Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report

(Announced)

Coalbrook Surgery, Hywel Dda University Health Board

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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 Coalbrook Surgery, Hywel Dda University Health Board on 12 November 2024.

Our team for the inspection comprised of two HIW senior healthcare inspectors and three clinical peer reviewers. The inspection was led by a HIW senior 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 19 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:
We found Coalbrook Surgery was committed to providing a positive experience for its patients. Patient feedback was generally positive, with respondents rating the service as 'good' or 'very good'. Processes were in place to help reduce the waiting times for patient's telephone calls, and we found access to appointments was good.

There was a wide range of health promotion material available and on display to patients. The practice was part of a GP cluster and through this, the practice accessed a Persistent Pain Multidisciplinary Team, who looked after patients on high dose pain medication. We found this to be notable practice

There was a ramp up to level access to the practice enabling wheelchair users or those with reduced mobility to access the facilities easily.

For patients requiring urgent mental health support or who were in crisis, following triage this would be followed by a face-to-face assessment if the referral to mental health services was considered likely.

Chaperones were used where required, this service was well advertised throughout the practice and both patients who responded to the specific question for its relevance, confirmed that they were offered a chaperone where appropriate.

This is what we recommend the service can improve:

- Ensure that there is a documented care navigation policy in place to ensure staff know where and how to direct patients.

This is what the service did well:

- Bringing settings together to advertise what services were offered
- Good supply of health promotion materials
- Clear communication in a language suited to the needs of the patient
- Level access for patients with mobility issues
- Patients felt they were treated with dignity and respect and had good service.

Delivery of Safe and Effective Care

Overall summary:

We found the staff team were dedicated and committed to providing patients with safe and effective care in an environment that was clean, tidy and free of clutter.

Staff were familiar and compliant with the infection prevention and control (IPC) measures in place and the lead nurse oversaw matters around IPC.

The practice had a clear process for patient safety alerts, with a dedicated member of staff responsible for receiving and disseminating these.

Overall, the patient medical notes were of good quality, containing clear and appropriate information.

We found that services were arranged in an efficient manner and person centred, to ensure people felt empowered in their healthcare journey whilst knowing they could also be supported by the practice.

Immediate assurances:

- During the inspection we found clinical items which had passed their expiry dates
- We noted an absence of a children not brought policy, to support the appropriate follow up of children who did not attend hospital or GP appointments and a local safeguarding children and adults policy to support staff alongside the Wales Safeguarding procedures
- In addition, we found no formal process in place at the practice to consider and monitor children at risk or vulnerable adults.

This is what we recommend the service can improve:

- Update business continuity plan to include business partnership risk
- Create a policy for significant events
- Location of the clinical waste could pose a fire risk.

This is what the service did well:

- Referrals to other services
- Medication reviews process
- Good collaboration between the practice and the local GP cluster.

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 a high standard of care for their patients.

Staff had the necessary skills to carry out their roles and responsibilities and had access to training opportunities to fulfil their professional obligations and for career development.

There was evidence of a comprehensive induction process, with good compliance to staff recruitment procedures, including a record of job descriptions, reference checks and Disclosure and Barring Service (DBS) certification. All staff had undertaken mandatory training relevant to their roles. Annual appraisals were completed for all when due. More frequent reviews took place for new starters.

The practice had many comprehensive and up to date policies and procedures. Cluster wide meetings were taking place, and feedback via minutes for those absent. However, practice wide and clinical meetings were informal only.

This is what we recommend the service can improve:

- Formalise practice and clinical meetings
- Ensure all meetings are minuted and where appropriate implement an action log to keep monitor progress of actions.

This is what the service did well:

- Regular appraisals for all staff
- Good access to training opportunities
- Up to date policies and procedures.

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 Coalbrook Surgery as part of the inspection undertaken in November 2024. In total, we received 19 responses, which were mostly positive across all sections. However, accessing the GP and appointments were the main negative experiences. Most respondents rated the service as 'very good' or 'good'. The comments we received about the service and how it could improve are highlighted below:

> *"The nursing staff are lovely, and I have had no issues with them. However, If I were to rely on this GP surgery, I would be very ill. I have to access private healthcare to get the care I need. When I do interact with them there are often issues. Whilst the Doctors are pleasant to talk to, the service they provide is limited for those who have medical conditions that require monitoring and knowledge. There are constant problems with my prescriptions that I have to spend excessive amounts of time to rectify."*

> *"As I noted, the service offered by my GPs don't fit into the options offered in this survey. We've been registered with Coalbrook GP surgery for over 3 years and until last week, I was only aware of ringing for an on the day appointment at 8 am. I've always been able to have a phone appointment on the day, although I've not known what time that would be. The GPs are always helpful, but I have never met any in person. The receptionists are also lovely and when I called at the end of last week to follow-up on test results and a sick note extension, it was only when I asked about how best to do this, e.g. on the day appointment, that I was told about the eConsult appointments. I tried this for the first time this morning and it was really easy to use and I was impressed with how quickly a GP replied to me (by email)."*

> *"Saturday Morning appointments [would be helpful] for people who work long hours during the week."*

> *"Getting appointment with a doctor is impossible - if you're lucky enough to get one, it isn't for another 3-4 weeks."*

"Receptionists need to be aware of people with hearing problems and should take this into account as my delay seeing GP was very painful."

"Just wish in person appointments were given as an option and also online consult was available all day not just for 2 hours."

Person-centred

Health promotion
During our inspection we found a wide range of health promotion material displayed in the practice and on the practice website. This ensures that those who use the service can access information to help promote their health, prevent disease and lead a healthy lifestyle. The information available included smoking cessation with a visual smoking 'tar jar', menopause support, accessing mental health services, weight management, diabetic eye screening, waiting list support, stress control and support for unpaid carers.

We were told that the practice worked with several agencies to improve access to other healthcare professionals, including the voluntary sector and secondary care services. The practice is part of a cluster, enabling access to shared professionals, a physiotherapist, pharmacist and social prescriber, amongst others. We were told that the practice accessed a Persistent Pain Multidisciplinary Team, that looked after patients on high dose pain medication. We found this to be notable practice. The pharmacist, physiotherapist and psychologist would make any referrals to this team for patients requiring higher pain management.

Patients were made aware of the services on offer via notices at the practice, its social media page and website, and was bilingual.

There were processes in place to support patients in a mental health crisis, with referrals made to the mental health crisis team as appropriate. Mental health services were also available through the "Jack Lewis Foundation"; a mental health charity funded by the cluster, to support children and adults with mental health needs. This service was in addition to the NHS 111, option 2 service. Alternative support and signposting were also available for patients needing mental health support, which included the charity Mind.

All the respondents to the questionnaire felt that health promotion information was on display at the practice, and all but two patients felt they were offered healthy lifestyle advice.

Staff confirmed that the winter flu vaccination service commenced in September. This service was promoted within the practice, on social media, the practice

website and by text messaging. For those patients without digital access, the campaign was promoted at the practice, and staff telephoned eligible patients.

Dignified and respectful care
During our inspection we observed patients being treated with kindness and compassion. It was clear that staff made every effort to respect a patient's privacy and dignity throughout the assessment and treatment journey. We found clinical rooms provided patients with an appropriate level of privacy, with doors kept closed during consultations. Privacy curtains were also available in treatment and consulting rooms, which optimised general privacy and dignity.

Consultation and treatment rooms were located away from the main reception area, which maintained patient privacy and dignity. All but one questionnaire respondent felt they were treated with dignity and respect, and all but two felt measures were taken to protect their privacy.

Reception staff were observed welcoming patients in a professional and friendly manner. To protect confidentiality, most telephone calls were taken in the administration office, away from the reception desk. Whilst conversations could be overheard when patients were at the reception desk, a room would be made available should the need arise for more privacy. During the inspection, we only noted patients confirming their attendance to reception staff and were not discussing any confidential matters. Of the respondents to the question regarding patient's ability to talk to reception staff without being overheard; four agreed and four disagreed.

We saw various notices displayed throughout the practice, including consultation room doors, offering a chaperone service. All staff had been trained as chaperones and we were told that any new starters would be trained at induction. The induction policy was viewed alongside an induction pack, which confirmed this. The two patients who responded to the chaperon question, confirmed they were offered a chaperone when appropriate.

Timely

Timely care
There were processes in place to ensure patients could access care via the appropriate channels in a timely way, with the most appropriate person. Patients were made aware of how they could access face-to-face consultations via the patient information leaflet, website or notices at the practice. The practice access policy also included this information. Patients could either telephone the practice or visit in person to arrange an appointment.

The practice regularly sought the views of patients regarding the appointment system via the practice website, patient surveys using a QR code, and a feedback box at the practice. For those without digital access, the patient survey was available in paper format.

The reception staff would carry out relevant care navigation for the GP to triage. We were told there was inhouse training for care navigators provided by suitably trained staff. We found there was a good patient pathway in place. There was also a very comprehensive folder containing directions for certain symptoms. However, there was no written care navigation policy in place.

The practice must ensure that there is a documented care navigation policy in place to ensure staff know where and how to direct patients.

We found the care navigators were assigning patients to the most appropriate person or service. If care navigators queried where to signpost, a GP was available all day every day to provide guidance as necessary. Similarly, if patients required clinical triage, this would be done by the GP.

For patients requiring urgent mental health support or who were in crisis, following triage this would be followed by a face-to-face assessment if the referral to mental health services was considered likely. This would be by letter or telephone referral according to the urgency. **We found the practice made good use of cluster-based support services.**

In response to the patient questionnaire, 95% felt satisfied with the opening hours of the practice. A total of 78% felt able to contact the practice when needed and knew how to access out of hours services if they needed medical advice or an appointment that could not wait until the GP was next open. In addition, 84% of patients reported being able to access routine appointments when needed and 64% felt able to have a same-day appointment when they need to see a GP urgently. Whilst attending the practice, only 56% said their appointment was on time.

Three comments were given about accessing the GP:

> *"…..initially either telephone appointment or eConsult where you answer a few questions and a GP sends you an email response - in my case this was an hour later and I was very happy with this."*

> *"Was offered over the phone contact on the day, I have hearing problems. So, face to face, I had to wait 10 days.".*

"Often I am automatically put down for a telephone consultation and most of the time I am then told to come in, which I would rather just have."

Equitable

Communication and language
We observed staff at the practice communicating in a clear and appropriate manner, in a language suitable to the needs of the patient. All staff seemed familiar with the community it served and did not always need to use prompts available on the electronic system regarding communication needs or preferences. We noted a hearing loop was installed for those patients who used a hearing aid, and this was clearly displayed in reception.

Patients were made aware of the services on offer via notices, the practice social media page and website, bilingually. Where patients were known not to have digital access, letters would be sent to individuals, as well as telephone calls to the patient, or via a nominated relative or carer. We were also told that recently, the cluster held an open day where several services came together for a patient information day, which included the practice. This was for all patients but was said to greatly assist those without digital access.

We were told the majority of staff spoke Welsh and could assist patients where needed. We saw a notice by reception informing patients they could communicate through the medium of Welsh and a variety of bilingual patient information posters were also available. The practice also had access to translation services, if required.

Where information was for staff, the practice ensured those messages were communicated internally to the appropriate people, by using the practices' electronic system, with read receipts and flagged tasks enabled for confirmation of receipt.

There were processes in place with medical oversight of incoming mail relevant to specific patients. Staff described how information was reviewed and recorded promptly in the patient's notes, then directed to the correct health care practitioner to action as required. However, as there was a newly installed electronic patient record system in place, the workflow processes and policy were under review. Whilst processes were in place, it is important that the staff have clear instructions on what actions should be taken on receiving letters into the surgery and who assign the document to.

We recommend the workflow policy and process is updated in a timely manner to provide up to date information around the process, audits and delegation of responsibility.

Rights and equality

The practice provided good access to the premises, with a small dedicated free car park available, and a larger free car park close by. There was a ramp in place enabling access for wheelchair users or those with reduced mobility. All treatment rooms and the accessible toilet were located on the ground floor. All patients who responded to the questionnaire felt the building was easily accessible.

We found equality and diversity were promoted to staff through practice policies and mandatory staff training. We were provided with an up-to-date equality and diversity policy and complete records of the training staff had undertaken.

Staff provided examples where reasonable adjustments were made, so that everyone, including individuals with protected characteristics, could access and use services on an equal basis. This highlighted that people's rights and equality were upheld for both patients and staff.

The rights of transgender patients were also upheld, staff confirmed that the patient's preferred name and pronouns were always used, the electronic patient system flagged this to mitigate the risk of addressing people incorrectly.

All patients who responded to our questionnaire said they had not faced discrimination when accessing or using this service, and they felt able to access the right healthcare at the right time. Most respondents to the questionnaire felt involved in decisions about their healthcare.

Delivery of Safe and Effective Care

Safe

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

The practice had a business continuity plan which was up-to-date and contained relevant information. We noted that partnership risk was not included in the continuity plan, we therefore recommended adding this to cover all eventualities. The business continuity plan was available to all staff via a shared drive and copies were kept securely at home.

The practice demonstrated good collaboration with the cluster, working together to improve care for patients. The cluster met five times a year and had several noteworthy projects in place, including the pain management project.

The practice had a clear process for patient safety alerts with a dedicated member of staff responsible for receiving and sharing these. The alerts would be communicated to the appropriate people and the process was robust.

Staff were aware of the sustainability framework, which is linked to escalation levels. The practice reported on escalation levels monthly. We were told the finance manager would cover the reporting process, should the practice manager be absent.

Learning from significant events, including patient safety incidents would be shared via email. These would be reviewed and discussed with staff face to face if needed. Where appropriate, analysis of incidents would be completed, and delegated to appropriate staff to investigate. These would then be discussed in partner meetings. All incidents would be recorded in patients notes and reported via Datix where required. The practice manager would be informed, and recurring themes brought to their attention. However, whilst the process appears to be robust, there was no policy for significant events.

The practice must develop and implement a significant event policy and a template to appropriately record incident details consistently.

We considered the process in place and safety of lone workers attending home visits to review patients. We were advised that home bound patients would be

added to the home visit list, and the need for a home visit was triaged by a GP. Staff were aware of when clinicians were attending house calls, however, we found there was no formal policy in place regarding home visits, neither was a risk assessment in place to manage the safety of lone workers.

The practice should develop and implement a home visits policy to ensure staff are aware of the process required before, during and after a home visit, which should include maintaining the safety of both staff and patients.

Infection, prevention and control (IPC) and decontamination
The environment, policies and procedures, staff training, and governance arrangements upheld the standards of IPC, and protected patients, staff and visitors using the service.

The staff we spoke with had a clear understanding of their responsibilities regarding IPC and personal protective equipment (PPE) available to them. A practice nurse was the lead for IPC, and staff were aware of who this is.

All clinical staff had completed online training for IPC. A training matrix was held by the practice manager, who prompted staff when their training was due.

All IPC policies were stored digitally, and hard copies were available in the main office and were accessible to all staff. Any changes to policies and the procedural aspects of the IPC policy were completed and shared in a timely manner.

Sterile packs for minor surgical procedures were provided by Prince Philip Hospital, and a designated GP provided the procedures at the practice. Where procedure packs are returned to Prince Philip Hospital for sterilisation, these are checked by two nurses. Disposable single use equipment was also used for nursing procedures, such as venepuncture, dressing changes and injections. The nursing staff would safely dispose of single use equipment. There was a sterilisation policy available to staff.

All sharps' bins were signed and dated, they were not overfilled, and the lids were appropriately closed. We were provided with the in-date waste management policy.

A Healthcare Assistant (HCA) was responsible for clinical waste storage and waste audits. We saw that the storage of the clinical waste was on site and sharps bins were stored in a locked outdoor storage unit. Yellow clinical waste bins and general waste was stored securely against the building outside.

Suitable hand hygiene, decontamination and sterilisation facilities were available at the practice, and each clinical room was appropriately equipped to maintain hand hygiene and surface cleaning. All floors had a non-slip linoleum covering.

There are wipe clean seating and couches in the treatment rooms and pillows with plastic wipeable cases. There were two clinical rooms with elbow operating taps, which were used where clinical procedures were undertaken, such as smears and minor ops.

There was a blood borne virus policy in place and there were blood spillage kits in treatment rooms.

We were told there was a non-documented cleaning regimen carried out by nurses. Daily cleaning of clinical rooms and in between patients was the responsibility of the nursing staff. The cleaners had a schedule on the door in the reception where cleaning equipment was stored. However, we were told that staff often undertook cleaning duties where the contracted cleaners failed to complete the cleaning adequately. This issue was under discussion between the practice manager and the cleaners.

Newly recruited staff were required to demonstrate their vaccination status. On review of staff files, we found an appropriate system in place to record hepatitis B status and staff immunity.

There were appropriate rooms available to accommodate any infectious patients. Respondents to our questionnaire said there were signs at the entrance explaining what to do if they had an infection. All but one respondent said there were hand sanitizers available, and all but two agreed healthcare staff washed their hands before and after being treated. Of those who indicated they had received an invasive procedure at the practice, all but one said staff used gloves during the procedure.

During the inspection we also found clinical items which had passed their expiry dates. These included: medication, swabs, dressings, sample bottles and testing strips. These posed a risk to patient safety and were dealt with under our immediate assurance process at **Appendix B**.

Medicines management
Processes were in place to ensure the safe prescribing and management of medication.

The process for patients to request repeat medication was clear, and prescriptions were processed in a timely manner by suitably trained administrative staff and signed by a GP.

There were Controlled Drugs (CDs) held at the practice which were kept securely, and the key only available to clinical staff. The CDs were checked weekly by two qualified members of nursing staff, and the checks were appropriately documented. However, the process for issuing a Controlled Drug (CD) prescription to patients could be strengthened. When collected, there was no process in place for anyone collecting to sign on receipt of the prescription, to maintain an audit trail up to dispensing.

The practice must ensure that all prescriptions for controlled drugs are signed for by the recipient on collection of the prescription.

Prescription pads were securely stored in a locked filing cabinet, and staff described the process to securely dispose of prescription pads when a GP left the practice.

There was a cold chain policy in place for medications that required refrigeration. There were dedicated clinical refrigerators in place to store applicable medicines and vaccines. Daily checks of the fridge temperatures were completed and documented. Nursing staff were aware of the upper and lower temperature limits, and what to do in the event of a breach to the cold chain, and who to report this to.

We found that the refrigerators were full, necessitating the need to store items on the bottom, which could impede the air flow and impact on the ability to maintain appropriate temperature control. There was a large quantity of flu vaccinations stored, contributing to the volume of items stored, and staff explained that the vaccination stock had been reduced to one delivery from the previous two. We were also told that occasionally, one refrigerator, which was not subject to temperature checks, was used to store samples overnight.

The practice must ensure that:

- **Clinical refrigerators are not overfilled with vaccines and medication to ensure appropriate circulation of cool air.**

- **Any refrigerators used to store medicines, or clinical samples are stored in the appropriate unit, which is fit for purpose, and that the temperature is appropriately monitored and checked.**

There was appropriate resuscitation equipment and drugs in place for use during a patient emergency, such as a cardiac arrest. These met the primary care equipment standards as outlined by the Resuscitation Council UK guidance. Staff were aware of the location of the equipment which was clearly signposted. This included the automatic external defibrillator (AED). There were clear audit processes in place for the regular checking and replacement of all resuscitation equipment, consumables and relevant emergency drugs, including oxygen. However, the emergency drugs and equipment were being stored in a treatment room. This was not appropriate because the room was used daily, including potentially for intimate examinations. This could cause delays in accessing the equipment and drugs in the event of a cardiac emergency or impact on patient privacy.

The practice must ensure that the emergency drugs and equipment are relocated to an area that allows ease and speed of access. The new location must be communicated to all staff.

Staff had completed appropriate training for medical emergencies, and all clinical staff had undertaken appropriate basic life support training.

Safeguarding of children and adults
We reviewed the safeguarding policy and procedure in place for both children and vulnerable adults. It was up to date and contained relevant contact details of designated people for staff to contact if they had any safeguarding concerns. These included a named safeguarding lead at the practice and local authority contacts. The training matrix showed that all staff had received relevant safeguarding training, at the appropriate level, including the safeguarding lead who had been trained to level four.

We were given an example of where the safeguarding processes needed to be followed (this resulted in a meeting between safeguarding and the practice lead) and a safeguarding meeting attended regarding the incident. Minutes from the meeting and actions were shared with the relevant practice staff and actions as a result were cascaded. This demonstrated that the safeguarding process was suitable, and processes followed adequately.

When reviewing other policies and procedures in place to safeguard children, we noted an absence of the following documents to support and guide staff:

- Children not brought policy, to support the appropriate follow up of children who did not attend hospital or GP appointments.

- Local Safeguarding Children and Adults policy to support staff alongside the Wales Safeguarding procedures.

In addition, we found no formal process in place to consider and monitor children at risk or vulnerable adults. These findings posed a risk to patient safety and were dealt with by our immediate assurance process at **Appendix B**.

Management of medical devices and equipment
All clinical staff were responsible for checking medical devices and equipment daily, with electrical equipment having annual portable appliance testing and calibration annually via an external company. We saw calibration logs and stickers on individual pieces of equipment, with an annual contract in place.

We were told that each GP maintained their own clinical bag for off-site patient visits.

Effective

Effective care
The practice had processes in place to support safe and effective care, this included the provision of care at the practice or within the GP cluster and wider primary care services.

We found the process for ordering and relaying test results to patients was robust, with the individual GP or lead nurse holding overall responsibility for this. Follow up appointments and further testing would be arranged if required.

The process used for referrals to secondary care was described; urgent referrals, such as urgent suspected cancers, would be referred through the Welsh Clinical Communications Gateway (WCCG). Locum doctors highlight this within patient consultation notes and refer to administrative staff for uploading to WCCG. Routine referrals would also be completed in the same manner as the urgent referrals by the referring clinician.

The practice described how it had prepared for changes to legislation for death certification. We were advised this was working well.

The practice answerphone advised patients with "red flag" symptoms suggesting a medical emergency to call 999 rather than wait on the phone. However, in the unlikely event of a patient contacting the surgery when requiring 999, the receptionists would often deal with this on behalf of the patient.

Patient records
We reviewed a sample of 10 electronic patient medical records and multiple consultations for each. The records reviewed formed part of the Vision electronic system, and the practice had changed to the EMIS electronic system one week before the inspection and the transcription appeared complete.

Overall, the quality of patient medical records was very good. Records were very clear regarding evidence and reasoning for decisions made relating to patient care. They were of a good quality in terms of being up to date, complete, understandable and contemporaneous. There was a comprehensive recording of the history, examinations, investigations and planned treatment, with evidence of the use of diagnostic Read codes.

Records were being stored securely and in compliance with the Data Protection Act 1988 and the General Data Protection Regulations (GDPR).

Efficient

Efficient
We found that services were arranged in an efficient manner and were person centred, to ensure people feel empowered in their healthcare journey. As well as being referred, patients could self-refer via the website for services including physiotherapy and weight loss management.

We found staff worked across services to effectively coordinate care, promoting the best possible outcomes for patients and to prevent unnecessary hospital admissions. This was done by directly referring to a specific consultant or specialist nurses. The staff had a close working relationship with the specialist nurses they had frequent contact with. Additionally, there were referrals made to district nurses where applicable, who were based elsewhere.

Nebuliser therapy could also be offered for acute asthma exacerbations on site. The lead practice nurse was an independent prescriber, therefore managing asthmatic patients was part of her scope of practice.

Quality of Management and Leadership

Staff feedback

HIW issued a questionnaire to staff to obtain their views about Coalbrook Surgery. We received two responses from staff at this setting. Whilst the responses given by staff were positive, due to the low number it was not possible to identify any themes.

Leadership

Governance and leadership
There were distinct operational systems and processes in place to support effective governance, leadership and accountability at the practice. It was also clear there was a supportive and committed management team working in the best interests of staff and patients.

From our discussions with senior staff, we found they were knowledgeable about their roles and responsibilities, and they felt adequately supported to discharge their duties. Of those we spoke with, all confirmed they felt able to approach managers with any problems or concerns that arose, and that these would be addressed appropriately and promptly. Managers confirmed that there was an open-door policy for staff to share concerns and ideas for the practice.

The practice had a range of in date policies and procedures in place. These were clear, named and dated for review. Staff had easy access to these via a shared drive and a hard copy was also available in the practice managers office. The practice manager held a review schedule of the policies, and it was evident that this was adhered to.

The practice manager confirmed that formal meetings did not take place at the practice, however, informal meetings took place regularly. Where information needed to be shared amongst all staff, such as a policy or procedural change, this was completed through emails with delivery notifications and read receipts. These were then stored on the shared drive.

The practice should formalise meetings, record meeting minutes and where applicable have an action log to ensure actions can be monitored and implemented.

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

Workforce

Skilled and enabled workforce

The practice manager confirmed there were enough staff with the correct skill mix to carry out the services expected. From discussions with staff across a range of roles, all agreed they worked within their scope of practice, and that there was enthusiasm for study and opportunities to progress skills if desired.

Nursing staff advised us they had access to continuous professional development (CPD) opportunities, and this was being supported. There was a positive ethos regarding knowledge and learning, with some staff working towards further clinical development. The practice manager also supported the progression of the entire workforce. Time was apportioned to enable attendance at relevant training. We were provided with a training matrix which confirmed that most staff had completed all mandatory training and plans were in place for staff to renew their training where applicable.

During the inspection, we viewed a sample of job descriptions and were told these were reviewed at appraisals. New starters would undergo an induction, and reviews would take place more frequently until they completed the induction pack and a probationary period. We viewed evidence that these reviews and annual appraisals had been undertaken when due, and that any additional training needs were identified to support their professional development.

There were appropriate recruitment policies and procedures in place. The practice manager described the required pre-employment checks for any new members of staff before they joined the practice. This included checking of references and undertaking Disclosure and Barring Service (DBS) checks appropriate to their role. There would also be a check of a healthcare professional's registration with their regulatory body to ensure it was current and no restrictions imposed.

Culture

People engagement, feedback and learning

The practice had a complaints procedure which was aligned to the NHS Wales Putting Things Right process. The practice manager was responsible for managing all complaints and this was clear within the complaints policy and procedure documents. The practice complaints folder was reviewed, however, as the practice was quite small, there were only a small number over the year. We saw that complaints were dealt with in a timely manner, in line with the policy. However, the practice did not hold a log of complaints. We were told that as the practice was small and complaints were minimal, themes could be drawn without a log.

The practice should implement a complaints log, with clear information about the complaint, person responsible for managing the complaint, any actions taken, and lessons learned. This should be stored electronically for ease of access.

The practice manager understood the Duty of Candour (DoC). A DoC policy was in place that met the requirements of the Health and Social Care (Quality and Engagement) (Wales) Act 2020. This was clear and set out the roles and responsibilities of staff. We saw evidence that staff had received training on this, and we were assured that staff were aware of the actions to take should something go wrong.

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, including a suggestions box in the reception area.

Staff felt comfortable to speak up regarding any concerns they may have, and a whistleblowing policy was in place to support this. In addition, staff felt comfortable to share any suggestions they might have and could provide these to their manager for consideration.

Information

Information governance and digital technology

Processes were in place to securely collect, share and report data and information relating to patients. There were various policies and procedures in place supporting this, such as Freedom of Information, Information Governance and the GDPR.

We saw evidence of patient information being stored securely and the practice's process for handling patient data was available for review on their website.

Learning, improvement and research

Quality improvement activities

The practice held regular meetings with the cluster to help improve services and strengthen governance arrangements. We found that staff engaged with quality improvement by developing and implementing innovative ways of delivering care. These included direct involvement in cluster projects, such as the Persistent Pain management, for patients on high dose pain medication. Another being the Jack

Lewis Foundation, a local charity funded by the cluster for signposting children and adults requiring mental health support.

There was also evidence of clinical and internal audits taking place, in addition to a statutory requirement for monthly reporting statistics on activities and performance.

The practice engaged in learning from internal and external reviews, including mortality reviews, incidents and complaints. All learning was shared across the practice to make improvements, however, as highlighted earlier, there was no evidence of minutes and action logs to share with staff who were not present.

Whole-systems approach

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

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.

We were also informed of good arrangements between the practice and secondary care, which included following health board clinical pathways and third sector organisations, such as charities, which included support for mental health, stop smoking, weight management and unpaid carers.

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: Coalbrook Surgery

Date of inspection: 12 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 the inspection we found clinical items which had passed their expiry dates. These included: medication, swabs, dressings, sample bottles and testing strips. This, therefore, may pose a risk to patient safety.	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 items, and to monitor medication expiry dates.	Health and Care Quality Standards – Safe (Devices)	All expired items were removed from the clinical areas and disposed of in an appropriate manner on Tuesday 12th November, 2024. Monthly Drug Check Audit form implemented on Tuesday 12th November, 2024. Please see attached.	Gwen Bonar, Senior Nurse Gwen Bonar, Senior Nurse	Actioned 12/11/24 Actioned 12/11/24

2.	During our inspection, we reviewed the policies and procedures in place and noted an absence of the following documents to support and guide staff: • Children not brought policy, to support the appropriate follow up of children who did not attend hospital or GP appointments. • Local Safeguarding Children and Adults policy to support staff alongside the Wales Safeguarding procedures. In addition, we found no formal process in place at the practice to consider and monitor children at risk or vulnerable adults.	The practice must: • Implement a child not brought policy and local safeguarding children and adult's policies • Ensure all staff are aware of and understand the content of the policies above. • Implement a robust process to consider and monitor children at risk and vulnerable adults.	Health and Care Quality Standards –Safe (Safeguarding) Health and Care Quality Standards - Leadership	Was Not Brought policy has been implemented (see attached). Practice specific Safeguarding children and adult's policy has been implemented (see attached). DNA policy implemented (see attached). Three new policies emailed to staff and added to staff handbook (see attached). Quarterly safeguarding meetings will be implemented involving a GP, HV, MW and PM, with invitations to local authority representatives also. Looked after Children and Child Protection Register cross referenced on receipt of LA reports on a monthly basis.	Catrin Davies, Practice Manager Catrin Davies, Practice Manager Catrin Davies, Practice Manager	Actioned Actioned Meeting scheduled for 11/12/24.

	These findings pose a risk to patient safety.					

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: Catrin Davies

Name (print): Catrin Davies

Job role: Practice Manager

Date: 20/11/24

Appendix C - Improvement plan

Service: Coalbrook Surgery

Date of inspection: 12 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.	We found there was a good patient pathway in place. There was also a very comprehensive folder containing directions for certain symptoms. However, there was no written care navigation policy in place. This, therefore, may pose a risk to patient safety.	The practice must ensure that there is a documented care navigation policy in place to ensure staff know where and how to direct patients.	Health and Care Quality Standards – Timely Care	Care Navigation Policy created and circulated to staff on 22.1.25.	Catrin Davies, Practice Manager	Actioned

2.	As there was a newly installed electronic patient record system in place, the workflow processes and policy were under review. Whilst processes were in place, it is important that the staff have clear instructions on what actions should be taken on receiving letters into the surgery and who assign the document to.	We recommend the workflow policy and process is updated in a timely manner to provide up to date information around the process, audits and delegation of responsibility.	Health and Care Quality Standards – Equitable (Communication and Language)	Workflow and Document Policy created and circulated to staff on 22.1.25.	Catrin Davies, Practice Manager	Actioned
3.	Staff were aware of when clinicians were attending house calls, however, we found there was no formal policy in place regarding home visits, neither was a risk assessment in place to manage the safety of lone workers.	The practice should develop and implement a home visits policy to ensure staff are aware of the process required before, during and after a home visit, which should include maintaining the safety of both staff and patients.	Health and Care Quality Standards – Equitable Health and Care Quality Standards - Safe	Lone worker policy already in place and was reviewed in October 2024 and available on day of inspection. Has now been renamed to Lone worker/Home Visiting Policy.	Catrin Davies, Practice Manager	Actioned

4.	The process for issuing a Controlled Drug (CD) prescription to patients could be strengthened. When collected, there was no process in place for anyone collecting to sign on receipt of the prescription, to maintain a **full** audit trail. This poses a risk to patient safety.	The practice must ensure that all prescriptions for controlled drugs are signed for by the recipient on collection of the prescription.	Health and Care Quality Standards – Safe (Meds Management)	Controlled Drugs logbook has been implemented, whereby, reception team now document all prescriptions for Controlled Drugs and are signed for by patient on collection.	Catrin Davies, Practice Manager	Actioned
5.	We found that the refrigerators were full, necessitating the need to store items on the bottom, which could impede the air flow and impact on the ability to maintain appropriate temperature control. We were also told that occasionally, one	The practice must ensure that: • Clinical refrigerators are not overfilled with vaccines and medication to ensure appropriate circulation of cool air. • Any refrigerators used to store medicines, or	Health and Care Quality Standards – Safe (Meds Management)	Fridges have been checked and are not overfilled with vaccines. All refrigerators used to store medicines and/or clinical samples	Gwen Bonar, Senior Practice Nurse Gwen Bonar, Senior Practice Nurse	Actioned Actioned

	refrigerator, which was not subject to temperature checks, was used to store samples overnight. This poses a risk of cross contamination and samples being unfit for testing or giving incorrect results.	clinical samples are stored in the appropriate unit, which is fit for purpose, and that the temperature is appropriately monitored and checked.		have the temperature appropriately monitored and checked.		
6.	The emergency drugs and equipment were being stored in a treatment room. This was not appropriate because the room was used daily, including potentially for intimate examinations. This could cause delays in accessing the equipment and drugs in the event of a cardiac emergency or impact on patient privacy.	The practice must ensure that the emergency drugs and equipment are relocated to an area that allows ease and speed of access. The new location must be communicated to all staff.	Health and Care Quality Standards – Safe (Meds Management)	Emergency drugs and equipment were relocated on day of inspection. New location was communicated to all staff on the same day.	Gwen Bonar, Senior Practice Nurse	Actioned

7.	The practice manager confirmed that formal meetings did not take place at the practice, however, informal meetings took place regularly. Informal meetings were not minuted and no actions recorded.	The practice should formalise meetings, record meeting minutes and where applicable have an action log to ensure actions can be monitored and implemented.	Health and Care Quality Standards - Leadership	GP meetings are being held regularly and are being minuted. Safeguarding meetings are now scheduled to take place quarterly, the first meeting was held and minuted on 18/12/24. Clinical meetings are scheduled to commence in February, this was delayed due to staff sickness in December and January due to Flu.	Catrin Davies, Practice Manager	Actioned
8.	We saw that complaints were dealt with in a timely manner, in line with the policy. However, the practice	The practice should implement a complaints log, with clear information about the complaint, person responsible for managing	Health and Care Quality Standards – Culture	Complaints log has been implemented. SEA log has been implemented.	Catrin Davies, Practice Manager	Actioned

	did not hold a log of complaints.	the complaint, any actions taken, and lessons learned. This should be stored electronically for ease of access.		Datix log has been implemented. All have been created electronically and are accessible on shared drive.		
9.	Whilst the process appears to be robust, there was no policy for significant events.	The practice must develop and implement a significant event policy and a template to appropriately record incident details consistently.	Health and Care Quality Standards – Risk	Significant event policy was already in place but not presented during inspection. Policy has now been reviewed in January 2025 and renamed to Significant Event/Incident Management Procedure. Template to appropriately record incident details already in place as part of policy. All significant events will be added to Clinical meetings agenda for discussion	Catrin Davies, Practice Manager	Actioned

			and learning outcomes to be identified.		

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): **Catrin Davies**

Job role: **Practice Manager**

Date: **22.1.25**