they wanted to be in decisions about their healthcare.

Dignified and respectful care

We found patients were treated with dignity and respect throughout their patient journey. Clinical rooms provided patients with an appropriate level of privacy, with doors kept closed during consultations. Privacy curtains were also available. The practice had a dedicated access for ambulances. In an emergency, clinicians can transport patients via this access instead of them having to go through the waiting area.

All respondents to the patient questionnaire felt they were treated with dignity and respect, and that measures were taken to protect their privacy.

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. The reception desk is located near the entrance with patient seating situated opposite, which offered some level of privacy from the waiting area.

The patient who responded in the questionnaire regarding their ability to talk to reception staff without being overheard; disagreed.

We saw notices displayed offering a chaperone service. The surgery offered male and female chaperones and patients could request one at any time. A chaperone policy was in place. We found that chaperones were not making notes in patient records as per the policy, we therefore recommended the practice review the policy and process to ensure they align.

The practice must review the chaperone policy to ensure the tasks required to be completed by the chaperone are being recorded.

Timely

Timely care

There were processes in place to ensure patients could access the right service at the right time and in a timely manner. Appointments were mostly made via telephone, but online booking and in-person appointments could also be made. Respondents to the survey told us one had made an appointment in person at the practice and another via telephone.

We were told that reception staff will explain to patients what options they have regarding the type of appointment. The decision as to whether an appointment is by telephone or face to face is determined by negotiation between the practice and patient, with the patients' wishes taking precedence. Children requiring a face-to-face appointment are accommodated.

We found that information about accessing appointments required updating, specifically on the website. There was no practice access policy in place, and we recommended one is introduced, which details the appointments and how they can be accessed. It must include all appointment types at the practice.

The practice must update their website regarding accessing appointments and introduce an access policy, detailing how appointments can be accessed and the types available.

We found the care navigators had a good pathway in place, assigning patients to the most appropriate person or service. The pathway was available to all staff, and the care navigators had access to the on-call doctor who was available to provide guidance as necessary. Staff signpost people to appropriate services using their pathway and made good use of cluster-based support services. There was no policy in place to support the pathway process and we recommended one is implemented.

The practice must implement a pathway process policy to support the care navigation process in place.

There were suitable processes in place to support patients in a mental health crisis. Where appropriate, patients are referred to the community mental health team. Alternative support and signposting were also available for patients needing mental health support, including counselling and therapy services from third sector services and mental health staff via the cluster group.

In response to the HIW questionnaire, all patients agreed:

- they were satisfied with the opening hours of the practice

- they were able to contact the practice when they need to by phone/online booking system
- they were able to have a same-day appointment when they need to see a GP urgently.

Equitable

Communication and language
We found staff communicating in a clear manner and in a language appropriate to patient needs. They provided information in a way that enabled patients to make informed decisions about their care. The surgery also had a hearing loop to support those hard of hearing.

The practice had one Welsh speaking doctor, and a notice was displayed in the waiting area informing patients of this service. We were told very few patients requested services in Welsh, however the practice had access to translation services to support any patients who require services in a different language.

Patients are usually informed about the services offered at the practice through the website, social media, and by sharing information and updates via a text messaging service. Where patients are known not to have digital access, letters would be sent to individuals, and communication through telephone calls. The practice has a good relationship with Dinas Powys voluntary concern group and can publish articles in their newsletter. This enables those without digital access to keep up to date with practice information.

There were appropriate processes in place for the recording and action of information from secondary care. Letters and documents are scanned onto patient notes and directed to the correct health care practitioner to action as required. From the notes observed, we saw healthcare staff had provided information to patients in a way that met their individual needs.

The practice ensured messages were communicated internally to the appropriate people, by using the practices communication and technology (ICT) systems. Staff told us emails were the preferred option because the read receipt ensured communications were read, and where applicable, acted upon.

We found there was no workflow policy and recommended one is put in place. At the time of the visit, staff organise letters and decide which are sent to the doctors for review. A policy would make it clear what information should be forwarded to clinicians and what can be filed.

We found the process and management for following up results was excellent and involved a whole team approach. The system identifies patients requiring follow up appointments, and if a patient misses three of these, it is passed back to the clinician. We identified this as good practice and an effective way of following up on a process that is not straight forward.

Rights and equality
The practice offered good access for patients. All patient facilities, including the treatment rooms, baby changing and an accessible toilet were located on the ground floor. The waiting area had sufficient seating including bariatric and high-leg chairs to help assist with any mobility issues. The reception area had a lowered desk to aid access for patients in wheelchairs.

Patients responding to our questionnaire thought the building was easily accessible and had enough seats in the waiting area.

The practice had a carers champion and information was clearly displayed in the waiting area. This initiative is good practice to help assist carers find support and information.

We saw evidence of an equality and diversity policy in place, and staff had completed equality and diversity training. All respondents who answered the question confirmed they had not faced discrimination when accessing or using this health service.

The rights of transgender patients were also upheld, staff confirmed that preferred pronouns and names were used from the outset of transition.

Delivery of Safe and Effective Care

Safe

Risk management
There were processes in place to protect the health, safety and wellbeing of all who used the service, including within clinical rooms. The practice was clean and tidy, free of clutter and in a good state of repair.

A business continuity plan (BCP) was in place and readily available for all staff. We found the BCP did not include information regarding the business partnership risk, and whilst we recognised the limited risk at the time of our visit, we recommend this is included. The policy adequately covered how the practice would deal with a significant health emergency and referred to additional policies.

The practice must update their business continuity plan to include business partnership risk.

The practice demonstrated good cluster cooperation to ensure patient care could continue in the event of an extreme situation.

We saw how patient safety alerts were received and disseminated to the practice and communicated in meetings. The process in place for managing patient safety alerts and significant incidents was robust. We recommended a significant events policy is implemented to support the significant events protocols and process.

The practice must implement a significant events policy to support the protocols and process used at the practice.

There was an appropriate mechanism in place should help be urgently required within the practice. The emergency drugs and equipment were stored appropriately, and staff were able to locate this in an emergency.

We were told in the event of a patient facing a lengthy wait for an ambulance, doctors would assess the suitability of alternative transport against the urgency of the case.

Infection, prevention and control (IPC) and decontamination
Overall, the IPC arrangements in place were appropriate. The procedures in place ensured the practice upholds the required standards of IPC to maintain the safety of staff and patients.

An IPC policy was in place and all staff had access to this. The practice had a named nurse identified as the IPC lead.

We found staff understood their roles and responsibilities in upholding IPC standards and nursing staff were up to date with their training. Records confirmed all relevant clinical staff had Hepatitis B immunity, and flu vaccines were offered to staff.

A needlestick policy was in place and staff had access to this. The process staff follow should they sustain a needlestick injury was described to us and reflected what the policy included. There were no needlestick advice posters displayed on the walls, and we recommended these are displayed in each clinical room.

The practice must ensure that a needlestick injury advice notice is implemented and displayed in each clinical room.

Appropriate procedures were in place for the management and disposal of all waste, and a policy was in place to support this. We found sharps bins were locked and signed, and waste bags closed and labelled. Waste was stored appropriately in a locked cupboard. On the day of our visit, there was only one hygiene bin available at the practice. A change in contract had resulted in the delay of bins being delivered. This was raised at the time and confirmation was given the following day to confirm hygiene bins had been delivered and suitably located throughout the practice.

Suitable arrangements were in place to segregate people with transmissible infections to reduce the risk of cross infection. Patients responding to the questionnaire agreed there were signs at the entrance explaining what to do if they had a contagious infection.

The IPC policy stated an IPC audit would be completed every 12 months and the audit documentation confirmed this.

The practice had a cleaning contract in place and cleaning schedules were visible. The cupboard used to store cleaning materials and equipment was clean and well organised. COSHH signs were displayed and a safety file on the chemicals within the cleaning cupboard was available.

The patients responding to the questionnaire felt there were hand sanitizers available, and those that answered the question said in their opinion the practice was very clean.

Medicines management
Processes were in place to ensure the safe prescribing of medication. We saw prescriptions were kept securely and any unused prescription pads are destroyed by the practice or returned to the health board for appropriate disposal and prevention of unauthorised use.

We were told there was an audit trail in place for controlled drugs for when these are collected. There was no audit trail in place for the remaining scripts due to the time the process takes.

The process for patients to request repeat medication was clear. Staff told us that patients can order prescriptions online, via email and the pharmacy. Prescriptions were processed in a timely manner by the pharmacy technician and authorised by a doctor. We saw a prescribing policy was in place and available to staff.

A medication cold chain policy was in place for medicines and vaccines that require refrigeration, and clinical refrigerators were used to store them as appropriate. Daily temperature checks were completed and recorded. The fridges we checked had good air circulation due to the appropriate storage of the medicines as per the manufacturer's guidelines.

Staff were knowledgeable of the procedure they followed in a recent cold chain breach which was appropriately escalated. The lessons learnt from this breach has resulted in the fridges being checked three times a day and the room temperature checked and recorded daily.

The drugs we checked during the inspection were all in date. The practice had a nominated person responsible for checking the drugs on a weekly basis, and the nursing staff were aware of who this is and take responsibility for checking. Records were kept evidencing the drugs and their expiry dates.

All the emergency drugs and equipment in place met the standards of the UK resuscitation council guidelines. A named person is responsible for checking these on a weekly basis and the checks are documented. The recording of the emergency drugs and equipment also included expiry dates.

An automated external defibrillator (AED) was in place and was fully charged. A spare battery pack was also available. We found the AED had pads for both adults and children. All staff knew the location of the AED, but there was no sign on the room to indicate this. The practice might want to consider implementing a notice to indicate its location.

We saw that oxygen cylinders were in date, with appropriate stock levels and arrangements were in place for reporting any incidents. We were told all clinical staff were aware of how to turn on the oxygen cylinder and training is delivered as part of the CPR training.

No controlled drugs are kept at the practice.

Safeguarding of children and adults
We considered the safeguarding procedures in place at the practice and found the policy included both adults and children. The policy referenced the national Wales safeguarding procedures and was available for all staff on the shared drive. The practice had named safeguarding leads which were recorded in the policy.

The safeguard lead named in the policy was unaware they were the principal person. Staff were aware of the procedures to follow in the event of a safeguarding incident and did name the doctor as their safeguarding lead.

The practice must ensure named safeguarding leads know about their responsibilities. Any changes to this must be communicated to all staff and documents updated.

There were processes in place to monitor patients, including children and vulnerable or at-risk groups, for their attendance at emergency departments in addition to the 'did not attend/was not brought' policy. Letters for those not attending appointments are sent to doctors for review.

The multi-agency safeguarding meeting was due to re-start at the end of January. Health visitors at the practice will approach doctors as and when needed. Palliative care meetings take place regularly with multidisciplinary attendance. These measures help to ensure that people and staff can report safeguarding concerns, and necessary actions can be taken to protect the welfare of vulnerable patients.

We found that the level of safeguarding training relevant to staff roles, and as listed in the policy, did not correlate with staff records.

The practice must ensure all staff undertake the required level of safeguarding training (both children and adult) appropriate to their role, and a record should be kept to evidence this.

Management of medical devices and equipment
We found medical devices and equipment were in good condition, safe to use and had been appropriately checked. Suitable contracts were in place for the repair or

replacement of relevant equipment. Single use items were used where appropriate and disposed of correctly.

Effective

Effective care

Suitable processes were in place to support the safe, effective treatment and care for patients. We were told that any changes or new guidance is emailed and discussed with staff and the information is stored on the shared drive where all staff can access.

Appropriate processes were in place for reporting incidents, including completing forms, discussions at internal meetings, and reviewing them after a period of time. This system helps improve processes and safer procedures. We recommended a significant event policy is put in place to support the processes followed by staff.

Patient referrals were managed to a good standard, including those which are urgent. Patient records contained investigation/ test results and had narrative as to why investigations were requested.

Patients in need of urgent medical help or those in a mental health crisis were provided with suitable support and information. The practice also has access to a mental health nurse. Doctors provide support for people who have contacted the practice in crisis. Correspondence is provided to the practice from the local mental health crisis team if a patient has previously received intervention for their mental health needs.

Patient records

We reviewed ten electronic patient records, which were stored securely and were password protected from unauthorised access. Overall, the records were clear, written to a good standard, and complete with appropriate information. They were contemporaneous and information was easy to understand for other clinicians reviewing the records. However, we found there were a lack of management plans in the records we looked at.

The practice must ensure that where appropriate, management plans are included in patient records.

We found the use of clinical Read codes were not being used consistently, which makes analysis and audit difficult. The practice is scheduled to migrate their records to a new system, which will help mitigate this issue.

The patient records where chronic disease was recorded, contained a full summary of the condition/s, including all past and continuing problems as well as the medication being taken.

From the notes reviewed, we found that the patient's language choice was not always recorded.

The practice must ensure that patient language preference is recorded and easily identified in their clinical records.

Efficient

Efficient
We found that services were arranged in an efficient manner and are person centred, to ensure people feel empowered in their healthcare journey.

The practice can refer to physiotherapy and mental health services and most patients are able to self-refer for certain services.

There are close working relationships with district nurses and specific clinics for asthmatic and diabetic patients.

Quality of Management and Leadership

Staff feedback

We engaged with staff throughout the inspection, and within our survey, staff comments included:

> *"Good place to work, very busy but we are cared for and supported to do our job. It is very challenging since Covid – so busy and patients demands have increased and expectations sometimes not reasonable".*

> "A lovely place to work".

Leadership

Governance and leadership

There were processes in place to support effective governance, leadership and accountability, to ensure a sustainable delivery of safe and effective care. Staff were clear about their roles, responsibilities and reporting lines and the importance of working within their scope of practice.

The practice had a process in place for sharing information with staff, such as changes in policies or procedures. All policies and procedures were on the shared drive and all staff would be told about any changes via email, WhatsApp and through team meetings.

The document control on the polices we saw included a review date and approved by. Overall, the policies we reviewed were detailed and specific to the practice. Policies are saved on a shared drive which allows all staff access to them. Paper copies were available in the receptionist's area.

We found appropriate measures were in place to share any safety notices with staff.

We were told staff meetings were routine, however, there was no evidence of minutes for clinical meetings. Meetings should be documented to ensure information can be shared to those unable to attend. Any lessons to be learned are shared with staff to ensure the practice retains good service standards and improvements, where applicable.

The practice must document meeting minutes and ensure these are circulated to appropriate persons if they are unable to attend.

The practice worked closely within the Health Board cluster group and worked collaboratively to lead projects, share learning and jointly manage initiatives.

Workforce

Skilled and enabled workforce
We spoke with staff across a range of roles. They all had sound knowledge of their roles and responsibilities, and each appeared committed to providing a quality service to patients. We were told the practice encourages professional development, and some staff were involved in training to develop their knowledge and skills in specific clinical specialities.

Staff told us about the process in place for recruitment and conducting pre-employment checks, which included written references, evidence of registration with professional bodies and disclosure and barring (DBS) checks supported by a recruitment policy. An induction process was in place for new staff.

We found the system being used to check a healthcare's professional registration involved nursing staff submitting a copy of their certificate for their staff file. Doctors' registrations can be checked using the General Medical Council register.

The practice ask staff to provide a self-declaration to confirm they remain suitable to work for the service, and no changes have occurred since their last DBS check. We saw that formal appraisals had taken place for nursing and administration staff. There were no records for doctors, because they source supervision and appraisals externally.

We found there was an appropriate skill mix across the teams to deliver the services required, and the practice had a process in place for ensuring staff numbers and clinical staff levels are maintained.

There was no formal workforce plan, but the practice did have a criteria level for absences which helps identify where additional staff are required. We were told staff have skills that enable them to cover other roles. The practice continually reviews staffing levels to ensure appropriate capacity.

A review of staff training highlighted that a training matrix should be developed and maintained to have an overall picture of training compliance. We found that staff records had to be searched to identify compliance with mandatory training. We were told that due to GP appraisals and revalidations, doctors keep their certificates and therefore, limited evidence was available in their files. A training matrix will enable the practice to ensure compliance can be monitored effectively and to ensure staff skills and knowledge are up to date in line with their role.

The practice must develop a training matrix for all staff and ensure it is monitored regularly to confirm staff skills and knowledge remain current.

Culture

People engagement, feedback and learning
Of those who responded to our survey, all patients confirmed they had not been asked by the practice about their experience of the service provided. None of the respondents knew how to make a complaint about the service, however, all agreed that the service they had received was 'very good' or 'good'.

We did, however, find evidence that patient suggestions are welcomed and acted upon. A feedback box was available by the entrance and on a notice board there was a 'you said, we did' poster. We recognised this as good practise because the information on the poster showed how the practice collected patient feedback and how they would use this for service improvement.

The practice had a patient complaints procedure and policy which was aligned to the NHS Wales Putting Things Right process. The practice manager was responsible for managing all complaints and a clinician for clinical concerns. This was clear within the complaints policy. Complaints/concerns are monitored to identify any themes and trends, and any actions for improvement are communicated to staff.

Staff felt able to speak to the practice manager regarding any concerns they may have, in addition, they felt comfortable to share any suggestions they might have with the practice manager for their consideration.

Information

Information governance and digital technology
The practice understood its responsibility when processing information and demonstrated that data is managed in a safe and secure way. A current information governance policy was in place to support this.

The practice had a privacy notice, which was available for review on the website. We recommended that the notice is updated to include more detail on data handling.

The practice must update the privacy notice to include more detail on patient data handling.

Audits are completed to ensure that data at the practice is of a high quality to provide safe and effective services to patients. There are also arrangements in

place to ensure data and notifications are submitted to external bodies as required.

Learning, improvement and research

Quality improvement activities
There was evidence of some clinical and internal audit in place to monitor quality. We were told learning was shared across the practice to make improvements.

Whole-systems approach

Partnership working and development
The practice provided examples of how it, as a stakeholder in patient care, impacts on other parts of the healthcare system. This included following health board clinical pathways. The practice also interacts and engages with system partners at various multidisciplinary meetings, such as cluster meetings and voluntary groups.

There were good collaborative relationships in place with external partners and within the cluster. The practice worked within the local GP 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 area.

4. Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

The improvement plans should:

- Clearly state how the findings identified will be addressed
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

Appendix A – Summary of concerns resolved during the inspection

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

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

Appendix B - Immediate improvement plan

Service: Dinas Powys Medical Centre

Date of inspection: 08 January 2025

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

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	No immediate improvements identified at this inspection.					
2.						

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

Service representative:

Name (print):

Job role:

Date:

Appendix C - Improvement plan

Service: Dinas Powys Medical Centre

Date of inspection: 08 January 2025

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	We found that chaperones were not making notes in patient records as per the policy, so recommended the practice review the policy and process to ensure they align.	**The practice must review the chaperone policy to ensure the tasks required to be completed by the chaperone are being recorded.**	Health & Care Quality Standards - Information; Safe	Policy reviewed and staff emailed to remind them to read code record of chaperone or if declined.	C Bates - Practice Manager	Email sent 19/02/2025.
2.	We found that information about accessing appointments required updating, specifically on the website. There was no	**The practice must update their website regarding accessing appointments and introduce an access policy, detailing how appointments can be**	Health & Care Quality Standards - Information	Website updated to reflect how to book appointments/types. New policy - Care Navigation and Triage Policy - outlines how to book an	C Bates - Practice Manager	Website updated & new policy prepared and uploaded to evidence.

	practice access policy in place, and we recommended one is introduced which details the appointments and how they can be accessed. It must include all appointment types at the practice.	**accessed and the types available.**		appointment and the types of appointment offered.		
3.	There was no policy in place to support the pathway process.	**The practice must have a pathway policy to support the care navigation process in place.**	Health & Care Quality Standards – Information	This is covered by the attached policy – Care Navigation & Triage.	C Bates - Practice Manager	Done 22/2/25.
4.	We found the BCP did not include information regarding the business partnership risk and whilst we recognised the limited risk at the time of our visit, we recommend this is included.	**The practice must update their business continuity plan to include business partnership risk.**	Health & Care Quality Standards – Information	Business Continuity Plan updated to reflect the business partnership risk, however it was deemed low risk.	C Bates – Practice Manager	Done 19/2/25

5.	We recommended a significant events policy is put in place to support the significant events protocols and process.	**The practice must put in place a significant events policy to support the protocols and process used at the practice.**	Health & Care Quality Standards - Information	Policy put in place to support this process and updated forms circulated.	C Bates - Practice Manager	Done - Policy uploaded to evidence.
6.	There were no needlestick advice posters displayed on the walls and we recommended these are displayed in each clinical room.	**The practice must ensure that a needlestick injury advice notice is implemented and displayed in each clinical room.**	Health & Care Quality Standards - Information; Safe	Needlestick posters have been prepared and displayed in all clinical rooms.	R Andrews - Practice Nurse.	18/2/25
7.	The safeguard lead named in the policy was unaware they were the principal person.	**The practice must ensure named safeguarding leads know about their responsibilities. Any changes to this must be communicated to all staff and documents updated.**	Health & Care Quality Standards - Information; Safe; Workforce	The Safeguarding Leads were reminded of their roles and there are responsible persons posters around the surgery.	C Bates - Practice Manager	Done - 18/2/25
8.	We found that the safeguarding levels staff require, as listed in the policy did not match the evidence	**The practice must ensure all staff undertake the required level of safeguarding training (both children and adult) appropriate to their role,**	Health & Care Quality Standards - Information; Safe; Workforce	The additional safeguarding training is underway and will be complete by early March. Certificates to	C Bates - Practice Manager	Completed by early March 2025.

	we found on certificates.	**and a record should be kept to evidence this.**		be printed and training matrix updated.		
9.	We found there were a lack of management plans in the records we looked at.	**The practice must ensure that where appropriate, management plans are included in patient records.**	Health & Care Quality Standards – Information; person-centred	Clinicians were reminder of the need to ensure management plans were included in records where appropriate.	C Bates – Practice Manager	Done verbally and on 25/2/25 by email.
10.	From the notes reviewed we found that the patient's language choice was not always recorded.	**The practice must ensure that patient language preference is recorded and easily identified in their clinical records**	Health & Care Quality Standards – Information	Staff to ensure that patient language preference is recorded when registering staff or retrospectively where possible.	C Bates – Practice Manager	Advised verbally – followed up in staff meetings in March.
11.	We were told staff meetings were routine, however we found no evidence of minutes for clinical meetings. Meetings should be documented to ensure information can be shared to those unable to attend.	**The practice must document meetings and ensure minutes are circulated to appropriate persons if they are unable to attend.**	Health & Care Quality Standards – Information; Workforce	Clinical meetings which are informal need to be minuted going forward, as we already do with significant event meetings, staff and partners meetings.	C Bates – Practice Manager	Clinical team are aware of this requirement and ensure compliance.

12.	A review of staff training highlighted that a training matrix should be developed and maintained to have an overall picture of training compliance. We found that staff records had to be searched to identify compliance with mandatory training. We were told that due to GP appraisals and revalidations, doctors keep their certificates and therefore limited evidence was available in their files. A training matrix will enable the practice to ensure compliance can be monitored effectively and to ensure staff skills and knowledge	**The practice must develop a training matrix for all staff and ensure it is monitored regularly to confirm staff skills and knowledge remain current.**	Health & Care Quality Standards – Information; Workforce	Admin staff training matrix to be expanded to include Nurses and Doctors, for ease of compliance.	C Bates – Practice Manager	By end of March 2025.

	are up to date in line with their role.					
13.	The practice had a privacy notice, which was available for review on the website. We recommended that the notice is updated to include more detail on data handling.	**The practice must update the privacy notice to include more detail on data handling.**	Health & Care Quality Standards – Information	Updated privacy notice has been updated and is more detailed on data handling.	C Bates – Practice Manager	Done – 19/2/25

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): **CAROL BATES**

Job role: **PRACTICE MANAGER**

Date: **25/02/2025**