Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Healthcare Inspection Report (Announced)

Cyncoed Consulting Rooms, Cardiff

Inspection date: 26 February 2025 and 7 April 2025
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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 Cyncoed Consulting Rooms, Cardiff on 26 February 2025 and 7 April 2025.

Our team for the inspection comprised of a HIW healthcare inspector and a clinical peer reviewer.

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of 14 questionnaires were completed by patients or their carers and none were completed by staff. Feedback and some of the comments we received appear throughout the report.

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

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

2. Summary of inspection

Quality of Patient Experience

Overall summary:
The clinic offered a light, airy and clean environment, accessible via a lift for those with mobility issues. It promoted patient privacy and dignity with lockable doors and disposable curtains in treatment rooms.

Information on smoking cessation and exercise benefits was available to encourage patients to take responsibility for their health.

Chaperone availability was well-advertised, ensuring protection during examinations.

Patients reported being treated with dignity and respect, with staff listening and answering questions. An informed consent policy was in place, with written consent needed to be recorded in medical records.

Information was mostly in English, but efforts should be made to provide it in Welsh. The clinic had access to a hearing loop and translation services. Patients received post-treatment care instructions and cost clarity.

Feedback was actively sought and acted upon, with a focus on inclusivity and respecting transgender patients' rights.

This is what we recommend the service can improve:

- Ensure that evidence of written consent is included in medical records
- Consider communication needs and wishes of the patients using the service.

This is what the service did well:

- Treating patients with dignity and respects
- Displaying information to encourage patients to look after their own health
- Feedback was actively sought and acted on.

Delivery of Safe and Effective Care

Overall summary:
The waiting room was welcoming and well-maintained, with adequate seating, including a chair with arms for those with mobility issues. The building was accessible and health and safety measures were in place, including up-to-date risk assessments and well-maintained gas and electrical systems.

Fire safety precautions were adequate, though we noted fire drills should be conducted more regularly. The clinic was clean, with effective infection control measures, including sufficient personal protective equipment and proper disposal of medical sharps. Medicines were stored securely and emergency drugs and equipment were available.

Safeguarding policies were up-to-date and staff were sufficiently trained. Patient records were well-maintained, though some improvements were noted.

We noted the registered manager must ensure annual returns to HIW are completed and patient records are securely managed.

This is what we recommend the service can improve:

- Carry out fire drills every six months and record these checks on file
- Complete the annual return as required by regulations
- Ensure patient medical records are kept securely.

This is what the service did well:

- The building was accessible with health and safety measures in place
- The clinic was clean, with effective infection control measures
- Safeguarding policies were up-to-date and staff trained in safeguarding.

Quality of Management and Leadership

Overall summary:
The clinic had a clear management structure, with an office manager assisting the practice manager. The registered manager recently stepped down, necessitating the need for the clinic to appointment a new registered manager and registering this with HIW.

The statement of purpose and patient guide were comprehensive but lacked a reviewer signature. Safety notices were disseminated through the medical centre link.

HIW certificates were not prominently displayed as required by legislation.

Policies were up-to-date and the complaints procedure was clear, with timely responses to complaints.

The recruitment policy needed to include reference to disclosure barring service (DBS) checks and full employment history. Staff appraisals were in progress and

should be completed by the end of April. Mandatory training was up to date, with face-to-face basic life support training being arranged. Staff meetings were infrequent, with information typically shared via email.

This is what we recommend the service can improve:

- Appoint a new registered manager and submit the paperwork to HIW
- Displaying all HIW certificates in a prominent place at the setting
- The recruitment policy including the documentation completed.

This is what the service did well:

- The statement of purpose and patient guide were comprehensive
- Policies were up to date
- Completing mandatory training for all staff.

3. What we found

Quality of Patient Experience

Patient feedback
HIW issued a questionnaire to obtain patient views on the care at Cyncoed Consulting Rooms for the inspection in February and April 2025. In total, we received 14 responses from patients at this setting. Overall, the respondents' comments were positive. All 14 patients rated the service as 'very good' (11/14) or 'good'. The two comments we received on the setting were:

> ***"Staff were very kind."***

> ***"Reception team are very friendly and efficient. Comms good, email reminders."***

Health protection and improvement
There was information available for patients on how they could take responsibility for their own health and wellbeing. These included smoking cessation and information on the benefits of exercise.

Dignity and respect
The setting was light, airy and clean and was on the first floor of the building above Cyncoed Medical Centre. There was a lift to ensure that those with mobility issues had access to the setting.

The environment of the clinic promoted the privacy and dignity of patients. The consulting and treatment rooms had lockable doors and the treatment room also had a disposable curtain to ensure patient dignity. We noted all rooms were closed when in use and the blinds to the windows were also closed. The reception area and waiting room at the clinic was an appropriate size. We noted that staff placed an emphasis on promoting the privacy and dignity of patients attending the clinic.

There was information displayed informing patients of their right to have a chaperone present when being seen by healthcare staff and staff had received training on this. Signs were also displayed on each consulting and treatment room door advertising patients of the availability of chaperones. The use of chaperones aimed to protect both the healthcare professional and patient when the patient was examined by the healthcare professional.

All patients who completed a HIW questionnaire told us staff had treated them with dignity and respect and measures were taken to protect their privacy during their appointment at the clinic. All patients agreed that staff listened to them and answered their questions.

Patient information and consent
There was an up-to-date written policy on obtaining informed consent. From the information displayed in the patient medical records it was clear that patients were given time to consider their treatment options. However, there was no evidence of consent being recorded in the medical records.

The registered manager must ensure that evidence of written consent is included within the medical records.

Communicating effectively
Most of the information on display at the setting was in English. Given that the service operates in Wales, further efforts should be made to routinely provide bilingual information in both Welsh and English.

The setting should consider the communication needs and wishes of the patients using the service.

There was a hearing loop available to assist those patients who were hard of hearing in the main medical centre to communicate with staff at the service. The setting also had access to a translation service for patients who could not speak English.

We saw information on the setting website with photographs and details about the professionals and consultants working at the clinic.

All patients that underwent a procedure or treatment, who responded to the questionnaire, confirmed that they were given post treatment aftercare instructions and clear guidance on what to do and who to contact in the event of an infection or emergency. All but one patient also said that the cost was made clear to them before they received treatment.

In total three patients who responded to the questionnaire said they were Welsh speakers. However, they stated that they were not actively offered the opportunity to speak Welsh throughout their patient journey.

Care planning and provision
We were told that consultants would inform staff in reception if there was a delay in seeing the next patient and patients would then be informed accordingly. There

was a sign in the waiting area telling patients to inform reception staff if there was a delay of more than 20 minutes.

Staff we spoke with believed that patients were provided with appointments to ensure consultants could provide care safely and that the number of reception staff was appropriate to meet the needs of the patients.

Equality, diversity and human rights
There were written policies in place that had recently been reviewed, relating to privacy, dignity and confidentiality, as well as bullying and cyberbullying. All staff completed equality and diversity training. We were told that the setting was an inclusive environment irrespective of any protected characteristic. We were assured that the rights of transgender patients would be actively upheld and preferred pronouns would always be used.

Citizen engagement and feedback
There were opportunities for patients to comment on their experiences of visiting the setting through a quick response (QR) code to provide feedback on an ongoing basis. The recent feedback had been analysed with staff commenting on the positive comments left by patients. There was a 'you said, we did' board to show the results of feedback and the action taken as a result of the feedback, including providing additional reading material.

Delivery of Safe and Effective Care

Environment
The general ambience in the waiting room was of a good standard and the clinic environment was well maintained and free from obvious hazards, it was also warm and welcoming. There was adequate seating in the waiting area including a chair with arms to aid patients with mobility issues.

All bar one patient who completed the questionnaire said that the building was accessible.

Managing risk and health and safety
The setting had taken appropriate measure to manage the risk to health and safety. There was a suitable workplace health and safety risk assessment in place, which was up to date. We saw evidence that appropriate checks were in place to ensure that the gas and electrical systems at the setting were in working order and had been well maintained.

The setting had appropriate fire safety precautions in place as regards fire equipment, extinguishers and regular checks of fire-safety equipment and fire detection equipment. However, we noted that a fire drill had not been held at the practice since the end of 2023.

The registered manager must ensure that fire drills are held every six months and that the record of these checks in maintained on file.

'No smoking' signs were clearly displayed, showing that the practice complied with the smoke-free premises legislation.

There were instructions clearly displayed for staff to follow in the event of a fire and there were adequate means of escape in the event of a fire, which were clearly displayed.

Infection prevention and control (IPC) and decontamination
Written policies and procedures were available to help guide staff on IPC. The service was clean and tidy and staff had access to personal protective equipment (PPE) to help prevent cross infection. Hand washing stations were available in all consultation rooms. There were hand hygiene signs at the sinks. Whilst the taps on the sinks could not be easily operated by elbows to reduce the risk of cross infection, we saw evidence that the setting had requested quotes from local tradesmen to install elbow operated taps.

Medical sharps (such as needles) had been placed in appropriate containers for safe disposal. This helped reduce the risk of injury, to staff and patients, and cross infection from used sharps. We noted most equipment used was single use.

All patients who completed the questionnaire said the setting was 'very clean' (13/14) or fairly clean. All patients with an opinion said that infection control measures were being followed.

There were arrangements for the safe disposal of waste and the disposal of medical sharps, dressings and PPE, in conjunction with the co-located medical practice. Waste was stored securely while awaiting collection by the waste carrier.

Whilst audits had not been conducted on the IPC at the setting, we were told that all consultants who used the setting brought their own equipment to ensure the cleaning and decontamination of the consulting rooms

Medicines management
Medicines were stored at the clinic in locked cupboards. However, room temperature checks were not carried out at the clinic. During the inspection a thermometer was purchased and a log created to monitor the temperature in the room where the medication was stored. This issue is noted in Appendix A.

We were told that private prescriptions would be written by the consultants operating at the premises for any patients who required any specific medications. The setting would then arrange for the prescription to be filled by the relevant chemist.

The setting had the use of the emergency drugs and equipment stored in the medical centre downstairs should there be a patient emergency (collapse). The setting had various policies relating to patient collapse, anaphylaxis and resuscitation. There was evidence of regular checks being conducted and recorded on the emergency drugs and equipment.

Any alerts would be received by the practice manager's mailbox and then disseminated to staff as necessary.

Safeguarding children and safeguarding vulnerable adults
There were established processes in place to ensure that the clinic safeguarded adults and children, with referrals to external agencies as and when required. Safeguarding policies were in place and up to date. The practice safeguarding lead was responsible for ensuring procedures for safeguarding children and adults at risk were kept up to date and was the point of contact for raising concerns.

Any changes to national safeguarding policies would be notified to the setting from the health board via the medical centre. Staff at the setting were trained to level one in safeguarding.

In addition to the safeguarding policy there were also a public interest disclosure policy and whistleblowing policy.

Medical devices, equipment and diagnostic systems
We noted that medical devices at the setting were calibrated, serviced and maintained in line with the arrangements at the medical centre. Any faults would be reported to the practice manager for further escalation.

Safe and clinically effective care
The staff we spoke with were happy working at the clinic and they believed that the care given was timely and that care to patients was provided in a safe environment with access to clinical policies and procedures. From speaking to staff at the setting, including senior staff, we were told that very few patients attending their clinic had additional needs.

The patient records we reviewed were being maintained to a good standard and provided a contemporaneous record of all patient interactions.

Participating in quality improvement activities
The quality of the services provided were assessed and monitored from feedback provided by the patients. The evidence provided showed that positive responses had been received.

However, the setting had not completed an annual return for HIW as required which regularly assessed and monitored the quality of the services provided in the carrying on of the setting against the requirements set out in the relevant regulations.

The registered manager must complete the annual return as required by regulations and forward this to HIW.

Information management and communications technology
The records used at the setting were a mixture of staff records in paper and accounts, appointments and other documentation was electronic. Patient medical records were kept on a mixture of electronic or paper records depending on the consultant. The consultants who kept their patient medical records on paper would take these records away from the setting at the end of the clinic. However, the setting was not aware of the system used to safely and securely manage patients' data and how secure the records were, once they left the setting.

The registered manager must ensure that all consultants using the consulting rooms at the setting confirm in writing the method used to ensure patient medical records are kept securely and that the records are retained for the periods required by legislation.

Records management
The standard of record keeping provided evidence of clear accountability and how evidence of decisions relating to patient care were made. Patient records checked were satisfactory but could be improved.

The registered manager must ensure that the consultants using the setting are informed of the need to ensure that the patient medical records:

- **Ensure that all documents are dated and signed when they are used as evidence from outside agencies**
- **Document those present during consultation with minors**
- **When medication is prescribed an allergy history is documented**
- **Letters are sent in a timely manner informing GPs of any assessment or diagnosis**
- **Document consent**
- **Document the drugs and sutures used for any excision procedures.**

All patients who responded in the questionnaire agreed that they had their medical history checked and signed a consent form before undertaking any treatment.

Quality of Management and Leadership

Governance and accountability framework
The clinic had an office manager to assist the practice manager in the day-to-day management of the clinic. There was a clear management structure in place, with clear lines of reporting and accountability shown. The registered manager held on file for the setting had recently stepped down from their role and the setting needed to appoint another registered manager and complete the relevant paperwork with HIW.

The setting must ensure that a new registered manager is appointed and the relevant paperwork amended with HIW.

We reviewed the statement of purpose and patient guide and found them to contain all the information required by the regulations, apart from who had reviewed the documents and their signature. Paper copies were available in reception for patients to take if requested. The services provided were in accordance with the statement of purpose.

The process to review and agree the policies and procedures was discussed, together with how staff were made aware of any new or changes to existing policies and procedures.

The setting received safety notices through their link with the medical centre and these would be disseminated as necessary.

Only two of the relevant HIW registration certificates were displayed, the setting needs to ensure that all HIW certificates are displayed at the setting.

The registered manager must ensure that all HIW certificates are displayed in a prominent place at the setting.

The practice had a number of policies in place, to which staff had access, these had been recently updated.

Dealing with concerns and managing incidents
The clinic had an up-to-date written complaints procedure, which was on display at the clinic. This set out to patients who they could contact for advice, including the details of HIW, in addition to the timescales for responding to complaints.

The complaints process was described by the practice manager. We were told there had been two complaints in the last 12 months, both complaints had been

acknowledged and dealt with in a timely manner. We were told that any risks and concerns were raised with the relevant consultant, who investigated and reported their findings as appropriate. Any learning was shared with all staff.

Workforce recruitment and employment practices
During the inspection, we found that the staffing levels and skill mix were sufficient to support patient safety and provide the services offered at the clinic.

There was a recruitment policy in place but this did not reference the need to obtain disclosure and barring service (DBS) checks and to have a full employment history, for new staff.

A system was also required to be in place for checking a person remained suitable to work for the service, this could be through repeating DBS at regular intervals and a self-declaration by staff to confirm there had not been a change to their DBS status.

An induction checklist was in place for new staff to ensure they were sufficiently trained in the operation of the setting. However, there was not a requirement for an induction checklist to evidence that the staff had completed the induction with an appropriate sign off.

The registered manager must ensure that:

- **The recruitment policy includes reference to the need for DBS checks and to have a full employment history for new staff before they commence employment**

- **There is a system in place for checking a person remains suitable to work for the service though repeating DBS at regular intervals and a self-declaration by staff to confirm there has not been a change in their DBS status**

- **An induction checklist is completed and signed off for all new staff.**

Workforce planning, training and organisational development
The registered manager explained that the clinic was staffed depending on the number of consulting rooms operating. Part time staff were employed whose hours could be flexed to enable shifts to be covered.

We were told that appraisals had not been completed for staff for some time, but the office manager was now responsible for this and was in the process of appraising staff and these should be completed by the end of April.

The registered manager must ensure that staff appraisals are completed for all staff employed at the setting and that a process is put in place to ensure staff receive an appraisal on an annual basis.

A sample of three staff training records showed that all staff had completed mandatory training including IPC, safeguarding, oxygen cylinder training and basic life support online.

We were told that staff meetings were not held very regularly and information was normally passed to staff by email, some members of staff only worked four to five hours a week and were not always present at the setting during normal working hours. The last full meeting was in August 2024 and there was a part meeting in December 2024.

The setting should ensure that there are regular monthly staff meetings, which are minuted and the minutes of the meetings are passed onto all staff. Should staff not be able to attend they should be given the opportunity to raise any issues and to attend the meetings remotely if they wished.

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
Medicines were stored at the clinic in locked cupboards. However, room temperature checks were not carried out at the clinic during the inspection.	Medication could be stored at temperatures which effects their efficacy.	Management informed.	A thermometer was purchased and a log created to monitor the temperature in the room where the medication was checked.

Appendix B – Immediate improvement plan

Service: Cyncoed Consulting Rooms

Date of inspection: 26 February and 7 April 2025

The table below includes any immediate non-compliance 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 non-compliance issues were noted.					

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: Cyncoed Consulting Rooms

Date of inspection: 26 February and 7 April 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.	From the information displayed in the patient medical records it was clear that patients were given time to consider their treatment options. However, there was no evidence of consent being recorded in the medical records.	The registered manager must ensure that evidence of written consent is included within the medical records.	Independent Health Care (Wales) Regulations (IHR) 2011, regulation 9 (4) (b)	We have written to consultants to advise consent must be recorded in line with HIW regulations. We have implemented a policy and provided consultants with this policy and a consent for that can be utilised if required.	MK	Completed
2.	Most of the information on display	The setting should consider the communication needs		Welsh leaflets now put in waiting area.	SC	Completed

	at the setting was in English. Given that the service operates in Wales, further efforts should be made to routinely provide information in both Welsh and English.	and wishes of the patients using the service.	NMS standard 18 - Communicating Effectively	Also a sign to say that a Welsh speaking Doctor can be available with prior agreement.		
3.	The setting had appropriate fire safety precautions in place as regards fire equipment, extinguishers and regular checks of fire-safety equipment and fire detection equipment. However, we noted that a fire drill had not been held at the practice since the end of 2023.	The registered manager must ensure that fire drills are held every six months and that the record of these checks in maintained on file.	IHR regulation 26 (4) (d)	Fire drill will be undertaken and logged. Copies of records to be kept by CMC & CCR	ST	Completion by 30/06/2025

4.	The setting had not completed an annual return for HIW as required which regularly assessed and monitored the quality of the services provided in the carrying on of the setting against the requirements set out in the relevant regulations.	The registered manager must complete the annual return as required by regulations and forward this to HIW.	IHR regulation 19(2)	Application for new registered manager submitted and de-registration of previous registered Manager. Annual return will then be completed.	SC/ST	Dependant on response from HIW
5.	The consultants who kept their patient medical records on paper would take these records away from the setting at the end of the clinic. However, the setting was not aware of the system used to safely and securely manage patients' data and	The registered manager must ensure that all consultants using the consulting rooms at the setting confirm in writing the method used to ensure patient medical records are kept securely and that the records are retained for the periods required by legislation.	IHR regulation 23 (2) Data Protection Act 1998 / General Data Protection Regulations (EU) 2016	We have set up a consent for, for the consultants to sign to confirm that records are kept	We have devised a form that the consultants have to fill out to advise us how and where the records are stored securely.	Completed

	information how secure they records were once they left the setting.					
6.	The standard of record keeping provided evidence of clear accountability and how evidence of decisions relating to patient care were made. Patient records checked were satisfactory but could be improved.	The registered manager must ensure that the consultants using the setting are informed of the need to ensure that the patient medical records: • Ensure that all documents are dated and signed when they are used as evidence by outside agencies • Include those present during consultation with minors are documented • When medication is prescribed an allergy history is documented	IHR regulation 23 (1)	We have written to the consultants to advise them what needs to be recorded and advise that audits will be taken to check these details.	MK	Completed

		• Letters are sent in a timely manner informing GPs of any assessment or diagnosis • Consent must be documented • The drugs and sutures used for any excision procedure are documented.				
7.	The registered manager held on file for the setting had recently stepped down from their role and the setting needed to appoint another registered manager and complete the relevant paperwork with HIW.	The setting must ensure that a new registered manager is appointed and the relevant paperwork amended with HIW.	IHR regulation 11	This has now be actioned and all relevant paperwork submitted to HIW	ST	Completed
8.					SC	Completed

	Only two of the relevant HIW registration certificates were displayed, the setting needs to ensure that all HIW certificates are displayed at the setting.	The registered manager must ensure that all HIW certificates are displayed in a prominent place at the setting.	Care Standards Act 2000 regulation 28	Certificates now put up		
9.	The recruitment policy did not reference the need to obtain disclosure and barring service (DBS) checks and to have a full employment history for new staff. A system was also required to be in place for checking a person remains suitable to work for	The registered manager must ensure that: • The recruitment policy includes reference to the need for disclosure and barring service checks and to have a full employment history for new staff before they commence employment • There is a system in place for checking a person remains suitable to work for the service though	IHR regulation 21(2) and Schedule 2	The recruitment policy has been updated to reflect the need for a DBS Already in place	ST/SC	Completed

	the service, this could be through repeating DBS at regular intervals and a self-declaration by staff to confirm no change to DBS status. An induction checklist was in place for new staff. However, there was not a requirement for an induction checklist to evidence that the staff had completed the induction with an appropriate sign off.	repeating DBS at regular intervals and a self-declaration by staff to confirm there has not been a change in their DBS status • An induction checklist is completed and signed off for all new staff.	IHR regulation 9(1)(h)	Induction checklist created and forms part of the induction policy		
10.	We were told that appraisals had not been completed for staff for some time, but the office manager was now responsible for this and was in the process	The registered manager must ensure that staff appraisals are completed for all staff employed at the setting and that a process is put in place to ensure staff receive an appraisal on an annual basis.	IHR regulation 20 (2)	Appraisals now completed on staff	SC	Completed

	of appraising staff and these should be completed by the end of April.					
11.	We were told that staff meetings were not held very regularly and information was normally passed to staff by email, some members of staff only worked four to five hours a week and were not always present at the setting during working hours. The last full meeting was in August 2024 and there was a part meeting in December 2024.	The setting should ensure that there are regular monthly staff meetings, which are minuted and the minutes of the meetings are passed onto all staff. Should staff not be able to attend they should be given the opportunity to raise any issues and to attend the meetings remotely if they wished.	NMS standard 25 - Workforce Planning, Training and Organisational Development	Will offer teams meetings where possible. Circulate agendas and minutes and allow response times for any additions. Have a staff Whatsapp group Make sure everyone is kept up to date and given the option to contribute Keep records of meetings.	SC	Completed

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): **Sarah Thomas**

Job role: **CMC Practice Manager**

Date: **2 June 2025**