Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report

(Announced)

Cwm Calon Surgery, Aneurin Bevan University Health Board

Inspection date: 13 February 2025
Publication date: 16 May 2025

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

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

In writing:

Communications Manager
Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

Or via

Phone: 0300 062 8163
Email: hiw@gov.wales
Website: www.hiw.org.uk

Digital ISBN 978-1-83715-754-9

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 5

2. Summary of inspection 6

3. What we found 10

- Quality of Patient Experience 10
- Delivery of Safe and Effective Care 17
- Quality of Management and Leadership 24

4. Next steps 29

Appendix A – Summary of concerns resolved during the inspection 30

Appendix B – Immediate improvement plan 31

Appendix C – Improvement plan ..... **Error! Bookmark not defined.**

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 Cwm Calon Surgery, Aneurin Bevan University Health Board on 13 February 2025.

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

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. A total of 132 were completed. We also spoke to staff working at the service during our inspection. 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:
Patient responses to our questionnaire were mostly positive across all areas, with almost all rating the service as ‘very good’ or ‘good.’ We observed friendly and caring interactions between staff and patients during the inspection. Patients were treated with dignity and respect, with consultation rooms providing appropriate levels of privacy. Chaperone notices were displayed prominently, and male and female staff were available for chaperoned appointments. However, the chaperone policy lacked a review date.

Patients were able to access information to help promote their health and wellbeing and lead a healthy lifestyle, and they received sufficient information to allow informed decisions to be made about their care. However, improvements were needed to ensure relevant patient information was available and kept up to date within the practice and on the practice website.

There were good processes that enabled patients to access the right service at the right time. A triage policy prioritised patients with urgent healthcare needs, and most reception staff had received training in care navigation. A cluster paramedic and Psychological Health Practitioner (PHP) provided regular additional support to staff and patients, which we identified as examples of good practice. Patients could access appointments in a number of ways, and a high percentage of calls to the practice were answered within two minutes. However, some respondents to our patient questionnaire expressed dissatisfaction with the appointments process.

There were processes in place for recording and sharing information from secondary care. However, we found they were not consistently followed, with instances of documents being filed by administrative staff without being shared with the GPs for necessary action and coding.

All areas of the practice were accessible, and a lift was available to assist patients with mobility needs. Equality and diversity were promoted through practice policies and staff training, but some patients reported facing discrimination and a lack of carers support from staff. Staff communicated clearly and in a language appropriate to patient needs. However, the language and communication needs of patients should be routinely recorded within their records, and the provision of services to Welsh speakers should be improved in accordance with the guidelines set out in 'More than just words'.

Delivery of Safe and Effective Care

Overall summary:
We found some suitable processes in place to protect the health, safety and wellbeing of patients and staff. All areas of the practice were in a good state of repair, and clinical rooms were well stocked with items and equipment. Effective patient care processes included cluster collaboration, quality improvement initiatives, and appropriate referral management. Services were arranged efficiently, with patients able to self-refer to various co-located services.

However, several potential risks to staff and patient safety were identified, including a lack of appropriate signage for oxygen cylinder storage. The practice lacked a formal significant events policy and there were no follow-up processes to ensure incidents were routinely reviewed. Additionally, patient safety alerts were sent exclusively to the practice manager, with no backup process in place to ensure they were received by other staff members.

Effective infection prevention and control (IPC) measures were evident, with a visibly clean environment and staff demonstrating good hand hygiene. However, improvements were needed to ensure IPC and waste management audits were routinely conducted, and that staff were trained to the required level. In addition, the disposable curtains in consultation rooms lacked installation dates, and the disabled toilets had maintenance issues.

We found suitable processes to support the safe prescribing of medication, but improvements were required to implement a prescribing policy and an audit process to monitor the movement of prescription forms. We also found some medications were insecurely stored and a clinical fridge was overstocked, potentially affecting medication viability.

Safeguarding procedures were in place, but not all staff had completed the required training. The practice had a 'Was Not Brought' policy for missed appointments, but safeguarding concerns were not consistently flagged within patient records.

Patient records were maintained to a good standard, with well-documented consultation narratives, evidence of shared decision-making and appropriate referrals. However, there was no written guidance for medical secretaries on clinical coding, and no audits were conducted to monitor their accuracy.

Immediate assurances:

We were not assured that the processes in place to maintain staff and patient safety were robust. The following issues required immediate action:

- There was no emergency panic alarm system to allow staff to call for assistance in the event of an emergency
- Appropriate checks were not being undertaken on the emergency drugs and equipment
- The defibrillator's second battery was missing.

Details of the concerns for patient's safety and the immediate improvements and remedial action required are provided in Appendix B.

Quality of Management and Leadership

Overall summary:
The practice had a clear and supportive management and leadership structure, with staff understanding their roles and responsibilities. Processes were being implemented to improve existing governance and leadership systems following recent management changes. Partnership working was evident within the GP cluster, with medical staff attending cluster meetings and providing services on a cluster-wide basis. However, staff team meetings were not routinely conducted, and there was no documentary evidence of any practice meetings to provide governance oversight, identify trends, or promote shared learning opportunities.

The practice had an appropriate skill mix of staff, but recruitment and pre-employment checks required immediate improvement. A training matrix had been created to monitor staff training compliance, but some areas of non-compliance were identified. The practice must ensure all staff complete and remain compliant with mandatory training relevant to their roles.

A wide range of policies and procedures were in place to support the effective running of the practice. However, several key policies were unavailable or overdue for review. There was no induction policy in place, and we found no evidence of a formal supervision or appraisal process for staff.

Robust improvements were required to ensure that patients, relatives and carers were adequately supported in providing feedback or raising concerns about the service. The complaints policy was overdue for review, and there was no process to log or monitor complaints and feedback and communicate actions for improvement to staff. No details about the complaints process were displayed in the waiting area or provided on the practice's website for patient awareness.

All staff we spoke with during the inspection were receptive to our views, findings and recommendations, and showed commitment to addressing areas of improvement. Further work will be required to strengthen management and leadership processes in relation to the improvements identified in this report, and action must be taken to sustain the improvements made.

Immediate assurances:

We were not assured that the governance processes in relation to recruitment and pre-employment checks were robust. We reviewed a sample of five staff records and identified the following issues:

- Only one staff record had a suitable Disclosure and Barring Service (DBS) certificate in place
- Staff confirmed that only three of the five doctors working at the practice had DBS certificates
- No staff records included contracts of employment
- Only one staff record contained an up-to-date job description
- There was no Hepatitis B register to monitor the immunity status of staff
- Evidence of immunity was absent within the records of two of the five doctors working at the practice.

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 provided by Cwm Calon Surgery. In total, we received 132 responses from patients for this setting. Responses were mostly positive across all areas, with some negative responses related to accessing the GP and booking appointments. All but five of the respondents rated the service as 'very good' or 'good'.

Patient comments included:

> *"Always very happy with the service provided by the practice. In comparison to what I hear about other practices I feel Cwm Calon is excellent."*

> *"This is the most well run & efficient GP surgery in our borough. The reception staff are friendly and polite. The Dr's are absolutely amazing! They listen to me and are never dismissive. I can always get appointment (usually same day) and can pre book follow ups if needed. I literally can't fault anything."*

> *"Everyone at this practice (is) friendly, helpful & empathetic. They have a great reputation and I for one think they should be applauded-especially speaking to family members who are in other practices. In my opinion they are the best practice around. Only negative is trying to call for an appointment, call for an appointment at 8am, get a load of helpful information then when you get through the appointments are gone. Not very helpful especially if you are a working person."*

> *"Cwm Calon surgery is outstanding it's run very professional and efficient. It's stress free to make an appointment the reception staff nurses Dr's are so friendly understanding and very helpful best practice by far very pleased always have a five-star service."*

> *"The reception staff are very friendly and helpful. The Doctors make you feel you are listened to with care and compassion. Cannot fault the service they provide."*

"This doctor's surgery is amazing never had a negative experience in all the time of being here even the receptionists (are) absolutely fantastic."

"Excellent surgery, from booking staff to GP. Very person centred and effectively managed."

"I find this surgery absolutely brilliant. The receptionist(s) are excellent, professional and very good. Phones are answered very quickly. No waiting for ages to speak to someone. Excellent service."

"I am very pleased with the GPs at Cwm Calon, they are caring and very knowledgeable. The reception staff are very helpful and very professional."

Person-centred

Health promotion
A wide range of health information leaflets and posters were available for patients in the reception area. These included information on smoking cessation, alcohol reduction and healthy eating. A display screen in the waiting room provided additional health information on various topics. Information about the practice was available on the practice website and within a leaflet distributed to patients upon registration. However, the leaflet was not displayed in the reception area, and some information within the leaflet and on the practice website was outdated.

The practice must ensure the patient information leaflet is accessible to all patients and that all information provided to patients is accurate and up to date.

The practice engaged with several agencies to improve access to various healthcare professionals through their cluster group. This included access to pharmacy, mental health services and a diabetic nurse specialist, enabling patients to access timely help and support from other agencies. Additionally, various co-located services were offered, and a directory in reception supported staff in signposting patients to self-refer to these services.

Staff at the practice worked closely with the patient group to ensure they received the right care from the right services. To ensure vulnerable patients and those without digital access received timely care and access to services specific to their needs, the practice contacted patients by telephone and by letter where applicable. The practice's arrangements for managing the annual winter vaccination programme were appropriate.

Dignified and respectful care
We found patients were treated with dignity and respect throughout their patient journey. The consultation rooms provided appropriate levels of privacy, with lockable doors and privacy curtains in place, with the doors kept closed during consultations. Almost all respondents to the patient questionnaire felt they were treated with dignity and respect and almost all agreed that measures were taken to protect their privacy.

Patients used a touch screen computer to sign in upon arrival. The waiting area was located behind a glass partition, which helped ensure most conversations between reception staff and patients were held in private. There were suitable rooms available where patients could speak to staff if they required additional privacy.

Chaperone notices were prominently displayed on consultation doors and reception areas and promoted on the practice website. We confirmed that male and female staff were available, and chaperoned appointments could be arranged to suit patient requirements. We were told that some administrative staff had received chaperone training and a chaperone policy was in place to provide guidance to staff. However, the policy lacked a review date.

The practice must ensure the chaperone policy includes a review date to ensure the information is kept up-to-date, and that the policy is reviewed within set timescales.

Timely

Timely care
An up-to-date practice access policy was in place, which outlined the arrangements for patients to access care promptly. We were told that appointments could be made via telephone, online and in-person. A telephone queuing system facilitated timely access to care, and it was positive to note that a high percentage of calls to the practice were answered within two minutes. However, the information about the appointment-making process was limited, both on the practice's website and within the practice.

The practice must ensure comprehensive guidance regarding the appointment process is clearly presented on the website and prominently displayed within the practice to raise patient awareness.

A triage policy was in place to prioritise patients with the most urgent healthcare needs. Most reception staff had received training in care navigation, enabling them to guide patients to the right services for their needs. Non-clinical care navigators

could consult with an on-call doctor for guidance when necessary. Patients were directed to the most appropriate member of the practice team or referred to other healthcare professionals in the community as appropriate.

A cluster paramedic supported the practice five days per week every other week, which we identified as an example of good practice. Robust processes were in place to support patients facing a mental health crisis. A Psychological Health Practitioner (PHP) attended the surgery three times a week to provide support to patients and staff.

Most patients who responded to our questionnaire told us they were able to get a same-day appointment when they need to see a GP urgently, and that they could get routine appointments when they need them. Just over half of the respondents said they were offered the option to choose the type of appointment they preferred. However, we received mixed feedback regarding the process of making appointments and accessing the GPs. Patients commented:

> *"Brilliant practice. Always professional and happy to help. Can always get an appointment. Really couldn't wish to have a better surgery. We are very fortunate for an excellent service. Thank you, every member of staff (is) amazing."*
>
> *"Sometimes a little wait to get through on the phone but always get an appointment when needed. Great surgery."*
>
> *"Always a brilliant service and very fast at arranging appointments for children."*
>
> *"It would be helpful to be able to discuss more than one medical issue per appointment. A limit of two issues per appointment maybe."*
>
> *"A great surgery, appointments on time, friendly staff and always feel like I've been supported."*
>
> *"They need a better system when it takes you 60 or more times to get to speak to someone and longer in with the doctor and doctors don't listen to you they brush your symptoms off."*
>
> *"On the whole my experience with the GP surgery is positive. I would like to see varied opening times, for example some later or earlier times for those of us who work 9-5 jobs and cannot take time off during working hours easily for appointments. The same day appointment rule is a difficult one. It is handy for emergencies but I find the staff push you to use this*

service for routine appointments or non-urgent matters rather than allowing you to easily book a non-urgent appointment in a week or so."

"Would like to see GP practice open from at least 8.00am for the people working as we can be in and gone before the majority of the community arrives at normal GP hours."

"Some staff on reception are rude and unhelpful, especially when on the phone. They are very abrupt when asked are there any appointments and it is extremely difficult…to book appointments in advance, with no help apart from telling you to ring at 8 o'clock on the day."

"The ring at 8am does not work adequately. If you are really ill you should be able to pre book appointments with doctor of your choice."

"If you wish to see the same doctor there can sometimes be a waiting time of 3 weeks. I have failed to get through to reception to make an appointment between 8 and 8:30 and have to try again the following day."

"There's confusion around getting appointments, I have been told you have to ring on the day for an appointment, they cannot be booked in advance. This isn't feasible for people who work and would delay access for their health needs due to inconvenience…An online booking system would better suit a large part of the demographic. Especially those who work and do not have the ability to call easily."

"…The 8am phone struggle for an appointment is frustrating. Sometimes it can take dozens of calls to get through. It would be good to be able to book non-urgent appointments in advance instead of going through the 8am phone fight…"

"When you receive a letter from the GP surgery asking you to contact them to make an (appointment) to discuss results, why do you have to ring at 8am.They already know why they need to see you so why can't you get an (appointment)."

The practice must evaluate the patient feedback regarding the processes for making appointments and accessing GPs and consider whether any improvements can be made.

Equitable

Communication and language

Staff communicated in a clear manner and in a language appropriate to patient needs. Information specific to each patient was recorded promptly within their patient records, including appropriate actions and follow-up requirements. The patient records we reviewed evidenced that sufficient information was being provided to patients to allow informed decisions to be made about their care.

Staff told us that they would accommodate any known language or communication needs and were familiar with services, such as Language Line, to support the need for translation. However, we saw no evidence that the service was making an 'active offer' to Welsh speakers in line with 'More than just words.' The language and communication needs of patients were also not routinely recorded within the patient records we reviewed.

The practice must ensure that language and communication needs are routinely recorded within patient records and do more to implement the characteristics of a service that provides an 'Active Offer' as set out in 'More than just words.'

There were processes in place for the recording and sharing of information from secondary care. Letters and documents were generally scanned onto patient notes and directed to the correct health care practitioner to action as required. However, we found evidence that this process was not being consistently followed, with instances of documents being filed by administrative staff and not forwarded to the GPs for action and coding as appropriate. In addition, there was no audit process to maintain governance oversight and ensure consistency and accuracy in the handling of letters and correspondence.

The practice must:

- **Implement a linear workflow policy to provide clear guidance to staff on which documents can be filed without GP review**
- **Establish an audit process to maintain governance oversight and ensure consistency and accuracy in the handling of letters and correspondence.**

Rights and equality

Equality and diversity were promoted through practice policies and staff training. Staff we spoke with showed a strong commitment to upholding individual patient rights and preferences. Preferred names and pronouns were recorded within patient records and respected by staff, ensuring care was tailored to individual needs.

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

However, we received mixed responses to our patient questionnaire in relation to equality, diversity and inclusion. Ten respondents felt they could not access the right healthcare at the right time. Four respondents told us that they had faced discrimination when accessing the service across the range of protected characteristics. Some respondents chose multiple options.

Among the 39 respondents to our questionnaire with caring responsibilities, only five patients who cared for someone with disabilities, long-term care needs or a terminal illness had been offered an assessment of their needs as a carer. In addition, only 12 said the practice had given them details of organisations or support networks that can provide information and support.

The practice must reflect on the patient feedback provided in relation to equality, diversity and inclusion, and support for patients with caring responsibilities, and consider what improvements can be made.

Delivery of Safe and Effective Care

Safe

Risk management
The practice was clean, well-maintained and in a good state of repair. Some appropriate processes were in place to protect the health, safety and wellbeing of patients and staff. Clinical rooms were well stocked with necessary items and equipment. An up-to-date home visit policy was in place, which set out the procedures for triaging and prioritisation of home visits, as well as identifying and mitigating against any potential risks. However, we found several immediate risks to staff and patient safety that required immediate action by the practice:

- There was no emergency panic alarm system in the treatment and consultation rooms to allow staff to call for assistance in the event of an emergency
- Appropriate checks were not being undertaken on the emergency drugs and equipment. We were told that monthly checks were being conducted; however, these should be carried out weekly, in line with the Resuscitation Council UK; Quality Standards: Primary care equipment and drug list. Additionally, there was no documentation to evidence that these checks were being completed.
- The defibrillator's second battery was missing and was not located during our inspection.

Our concerns regarding these issues were dealt with under our immediate assurance process in Appendix B.

Oxygen was stored securely and appropriately. However, there was no signage to indicate its location in the practice. Additionally, this information was not included in the practice fire plan, posing a potential risk to staff and patient safety.

The practice must install appropriate signage to clearly indicate the location of oxygen storage. Additionally, this information must be incorporated into the practice fire plan to enhance safety measures for staff and patients.

The practice Business Continuity Plan (BCP) was overdue for review and did not adequately cover some key areas, including business partnership risk and significant health emergency procedures.

The practice must ensure the BCP is reviewed and updated to cover all key areas, including business partnership risk and significant health emergency procedures.

A significant events process was in place to ensure significant events and patient safety incidents were documented and discussed by GP partners. However, the practice lacked a formal significant events policy and follow-up processes to ensure incidents were routinely reviewed post occurrence. Additionally, patient safety alerts were sent exclusively to the practice manager's email account, with no backup process to ensure they were received by other staff members when the practice manager was unavailable.

The practice must:

- **Implement a significant events policy to provide clear guidance to staff**
- **Ensure significant events and patient safety incidents are routinely reviewed to confirm the ongoing effectiveness and appropriateness of any actions implemented**
- **Implement a backup system to ensure patient safety alerts are always received.**

Infection, prevention and control (IPC) and decontamination
We found some effective IPC procedures and processes in place, but some areas required strengthening to ensure the practice upheld the required standards of IPC to maintain the safety of staff and patients.

The practice was visibly clean and uncluttered across all areas. All respondents to our questionnaire felt that the setting was 'very clean' or 'clean'. A nurse had been designated as the IPC lead for the practice and an up-to-date IPC policy and other supporting policies were available. Staff demonstrated a clear understanding of their IPC roles and responsibilities.

Appropriate hand hygiene, decontamination and sterilisation facilities were available, and we witnessed staff practicing good hand washing techniques during the inspection. Procedures were in place for the management and disposal of all waste, and clinical waste was stored securely.

However, we identified the following areas for improvement:

- We found no evidence that IPC and waste management audits were routinely conducted and reviewed in line with policy
- Not all staff had completed IPC training at the required level

- While the practice was suitably cleaned by NHS domestic staff, practice staff had no access to the cleaner's cupboard or the cleaning schedules maintained
- Disposable curtains in the consultation rooms lacked installation dates, posing a risk that they would not be replaced within the recommended timescales
- The disabled toilets had a leaking tap and an insecure floor seal, which prevented effective IPC
- Pathway guidance for needle stick injuries was not appropriately displayed within the practice.

The practice must:

- **Implement an IPC and waste management audit process to routinely identify and address areas of non-compliance**
- **Ensure all staff complete IPC training to the required level**
- **Provide practice staff with access to cleaning schedules and equipment, and implement governance processes to ensure cleaning schedules are maintained**
- **Record installation dates on all disposable curtains and replace them within recommended timescales**
- **Repair or replace the leaking tap and insecure floor seal in the disabled toilets**
- **Display needlestick injury pathway guidance in appropriate areas.**

Medicines management
Processes were in place to ensure the safe prescribing of medication, though some areas required strengthening to enhance governance oversight of medicines management processes and support patient safety.

The process for requesting repeat medication was clear, with appropriate reauthorisation controls implemented when necessary. Medication prescribing was supported by a pharmacy technician and cluster pharmacist, and patient medication review audits were conducted to ensure medications were safe and appropriate. We observed appropriate prescribing of medications in accordance with patient needs.

Medications requiring refrigeration were securely stored in dedicated clinical refrigerators, with daily temperature checks completed and documented. However, there was no cold chain policy to provide clear guidance to staff on the action to be taken in the event of a breach to the cold chain. Additionally, one clinical fridge was overstocked, which could potentially impede the effective circulation of cold air.

The practice must ensure that there is a cold chain policy written and clinical fridges are not overstocked to allow for effective cool air movement.

Resuscitation equipment and emergency drugs were available at the practice to manage a patient emergency, such as cardiac arrest. Whilst most medications were securely stored, we found emergency equipment and some medications stored in an unlocked cupboard outside the nurse's room, where they could potentially be accessed by patients. We raised this issue with staff and the items were suitably stored during the inspection.

Prescription pads were securely stored in a locked cupboard. We were told there was a process to securely dispose of prescription pads when a GP left the practice. However, there was no prescribing policy and no audit process to monitor the management of prescription forms, the collection of controlled drug pharmacy prescriptions, or manual prescriptions used during home visits. Practice managers confirmed there was no system for controlling and recording prescription form movement, which posed a potential risk of prescription form theft, fraud and misuse.

The practice must:

- **Develop an organisational prescribing policy to provide clear guidance to staff**
- **Implement a robust and safe system to record, control and monitor prescription form movement**
- **Develop local action protocols outlining the actions to take in the event of loss, theft or missing prescription forms.**

Safeguarding of children and adults
The practice had a named safeguarding lead for adults and children. Staff had access to up-to-date safeguarding policies and procedures, which included the contact details of the designated lead. However, not all staff had completed safeguarding training at the required level.

The practice must ensure all staff complete safeguarding training at the required level.

The practice had a 'Was Not Brought' policy to manage children and vulnerable adults who failed to attend their appointments. The policy included guidance on the process to follow when children or vulnerable adults missed their appointments. We were told that staff attended multi-agency meetings to discuss safeguarding concerns.

Processes were in place to flag individuals with safeguarding concerns and ensure a suitable safeguarding pathway was followed. However, we found this process was not always applied consistently. We identified gaps in the documentation of safeguarding risks, including a child flagged on the at-risk register while other children in the same household were not.

The practice must review its safeguarding arrangements and provide additional staff training to ensure safeguarding concerns are appropriately identified, flagged and managed effectively.

Management of medical devices and equipment
The practice had processes in place to safely maintain equipment. Single use disposable equipment was used whenever possible. There were contracts in place for maintenance and calibration of equipment as appropriate and for any emergency repairs and replacement. We found all equipment was in a good condition and well maintained.

Effective

Effective care
Suitable processes were in place to support the safe and effective treatment and care of patients. These included staff meetings to discuss clinical updates, learning, and new guidance. Quality improvement initiatives, multidisciplinary meetings, and cluster working arrangements further supported these efforts.

Referrals were being managed appropriately, including both standard and urgent referrals. We were told that the practice currently did not undertake analysis of referral rates to identify whether referrals were higher or lower than other practitioners in the local area. The practice may wish to consider working with other practices in their cluster to compare referral rates and discuss potential reasons for any differences found.

Patients who responded to our questionnaire generally provided positive feedback regarding the standard of care and treatment provided at the practice. They told us:

> *"I cannot praise this practice enough as ALL the staff from receptionists to HC staff and doctors are excellent. Very caring surgery. I have always received very good care and support."*

> *"Very friendly and professional staff behind the desk. Doctors always give you time to explain any problems and you feel listened to."*

"A great surgery, appointments on time, friendly staff and always feel like I've been supported."

"In my experience I have always been listened to, felt respected and spoken to professionally and in a language that I can understand. I have received good support and kindness on times, when necessary, from reception staff, nurses to the GP's. An excellent service and I feel one of the best practices."

"Every member of staff at this practice goes above and beyond to help and support patients. All my family are registered with this group and from a personal and observational view, the care, advice and ongoing support can only be described as exceptional."

"Always very happy with the service provided by the practice".

All the staff at the surgery are amazing and go out of their way to help and support you at all times regardless of how urgent or not your request is. I am grateful for the care that is given to me and my family and it makes me feel well supported in the knowledge that I would promptly be seen in the case of an illness etc.

"Excellent service couldn't ask for better…kind and caring with my elderly mum and disabled brother. Can't praise them enough."

"The service is excellent, especially with my son. The GPs have been so supportive and anytime I have phoned I have had appointments for him even within the hour."

Patient records

The electronic patient record system was suitably password protected to help prevent unauthorised access. Our review of nine patient records demonstrated that the records were maintained to a very high standard. Consultation narratives were thorough, with evidence of appropriate decision-making, suitable management plans and appropriate referrals when necessary. Patient records were completed contemporaneously, and the information was presented in a manner that was easy for other clinicians to review.

We found that clinical Read codes were used effectively and consistently, supporting analysis and audit processes. Patient records where a chronic disease was recorded contained a full summary of conditions, detailing past and continuing problems, as well as the medications being taken.

Medical secretaries at the practice were responsible for summarising patient information and undertaking appropriate clinical coding. However, there was no written guidance to support them in completing this task, and no process to routinely review the quality of this work. There was no evidence that audits of the clinical coding and summaries were being undertaken to check the quality of the data entry.

The practice must ensure that regular audits of clinical coding are completed to monitor their accuracy. Clear guidance must be provided to support staff in completing this task.

Efficient

Efficient

We found that services were arranged in an efficient manner and were person centred, to ensure people felt empowered in their healthcare journey. Patients were able to self-refer to a range of services, including physiotherapy, weight management and mental health services, including the PHP. Additional services available through the practice included podiatry and a diabetic specialist nurse. In addition, a range of co-located services were accessible, including dental care, optician, audiology, family planning and child health services.

Quality of Management and Leadership

Leadership

Governance and leadership
There appeared to be a clear and supportive management and leadership structure in place. Staff we spoke with understood their roles and responsibilities, and both the practice manager and GP partners were described as visible and approachable by the wider practice team. The practice had endured recent pressures in relation to sudden and unexpected changes to management roles, and processes were being implemented to address these issues and improve existing governance and leadership systems.

A wide range of policies and procedures were in place to support the effective running of the practice. However, several key policies were missing, including the significant events policy, induction policy, waste management policy, prescribing policy and workflow policy. In addition, some existing policies were past their review dates, including the complaints policy and resuscitation policy.

The practice must ensure that all key policies and protocols are in place, accessible to staff and reviewed within set timescales.

The practice was part of a cluster group and GP partner meetings were reported to occur regularly. However, staff team meetings were not routinely conducted and there was no documentary evidence of any staff meetings to provide governance oversight, identify trends, or promote shared learning opportunities.

The practice must:

- **Implement a staff team meeting process to facilitate staff engagement, discuss issues, and share feedback following concerns or incidents**
- **Ensure all staff meetings are minuted to evidence and action matters discussed, identify themes and drive quality improvement**
- **Share lessons learned with all relevant staff to maintain high service standards and sustain improvements.**

Workforce

Skilled and enabled workforce
We spoke with staff across a range of roles and they appeared committed to providing a quality service to patients. There was an appropriate skill mix across the teams to deliver the services required. However, we reviewed the governance

processes in relation to recruitment and pre-employment checks and were not assured they were robust. Our review of a sample of five staff records across various professions highlighted the following issues:

- We were told that the practice had signed up to the 'UCheck' service to provide DBS checks. However, only one out of the five staff records we reviewed had a suitable Disclosure and Barring Service (DBS) certificate in place. Staff confirmed that only three of the five doctors working at the practice had DBS certificates, and the remaining staff did not
- None of the five staff records we reviewed included contracts of employment
- Only one of the five staff records we reviewed contained an up-to-date job description
- There was no Hepatitis B register to monitor the immunity status of staff. Evidence of immunity was absent within the records of two of the five doctors working at the practice.

Our concerns regarding these issues were dealt with under our immediate assurance process at Appendix B.

We were informed that a training matrix had recently been created to monitor the training records of clinical and administrative staff. While most staff were compliant with their mandatory training, we identified some areas of non-compliance in addition to those previously outlined in this report. This included one staff member who had not completed care navigation training within the first three months of their appointment. We were told that further training courses were being organised for staff and we recommend that these are arranged without delay, to ensure the safety of patients and staff.

The practice must:

- **Ensure all staff complete and remain compliant with mandatory training relevant to their roles, to maintain the safety of patients, staff and visitors**
- **Provide evidence of staff training compliance to HIW upon completion**
- **Implement robust governance oversight to continuously monitor staff training compliance and promptly identify when updates are required.**

An appropriate recruitment policy was available to staff. However, there was no induction policy in place. Staff were unable to describe the induction process for new employees.

The practice must implement an induction policy to ensure new staff receive adequate support and training to perform their roles.

During the inspection we found no evidence of a formal supervision or appraisal process for staff. Our staff engagement confirmed a lack of regular supervisions and appraisals over a period of years. This lack of oversight extended to practice management, with no regular supervisions conducted by GP partners.

The practice must ensure that all members of staff receive regular clinical supervisions and an annual appraisal to discuss their performance, set annual objectives and identify any training needs.

Culture

People engagement, feedback and learning
The practice had a patient complaints procedure and policy which was aligned to the NHS Wales Putting Things Right (PTR) process. However, the complaints policy was overdue for review, and we were not assured that patients, relatives and carers were adequately supported in providing feedback or raising concerns about the service. No details about the complaints process, the PTR process, or Llais were displayed in the waiting area or provided on the practice's website.

The practice must:

- **Update the complaints policy to provide clear and current guidance to staff**
- **Ensure relevant information is clearly displayed and provided to encourage feedback and support patients, relatives and carers in raising concerns about the service.**

The practice manager was responsible for managing all complaints but we were told that complaints and concerns were not logged or monitored. Additionally, there was no process in place to review complaints and feedback, identify any themes and trends and communicate any actions for improvement to staff. One patient who completed our questionnaire told us:

> *"I've made multiple complaints and all I ever get back is that the practice manager will contact me. I'm still waiting for a response to a complaint from over a year ago."*

The practice must implement an effective complaints process and tracking system to monitor, review and resolve complaints and feedback.

Staff confirmed that annual patient surveys were conducted via social media and QR codes displayed within the practice. Patients could also provide feedback via a website link, but there was no information available to demonstrate how concerns and comments from people had been used to develop and improve the service. Additionally, there was no suggestions box and no "You Said, We Did" notice board to inform patients of actions taken as a result of their feedback.

The practice should consider adding a suggestions box and a "You said, we did" information board or poster, to demonstrate actions taken as a result of feedback received.

Information

Information governance and digital technology
We considered the arrangements in place for patient confidentiality and compliance with Information Governance and the General Data Protection Regulations (GDPR) 2018. We saw evidence of patient information being stored securely.

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

Learning, improvement and research

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

There was evidence of clinical and internal audit in place to monitor quality. However, as outlined previously in this report, improvements were needed to ensure audit outcomes, complaints and feedback were routinely collated, discussed and shared across the practice to drive continuous improvement.

All staff we spoke with during the inspection were receptive to our views, findings and recommendations, and showed commitment to addressing areas of improvement. Further work was required to strengthen management and leadership processes in relation to the improvements identified in this report, and action must be taken to sustain the improvements made.

Whole-systems approach

Partnership working and development

We found evidence of strong partnership working in the practice's collaboration within the GP cluster. Medical staff attended cluster meetings and provided services on a cluster-wide basis to ensure comprehensive patient care. The practice signposted patients to cluster-based services, the health board, alternative health providers, and All Wales health services, including the PHP service.

The practice was located in the heart of the community with a wide variety of other services co-located within the same building. This presented additional opportunities for the practice to strengthen its links with the community.

4. Next steps

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

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

The improvement plans should:

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

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

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

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

Appendix A – Summary of concerns resolved during the inspection

The table below 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
Emergency equipment and some medications were being kept in an unlocked cupboard in an area of the practice which was accessible to patients.	This posed a potential risk to staff and patient safety	We recommended to staff that the medications must be moved to a lockable cupboard to prevent unauthorised access to these items.	The items were appropriately stored during the inspection.

Appendix B – Immediate improvement plan

Service: Cwm Calon Surgery

Date of inspection: 13 February 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.	HIW was not assured that the processes in place to maintain staff and patient safety were robust. This was because there was no emergency panic alarm system in the treatment and consultation rooms to allow staff to call for assistance in the event of an emergency. This posed an immediate	The practice must install an emergency panic alarm system to protect staff and patient safety.	Health and care Quality Standards 2023 - Risk Management	SAFE panic button system has been installed	Angela Jarrett, Practice Manager	Already installed

	potential safety risk for staff and patients.					
2.	HIW was not assured that the governance processes in relation to recruitment and pre-employment checks were robust. Our review of a sample of five staff records across various professions highlighted the following issues: • We were told that the practice had signed up to the 'UCheck' service to provide DBS checks. However, only one out of the five staff records we reviewed had a	The practice must ensure that: • All staff complete a DBS check relevant to their role • Staff confirm annually whether any new information has been added to their DBS certificate since previously issued • All staff records contain contracts of employment and up-to-date job descriptions.	Health and care Quality Standards 2023- Workforce; Risk Management	DBS checks have been applied for. Contracts of employment and up to date job descriptions to be added to all staff records	Angela Jarrett, Practice Manager Angela Jarrett, Practice Manager	All results of the DBS checks should be available within the next 2 weeks Within the next 4 weeks

	suitable Disclosure and Barring Service (DBS) certificate in place. Staff confirmed that only three of the five doctors working at the practice had DBS certificates, and the remaining staff did not • None of the five staff records we reviewed included contracts of employment • Only one of the five staff records we reviewed contained an up-to-date job description.					

3.	HIW was not assured that the practice could assure itself regarding the Hepatitis B immunity status of clinical staff, to protect themselves, those they were close to and work with, and people attending the practice for clinical consultations or care. There was no Hepatitis B register to monitor the immunity status of staff. Evidence of immunity was absent within the records of two of the five doctors working at the practice.	The practice must ensure: • A Hepatitis B immunity register is implemented, to record the immunity status of the clinical staff • Staff provide evidence to the practice manager of their immunity status Risk assessments are undertaken and action implemented for any staff who are unable to demonstrate immunity following Hepatitis B vaccination.	Health and care Quality Standards 2023- Workforce; Risk Management Immunisation against infectious disease (The Green Book) 2006 – Chapter 18	Hepatitis B register has been implemented	Angela Jarrett, Practice Manager	Register in place – still awaiting evidence of immunity for 1 GP – has promised to bring in this week
4.	HIW was not assured that appropriate checks were undertaken on the	The practice must ensure all emergency drugs and equipment are checked and recorded on a weekly basis.	Health & Care Quality Standards (2023) – Safe; Timely; Information	Emergency equipment checked weekly and recorded	Louise Lewellyn Practice Nurse	Already in place

emergency drugs and equipment. We were told that monthly checks were being conducted; however, these should be carried out weekly, in line with the Resuscitation Council UK; Quality Standards: Primary care equipment and drug list. Additionally, there was no documentation to evidence that these checks were being completed. We also found the defibrillator's second battery was missing during our inspection.					
	The practice must locate or replace the defibrillator's second battery.	Health & Care Quality Standards (2023) – Safe; Risk Management	Replacement batteries ordered and spare set are with defib	Angela Jarrett, Practice Manager	Done

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): Angela Jarrett,

Job role: Practice Manager

Date: 24 February 2025

Appendix C - Improvement plan

Service: Cwm Calon Surgery
Date of inspection: 13 February 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.	Information about the practice was available on the practice website and within a leaflet distributed to patients upon registration. However, the leaflet was not displayed in the reception area, and some information within the leaflet and on the practice website was outdated.	The practice must ensure the patient information leaflet is accessible to all patients and that all information provided to patients is accurate and up to date.	Health and Care Quality Standards - Health Promotion	The Website has been updated and the practice leaflet is currently being updated	Dr Shore-Nye	1 month
2.	The chaperone policy lacked a review date.	The practice must ensure the chaperone policy	Health and Care Quality Standards -	The policy has been reviewed, updated and dated.	Dr Shore-Nye	February 2025

		includes a review date to ensure the information is kept up-to-date, and that the policy is reviewed within set timescales.	Dignified and Respectful Care			
3.	The information about the appointment-making process was limited, both on the practice's website and within the practice.	The practice must ensure comprehensive guidance regarding the appointment process is clearly presented on the website and prominently displayed within the practice to raise patient awareness.	Health and Care Quality Standards – Timely Care	We are reviewing the information regarding accessing appointments on our website to make the information clearer and also displaying it in the practice.	All staff and overseen by Dr Shore-Nye	1 month
4.	Various patient comments about the process of making appointments and accessing GPs.	The practice must evaluate the patient feedback regarding the processes for making appointments and accessing GPs and consider whether any improvements can be made.	Health and Care Quality Standards – Timely Care	We are currently looking at our appointment system as part of our access standards report	Angela Jarrett, Practice Manager	End of April 2025
5.	We saw no evidence that the service was making an 'active offer' to Welsh speakers in line with	The practice must ensure that language and communication needs are routinely recorded within	Health and Care Quality Standards – Communication and language	New patient questionnaire is being updated to include	Angela Jarrett, Practice Manager	1 month

	'More than just words.' The language and communication needs of patients were also not routinely recorded within the patient records we reviewed.	patient records and do more to implement the characteristics of a service that provides an 'Active Offer' as set out in 'More than just words.'		language and communication needs		
6.	Letters and documents were generally scanned onto patient notes and directed to the correct health care practitioner to action as required. However, we found evidence that this process was not being consistently followed, with instances of documents being filed by administrative staff and not forwarded to the GPs for action and coding as appropriate. In addition, there was no audit process to maintain governance oversight and	The practice must: • Implement a linear workflow policy to provide clear guidance to staff on which documents can be filed without GP review • Establish an audit process to maintain governance oversight and ensure consistency and accuracy in the handling of letters and correspondence.	Health and Care Quality Standards – Communication and language	Currently all scanned letters are directed to GP before completing/writing workflow policy – to be discussed at next months practice meeting.	All GP's	May 2025

	ensure consistency and accuracy in the handling of letters and correspondence.					
7,	We received mixed responses to our patient questionnaire in relation to equality, diversity and inclusion. Ten respondents felt they could not access the right healthcare at the right time. Four respondents told us that they had faced discrimination when accessing the service across the range of protected characteristics. Among the 39 respondents with caring responsibilities, only five patients who cared for someone with disabilities, long-term	The practice must reflect on the patient feedback provided in relation to equality, diversity and inclusion, and support for patients with caring responsibilities, and consider what improvements can be made.	Health and Care Quality Standards – Rights and Equality	All staff have completed "Treat me fairly" training. Wellbeing coaches have been employed by LHB and will be attending surgeries to provide patients with details of organisations and support networks. We are awaiting supporting materials off them.	Angela Jarrett, Practice Manager	6 weeks

	care needs or a terminal illness had been offered an assessment of their needs as a carer. In addition, only 12 said the practice had given them details of organisations or support networks that can provide information and support.					
8.	Oxygen was stored securely and appropriately. However, there was no signage to indicate its location in the practice. Additionally, this information was not included in the practice fire plan, posing a potential risk to staff and patient safety.	The practice must install appropriate signage to clearly indicate the location of oxygen storage. Additionally, this information must be incorporated into the practice fire plan to enhance safety measures for staff and patients.	Health and Care Quality Standards – Risk	Oxygen sign is now in place and details added to fire plan at main entrance	Angela Jarrett, Practice Manager	March 2025
9.	The practice Business Continuity Plan (BCP) was overdue for review and	The practice must ensure the BCP is reviewed and updated to cover all key	Health and Care Quality Standards – Risk	Business Continuity Plan has been updated	Dr Shore-Nye	March 2025

	did not adequately cover some key areas, including business partnership risk and significant health emergency procedures.	areas, including business partnership risk and significant health emergency procedures.				
10.	The practice lacked a formal significant events policy and follow-up processes to ensure incidents were routinely reviewed post occurrence. Additionally, patient safety alerts were sent exclusively to the practice manager's email account, with no backup process to ensure they were received by other staff members when the practice manager was unavailable.	The practice must: • Implement a significant events policy to provide clear guidance to staff • Ensure significant events and patient safety incidents are routinely reviewed to confirm the ongoing effectiveness and appropriateness of any actions implemented • Implement a backup system to ensure patient safety alerts are always received.	Health and Care Quality Standards – Risk	Significant events policy has been written. Review to be done at 3 monthly meeting/CPD	Angela Jarrett, Practice Manager	Policy written February 2025
11.	We identified the following areas for	The practice must:	Health and Care Quality Standards – IPC	IPC and waste management audit in place.	Practice Nurse/Dr Shore-Nye.	February 2025

	improvement in relation to IPC: • We found no evidence that IPC and waste management audits were routinely conducted and reviewed in line with policy • Not all staff had completed IPC training at the required level • While the practice was suitably cleaned by NHS domestic staff, practice staff had no access to the cleaner's cupboard or the cleaning schedules maintained • Disposable curtains in the consultation rooms lacked installation dates, posing a risk that they would not be replaced within the recommended timescales	• Implement an IPC and waste management audit process to routinely identify and address areas of non-compliance • • Ensure all staff complete IPC training to the required level • Provide practice staff with access to cleaning schedules and equipment, and implement governance processes to ensure cleaning schedules are maintained • Record installation dates on all disposable curtains and replace them within recommended timescales • Repair or replace the leaking tap and		IPC training completed to required level. Cleaners' cupboard is left open with cleaning schedules available. Disposable curtains have been dated. Disabled toilet is not part of our surgery as discussed at end of HIW inspection. Needlestick guidance now displayed in all clinical rooms.	The building is owned by the Health Authority. The issues with the disabled toilet have been reported to them.	

	• The disabled toilets had a leaking tap and an insecure floor seal, which prevented effective IPC • Pathway guidance for needle stick injuries was not appropriately displayed within the practice.	insecure floor seal in the disabled toilets • Display needlestick injury pathway guidance in appropriate areas.				
12.	There was no cold chain policy to provide clear guidance to staff on the action to be taken in the event of a breach to the cold chain. Additionally, one clinical fridge was overstocked, which could potentially impede the effective circulation of cold air.	The practice must ensure that there is a cold chain policy written and clinical fridges are not overstocked to allow for effective cool air movement.	Health and Care Quality Standards – Medicines Management	Cold chain policy written and fridge stock re-distributed.	Practice Nurse	February 2025
13.	There was no prescribing policy and no audit process to monitor the management of	The practice must: • Develop an organisational prescribing	Health and Care Quality Standards – Medicines Management	System now in place for recording prescription movement.	Angela Jarrett, Practice Manager	March 2025

	prescription forms, the collection of controlled drug pharmacy prescriptions, or manual prescriptions used during home visits. Practice managers confirmed there was no system for controlling and recording prescription form movement, which posed a potential risk of prescription form theft, fraud and misuse.	policy to provide clear guidance to staff • Implement a robust and safe system to record, control and monitor prescription form movement • Develop local action protocols outlining the actions to take in the event of loss, theft or missing prescription forms.		We have started a register to control and monitor the movement of controlled drug prescriptions that are being sent to each pharmacy daily.	Angela Jarrett, Practice Manager/Alison	April 2025
14.	Not all staff had completed safeguarding training at the required level.	The practice must ensure all staff complete safeguarding training at the required level.	Health and Care Quality Standards – Safeguarding	Safeguarding training completed	Angela Jarrett, Practice Manager	March 2025
15.	Processes were in place to flag individuals with safeguarding concerns and ensure a suitable safeguarding pathway was followed. However, we found this process was	The practice must review its safeguarding arrangements and provide additional staff training to ensure safeguarding concerns are appropriately	Health and Care Quality Standards – Safeguarding	New GP taken over as Safeguarding Lead. Regular meetings and patient records being updated.	Dr Hannan	April 2025

	not always applied consistently. We identified gaps in the documentation of safeguarding risks, including a child flagged on the at-risk register while other children in the same household were not.	identified, flagged and managed effectively.		All staff have now completed safeguarding training.		
16.	Medical secretaries were responsible for summarising patient information and undertaking appropriate clinical coding. However, there was no written guidance to support them in completing this task, and no process to routinely review the quality of this work. There was no evidence that audits of the clinical coding and summaries were being undertaken to	The practice must ensure that regular audits of clinical coding are completed to monitor their accuracy. Clear guidance must be provided to support staff in completing this task.	Health and Care Quality Standards – Patient Records	The written guidance to be done as part of the workflow policy	Angela Jarrett, Practice Manager/Dr Shore-Nye	1 Month

	check the quality of the data entry.					
17.	A wide range of policies and procedures were in place to support the effective running of the practice. However, several key policies were missing, including the significant events policy, induction policy, waste management policy, prescribing policy and workflow policy. In addition, some existing policies were past their review dates, including the complaints policy and resuscitation policy.	The practice must ensure that all key policies and protocols are in place, accessible to staff and reviewed within set timescales.	Health and Care Quality Standards – Governance and Leadership	Existing policies have been reviewed and dated. Significant events/waste management policy done. Induction and workflow policies need to be completed	Angela Jarrett, Practice Manager/Dr Shore-Nye	March 2025 6 weeks
18.	Staff team meetings were not routinely conducted and there was no documentary evidence of any staff meetings to provide governance	The practice must: • Implement a staff team meeting process to facilitate staff engagement, discuss	Health and Care Quality Standards – Governance and Leadership	Since the inspection we have had minuted monthly staff meetings.	Dr Shore-Nye	March 2025

	oversight, identify trends, or promote shared learning opportunities.	issues, and share feedback following concerns or incidents • Ensure all staff meetings are minuted to evidence and action matters discussed, identify themes and drive quality improvement • Share lessons learned with all relevant staff to maintain high service standards and sustain improvements.				
19.	We were informed that a training matrix had recently been created to monitor the training records of clinical and administrative staff. While most staff were compliant with their mandatory training, we identified some areas of non-compliance in addition to those	The practice must: • Ensure all staff complete and remain compliant with mandatory training relevant to their roles, to maintain the safety of patients, staff and visitors • Provide evidence of staff training compliance to HIW upon completion	Health and Care Quality Standards – Skilled and enabled workforce	Care navigation training has been completed by all staff members. Mandatory staff training still on-going, and planning for everyone to complete by end of April 2025.	Angela Jarrett, Practice Manager	Care navigation completed March 2025

	previously outlined in this report. This included one staff member who had not completed care navigation training within the first three months of their appointment. We were told that further training courses were being organised for staff and we recommend that these are arranged without delay, to ensure the safety of patients and staff.	• Implement robust governance oversight to continuously monitor staff training compliance and promptly identify when updates are required.				
20.	Staff were unable to describe the induction process for new employees.	The practice must implement an induction policy to ensure new staff receive adequate support and training to perform their roles.	Health and Care Quality Standards – Skilled and enabled workforce	As previously mentioned, induction policy still to be written.	Angela Jarrett, Practice Manager	6 weeks
21.	Our staff engagement confirmed a lack of regular supervisions and appraisals over a period	The practice must ensure that all members of staff receive regular clinical supervisions and an annual	Health and Care Quality Standards – Skilled and enabled workforce	The practice will offer annual appraisals to all staff members this year (2025)	Dr Shore-Nye	For all appraisals to be completed

	of years. This lack of oversight extended to practice management, with no regular supervisions conducted by GP partners.	appraisal to discuss their performance, set annual objectives and identify any training needs.				by end of 2025
22.	The complaints policy was overdue for review, and we were not assured that patients, relatives and carers were adequately supported in providing feedback or raising concerns about the service. No details about the complaints process, the PTR process, or Llais were displayed in the waiting area or provided on the practice's website.	The practice must: • Update the complaints policy to provide clear and current guidance to staff • Ensure relevant information is clearly displayed and provided to encourage feedback and support patients, relatives and carers in raising concerns about the service.	Health and Care Quality Standards – People engagement, feedback and learning	Website has been updated to include PTR and Llais details	Dr Shore-Nye	March 2025
23.	We were told that complaints and concerns were not logged or monitored. Additionally,	The practice must implement an effective complaints process and tracking system to monitor,	Health and Care Quality Standards – People engagement,	Complaints log has been implemented.	Angela Jarrett, Practice Manager	February 2025

	there was no process in place to review complaints and feedback, identify any themes and trends and communicate any actions for improvement to staff.	review and resolve complaints and feedback.	feedback and learning			
24.	There was no suggestions box and no "You Said, We Did" notice board to inform patients of actions taken as a result of their feedback.	The practice should consider adding a suggestions box and a “You said, we did” information board or poster, to demonstrate actions taken as a result of feedback received.	Health and Care Quality Standards – People engagement, feedback and learning	This was discussed at the last practice meeting but no decision has been made yet so will be discussed again at next meeting	Angela Jarrett, Practice Manager	1 month

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): Angela Jarrett,
Job role: Practice Manager
Date: 24 April 2025