Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report
(Announced)
Cwm Garw Practice, Cwm Taf Morgannwg 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 Cwm Garw Practice, Cwm Taf Morgannwg University Health Board on 04 November 2025.

Our team for the inspection comprised of two HIW healthcare inspectors, two clinical peer reviewers and a practice manager 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 one questionnaire was completed by patients or their carers and two were completed by staff. The number of completed questionnaires was too low to provide reliable or representative findings. Because of this, the feedback cannot be used in this report.

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 practice demonstrated a strong commitment to delivering a person-centred, inclusive, and accessible service. Health promotion was embedded within daily practice, with a variety of approaches used to support healthy lifestyles. Patients benefited from a wide range of clinics, including those for chronic conditions such as cardiovascular disease (CVD) and chronic obstructive pulmonary disease (COPD), and were supported by additional services such as lifestyle advice and cluster-funded physiotherapy, nursing, and mental health support. The practice also demonstrated a proactive approach in supporting patients who were housebound, older, or digitally excluded.

Patients were treated with dignity and respect. Clinical consultations took place in private settings, and appropriate chaperone arrangements were in place. However, chaperones were not recording their presence in patient notes, contrary to the practice's own policy, and privacy in the reception area was limited for those not using the electronic check-in.

Timely access to care was well supported through a responsive appointment system, including same-day access, telephone triage, and pre-bookable options via the NHS Wales App. Older patients and those with communication difficulties were supported through flexible access options. However, the absence of a formal Access Policy and Care Navigation Policy represented a gap in governance, despite staff having received relevant training.

Communication with patients was clear and inclusive, with adjustments available for those with additional needs, such as hearing loops and large print documents. Information was made accessible through various channels, including bilingual materials and access to translation services. Internally, the practice maintained strong clinical communication processes and ensured timely action on information received from secondary care.

The practice promoted equality and diversity through staff training and supportive policies. The building was accessible, with all patient areas located on the ground floor. However, the accessible toilet lacked an emergency call bell, which must be addressed. The practice showed sensitivity in caring for vulnerable groups, including transgender patients, and supported patients unable to attend in person through home visits.

This is what we recommend the service can improve:

- Chaparone documentation
- Written Access and Care Navigation policies
- Emergency call bell in accessible toilet.

This is what the service did well:

- A strong emphasis on health promotion
- Effective use of the multidisciplinary team and proactive collaboration with external partners
- Communication with patients was inclusive and adaptable.

Delivery of Safe and Effective Care

Overall summary:
The practice had appropriate arrangements in place to protect staff and patient safety, including an up-to-date business continuity plan, regular workforce planning, and established systems for managing patient safety alerts and significant events. However, while incidents were reviewed, there was no formal written Significant Events Policy.

Infection prevention and control (IPC) arrangements were in place, with a nominated lead and annual staff training. However, some IPC and clinical policies were out of date, and audits had only recently started. Daily cleaning records were not available, and cleaning equipment did not meet best practice standards.

Medicines were generally well managed, including the secure storage of prescription pads and use of automated alerts in the clinical system. However, concerns were identified in the storage and monitoring of emergency drugs and equipment. Expired and damaged items were found, and no formal checks or responsible person had been assigned.

The dispensary was well managed and operated to a high standard. All staff were appropriately qualified, and dispensing processes were supported by effective standard operating procedures (SOPs). Noteworthy practice included the use of real-time temperature monitoring for medication storage. The system for handling medication requests and safety alerts was strong, and staff were encouraged to report and learn from any dispensing errors.

Safeguarding arrangements were effective. Policies were up to date, and staff had received training appropriate to their roles.

The practice shared clinical updates and National Institute for Health and Care Excellence (NICE) guidance with staff and used the Datix system for incident reporting. Care navigation training had been completed by administrative staff.

The appointment system worked well, with minimal call waiting times observed. Referrals were processed efficiently using the Welsh Clinical Communications Gateway. Test results were followed up promptly.

Patient records were secure, clear, and well maintained. However, consent for intimate examinations was not always documented. Doctors were summarising patient notes, which could be done by trained administrative staff to free up clinical time.

This is what we recommend the service can improve:

- Strengthen Infection Prevention and Control
- Improve emergency equipment readiness
- Enhance clinical governance documentation.

This is what the service did well:

- Well managed dispensary service
- Effective appointment system
- Strong safeguarding arrangements.

Quality of Management and Leadership

Overall summary:
The inspection found that the practice demonstrated clear and committed leadership, supported by effective governance structures, collaborative working, and a positive organisational culture. The service also showed a strong commitment to learning, staff wellbeing, and data protection. However, several areas for improvement were identified to enhance consistency and staff support.

Leadership roles were clearly defined, with designated leads for key areas such as safeguarding, infection prevention and control (IPC), prescribing, and clinical oversight. Regular meetings were held, with minutes shared to support transparency and staff engagement, including for those unable to attend.

Staff wellbeing was prioritised through access to occupational health and counselling services, along with informal initiatives such as staff social events. The practice also contributed to shared learning and system development through engagement at cluster level.

Recruitment processes were safe and compliant, with appropriate documentation in place for recently recruited staff, including Disclosure and Barring Service (DBS) checks, employment histories, and professional qualifications. However, some staff files lacked up-to-date job descriptions, which are essential for role clarity and

accountability. Additionally, there was no formal induction policy or programme in place to support new staff.

Mandatory training was largely up to date, and staff received regular appraisals. Workforce planning was effective, with use of rotas and meetings to ensure adequate staffing to meet patient needs.

The practice had systems for managing complaints and concerns, aligned with the Putting Things Right guidance. Information on how to raise a concern was available on the website but not displayed in the waiting area. Patient feedback was collected through an annual survey, but there was no process to share resulting changes with patients.

Staff felt comfortable raising concerns and making suggestions. Whistleblowing and Duty of Candour policies were in place.

The practice had robust information governance procedures in place. Patient data was stored securely, and regular audits supported data quality and compliance with UK GDPR.

The practice showed a commitment to continuous improvement. Complaints, incidents, and mortality reviews were discussed in meetings, and minutes were shared. The practice explored innovative solutions, such as the “Think Healthcare” system, to improve patient contact.

This is what we recommend the service can improve:

- Develop a formal induction programme
- Ensure all staff have up-to-date job descriptions
- Improve visibility of the complaints process.

This is what the service did well:

- Recruitment processes were safe and thorough
- Robust information governance
- Commitment to continuous improvement and innovation.

3. What we found

Quality of Patient Experience

Person-centred

Health promotion
During the inspection, we found that the practice promoted healthy lifestyles through a range of accessible and person-centred approaches. Staff provided health information using printed leaflets, website resources, and text message links. Leaflets were available in the waiting area, and staff could print materials during consultations. Patients with specific conditions, such as chronic kidney disease, received tailored letters offering advice and support.

The practice ran dedicated clinics for cardiovascular disease (CVD) and chronic obstructive pulmonary disease (COPD), where patients received lifestyle advice and condition-specific education. A Lifestyle Advisor was available to offer personalised support. The CVD and Health Advice Service (WISE) provided cardiovascular risk assessments and delivered health education clinics focused on managing hypertension, improving lipid control, and supporting lifestyle changes.

Patients with musculoskeletal conditions accessed the First Contact Physiotherapy Service, which was funded through the cluster. This service allowed patients to be assessed and advised by a physiotherapist without needing a GP appointment. Reception staff referred patients directly, which helped reduce delays and improve access to care.

A shared clinical pharmacist supported the practice by reviewing medications, monitoring anticoagulants, and ensuring safe and effective prescribing. The pharmacist also contributed to quality improvement work and helped manage repeat prescriptions.

The cluster-funded nursing team included a Chronic Disease Nurse and a Health Care Assistant. They carried out home visits and reviews for housebound patients, helping to ensure that those with limited mobility or other vulnerabilities received the care they needed. A mental health nurse attended the practice once a week to support patients with emotional or psychological needs.

The practice had clear processes in place to manage missed appointments. This included “Did Not Attend” and “Was Not Brought” policies, which helped staff follow up appropriately. Notably, the practice also monitored when patients

missed hospital appointments, which was an example of good practice in identifying barriers to care and supporting continuity.

The practice took proactive steps to support older adults and individuals who may lack digital access, ensuring they are not disadvantaged. Staff actively signpost such patients to external services aimed at disease prevention and health promotion, reflecting a person-centred ethos that prioritises inclusion and continuity of care.

Dignified and respectful care
We found that patients were consistently treated with compassion and respect. Reception staff greeted patients in a courteous and professional manner. Consultation and treatment areas were located away from the main reception, which helped maintain patient privacy.

Clinical rooms provided appropriate levels of privacy during consultations and examinations. Doors were kept closed, and privacy curtains were in place around examination areas.

However, the reception area offered limited privacy for patients who did not use the electronic check-in device. This may have affected the confidentiality of conversations at the front desk. We were told patients arriving at reception could be taken to an empty room if they wished to have a private discussion with a member of staff.

Male and female chaperones were available and had received appropriate training. Notices informing patients of the chaperone service were clearly displayed in both the waiting area and clinical rooms. The chaperone policy was up to date and aligned with expected standards. Despite this, we noted that chaperones did not record their presence in the medical notes. This practice was not in line with the current policy.

The service must ensure that chaperones document their involvement in patient records.

Timely

Timely care
The practice had systems in place to support timely and equitable access to healthcare for all registered patients. The appointment system was designed to be both flexible and responsive, catering to different levels of clinical urgency and patient preference. Patients were able to request same-day urgent appointments by telephoning the practice or by attending in person, with a limited number also made available via the NHS Wales App to support digital convenience.

Routine appointments for non-urgent and follow-up care were pre-bookable through multiple routes, including by telephone, in person at reception, or online through the NHS Wales App.

Older individuals or those who were digitally excluded were able to make appointments by visiting the practice or calling by phone, and arrangements were in place to support those requiring face-to-face consultations due to vulnerability or communication difficulties.

The practice operated a telephone triage system to assess patients based on clinical need and direct them to the most appropriate healthcare professional, including GPs, nurses, or pharmacists.

Efforts were made to keep patients informed about how to access care through notices displayed in the waiting area, and information shared on the practice website and social media. Although the practice did not have a formal Access Policy or a written Care Navigation Policy, staff had received care navigation training, enabling them to guide patients to the appropriate services or clinicians.

The service must develop and implement a written Access Policy and a Care Navigation Policy.

There were processes in place to support patients with mental health needs. Where appropriate, patients are referred to the mental health crisis team/child and adolescent mental health service for urgent crisis support. Alternative support and signposting were also available for patients needing mental health support, including counselling funded by the cluster and NHS 111 option 2.

Equitable

Communication and language
We observed staff communicating clearly and appropriately with patients. They used language that suited the needs of everyone. The practice had a hearing loop installed for patients who used hearing aids. This was displayed at reception. Staff told us they could provide easy read documents or larger print on request. These options supported older patients and those with communication barriers.

Information about the services offered by the practice was communicated through multiple channels, including the practice website, social media, and posters displayed in the waiting area. This approach ensured that patients could access essential information in a way that best suited their circumstances.

We were informed that all incoming information from secondary care was reviewed, recorded, and acted upon appropriately. These processes were electronic and audit trailed, ensuring accountability and supporting continuity of care. The practice also had robust systems in place for internal clinical communication.

For patients who were older or digitally excluded, the practice took additional steps to ensure they received the information they needed. Communication regarding conditions, investigations, and management plans was provided via telephone or by sending a text message inviting the patient to make an appointment.

The practice had an up-to-date Consent Policy. It covered patients who lacked capacity and those under the age of 18.

The practice supported bilingual communication, with two Welsh-speaking staff members available for appointments upon request. Bilingual signage and information materials were also present in the waiting area. Furthermore, the service had access to translation services, allowing patients who spoke other languages to engage fully with their care and receive information in a language they understood.

Rights and equality
We found equality and diversity were promoted to staff through up to date practice policies and mandatory annual staff training. We confirmed all staff had completed relevant training.

Patients had good physical access to the building. All patient areas, including treatment rooms and an accessible toilet, were located on the ground floor. The accessible toilet included a baby nappy changing table. However, it did not have an emergency call bell.

The practice must install an emergency call bell (or pull cord) in the accessible toilet.

To support patients who require greater confidentiality, the practice has implemented measures that facilitate unobtrusive access to care.

Patients who could not attend the practice in person were able to request a home visit ensuring that those with mobility issues or other barriers to access were still able to receive care.

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
The practice had arrangements in place to protect the safety and wellbeing of staff and people visiting the premises. An up-to-date business continuity plan was in place, ensuring the practice could respond effectively to disruptions in service delivery and maintain patient care during emergencies. Staff were supported through regular workforce planning.

Patient safety alerts were managed by the practice manager and shared with GPs and discussed in clinical meetings with shared learning implemented. Staff were aware of emergency procedures, including the locations of emergency drugs and equipment.

The practice had an established process for reviewing and discussing significant events, including patient safety incidents. However, while the process appeared to be functioning effectively, there was no formal Significant Events Policy in place to underpin this work.

The practice should develop and implement formal written Significant Events policy.

Waste and recycling bins were kept away from the building, which helped reduce environmental and safety risks. However, the bins were not stored in a secure area. This posed a potential risk to public safety and environmental hygiene.

The practice must ensure that all waste and recycling bins are stored in a secure, enclosed area.

Infection, prevention and control (IPC) and decontamination
The practice had assigned leadership roles for infection prevention and control (IPC), a lead had been nominated and a dedicated cleaner was employed by the practice. However, staff awareness of IPC responsibilities was inconsistent.

Staff completed annual IPC training at a level appropriate to their roles. Despite this, several areas of concern were noted during the inspection. The IPC policy and some clinical policies, including those for blood-borne viruses (BBV) and needlestick injuries, were out of date. This may have affected the clarity and consistency of guidance available to staff.

The practice must review and update its IPC and clinical policies to ensure they reflect current guidance.

During the inspection, we found sharps bins in clinical areas that had been assembled in 2022 and 2023. The bins contained discarded sharps but were not close to the full indicator line. Staff confirmed the bins were still in use.

The practice should review its procedures for monitoring the duration of use and replacement of sharps bins.

The practice had recently introduced IPC audits. The practice manager had initiated audits for clean curtains, sharps bins and hand hygiene. These were positive steps, but further work was needed to embed IPC as a routine part of quality assurance.

The practice should ensure that IPC audits are completed and embedded into routine processes, maintaining a continuous focus on infection prevention and control. At a minimum, this should include conducting an annual audit.

While cleaning schedules were referenced in policy documents, daily cleaning records were not seen, making it difficult to verify whether routine environmental cleaning was being carried out as intended.

The practice should ensure that the cleaning schedule is readily accessible to cleaning staff and includes a system for staff to sign upon completion of tasks.

During the inspection, concerns were also identified in relation to cleaning equipment and its potential impact on infection control standards. When reviewing the cleaner's cupboard, it was noted that there was only one mop bucket in use. Best practice in infection prevention and control requires that separate mop buckets are used for different zones within the practice to prevent cross-contamination between potentially high-risk areas.

The practice must ensure that cleaning equipment complies with best practice for infection prevention and control.

The practice maintained a completed Hepatitis B vaccination register. An annual healthcare waste audit was carried out by the practice's waste management provider. The most recent audit was conducted in October 2025, and we were told the practice was in the process of implementing its recommendations.

The practice should implement the outstanding recommendations from the annual healthcare waste audit without delay.

Medicines management
There were systems in place for the secure storage of prescription pads, and processes were established to track prescription stationery and ensure the safe disposal of unused pads. Most prescriptions were sent to the adjoining pharmacy. However, there was no audit trail for Controlled Drug prescriptions that were collected from the practice by patients or carers. This limited the practice's ability to monitor and account for these prescriptions.

The practice should establish a robust audit trail for Controlled Drug prescriptions collected by patients or carers.

Repeat prescriptions could be ordered through multiple routes, which supported accessibility for patients. However, we were told that the repeat prescribing process was not always followed consistently by the practice, indicating a need for better adherence to and monitoring of prescribing protocols to ensure accuracy and safety in medication provision.

The practice must ensure consistent adherence to its repeat prescribing protocols and implement a system to monitor compliance.

The practice had systems in place to maintain the cold chain for vaccines and immunisations and the vaccine refrigerator was serviced annually in accordance with safety guidance. However, the Cold Chain Policy was not dated, making it difficult to confirm whether it reflected current guidance. Additionally, during the inspection, some vaccines were observed to be in contact with the sides of the fridge, which could compromise temperature regulation and vaccine efficacy.

The practice must:

- **Review and update its Cold Chain Policy to ensure it is dated and reflects current guidance.**
- **Ensure that vaccines are stored in accordance with national guidance, avoiding contact with fridge surfaces and ensuring proper shelf placement.**

There was no named individual responsible for the checking of emergency items, and no formal checklists were available at the time of inspection. Although staff reported that checks were carried out daily, the absence of documentation meant there was no way to verify this or to track when items had last been reviewed. Furthermore, some drugs and consumables used for resuscitation were found to be unsuitable for use: certain syringes and needles were past their expiry date, while packaging on some disposable airways was open and dust covered.

The practice must:

- **Appoint a named individual responsible for checking emergency equipment and drugs on a weekly basis**
- **Implement a formal documented system using checklists in line with Resuscitation Council UK guidance**
- **Ensure all emergency items are inspected regularly, and expired or damaged consumables replaced promptly to ensure readiness for resuscitation and patient safety.**

The storage room for the Automatic External Defibrillator (AED) and associated emergency equipment had no external signage, which could delay access in critical situations.

The practice must ensure that appropriate signage is in place to show the location of emergency equipment.

Dispensary

This surgery was part of a dispensing GP practice. All dispensary staff were qualified to at least NVQ Level 2 in Pharmacy Services, which met national standards. Staff qualifications had been independently verified and were recorded in personnel files. The practice carried out regular competency assessments and refresher training. All dispensers received formal annual appraisals to support professional development and ensure continued compliance.

The dispensary operated under a comprehensive set of Standard Operating Procedures (SOPs), which governed stock management, dispensing processes, and safety protocols. All ordering and receipt of medication stock were fully documented and auditable in accordance with these SOPs. Where medication supply issues or delays occurred, dispensary staff recorded them in a stock shortage log and escalated the issue to a supervisor. Continuity arrangements were in place, including established support from local community pharmacies, to manage urgent supply needs or mitigate the impact of stock shortages.

The dispensary had robust storage and stock-checking processes in place. Fridge and room temperatures were monitored using a system that transmitted data remotely to a tablet device, which triggered alerts in the event of temperature breaches. **This use of real-time monitoring and automated alerts was considered noteworthy practice** and represented a proactive approach to maintaining medication integrity.

Patients could request repeat prescriptions through a variety of channels, including in person at the dispensary, by telephone during set hours, in writing using the repeat slip, by email, or via the Healthera and NHS Wales apps. These requests

were entered into the clinical system and reviewed against the patient's authorised medication list to confirm eligibility and the validity of review dates. Any discrepancies, early requests, or queries were referred to the prescribing GP for review before dispensing proceeded, ensuring an additional layer of clinical oversight.

All prescriptions were generated through the clinical system, which incorporated automated safety alerts, including warnings about drug–drug interactions, allergies, dosage limits, and duplicate therapies. Dispensary staff were trained to respond appropriately to these alerts and to confirm relevant clinical information before completing the dispensing process, thereby enhancing medication safety.

The practice had a clear process for managing clinical incidents related to dispensing errors. Staff were encouraged to log all errors and near misses. The Dispensing Lead GP and Practice Manager reviewed all incidents within 24 hours to assess severity, investigate root causes and take immediate corrective action. Incidents and near misses were reviewed regularly as part of the practice's clinical governance programme and were included in the annual significant event audit.

Safeguarding of children and adults

Safeguarding policies and procedures within the practice ensured staff and patients could report concerns, with appropriate investigations and actions to protect vulnerable children and adults. The practice demonstrated good evidence of effective multi-agency and multi-professional working, with regular meetings and accessible services such as health visitors, district nurses and palliative care teams.

We confirmed that staff had undertaken safeguarding training according to their clinical roles and responsibilities, including level three training for the designated practice safeguarding lead.

Management of medical devices and equipment

The practice used single-use equipment wherever possible, reducing the risk of cross-contamination and supporting infection prevention and control. All medical devices and equipment observed during the inspection appeared to be in good working order, with no visible damage or defects noted. The practice had contracts in place for the servicing and maintenance of medical devices and equipment.

Emergency repairs were managed by removing the equipment from service and arranging repairs or replacements through the practice manager. However, it was noted that despite having a named individual responsible, no regular checks of medical devices and equipment had been carried out.

The practice must ensure that formal, documented checks of all medical devices and equipment are carried out regularly and recorded.

Effective

Effective care

The practice had systems in place to support the delivery of effective care. New clinical information was circulated to relevant staff through a combination of email communication and updates posted to a shared staff folder. The practice used the Datix system for reporting and recording incidents, supporting organisational learning. NICE guideline updates were disseminated to GPs and were discussed during team meetings, contributing to ongoing clinical awareness and evidence-based practice.

All administrative staff had completed Care Navigation training, enabling them to effectively guide patients to the most appropriate healthcare professional or service.

The appointment system was well managed. During the inspection, we saw minimal numbers of calls waiting. The practice manager attributed this to the use of pre-bookable appointments and the provision of additional services such as COPD and cardiovascular disease (CVD) clinics. These measures helped reduce demand on the phone system and improved access for patients.

Routine and urgent referrals were processed using the Welsh Clinical Communications Gateway (WCCG), which supported a standardised and efficient referral process. There was a well-established and effective system in place for following up test results and arranging repeat tests where needed.

Patient records

We reviewed six electronic patient records during the inspection. These were stored securely and protected by password access, in line with data protection requirements. The records were clearly written, of a good standard, and contained appropriate and complete information. Entries were contemporaneous and presented in a way that was easy for other clinicians to interpret.

Significant past medical history was clearly documented, repeat medications were correctly recorded with appropriate review dates, and allergies to medication were noted where applicable. There was also evidence of the use of appropriate READ coding.

Consent for an intimate examination was not recorded in one set of notes, although the offer of a chaperone was documented.

The practice should ensure that consent for all intimate examinations is clearly documented in the patient's clinical notes, alongside the offer or presence of a chaperone.

It was also observed that doctors were routinely summarising patient notes. While this task was being completed appropriately, it was not considered an efficient use of clinical time. This administrative function could be more suitably undertaken by trained non-clinical staff, freeing up clinician time for direct patient care.

The practice should consider formalising the role of trained administrative staff in summarising patient notes and introduce a system of regular audits to monitor accuracy and consistency.

Efficient

Efficient
The practice had systems in place to support the efficient delivery of care. Patients could be referred to external clinics where appropriate, and self-referral options were available for a range of services, enhancing accessibility and reducing unnecessary delays in care.

Clinical records showed a clear narrative and evidence of patient-centred decision making. Staff described appropriate systems for reporting and learning from significant events, indicating a culture of continuous improvement.

Quality of Management and Leadership

Leadership

Governance and leadership
Staff and managers demonstrated understanding of their roles, responsibilities and reporting lines, and recognised the importance of working within their scope of practice. There was a system in place for recording and sharing minutes of meetings, including with staff who were unable to attend. Information, including updates to policies and procedures, was shared with all staff through established communication channels.

The practice had designated leads for key areas, including safeguarding, infection prevention and control (IPC), prescribing and clinical oversight. The senior partner held overall responsibility for the dispensaries, clinical governance, and complaints. Regular clinical meetings were held.

Wellbeing support was made available through access to occupational health services and counselling, providing staff with professional resources to manage physical and emotional health concerns. We were told that staff nights out had also been arranged.

There was also evidence of collaboration at cluster level, indicating the practice's commitment to integrated care and shared learning across the wider health community.

Workforce

Skilled and enabled workforce
The inspection found that the practice had appropriate systems in place to support safe and compliant recruitment processes. For recently recruited staff, documentation was in good order and included proof of identity, Disclosure and Barring Service (DBS) checks at the appropriate level, a full employment history, written references from previous employers, and evidence of relevant qualifications. For healthcare professionals, verification of registration with the appropriate regulatory body was also confirmed, ensuring that only properly accredited individuals were delivering clinical care.

However, some staff files did not include up-to-date job descriptions. These are essential documents for defining roles and responsibilities, setting expectations, and supporting accountability.

The practice should ensure that all staff files contain up-to-date job descriptions that clearly outline roles and responsibilities.

There was no formal induction programme or policy in place to support new staff. While some informal arrangements were in place, a structured induction would help ensure consistency and support new staff to understand their roles and responsibilities from the outset.

The practice should develop and implement a formal induction policy or programme for all new staff.

Mandatory training was generally well maintained across the team. Staff received appraisals, and training needs were identified as part of this process. Workforce planning was effective, with rotas and meetings used to ensure the availability of appropriately skilled staff to meet patient needs.

Culture

People engagement, feedback and learning
The practice had established systems for engaging with patients and staff, and for learning from feedback and concerns. Complaints and concerns were monitored, and a named member of staff was responsible for managing them. The practice followed its current complaints policy, which was well documented and aligned with the Putting Things Right (PTR) guidance. The website provided information for patients on how to raise concerns. However, there was no information displayed in the waiting area about how to make a complaint or raise a concern, including details about the PTR process.

The practice must ensure that information about how to raise a concern or make a complaint, including Putting Things Right guidance, be displayed in the waiting area.

Patient feedback was obtained through an annual survey. However, we found that there was no process to communicate changes to patients. The practice may wish to consider tools, such as "you said, we did" board.

The practice had an up-to-date Duty of Candour policy in place. Staff felt comfortable to speak up regarding any concerns they had and a whistleblowing policy was in place to support this. In addition, staff felt comfortable to share any suggestions they might have and could provide these to the practice manager for consideration.

Information

Information governance and digital technology

The practice had established clear and robust arrangements for managing information governance. An up-to-date information governance policy was in place, covering all aspects of data processing within the practice. This policy outlined the responsibilities of staff in handling patient and organisational data securely and in compliance with relevant legislation, including the UK General Data Protection Regulation (UK GDPR).

A Data Protection Officer was in place to oversee compliance with data protection requirements. Staff had access to relevant information governance policies, which were readily available and clearly set out the protocols for managing, storing, and sharing personal data safely.

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

Learning, improvement and research

Quality improvement activities

The practice demonstrated a commitment to continuous learning and improvement, with well-established processes in place to support reflective practice and service development. Regular clinical meetings provided a structured forum for discussing complaints and concerns related to clinical care.

The practice also engaged in wider learning through the review of both internal and external sources, including mortality reviews, incident reports, and patient complaints. These were regularly discussed in team meetings, with minutes recorded and shared among relevant staff.

In addition to traditional review mechanisms, the practice demonstrated a willingness to explore innovative solutions to support service delivery. One example was the exploration of the "Think Healthcare" system, to manage patient contact more efficiently.

Whole-systems approach

Partnership working and development

The practice demonstrated a clear understanding of its role within the wider healthcare system and took account of the implications of its actions on other services.

The practice maintained regular engagement with system partners through various forums, including multidisciplinary team meetings, cluster meetings, and practice manager meetings.

Collaborative relationships were maintained with a range of external partners, including the health board, other primary care providers, and cluster colleagues. These partnerships helped build a shared understanding of population needs and supported the delivery of coordinated responsive care.

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: Cwm Garw Practice

Date of inspection: 04 November 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.	There were no immediate assurance issues.					
2.						
3.						
4.						

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: Cwm Garw Practice

Date of inspection: 04 November 2025

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

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	We noted that chaperones did not record their presence in the medical notes. This practice was not in line with the current policy.	The service should ensure that chaperones document their involvement in patient records to support safe and transparent care.	Health and Care Quality Standards (2023) – Patient-centred, Safe.	This has now been implemented	Mark Williams	In Place
2.	The practice did not have a formal Access Policy or a written Care Navigation Policy, staff had received care navigation training, enabling them to guide patients to the	The service must develop and implement a written Access Policy and a Care Navigation Policy to support consistency and transparency in how patients access care.	Health and Care Quality Standards (2023) – Patient-centred, Equitable, Effective, Leadership, Information,	Policy to be written and completed using templates available	Mark Williams	End of Feb (delay due to new Clinical system installation)

	appropriate services or clinicians.		Whole Systems Approach.			
3.	It was noted that the accessible toilet did not have an emergency call bell, which could limit assistance in the event of a medical or mobility-related emergency.	The practice must install an emergency call bell (or pull cord) in the accessible toilet to ensure individuals can summon assistance promptly in the event of a medical or mobility-related emergency.	Health and Care Quality Standards (2023) – Safe, Person-centred, Equitable, Timely.	In discussion with local contractor to complete.	Mark Williams	Asap
4.	There was no formal Significant Events Policy in place.	The practice should develop and implement formal written policies for Significant Events. This policy will provide a clear framework to underpin existing processes, ensure consistency, and support governance.	Health and Care Quality Standards (2023) – Safe, Effective, Person-centred, Leadership, Workforce, Learning, Improvement and Research.	Policy to be written and completed using templates available this will support SEA recording system already in place.	Mark Williams	End of Feb (delay due to new Clinical system installation)
5.	The bins outside the practice were not stored in a secure area. This posed a potential risk to public	The practice must ensure that all waste and recycling bins are stored in a secure, enclosed area. This would help prevent unauthorised	Health and Care Quality Standards (2023) – Safe, Effective,	In discussion with local contractor to complete.	Mark Williams	Asap

	safety and environmental hygiene.	access, reduce the risk of contamination, and support compliance with waste management regulations.	Leadership.			
6.	The IPC policy and some clinical policies, including those for blood-borne viruses (BBV) and needlestick injuries, were out of date. This may have affected the clarity and consistency of guidance available to staff.	The practice must review and update its IPC and clinical policies to ensure they reflect current guidance.	Health and Care Quality Standards (2023) – Safe, Effective, Leadership, Workforce, Learning, Improvement and Research.	In process of updating	Practice Nurses	In progress – End Feb
7.	We found sharps bins in clinical areas that had been assembled in 2022 and 2023. The bins contained discarded sharps but were not close to the full indicator line. Staff confirmed the bins were still in use.	The practice should review its procedures for monitoring the duration of use and replacement of sharps bins.	Health and Care Quality Standards (2023) – Safe, Effective, Leadership.	In process of updating	Practice Nurses	In progress – End Jan

8.	The practice had recently introduced IPC audits. The practice manager had initiated audits for clean curtains, sharps bins and hand hygiene.	The practice should ensure that IPC audits are completed and embedded into routine processes, maintaining a continuous focus on infection prevention and control. At a minimum, this should include conducting an annual audit.	Health and Care Quality Standards (2023) – Safe, Effective, Leadership.	In process of updating	Practice Nurses	In progress – End Feb
9.	While cleaning schedules were referenced in policy documents, daily cleaning records were not seen, making it difficult to verify whether routine environmental cleaning was being carried out as intended.	The practice should ensure that the cleaning schedule is readily accessible to cleaning staff and includes a system for staff to sign upon completion of tasks.	Health and Care Quality Standards (2023) – Safe, Effective, Leadership, Information.	Updated	Managers / cleaners	In place
10.	When reviewing the cleaner's cupboard, it was noted that there was only one mop bucket in use.	The practice must ensure that cleaning equipment complies with best practice for infection prevention and control.	Health and Care Quality Standards (2023) – Safe, Effective,	Updated	Managers / cleaners	In place

			Leadership.			
11.	The most recent annual healthcare waste audit was conducted in October 2025, and we were told the practice was in the process of implementing its recommendations.	The practice should implement the outstanding recommendations from the annual healthcare waste audit without delay.	Health and Care Quality Standards (2023) – Safe, Effective, Leadership, Learning, Improvement and Research.	In progress	Managers	End of Feb (delay due to new Clinical system installation)
12.	There was no audit trail for Controlled Drug prescriptions that were collected from the practice by patients or carers. This limited the practice's ability to monitor and account for these prescriptions.	The practice should establish a robust audit trail for Controlled Drug prescriptions collected by patients or carers.	Health and Care Quality Standards (2023) – Safe, Effective, Leadership, Information.	In progress	GP Lead / Prescribers	In Progress- End Feb
13.	We were told that the repeat prescribing process was not always followed	The practice must ensure consistent adherence to its repeat prescribing protocols	Health and Care Quality Standards (2023) – Safe,	Updated	Prescribing Clerks	Complete

	consistently by the practice, indicating a need for better adherence to and monitoring of prescribing protocols to ensure accuracy and safety in medication provision.	and implement a system to monitor compliance.	Effective, Leadership, Information, Learning, Improvement and Research.			
14.	The Cold Chain Policy was not dated, making it difficult to confirm whether it reflected current guidance. Some vaccines were observed to be in contact with the sides of the fridge.	The practice must: • Review and update its Cold Chain Policy to ensure it is dated and reflects current guidance • Ensure that vaccines are stored in accordance with national guidance, avoiding contact with fridge surfaces and ensuring proper shelf placement.	Health and Care Quality Standards (2023) – Safe, Effective, Leadership, Information, Learning, Improvement and Research.	In Progress – new data loggers in place.	Practice Nurses	End Jan
15.	There was no named individual responsible for the checking of emergency items, and no formal checklists were available at the time of inspection.	The practice must: • Appoint a named individual responsible for checking emergency equipment and drugs on a weekly basis	Health and Care Quality Standards (2023) – Safe, Effective, Leadership, Workforce,	Actioned	Practice Nurses	In progress- End Feb

	Although staff reported that checks were carried out daily, the absence of documentation meant there was no way to verify this or to track when items had last been reviewed. Furthermore, some drugs and consumables used for resuscitation were found to be unsuitable for use: certain syringes and needles were past their expiry date, while packaging on some disposable airways was open and dust covered.	• Implement a formal documented system using checklists in line with Resuscitation Council UK guidance • Ensure all emergency items are inspected regularly, and expired or damaged consumables replaced promptly to ensure readiness for resuscitation and patient safety.	Information, Learning, Improvement and Research.			
16.	The storage room for the Automatic External Defibrillator (AED) and associated emergency equipment had no external signage, which could	The practice must ensure that appropriate signage is in place to show the location of emergency equipment.	Health and Care Quality Standards (2023) – Safe, Effective, Leadership, Information.	In progress	Managers	In progress – awaiting some Welsh translated signs – End Feb

	delay access in critical situations.					
17.	No regular checks of medical devices and equipment had been carried out.	The practice must ensure that formal, documented checks of all medical devices and equipment are carried out regularly and recorded.	Health and Care Quality Standards (2023) – Safe, Effective, Leadership, Workforce, Information, Learning, Improvement and Research.	Williams Medical engaged to complete checks.	Managers	In Place
18.	Consent for an intimate examination was not recorded in one set of notes, although the offer of a chaperone was documented.	The practice should ensure that consent for all intimate examinations is clearly documented in the patient's clinical notes, alongside the offer or presence of a chaperone.	Health and Care Quality Standards (2023) – Person-centred, Safe, Effective, Leadership, Information, Workforce.	In place	GP/ Nurses	In Place
19.	Some staff files did not include up-to-date job descriptions, which are important	The practice should ensure that all staff files contain up-to-date job descriptions that clearly outline roles and responsibilities.	Health and Care Quality Standards (2023) – Person-centred, Effective,	In progress	Managers	In progress- End Feb

	for defining roles and responsibilities.		Leadership, Information, Workforce.			
20.	There was no formal induction programme or policy in place to support new staff.	The practice should develop and implement a formal induction policy or programme for all new staff.	Health & Care Quality Standards (2023) – Workforce, Leadership, Safe, Effective.	In process of being updated	Manager	End Feb
21.	There was no information displayed in the waiting area about how to make a complaint or raise a concern, including details about the PTR process.	The practice must ensure that information about how to raise a concern or make a complaint, including Putting Things Right guidance, be displayed in the waiting area.	Health and Care Quality Standards (2023) – Person-centred, Safe Effective, Leadership, Information, Learning, Improvement and Research.	In progress	Managers	End Jan

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): Mark Williams

Job role: **Practice Manager**

Date: **02/01/2026**