Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report
(Announced)
Meddygfa Cwm Rhymni, Aneurin Bevan 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.

Contents

1. What we did

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

Healthcare Inspectorate Wales (HIW) completed an announced inspection of Meddygfa Cwm Rhymni, Aneurin Bevan University Health Board on 18 February 2025.

Our team for the inspection comprised of one HIW healthcare inspector and three clinical peer reviewers.

During the inspection we invited patients 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 eight questionnaires were completed by patients and three were completed by staff. Feedback and some of the comments we received appear throughout the report.

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

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

2. Summary of inspection

Quality of Patient Experience

Overall summary:
Staff worked hard to provide a caring and professional service for patients. Patient feedback received through HIW questionnaires was generally good with most rating the service as 'good' or 'very good' although there were concerns about the practice answering patient telephone calls and arranging appointments. The practice engaged positively as a member of the local healthcare cluster to ensure a collaborative approach to serving the community.

We found a wide range of healthcare information available within the practice and on their website, while nurse-led clinics for chronic conditions were managed within NICE guidelines. There was good engagement in mental health initiatives with a practice counsellor in place and signposting to other sources of help.

The practice was in a building that was purpose built with level access into the premises from both the car park and street allowing patients with impaired mobility and wheelchair users access to facilities. The patient waiting room was clean and comfortable although it was linked to the reception which limited patient confidentiality when checking in.

We found a wide range of additional health care services co-located at the setting including district nurses and health visitors, enabling easier liaison between the services and providing patients with an effectively co-ordinated care system.

This is what we recommend the service can improve:

- To ensure all patients with carer responsibilities are provided with information and support as appropriate
- To ensure the use of chaperones is recorded in patient records in line with practice policy
- To provide details of plans to improve the response rate to incoming telephone calls and access to appointments.

This is what the service did well:

- The practice website had a wide range of information and links providing advice and support relating to gambling harm, drug use and alcohol reduction
- Patient dignity and respect was maintained with doors to clinical rooms kept closed when in use and privacy curtains available

- The building provided excellent access for patients with impaired mobility and wheelchairs.

Delivery of Safe and Effective Care

Overall summary:
Staff were committed to providing patients with safe and effective care in a clean, well-lit and clutter-free environment. Patient areas including toilets and baby change facilities were well maintained.

We found home visits had been risk assessed with an appropriate up-to-date lone worker policy in place. However, one GP partner was unaware of this policy.

Our review of infection prevention and control (IPC) measures found an appropriate policy was in place and that a recent clinical waste audit had been conducted. Staff had completed necessary training in this subject.

We found vaccines were stored appropriately. There was an up-to-date cold chain policy and evidence of daily fridge temperature checks.

All equipment was well maintained and in good condition, with evidence of regular checks and servicing. Emergency equipment was available and signposted for staff in the event of an emergency, although we considered the storage location could be improved for easier access. As only adult defibrillator pads were available, we recommended the relevant policy be updated to ensure staff were aware of the arrangements in the event of an emergency involving a child.

There was an up-to-date safeguarding policy that complied with the All Wales Safeguarding procedures with clinical and administrative leads appointed. Regular multi-disciplinary team child protection meetings were held. Overall, we considered safeguarding concerns were clearly documented and managed.

Patient records were stored securely and protected from unauthorised access. Overall, of the records that we reviewed, there was generally a high standard of documentation of clinical findings, including negative symptoms, examinations and decisions.

This is what we recommend the service can improve:

- To install a room thermometer where medication is stored
- To move the emergency equipment to a more central location where staff would be able to gain access more easily
- To ensure all relevant staff have completed necessary safeguarding training.

This is what the service did well:

- Good alternative arrangements in place if the premises were unavailable due to an emergency event
- Patient records with child protection status were found to be fully documented and appropriately coded
- We found all computers were locked and secure when not in use.

Quality of Management and Leadership

Overall summary:
We found the practice had good leadership and clear lines of accountability. The staff team worked very well together and were committed to providing high quality healthcare for their patients. Staff stated they would be happy with the standard of care provided by the practice for friends and family.

Team and partner meetings were held on a regular basis with evidence that minutes were being recorded and shared appropriately with staff. A recent amalgamation with another GP service had resulted in new ways of working.

The practice had a comprehensive range of policies which were regularly reviewed and available to all staff. However, there was no record to indicate who had read the policies, and version control was inconsistent.

Staff files included contracts of employment, job descriptions and evidence of annual appraisals. However, we found that references and copies of disclosure and barring service (DBS) certificates were missing for several staff members. Mandatory training was largely up to date, although evidence on staff files did not always correspond with the training matrix.

We found evidence that complaints were handled in accordance with practice policy and that these were subject to annual audit to inform the shared learning process.

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

This is what we recommend the service can improve:

- To implement a recruitment policy
- To ensure references are obtained for all new staff with non-responses recorded
- To ensure that patients are aware of how they may provide feedback about their experience of using the service

- To ensure staff are fully compliant with mandatory training and provide HIW with evidence when completed.

This is what the service did well:

- Shared learning in conjunction with branch practice
- Reflective report based on patient survey created and published on website
- Good information governance with an up-to-date policy in place.

3. What we found

Quality of Patient Experience

Patient feedback

Before our inspection we invited the practice to hand out HIW questionnaires to patients to obtain their views on the service provided at the practice. Responses were mostly positive, with the main issue being accessing the GP and arranging appointments. Most all respondents who answered the question (6/7) rated the service as 'very good' or 'good'.

Person-centred

Health promotion
During our inspection we saw that the practice had a range of written health promotion information available that was displayed on notice boards and on the practice website. This included smoking cessation, mental health, dementia support, weight management and healthy eating advice. The website also had information and links providing advice and support relating to gambling harm, substance misuse and alcohol reduction.

The practice provided a range of nurse-led clinics for the management of chronic conditions and additional services. These included asthma, diabetes, high blood pressure and heart disease, and warfarin therapy. District nurses and health visitors were also co-located at the practice.

We found that the practice engaged in mental health promotion initiatives with signposting to MIND Cymru. We found the practice website also contained links to Melo Cymru, a free self-help website for patient mental health and wellbeing, and SilverCloud, a free online therapy course. We also found guidance to access support via Child and Adolescent Mental Health Services (CAMHS), Integrated Wellbeing Networks (IWN) and Community Hubs.

We were told that mental health support from the local health board was adequate with a practice counsellor in place and available, while the healthcare cluster helped fund projects including pharmacists, physiotherapists, community connectors and outreach nurses.

Of the eight patients who completed the HIW questionnaire, four agreed that there was health promotion information on display at the practice, whilst the remaining respondents skipped the question.

We were told that children and vulnerable adults on the safeguarding register who did not attend (DNA) appointments would be monitored and followed up according to the practice safeguarding policy.

One patient who answered the HIW questionnaire told us they were a carer. They said they had not been offered an assessment of their own needs as a carer nor been provided with details of carer support networks or organisations.

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

Dignified and respectful care

We observed that patients were treated professionally and with dignity and respect during the inspection. 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.

The reception and waiting area were adjoined, limiting confidentiality when reporting for appointments. A notice was displayed in reception advising patients that a spare room could be made available should they wish to discuss matters in private. Telephone calls for appointments and triage were handled in offices on the upper floor, away from public areas.

Three patients who responded to the HIW questionnaire agreed that they were able to talk to reception staff without being overheard. However, three disagreed, with one patient commenting:

"There's no privacy at reception when asked what the problem is."

The practice should ensure that patients speaking at the reception desk can do so in a manner that maintains their privacy and confidentiality.

There was a practice chaperone policy in place for intimate examinations. We saw chaperone posters clearly displayed in the waiting area and treatment rooms, and were told that GPs would offer chaperones to patients when necessary. We were told that only clinical staff would act as chaperones, ensuring they were aware of the requirements of the role and familiar with the procedures they were observing. However, when reviewing patient records, we found an instance of an

intimate examination undertaken where the use of a chaperone was not recorded within the record.

One respondent to the patient questionnaire indicated they had been offered a chaperone when required, whilst six respondents either skipped the question or said it was not applicable to them. However, there was one respondent who strongly disagreed.

The practice must:

- **Ensure the use of chaperones is annotated in patient records in line with practice policy**
- **Reflect on the issue raised in this feedback to ensure all patients are offered chaperones when appropriate.**

Seven respondents who answered the HIW questionnaire felt they were treated with dignity and respect. Six felt that the GP explained things well, answered their questions and felt involved in decisions about their healthcare.

Timely

Timely care

The surgery was open between 8:30am and 6:00pm Monday to Friday with out-of-hours cover over the weekends. Telephone lines were open from 8:00am to 6:30pm. Access to routine appointments were provided through the NHS Wales app, via walk-in and by telephone with appointments available two weeks in advance. The practice was not using e-consultations.

We were told all staff had completed care navigation training and that clinical staff were readily available to provide support if staff were unsure of the best options for a patient. A warning system was in place to highlight to staff which patients may require a face-to-face appointment. Urgent appointments were offered by telephone on a same day basis, with a duty GP available to triage patients. The practice access policy was available on the practice website.

We reviewed the practice activity data available on the practice website and found that of 13,000 calls in January, only 576 (4.36%) were recorded as answered within a two minute target time. 5,244 calls were recorded as abandoned during the same period. Senior staff told us there were errors with the data and that they were discussing the issues with the system providers. However, we tested the telephone response time and found our call remained unanswered after 15 minutes.

Four patients who responded to the HIW questionnaire agreed that they were able to contact the practice when they needed to, and that that they could get routine appointments when they needed them. However, three respondents disagreed on both points. Patient comments included:

> *"I desperately needed assistance and actually I was number 48 in the queue and I waited 1hr and 16 mins, then had to explain and wait for a call back. Very difficult for working people.*
>
> *"When I was able to use the NHS App it was impossible to get an afternoon appointment e.g. after work."*

The practice must:

- **Provide details of plans to improve the response rate to incoming telephone calls**
- **Reflect on the issue raised in this feedback and outline how it plans to improve patient access to appointments.**

There were processes in place to support patients in mental health crisis and, where appropriate, patients were referred to the Community Mental Health Team (CMHT) which was co-located in the building. The practice website also contained guidance for patients requiring urgent mental health support signposting the NHS Wales 111, option 2 (mental health support line). Alternative support and signposting were also available for patients needing mental health support.

We considered there was reasonable provision of care for patients with serious mental illness, although the practice expressed concerns that it was difficult accessing CAMHS.

Equitable

Communication and language

Patients were informed about the services offered at the practice through the practice website, social media and by notices displayed in the practice. We saw a practice leaflet providing useful information about the practice and services offered which was also available in large print format. A hearing loop was installed to assist patients with impaired hearing.

Bilingual signage and patient information were available. There were several Welsh speakers at the practice, and the Welsh Language Active offer was displayed to promote the use of Welsh language while at the practice. However, we were told that 'Iaith Gwaith' lanyards or badges were not currently worn by staff so patients

could identify them as a Welsh speaker. We discussed encouraging staff to wear visual aids that identify them as able to provide care in the medium of Welsh.

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.

We were provided with an up-to-date consent policy. This ensured that all patients were able to give informed consent whilst the practice adult safeguarding policy ensured those patients who were considered to lack capacity were appropriately protected. We were told the practice placed alerts on their clinical notes system to notify staff if there were any issues regarding a patient's capacity to give consent.

The practice ensured messages were communicated internally to the appropriate people by using alerts on the practice IT system. The system allowed for tasks to be managed, escalated and completed to ensure all messages had been acted upon. We found appropriate processes in place for the scanning and workflow of all incoming mail within the practice. We considered clinical secondary care information appeared to be well managed throughout the records that we reviewed.

We saw evidence that patient consultations were person centred and that patients were offered advice to help with self-management of their conditions.

Rights and equality
The practice was in a building that was purpose built with accessibility both inside and out a key requirement. There was a large dedicated free car park with cars able to pull up outside the main doors to allow patients with impaired mobility easy access into the building. We were told that there was a local bus service that stopped within easy walking distance.

Automatic doors to the front entrance of the practice, level flooring throughout and a lower reception desk area allowed for ease of access for patients in wheelchairs. The patient waiting area was spacious and clean with plenty of seating available. A lift was available for access to the upper floor of the premises.

We saw an up-to-date equality, diversity and inclusion policy was in place and that the practice was proactive in upholding the rights of transgender patients. We were told transgender patients were treated with sensitivity and it was confirmed that their preferred names and pronouns would always be used.

Delivery of Safe and Effective Care

Safe

Risk management
We found the clinical treatment rooms and patient areas at the practice to be well lit, clean and free from unnecessary clutter. The patient toilets, baby change and other facilities were well maintained. Appropriate signage was seen to alert patients to any dangers and sharps bins were kept in a safe location and out of the reach of children.

We were provided with a copy of the practice business continuity plan. This had been recently reviewed and contained all the necessary details to ensure appropriate action was taken in the event of an unforeseen incident, including emergency contacts. If the building should become unavailable, the details of the branch practice at New Tredegar and other alternative accommodation were in place to ensure patient care could continue. We found that appropriate arrangements were in place to account for the incapacity or the prolonged absence of a GP Partner.

The practice manager had responsibility for receiving patient safety alerts and distributing these to relevant personnel.

We discussed action taken when home visits were requested and found that these were scheduled via the practice IT system in consultation with the GP and Advanced Nurse Practitioners (ANP's). Appropriate systems were in place to ensure staff were aware of any current issues within nursing homes they attended. We saw an up-to-date risk assessment relating to lone working and home visits was in place. However, one GP partner we spoke to was not aware of this policy.

The practice must ensure all staff involved in home visits has access to the relevant policy and sign to confirm they have read and understand it.

Infection, prevention and control (IPC) and decontamination
We found all areas of the practice were visibly clean and free of clutter and there was a good standard of hand washing facilities available.

There were appropriate processes in place to ensure that the practice was cleaned to an appropriate standard including cleaning schedules for key clinical areas, such as treatment rooms. The building appeared to be well maintained by the local health board which assisted effective IPC management.

Staff had received IPC training appropriate to their roles. Responsibility for IPC was shared between practice teams and the local health board. We were told that the IPC lead had recently left the practice and that they were in the process of appointing a new lead. We discussed ensuring the new lead was trained to the appropriate level for the role.

There was an IPC policy in place, which had recently been reviewed. We saw personal protective equipment was readily available in all treatment rooms, along with suitable foot-operated waste bins.

The practice had an up-to-date waste management policy and we saw evidence of a recent clinical waste audit. Relevant arrangements were in place for the safe storage and disposal of healthcare waste generated at the practice.

Staff were knowledgeable of the process to follow in the event of a needlestick injury, with posters and flow charts put on display in relevant areas following discussions with the practice manager. Occupational health services were available to the practice through the local health board.

All patients that answered the question felt the practice was clean, confirmed that hand sanitiser was available for them in the practice and agreed that staff washed their hands before and after treatment.

Patients who had invasive procedures agreed that staff wore gloves during the procedure, that equipment was individually packaged and that antibacterial wipes were used to clean their skin prior to the procedure.

Medicines management
The practice had processes in place to ensure the safe prescribing of medication. The process for patients to request repeat medication was clear and patients could request repeat medication via various methods including via the NHS Wales app. An up-to-date repeat prescribing policy was in place.

Vaccines were stored appropriately within dedicated vaccine fridges which had received annual maintenance checks. An up-to-date cold chain policy was in place to ensure safe storage of refrigerated medicines and we were assured that staff were aware of the action to take should there be a breach in the cold chain. Evidence of twice daily temperature checks were provided to us to confirm adherence to the policy.

Stock checks of drugs and medications was undertaken by the nursing team. Whilst our review of medication found all to be securely stored and in date, the practice was unable to find the checklist of the drugs or vaccines retained by the practice.

We were supplied a copy of this shortly following the inspection. There was no room thermometer to ensure that drugs being stored at ambient temperature remained within the required temperature range.

We recommend the practice considers installing a room thermometer where medication is stored.

Management of medical devices and equipment
On the day of our visit, we found medical devices and equipment were found to be well maintained and in good working order. There was evidence of calibration and replacement of faulty equipment. Single use items were in use wherever possible. We were told that the GPs managed their own clinical bags for any off-site patient visits.

Emergency equipment including oxygen and a defibrillator were available and signposted so that staff could locate them in the event of an emergency. However, we found this equipment was within a treatment room which was locked using a key when not in use. This presented a potential issue both when the room was being used for treatment or when it was locked as each would limit access to the equipment in the event of an emergency.

We recommend the practice moves the emergency equipment to a more central location where staff would be able to gain access more easily.

We saw evidence that regular checks on the equipment and emergency drugs were conducted. However, we found that only adult defibrillator pads were in date and available.

The practice must complete a risk assessment based on the BLS guidance and ensure the guidance is reflected in the relevant practice policies to ensure staff are aware of the arrangements in the event of an emergency involving a child.

Safeguarding of children and adults
We saw that comprehensive and up to date adult and child safeguarding policies were in place at the practice that reflected the All Wales Safeguarding procedures. These identified the safeguarding lead and their deputy at the practice and included details of actions to take should staff have a safeguarding concern along with the contact details for the local safeguarding team.

We were told that the local area was classed as deprived and that there was a large safeguarding caseload which we considered was well managed. There was protected time for regular multi-disciplinary team (MDT) child protection meetings

that included school nurses and health visitors, with administrative support available and meeting minutes retained.

A process was in place to ensure the medical records of children with a safeguarding status, together with their parents/carers and siblings were identifiable to staff by way of an alert marker within the patient records. We reviewed a sample of records with child protection status and found them to be fully documented and appropriately coded, which we considered commendable.

All three staff who responded to the HIW questionnaire, said they were aware who the safeguarding lead was at the practice and knew how to report any safeguarding concerns.

Effective

Effective care

It was apparent that the practice had a dedicated team that worked hard to provide patients with safe and effective care. The practice manager kept staff up to date with the latest best practice and national guidelines by circulating emails and clinical meetings. We were told that there was a significant events process where incidents would be reported via the Datix online system.

The practice telephone answering service signposted callers with emergency conditions to dial 999. Reception staff were aware of other life threatening conditions and the necessary action to take should a patient present with symptoms.

Senior staff described a suitable organised process for ordering tests and relaying the results to patients. We were told that patients in crisis would be transferred to the duty doctor or signposted to the relevant mental health service.

Patient records

We reviewed a sample of ten electronic patient medical records. These were stored securely and protected from unauthorised access in compliance with relevant legislation. We found all computers were locked and secure when not in use. Our review of the information technology (IT) systems demonstrated effective recording, storage and retrieval of patient clinical information.

Overall, there was generally a high standard of documentation of clinical findings, including negative symptoms, examinations, decisions and safety netting. All consultations that we looked at had appropriate Read coding and we saw evidence that chronic disease management followed current NICE guidelines. However, we could not see any recording of patient language preference.

The practice must ensure that the language preference of patients is recorded within the patient records.

We were mindful that the practice had only recently switched to a new clinical IT system and were told that staff had experienced some difficulties with this transition. It was suggested that this may explain why we found medication linkage to diagnoses was low at 4%, that only 66% had a medication review, and only half of these had any narrative in the medical review. Additionally, whilst non-clinical staff carried out the majority of coding summarisation, senior staff were not aware of any annual audit of summarising accuracy. We agreed that this would add assurance to staff that important coding of diagnoses would not be missed.

The practice must ensure that:

- **There is appropriate linkage between repeat medication coding and the patient clinical condition**
- **Medication reviews are documented in full including discussion with the patient**
- **A regular audit of coding summarisation is completed to monitor accuracy.**

Efficient

Efficient
Patients had access to several services within the premises including opticians, physiotherapists and podiatrists. Practice nurses were able to liaise with other co-located services such as health visitors and district nurses to effectively co-ordinate care for patients.

Quality of Management and Leadership

Staff feedback

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

The response to the staff survey was generally positive. Staff felt satisfied with the quality of care provided to patients and would be happy with the standard of care if provided to their own friends and family. All agreed that care of patients was the practice's top priority and that they were content with the practice's efforts to keep staff and patients safe.

Staff comments included the following:

> ***"The practice has recently changed clinical system which has been quite challenging. Each member of staff has taken this on board really well."***

Leadership

Governance and leadership
Meddygfa Cwm Rhymni was operated by seven GP partners and is an active member of the Caerphilly North Cluster of Aneurin Bevan University Health Board. We found there was a clear management and leadership structure in place at the practice and staff we spoke with were clear about their roles and responsibilities and felt supported by senior staff. The practice provided good governance of their non-medical prescribers with regular debriefs, reviews of their scope of practice and access to clinical meetings.

We were told that team and partner meetings were held on a regular basis, and we saw evidence that minutes were recorded and disseminated to staff. Appropriate methods were described for sharing information, including procedural changes and safety notices with staff.

The practice had an index of policies and procedures that were in place to support the effective running of the practice. We found the policies were reviewed on a regular basis and appropriately shared with staff. However, we could not find a record of staff confirming that they had read and understood the policies. Additionally, we found version control was inconsistent.

The practice must ensure that:

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

Senior staff we spoke with felt the main challenges and pressures they faced were the changes in minimum wages and national insurance and considered this would impose a serious financial burden on the practice.

Workforce

Skilled and enabled workforce
We spoke with staff across a range of roles working at the practice, who felt that workload allocation was appropriate and within their scope of practice. We were told there had been many changes resulting from the recent amalgamation with another GP service which had resulted in new ways of working. We discussed how this needed to be carefully monitored and reviewed to maintain service quality for staff and patients.

We reviewed a selection of staff files and found contracts of employment, job descriptions and evidence of annual appraisals. Senior staff described the recruitment process which included an onboarding checklist. However, the practice was unable to produce a recruitment policy and we were told that relevant references were not requested when employing new staff.

The practice must ensure that:

- **A recruitment policy is implemented**
- **Relevant references are obtained for all new staff employed and that evidence of the references is kept on file**
- **Any non-responses to reference requests are documented and kept on file.**

We saw that staff had either Disclosure and Barring Service (DBS) certificates or DBS reference numbers in their staff files. Staff were required to declare any changes that would affect their DBS status as part of their contract. However, the practice did not actively request confirmation of the continued DBS status of staff. We recommended this be carried out as part of the annual appraisals process.

The practice must ensure that:

- **DBS checks are carried out on all new staff before starting work and a copy kept on file for the purposes of audit**
- **Staff complete and sign an annual declaration that there had not been any changes (i.e. criminal convictions or cautions etc) that would affect their DBS status.**

We found an induction process in place for newly appointed staff, which was documented and signed off by the responsible staff member. An appropriate system was in place to ensure that that all staff were protected against the transmission of hepatitis B.

The practice manager was responsible for monitoring staff training. We were told that Basic Life Support (BLS) was completed predominantly on-line, and discussed considering how face-to-face training in this, and other subjects may be worthwhile in future. It was noted that in a few instances, the staff training matrix indicated that mandatory training courses were completed but they were unable to provide evidence to confirm this. We found some staff were yet to complete equality and diversity training, while evidence of up-to-date safeguarding training was unavailable for several members of staff.

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

Although all staff who responded to the HIW questionnaire agreed there was an appropriate skill mix at the setting, one respondent felt more staff were required for them to do their job properly, and that they were unable to meet the conflicting demands on their time. Whilst two respondents said they had received appropriate training to undertake their role, one felt only partially so, commenting:

"Difficult to get study leave and time to do mandatory training."

Culture

People engagement, feedback and learning
The practice had in place an appropriate complaints policy and procedure which was recently reviewed and in line with the NHS 'Putting Things Right' process. We noted that the policy contained a timescale for response and a named member of staff responsible for investigating the complaint and details of how the complaint could be escalated should a resolution not be found.

We reviewed the practice complaints folder and found these had been acknowledged and resolved in accordance with the policy. We were told

complaints were discussed at partner meetings, while an annual audit of complaints was conducted enabling shared learning across the team and helped inform processes and policies.

We were told that analysis of patient feedback had led to changes including improvements in the telephone service. These were communicated to patients via the practice website. However, seven patients who responded to the HIW questionnaire said the practice had never asked about their experience of the service, whilst five respondents said they did not know how to complain about poor service if they want to do so.

The practice must reflect on the issue raised in this feedback to ensure patients are able to provide feedback and raise complaints as required.

The practice had a Duty of Candour policy in place and we were told that staff had attended workshops and completed online training on the subject. However, we saw no evidence of this within staff files. We were told that the training was conducted on the NHS website and therefore only available to the staff themselves.

The practice must ensure staff complete appropriate Duty of Candour training and provide HIW with evidence when completed.

Information

Information governance and digital technology

We saw evidence of systems in place to ensure the effective collection, sharing and reporting of data and information. There were notices in the waiting area and pages within the practice website explaining how the practice collected, used and shared patient information. An up-to-date information governance policy and a Data Protection Officer supported the practice to ensure compliance with their data handling responsibilities.

Learning, improvement and research

Quality improvement activities

Senior staff told us that they were using opportunities from the recent amalgamation of practices to continuously review the best way of providing services. We were told that lessons learnt from concerns and complaints and mortality reviews were widely shared among the team. We were told that shared learning involved staff from both sites, as part of their commitment to improving the entire service.

We were provided with evidence of audits including IPC and waste management that had been completed to demonstrate quality improvement activities undertaken by the practice. However, the last Practice Development Plan was dated 2018. Considering the changes experienced by the practice over recent years, a more recent plan would have been appropriate.

We recommend the practice develops an up-to-date Practice Development Plan that reflects the current circumstances of the setting.

Whole-systems approach

Partnership working and development
We were told that the practice worked closely within the local GP collaborative/ cluster to build a shared understanding of the challenges and the needs of the local population and to help integrate healthcare services for the wider Caerphilly North area.

The practice had established a good relationship with the local health board and other services located within the premises. The practice also provided GP support for a 10 bed step-down care unit that was on the ground floor of the practice, in addition to care home visits. This helped to achieve reliable, and sustainable outcomes that met the evolving needs of the community.

4. Next steps

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

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

The improvement plans should:

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

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

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

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

Appendix A – Summary of concerns resolved during the inspection

The table below 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: Meddygfa Cwm Rhymni

Date of inspection: 18 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.	No immediate assurance issues					
2.						

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

Service representative:

Name (print):

Job role:

Date:

Appendix C - Improvement plan

Service: Meddygfa Cwm Rhymni

Date of inspection: 18 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.	One patient/ carer told us they had not been offered an assessment of their own needs as a carer nor been provided with details of carer support networks or organisations.	The practice should provide HIW with details of the action taken to ensure all patients with carer responsibilities are provided with information and support as appropriate.	Health and Care Quality Standards - Health Promotion	Practice will actively send SMS to patients on Carers Register detailing support information and offer appt with our Carers Champion via SMS. We will also make the carers notice bolder, brighter and more eye catching to patients.	Victoria Neade Victoria Neade	4 weeks 4 weeks

2.	Three patients told us that they were unable to talk to reception staff without being overheard.	The practice should ensure that patients speaking at the reception desk can do so in a manner that maintains their privacy and confidentiality.	Health and Care Quality Standards – Dignified and Respectful Care	Practice have acted on this information and as a result have relocated the poster to ensure visibility in a location which can be seen before arriving at the reception desk.	Victoria Neade	Completed
3.	We found an instance of an intimate examination where the use of a chaperone was not annotated within the record, in line with the practice policy. Additionally, one patient strongly disagreed they had been offered a chaperone when required.	The practice must: • Ensure the use of chaperones is recorded in patient records in line with practice policy • Reflect on the issue raised in this feedback to ensure all patients are offered chaperones when appropriate.	Health and Care Quality Standards – Dignified and Respectful Care	Added to induction policy for Registrars/Trainees. Reiterate to Clinical staff To reiterate to the clinical team at the Clinical meeting.	Alyson Jones Alyson Jones/Victoria Neade	4 weeks 4 weeks
4.	We found that in January 2025 only 4.26% of calls were	The practice must:	Health and Care Quality	We have actively recruited 4 additional reception staff to	Alyson Jones	Completed

	recorded as answered within a two minute target time, while 5,244 calls were recorded as abandoned. In addition, three patients who responded to the HIW questionnaire said they were unable to contact the practice when they needed to, and that that they could not get routine appointments when they needed them.	Provide details of plans to improve the response rate to incoming telephone calls Reflect on the issue raised in this feedback and outline how it plans to improve patient access to appointments.	Standards – Timely Care	assist with the volume. Currently in discussions with IT company (Care Virtual Navigation) to assist with the navigation of calls that could be redirected rather than waiting in queuing system Practice meeting with Daisy telecoms 03/06/2025 also to ensure we are utilising the system to its full potential and reporting tools are accurate. We will continue to review our service provision and currently advertising for additional salaried GP's/Practice Nurses/IP Pharmacists.	Victoria Neade/Alyson Jones Victoria Neade/ Alyson Jones	4 weeks 4 weeks

				Interviews taking place from w/c 12/05/25		
5.	We saw an up-to-date risk assessment relating to lone working and home visits was in place. However, one GP partner we spoke to was not aware of this policy.	The practice must ensure all staff involved in home visits has access to the relevant policy and sign to confirm they have read and understand it.	Health and Care Quality Standards – Risk Management	Ensure all staff physically sign and date receipt of all practice policies.	Victoria Neade	8 weeks
6.	There was no room thermometer to ensure drugs were stored at the required temperature.	We recommend the practice considers installing a room thermometer where medication is stored.	Health and Care Quality Standards – Medicines Management	B12s are now stored in vaccine fridges which are monitored.	Alyson Jones	Completed

7.	Emergency equipment was located within a treatment room which was locked when not in use, presenting an access issue in the event of an emergency.	We recommend the practice moves the emergency equipment to a more central location where staff would be able to gain access more easily.	Health and Care Quality Standards – Management of Medical Devices and Equipment	Whilst awaiting renovations to the reception area emergency trolley has been relocated to the side room within the reception which has a keypad to enter and always manned.	Victoria Neade	1 week
8.	We found that only adult defibrillator pads were in date and available.	The practice must complete a risk assessment based on the BLS guidance and ensure the guidance is reflected in the relevant practice policies to ensure staff are aware of the arrangements in the event of an emergency involving a child.	Health and Care Quality Standards – Management of Medical Devices and Equipment	Risk Assessment completed and attached. Discussed with clinical staff and agreed Adult Pads can be used if need on children. Will attach Guidance to Defib informing staff of this and send message out to staff.	Victoria Neade	1 Week
9.	We could not see any recording of patient language preference within patient records that we reviewed.	The practice must ensure that the language preference of patients is recorded within the patient records.	Health and Care Quality Standards – Patient Records	Included language preference within the patient questionnaire' which is attached to registration forms.	Victoria Neade	Completed

				Staff advised to ask at every contact.		
10.	We found medication linkage to diagnoses was low at 4%, only 66% had a medication review and only half of these had any narrative in the medical review. Senior staff were not aware of any annual audit of summarising accuracy.	The practice must ensure that: • There is appropriate linkage between repeat medication coding and the patient clinical condition • Medication reviews are documented in full including discussion with the patient • A regular audit of coding summarisation is completed to monitor accuracy.	Health and Care Quality Standards – Patient Records	Clinicians have been advised to ensure repeat medication are linked to problems Clinicians have been advised to ensure full discussions are documented when undertaking medication reviews. Practice to introduce an annual summarisation audit.	Alyson Jones / Victoria Neade Alastair Williamson Pharmacist) Victoria Neade	Ongoing Ongoing 8 weeks
11.	We could not find a record of staff confirming that they had read and	The practice must ensure that: • All staff confirm they have read and understood	Health and Care Quality Standards –	Practice to ensure staff sign and date receipt of policies.	Victoria Neade	8 weeks

	understood the policies. Additionally, we found version control was inconsistent.	relevant practice policies to ensure compliance with practice processes • All policies contain version history, review dates and person responsible for reviewing the procedure.	Governance and Leadership	Review policies to show version history, review dates when updated.	Victoria Neade	8 weeks
12.	The practice was unable to produce a recruitment policy and we were told that relevant references were not requested when employing new staff.	The practice must ensure that: • A recruitment policy is implemented • Relevant references are obtained for all new staff employed and that evidence of the references is kept on file • Any non-responses to reference requests are documented and kept on file.	Health and Care Quality Standards – Skilled and Enabled Workforce	Recruitment policy introduced. References will be obtained as per recruitment policy and non-responses documented in personal records.		Completed. Evidence attached.
13.	We saw that some staff only had Disclosure and Barring	The practice must ensure that:	Health and Care Quality Standards –	Retain all DBS undertaken for new staff in personal.	Alyson Jones	Completed. Guidance attached

	Service (DBS) reference numbers in their staff files. Also the practice did not actively request confirmation of the continued DBS status of staff.	• DBS checks are carried out on all new staff before starting work and a copy kept on file for the purposes of audit • Staff complete and sign an annual declaration that there had not been any changes (i.e. criminal convictions or cautions etc) that would affect their DBS status.	Skilled and Enabled Workforce	Annual appraisal form amended to include declaration from staff no changes to status since undertaken DBS check at commencement of employment.	Alyson Jones	Completed
14.	The staff training matrix indicated that mandatory training courses were completed but were unable to provide evidence to confirm this. We found some staff were yet to complete equality and diversity training, while evidence of up-to-	The practice must ensure staff are fully compliant with mandatory training and provide HIW with evidence when completed.	Health and Care Quality Standards – Skilled and Enabled Workforce Rights and Equality Child and Adult Safeguarding	Ongoing work – staff completing.	Victoria Neade	12 weeks

	date safeguarding training was unavailable for several members of staff.					
15.	Seven patients who responded to the HIW questionnaire said the practice had never asked about their experience of the service, whilst five respondents said they did not know how to complain about poor service if they want to do so.	The practice must reflect on the issue raised in this feedback to ensure patients are able to provide feedback and raise complaints as required.	Health and Care Quality Standards – People Engagement, feedback and learning	We will look at enhancing our current posters within the reception waiting area.	Victoria Neade	4 Weeks
16.	We were told that staff had attended workshops and completed online training for Duty of Candour. However, we saw no evidence of this within staff files.	The practice must ensure staff complete appropriate Duty of Candour training and provide HIW with evidence when completed.	Health and Care Quality Standards – People Engagement, feedback and learning	Ongoing work – staff completing.	Victoria Neade	12 weeks

17.	The last Practice Development Plan was dated 2018. Considering the changes experienced by the practice over recent years we expected a more recent plan would have been in place.	We recommend the practice develops an up-to-date Practice Development Plan that reflects the current circumstances of the setting.	Health and Care Quality Standards – Quality Improvement Activities	We will endeavour to update PDP for 2025/26	Victoria Neade	16 weeks

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): Victoria Neade

Job role: Practice Manager

Date: 7th May 2025