Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report

(Announced)

The New Surgery, Cwm Taf Morgannwg 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 The New Surgery, Cwm Taf Morgannwg Health Board on 11 December 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 nine questionnaires were completed by patients and five 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:
Patient feedback was generally positive, with all respondents rating the service as ‘very good’ or ‘good’. Patients expressed satisfaction with opening hours, urgent appointment access, and out-of-hours advice. However, patients felt access to pre-bookable routine appointments could be improved.

Measures were in place to support dignity and respect throughout the patient journey. Patients reported that GPs communicated in ways that enabled patients to be involved with their care and the practice team demonstrated a strong commitment to quality care. The practice environment was considered accessible.

This is what we recommend the service can improve:

- The practice should better inform patients that self-check-in or a separate room for more in-depth discussions with reception staff are available if required to preserve confidentiality
- Some staff who acted as chaperones when required had not undertaken training.

This is what the service did well:

- Positive comments from patients praised staff at the practice
- The practice provided a range of services and were active in following up with patients who had missed hospital appointments.

Delivery of Safe and Effective Care

Overall summary:
The practice was found to be clean, tidy and generally well maintained. Staff and patients were encouraged to engage in hand hygiene and personal protective equipment was also available. However, formal Infection Prevention and Control (IPC) policies and risk assessments required updating, and some staff required IPC training.

All essential emergency equipment and drugs were in place although routine checks of emergency items needed to include review of expiry dates and required documenting.

Patient records were generally considered of good quality. However, recording of consent and discussions offering a chaperone for intimate examinations was not consistent.

Staff were aware of the safeguarding leads for the practice and of the steps they would take to follow up with patients who could be at risk.

This is what we recommend the service can improve:

- Not all staff had completed IPC training, and a detailed annual IPC audit was lacking. Clinical waste needed better segregation and security
- Improvements were needed for the safer storage of printed prescription papers and emergency drugs.

This is what the service did well:

- Referral pathways and communication aimed to empower patients and keep them informed regarding their care
- The practice was proactive in contacting patients due medication reviews and worked with the cluster pharmacist to ensure medication use was appropriate.

Quality of Management and Leadership

Overall summary:
Staff feedback was highly positive regarding the quality of care provided at the practice and workplace equality. Staff were clear about their roles, responsibilities and lines of reporting and told us they felt able to approach the management team with any issues or concerns. There was good evidence of robust investigation and appropriate communication in relation to concerns and complaints received from patients. Arrangements were in place for information sharing in-line with regulations. Quality improvement projects and audits were completed each year both internally to the practice within the GP cluster group. It was noted that the practice supported trainee doctors and nurses, contributing to overall primary care workforce development.

This is what we recommend the service can improve:

- Many policies and procedures were not bespoke to the practice and required updating
- Pre-employment checks were not consistently applied during recruitment.

This is what the service did well:

- Use of a pre-recorded vasectomy counselling video to provide patients with robust information and time for decision-making.

3. What we found

Quality of Patient Experience

Patient feedback

Responses given by patients to the HIW questionnaire were generally positive, with all rating the service provided as 'very good' or 'good'.

Most respondents were satisfied with the opening hours, ability to contact the practice and access to urgent appointments and out-of-hours advice. However, fewer said they could access routine appointments.

There were mixed responses on privacy when talking at reception, but most felt privacy was protected during consultations.

All respondents agreed the building was accessible although two respondents believed the environment was not child friendly.

All respondents considered the practice to be clean or very clean and most were confident that comprehensive infection prevention and control measures were in place.

Patient comments included:

> *"Online booking options to be more available for general doctors appointments. Generally ringing at 8am is the only option, which when working is very difficult…and also to fit in an appointment short notice on the day. Being able to book in advance would be very useful."*

> *"Always had a nice experience of all the staff at the practice."*

Person-centred

Health promotion
We saw a wide range of information promoting healthy lifestyles and sources of support available to patients and their carers within the practice premises and on the website. This included drug and alcohol services, dietary advice, keeping active, information regarding care agencies and dementia support groups. We were also told that the practice hosted regular drop-in sessions and coffee mornings through which patients and carers could form links with support agencies.

Information regarding the annual flu vaccination programme was visible. We were also informed that practitioners were skilled in opening up Making Every Contact Count conversations within clinics and consultations. These promote the uptake of vaccinations as part of a healthy lifestyle. We saw evidence of a recent project undertaken within the practice to increase stop smoking referrals, and more smoking cessation service information leaflets were to be ordered.

The practice had designated GP leads for specific chronic conditions and provided minor surgery and contraceptive services on behalf of secondary care. A physiotherapist was also available at the practice for specific sessions each week. Other co-located services were delivered by health board employed staff. These included sexual health, health visitors, speech and language therapy, and wound care teams. The New Surgery practitioners would signpost or refer patients to health board and other services as appropriate and regular meetings between professionals based within the practice, wider health board and third sector supported strong communication and continuity of care for patients.

The practice informed us that they would send a letter to follow up with patients who had not attended hospital appointments. This is considered noteworthy practice.

All respondents to the HIW patient questionnaire agreed that their GP communicated in ways that supported dignity and respect and enabled patients to be involved with their care.

Dignified and respectful care

We found patients were treated with dignity and respect throughout their patient journey. Clinical rooms provided patients with an appropriate level of privacy as rooms were not overlooked and doors were kept closed during consultations. Privacy curtains were also available.

We were told that appointments were staggered such to reduce the number of patients in the reception and waiting area at any time and therefore preserve confidentiality. A self-check-in screen was available for patients should they prefer this to speaking with reception staff. We observed all staff welcoming patients in a professional and friendly manner. A separate room was available for receptionists to speak with patients should in-depth personal information need to be discussed away from the open plan reception and waiting area. However, some respondents to our questionnaire indicated that they did not feel they could speak with reception staff without being overheard.

The practice should inform patients that self-check-in or a separate room for more in-depth discussions with reception staff are available if preferred to preserve confidentiality.

A chaperone policy was in place and chaperone notices were prominently displayed on treatment room doors. However, we found that some staff involved in offering this service had not been trained.

The practice should ensure all staff who act as chaperones have undertaken appropriate training, in line with General Medical Council guidelines.

Timely

Timely care

We saw that an up-to-date practice access policy was in place and access arrangements were also outlined for patients on the website.

The appointments system was flexible, with patients able to book online, over the telephone and in-person. Appointments could also be made by a patient's family member if the patient required and with their consent.

We were told that the practice answerphone message had been updated in 2024 to reduce telephone queuing and wait times. Patients were informed at the beginning of the message that calls were recorded.

Patients were advised to phone in the early morning for urgent appointments, and later for planned appointments. However, a duty doctor system allowed for some flexibility to ensure no patient who was assessed as requiring an urgent appointment would be left without clinical advice or a consultation that day. Reception staff had completed care navigation training and were able to discuss appointment requests with patients to understand whether an urgent consultation was required or a planned appointment could be offered, and whether in-person or telephone may be the most appropriate appointment format. Clinical advice would be sought if needed. Doctors would consider all home visit requests to ensure these were necessary. The length of time allocated to some types of appointments was discussed during the inspection as a point for the practice to consider.

All but one respondent to our questionnaire agreed that they could contact the practice and access urgent appointments as they required and all respondents indicated they knew how to access out-of-hours services. However, several respondents disagreed that they could access routine appointments.

The practice had offered NHS App training to 150 patients identified as less likely to be able to use this technology without assistance and were aiming to offer this again. This training intended to enable patients to use the NHS App and maximise their access to advance appointments. We considered this noteworthy practice.

Equitable

Communication and language
Information about the practice and services provided was shared with patients through the practice website, signs within the practice and letters to patients' homes. A performance infographic was published monthly on the practice website.

An electronic information touchscreen in the waiting area provided health and community information to patients in a large and visual format.

Patients received information regarding their own health via an online link, in printed format or face-to-face as clinicians deemed appropriate. The practice would proactively contact patients by text message or letter regarding medication reviews, inviting patients to make an appointment for a telephone consultation, or in-person appointment for certain types of medications.

Robust processes were in place for the recording and sharing of information from other care providers. Reception staff would forward on letters and emails received to appropriate colleagues to take the required action.

We saw that a hearing loop and large print formats of some patient information were available to assist communication with patients with hearing or visual impairments. Staff told us they could access a language line or interpreter to enable communication with patients unable to speak in English or Welsh.

We were told that there were two Welsh speakers at the practice whose roles spanned both administrative and clinical aspects of service delivery. Iaith Gwaith signage and Welsh versions of the NHS Putting Things Right process were displayed by the end of the inspection. However, the practice's understanding and implementation of the Welsh language Active Offer information could be strengthened further, for example through health board training and requesting Welsh versions of leaflets from external organisations displayed in the practice.

The practice should further develop their understanding and implementation of the Active Offer.

Rights and equality
We saw an equality and diversity policy and that consideration was given to protected characteristics and other personal aspects, for example, awareness of patients who were veterans of the armed forces in order to help inform their care, support and treatment needs.

Within the practice team training had been undertaken to raise awareness of sensory needs, autism, dementia and other mental health conditions patients may experience. One GP in the practice led on service provision for transgender patients, overseeing the contact and care patients were offered through specialist hospital services. We were told that patients had joined the practice list because of the availability of this support.

The practice environment was suitable for people with a range of needs. The practice was fitted with an automatic door at its entrance and access to all patient facilities was level throughout. Chairs within the waiting area were appropriate for people of varying mobility and the self-check-in screen and reception desk were of suitable heights for patients to access while standing or in a wheelchair. Accessible toilets and a breast feeding room were available. There was a lift in place for staff or contractors requiring this to access administrative areas.

A small area of the waiting room near the doorway to rooms where baby clinics were held had been designated for children and their parents. This contained some child-size furniture and colourful artwork, and the practice told us they were keen to develop this area further to engage and support children coming into the practice.

Delivery of Safe and Effective Care

Safe

Risk management
The practice was clean and tidy, free of clutter and generally well maintained. A repair to an essential door lock was completed on the day of the inspection. Further information on the issues we identified, and the actions taken by the service, are provided in Appendix A.

The practice had fire safety measures in place, including a trained fire warden, fire alarms and fire extinguishers and clearly signposted fire escape routes. Hazard warning signs were also available to indicate slip risks to patients should the floor be wet following a spillage or cleaning.

We found processes were in place to protect the health, safety and well-being of all who attended the practice, including in the case that patients medical condition deteriorated while on site. Clear processes were in place to ensure staff cover and report service escalation levels to the health board. However, we noted that the practice Business Continuity Plan required updating to ensure staff clarity should major disruption to service provision occur.

The practice should update the Business Continuity Plan to:

- **ensure the plan is sufficiently personalised to the practice, considering all relevant risks to business continuity and mitigations within the specific setting and cluster arrangement**
- **direct staff to other policies and clear actions to be taken should business continuity need to be invoked**
- **ensure that the details of the practice manager are up-to-date.**

We found that closer monitoring of GP safety following home visits was required. This was discussed with practice leadership and a solution identified and implemented on the day of the inspection. Further information on the issues we identified, and the actions taken by the service, are provided in Appendix A.

The practice manager had responsibility for receiving Welsh Health Circular and patient safety alerts and distributing these to relevant personnel via internal messaging systems. Concerns would also be discussed at monthly partners meetings and outcomes and learning communicated to practice staff and other professionals as appropriate. However, expanding the membership of Significant Adverse Event meetings would be beneficial.

The practice should consider expanding the membership of Significant Adverse Event meetings to support broader shared learning.

Infection, prevention and control (IPC) and decontamination
We saw that the IPC policy available to staff required some updates to ensure staff clarity regarding IPC precautions and how to seek IPC advice.

The practice should update the IPC policy to:

- **provide clarity for staff regarding who is the practice IPC lead and the process for escalating IPC issues and gaining advice**
- **provide enough detail to guide staff to meet IPC requirements**
- **include a date and owner and arrangements for regular policy review.**

An IPC risk assessment was seen. However, evidence of a more detailed audit was required.

The practice should complete a detailed annual IPC audit and ensure mitigations and resolutions are implemented for any issues.

We viewed staff training records in relation to IPC and found that this was not comprehensive across the practice, potentially hindering consistency in implementing IPC processes.

The practice should ensure all staff undertake IPC training appropriate to their role.

Hand sanitiser was available for staff and patients throughout the building accompanied by signs encouraging its use. Facemasks were also available should these be required for IPC or reassurance and an isolation room with a separate entrance from the car park could be used for patients with communicable diseases. Hand washing facilities within all clinical rooms had been newly installed and were of a good standard.

Most respondents to our questionnaire confirmed that healthcare staff washed their hands before and after providing treatment. All respondents to our questionnaire who had undergone invasive procedures agreed that staff wore gloves during the procedure, that equipment was individually packaged and that antibacterial wipes were used to clean their skin prior to the procedure.

We saw that sterile single use items were used where possible and that medical devices were cleaned in accordance with manufacturers guidelines. We observed sharps containers appropriately placed and not overfilled. Suitable contracts for

the safe disposal of clinical and other waste were in place. However, we observed that clinical waste was not segregated or secured while awaiting collection.

The practice should ensure that suitable arrangements are implemented to ensure clinical waste awaiting collection is segregated from clean items and areas and is secure from unauthorised access.

Blood-borne virus and needlestick policies were seen. However, no needlestick flowcharts were available in clinical rooms.

The practice should display needlestick flow charts to support clinical staff in their risk assessment in the event of sustaining a needlestick injury.

Systems were in place to ensure that relevant staff were offered appropriate vaccinations to maintain and promote their own and patients' health, and that Hepatitis B immunity was monitored and maintained through boosters as required.

Medicines management
Processes were in place to ensure the safe prescribing of medication. The Electronic Prescription Service was used to communicate with dispensing pharmacies for most prescriptions. Where printed prescriptions were issued from the practice checks were completed to confirm collection was by an appropriate person and for the intended patient's use. Prescription pads were managed appropriately. However, security of printer prescription papers required improvement.

The practice should ensure that printer prescriptions are kept secure and logged in and out.

We were told that a cluster pharmacy hub arrangement was working well, ensuring the timely request of repeat prescription authorisation and identification of medication overuse or underuse by patients so that this could be addressed by the practice. A prescribing policy was available. However, this required reviewing.

The practice should ensure that the prescribing policy is up-to-date and scheduled for review at appropriate intervals.

We reviewed patient group directions (PGDs) and found that these needed some attention to ensure they had been authorised correctly. This was actioned by practice leadership on the day of the inspection. Further information on the issues we identified, and the actions taken by the service, are provided in Appendix A.

We reviewed the equipment and drugs used to manage medical emergencies. A schedule was available to indicate what equipment and drugs should be present and all essential items were in place.

We were informed that stock levels of emergency drugs and equipment were completed on a weekly basis. However, there was no written evidence of this. We were also told that expiry dates for equipment were not routinely checked.

The practice should ensure that emergency equipment and emergency drug stocks and expiry dates are checked on at least a weekly basis and fully recorded.

We found that the practice defibrillator was not kept with other emergency equipment and drugs and discussed that keeping all items together would ensure ease of access in the event of a medical emergency. Security of the defibrillator and other emergency equipment and drugs was also a concern.

The practice should ensure the security of emergency equipment and drugs by:

- **storing emergency equipment and drugs together in a central location but which is out of sight of patients**
- **use of tamper-evident storage.**

Staff had completed appropriate training for dealing with medical emergencies including the delivery of cardio-pulmonary resuscitation, use of the defibrillator and how to respond to anaphylaxis. Arrangements were also being made for refresher training to ensure staff continued to have the appropriate knowledge and skills. Staff we spoke with were aware of where all emergency items and the first aid kit were kept and how to respond and summon medical assistance in the event of an emergency.

Staff were aware of a safety alert regarding oxygen cylinders which had been issued. However, training in relation to this to ensure oxygen cylinders were used correctly had not been completed.

The practice should ensure that all relevant staff complete training to ensure the safe use of oxygen cylinders.

No controlled drugs were kept on the premises. Robust procedures were in place for the acceptance of non-emergency, non-controlled drugs for storage and use by the practice. Separate drugs fridges were in place and daily documented temperature checks provided evidence of monitoring for cold chain integrity. However, some drug packaging was observed to be touching the sides of the fridge

and on the lowest shelf, which could cause freezing and render the drugs unable to be used.

The practice should ensure that refrigerated drugs are not stored on the bottom shelf or in contact with the sides of the fridge.

A Cold Chain policy was in place but required updating.

The practice should ensure that the Cold Chain policy is clear, up-to-date and scheduled for review at appropriate intervals.

We found that ambient room temperature monitoring was not undertaken in any locations where non-refrigerated drugs were stored.

The practice should make arrangements for ambient room temperature monitoring and identify appropriate actions to be taken should temperatures be recorded outside of acceptable limits.

We found no formal log of drugs clinicians had administered or disposed of so there was no means of identifying if items of stock went missing. Keeping an inventory and log would ensure security and also assist the staff member delegated to monitoring and ordering in drug stocks.

The practice should implement an inventory and logging system to provide an audit trail of drugs taken into the practice, administered and disposed of.

Safeguarding of children and adults
We considered the safeguarding procedures in place at the practice. We found that staff were aware of the safeguarding leads for the practice and of the processes to follow up with patients who had missed appointments or whom the practice had been notified had attended emergency departments on multiple occasions. The All Wales Child Protection Procedures were available and where there were concerns about patients under 5 years of age the Health Visitors were informed. Practice clinicians also met with Health Visitors on a bi-monthly basis to discuss safeguarding concerns.

However, although staff were clear about their safeguarding responsibilities we found that the policy required updating. This would provide further support to staff should there be a need to contact the local authority or other relevant agencies and to ensure staff remained up-to-date with their understanding and implementation of safeguarding procedures.

The practice should review their Safeguarding policy to ensure that:

- **the policy is personalised to the practice, including both the names of safeguarding leads within the practice and contact details for the local authority and other relevant agencies**
- **any links to national guidance or other documents are correct to enable staff access to information**
- **training requirements for all staff are clear and based on national requirements.**

Staff training records indicated that safeguarding training within the practice was not fully compliant with national requirements on inspection, including for the practice safeguarding leads.

The practice should ensure that all staff have undertaken safeguarding training relevant to their role.

A process was in place to ensure patient medical records were marked with a digital flag when safeguarding concerns had been raised regarding the individual or relevant family contacts. However, a review of a sample of medical notes indicated that this process was not consistently applied. Nor were digital flags always removed once safeguarding concerns had been resolved.

The practice should ensure that the use of digital flags within patients medical notes is consistent and appropriate.

Management of medical devices and equipment

We found medical devices and equipment were appropriately maintained. Responsibility for devices and equipment to be checked daily was appropriately delegated. Any problems identified would be escalated to the practice manager for resolution as soon as possible.

Effective

Effective care

Information sharing supported the safe and effective care of patients. Meetings, written communication and training were all used to raise clinicians' awareness of national and professional guidance and updates from the cluster.

Incidents could be reported via the Datix online system and we were told that learning from incidents and serious events would be shared with relevant personnel.

Clinicians took responsibility for completing and documenting agreed referrals to other services within appropriate timescales. Clear processes for receiving and communicating results in a sensitive and timely manner were also in place.

Patients presenting with mental health crisis were provided with support via the GP who would make referrals to the relevant mental health service and would follow up with patients accordingly.

Patients requiring less urgent mental health support could be referred or signposted to other agencies as appropriate. The practice manager informed us they planned to develop firmer links with community mental health organisations and provide all practice staff with mental health awareness training to ensure confidence that patients could access mental health support they required.

Patient records
We examined a sample of ten electronic patient records which were kept within a secure IT system.

Records were generally considered of good quality, being written contemporaneously and providing a narrative of the patient's presenting condition. Patient allergies, smoking status, BMI and alcohol intake were routinely recorded. There was clear evidence of decisions made regarding diagnosis, information provided to the patient, investigations and follow up required. Where a treatment decision was the discontinuation of medication this was clearly justified. The records we saw indicated that reviews and medications were used in-line with guidance.

However, in two out of three patient records seen where an intimate examination was required, formal consent and the offer of a chaperone were not documented.

The practice should ensure that consent and the offer of a chaperone is consistently documented within patient notes as applicable, in line with General Medical Council guidelines.

We saw evidence of appropriate READ coding in all but one of the records reviewed. Information received into the practice was appropriately summarised by trained administrative staff and the practice manager completed random summary quality checks. GP leads for specific conditions completed reviews of clinical practice and record keeping.

We noted that historic paper records contained within the practice were not stored within a sufficiently secure area.

The practice should ensure that all patient identifiable information is securely stored to prevent unauthorised access.

Efficient

Efficient
We found that the practice delivered GP services to patients in an efficient and person-centred manner. Clear information and referral pathways aimed to empower patients and ensure they were informed regarding access to available health services.

The practice worked within a cluster to develop service delivery. The cluster pharmacy hub was reported to have had a positive impact on the issuing of patient prescriptions, with the practice and pharmacists working together to reduce prescriptions where possible to avoid medication overuse and reduce costs.

Quality of Management and Leadership

Staff feedback

All respondents to the HIW staff questionnaire strongly agreed that they were satisfied with the quality of care and support given to patients, that patient care was the practice's top priority, and that they would be happy with the standard of care provided for themselves, friends and family. All also agreed that equality and diversity was supported in the workplace.

Leadership

Governance and leadership
There were processes in place to support effective governance and accountability to ensure sustainable delivery of safe and effective care.

The practice manager and partners provided clear and visible leadership and demonstrated an emphasis on continuous development for quality service provision. Staff were clear about their roles, responsibilities and lines of reporting and told us they felt able to approach the management team with any issues or concerns. An employee handbook and an employee assistance programme were available to all staff. We observed good working relationships at the practice and discussions indicated a positive and well-supported team.

Staff could access relevant policies and procedures. However, most of these were not bespoke to the practice and needed more detail and regular reviews to ensure they were effective in supporting staff in the delivery of quality care.

The practice should review their policies and procedures to ensure they are specific to the practice and regularly reviewed and updated.

We discussed implementing a matrix or other systematic approach to tracking policy and procedure updates and staff training.

Practice meetings focused on the delivery of quality clinical services and operational management and were attended by the practice partners and practice manager. Trainee doctors were invited to provide anonymous feedback for leaders to reflect on and consider any adjustments to the workplace or processes that may better support the team. Vacancies would also be considered in terms of any feedback from leaving staff and what knowledge and skills the practice needed to attract through recruitment. Team members would be provided with relevant updates from meetings through informal discussions or messages as appropriate.

Workforce

Skilled and enabled workforce

Posters were seen emphasising a zero tolerance policy with respect to violence or abuse towards staff indicating that staff safety and support were a priority for the practice.

Staff we spoke with told us they felt enabled and strongly committed to delivering a quality service to patients.

Protected training time was provided for all staff to engage in in-house learning and attendance at external learning events was also supported. A room had been set aside to enable trainee doctors to complete academic studies and exams within the familiar and supportive practice environment.

There was evidence that an induction programme was in place for new staff and we were told that this provided appropriate information, side-by-side working opportunities and regular support and feedback to enable staff to learn their role and relevant processes and settle into the practice team.

We found that a recruitment policy was in place but that more consistency was needed in its application.

The practice should ensure that pre-employment checks are undertaken for all new members of staff in line with published expectations for NHS employment.

GPs underwent an annual appraisal with an external peer through which continuous professional development, professional obligations and good character were confirmed. Use of appraisals or risk assessments were discussed as mechanisms the practice could use to ensure the professional obligations of other staff also remained in place each year.

Culture

People engagement, feedback and learning

We saw that the practice had a suggestion box in the waiting area to collect patient feedback and staff told us they would also inform the practice manager of any verbal feedback received. Staff were clear on the process to follow should a patient express a concern or wish to make a complaint and the NHS Wales Putting Things Right procedure was available to patients.

There was good evidence of robust investigation and appropriate communication in relation to concerns and complaints received. The practice reported to have a

good relationship with Llais, working together when appropriate and responding to feedback from a recent Llais visit.

We saw service user feedback groups hosted by other organisations promoted within the practice. We were informed that the practice were aiming to re-establish a patient participation group of their own in the near future.

Only two out of five respondents to the HIW staff questionnaire reported they felt able make suggestions or influence decisions regarding change in the practice. However, all staff felt able to speak up if they had any concerns. Whistleblowing and external human resources support mechanisms were available.

Information

Information governance and digital technology

We found robust arrangements were in place for information sharing in-line with Information Governance principles and the General Data Protection Regulations (2018). Annual returns provided overall reports, for example, to the Medical Examiner Service and via the Quality Assurance and Improvement Framework process.

Information Governance expectations for staff were refreshed every quarter and staff signed to confirm they had read and understood the arrangements. We saw that a data breach that had occurred was reported and appropriately handled.

We were told that the practice was increasing its use of digital technology internally, for example, to maintain staff training records.

A recorded vasectomy counselling video had been created and was shared with relevant patients via a secure platform. This ensured patients were provided with comprehensive information and time to consider their decision prior to any further face-to-face consultation. The inspection team considered this to uphold the principles of shared decision making and informed consent and to be an example of innovative and noteworthy practice.

Learning, improvement and research

Quality improvement activities

We were informed that quality improvement projects and audits were completed each year, both internally to the practice and shared with the GP cluster group. These considered both clinical and operational aspects of service delivery.

It was noted that the practice supported trainee doctors and nurses, contributing to overall primary care workforce development.

No research was undertaken by the practice but external projects were advertised on behalf of the wider health board and other organisations within the waiting area.

Whole-systems approach

Partnership working and development
Co-location, shared events, effective signposting and referral pathways had established the practice as an active contributor to the local community and supported holistic care for patients.

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
Essential door lock broken	Substances hazardous to health were accessible to members of the public	Discussed with practice leadership	Practice Manager escalated repair as urgent to Facilities who fixed the lock on the day of inspection.
Closer monitoring of GP safety following home visits required	Inadequate support for staff and patients in relation to home-based care	Discussed with practice leadership	Senior Partner discussed a safe reporting system with relevant colleagues and set this up on the day of the inspection.
Patient group directions (PGDs) not authorised correctly.	Patient group directions incomplete, which could result in inappropriate treatment provision	Discussed with practice leadership	PGDs updated by Practice Manager and Senior Partner on the day of the inspection to ensure clarity regarding authorised use.

Appendix B - Immediate improvement plan

Service: The New Surgery

Date of inspection: 11 December 2025

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

	Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	No immediate assurances were identified on this inspection					

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: The New Surgery

Date of inspection: 11 December 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.	Some patients felt they could be overheard at reception.	Patients to be informed that self-check-in or a separate room for more in-depth discussions with reception staff are available if preferred to preserve confidentiality.	Health and Care Quality Standard (2023) – Person Centred	I have put up large signs to let patients know that a private room is available for them to use any time.	Charmain Goldsworthy	Resolved 27.1.26
2.	Not all staff who act as chaperones had undertaken appropriate training.	All staff who act as chaperones to undertake appropriate training in line with General Medical Council guidelines.	Health and Care Quality Standard (2023) – Safe	I have looked to arrange chaperone training in March. Until then, only practice nurses or HCAs are used as they have done the training	Charmain Goldsworthy	Resolved
3.	Understanding and implementation of the	Understanding and implementation of the	Health and Care Quality Standard	I have added welsh language to our self-	Charmain Goldsworthy	Resolved 20/12/25

	Welsh language Active Offer needed strengthening.	Active Offer to be further developed.	(2023) – Person centred	check-in and have also added the orange Cymraeg bubble in the waiting area, and our Welsh speakers wear lanyards with the orange Cymraeg bubble on		
4.	The practice Business Continuity Plan required a number of updates.	Business Continuity Plan to be updated to ensure it: is sufficiently personalised to the practice; considers all relevant risks and mitigations; directs staff to other policies and clear actions.	Health and Care Quality Standard (2023) - Effective	I have updated the plan to meet the standards	Charmain Goldsworthy	Resolved 15/12/25
5.	Significant Adverse Event meetings only attended by GP partners.	Expanded membership of Significant Adverse Event meeting to be considered for broader shared learning.	Health and Care Quality Standard (2023) - Effective	From April 2026 we will have annual SEA meetings with all staff	Charmain Goldsworthy	30/4/26
6.	The practice Infection Prevention and Control (IPC) policy required a number of updates.	IPC policy to be updated to: provide clarity regarding the practice IPC lead and the process for escalating IPC issues and gaining advice; provide enough detail to guide staff to meet	Health and Care Quality Standard (2023) - Safe	The policy has been updated to meet the standards	Charmain Goldsworthy	2/1/26

		IPC requirements; support appropriate version control.				
7.	No detailed annual IPC audit completed.	Annual completion of a detailed IPC audit and mitigations and resolutions for issues implemented.	Health and Care Quality Standard (2023) – Safe	To complete a detailed annual IPC audit	Charmain Goldsworthy	30/4/26
8.	Not all staff had undertaken IPC training appropriate to their role.	All staff to undertake IPC training appropriate to their role.	Health and Care Quality Standard (2023) - Safe	All staff have now completed the IPC training appropriate to their roles	Charmain Goldsworthy	26/1/26
9.	Clinical waste awaiting collection not in a segregated from clean items or secured area from unauthorised access.	Clinical waste awaiting collection to be segregated and secure.	Health and Care Quality Standard (2023) – Safe	I have moved the clinical waste bin into a separate room away from clean items. It is now stored in our dirty utility room and gets emptied every week. The door is locked at all times, and only staff have access	Charmain Goldsworthy	5/2/26
10.	No needlestick flow charts displayed in clinical areas.	Needlestick flow charts to be displayed to support staff in their risk assessment in the event of sustaining a needlestick injury.	Health and Care Quality Standard (2023) - Safe	I have now added the needlestick flow charts to all clinical rooms	Charmain Goldsworthy	15/12/25

11.	Security of printer prescription papers required improvement.	Printer prescriptions to be kept secure and logged in and out.	Health and Care Quality Standard (2023) - Safe	The prescription boxes have now been numbered and have a log that staff fill in if they remove a box from the secure room	Charmain Goldsworthy	15/12/25
12.	The practice prescribing policy required updating.	Practice prescribing policy to be updated and scheduled for review at appropriate intervals.	Health and Care Quality Standard (2023) - Safe	Matthew Bunston has now updated the prescribing policy	Matthew Bunston	15/12/25
13.	No evidence of regular checks of emergency equipment and drugs.	Emergency equipment and emergency drug stock and expiry date checks to be completed on at least a weekly basis and fully recorded.	Health and Care Quality Standard (2023) - Safe	A check sheet has been implemented to ensure the equipment and drugs are monitored on a weekly basis	Bev Davies/Zarah Maccalino	9/2/26
14.	Emergency equipment and drugs not stored securely.	Emergency equipment and drugs to be out of sight of patients and within tamper-evident storage.	Health and Care Quality Standard (2023) - Safe	We have now moved the drugs and equipment under the main stairwell, which is accessible to all staff but not accessible to patients	Charmain Goldsworthy	15/12/25
15.	Staff not trained on the use of oxygen cylinders as required.	All relevant staff to complete training regarding the safe use of oxygen cylinders.	Health and Care Quality Standard (2023) - Safe	6 members of the team have completed. I have 2 more staff members to complete	Charmain Goldsworthy	1/4/26

16.	Refrigerated drugs stored in a way that could render them unable to be used.	All refrigerated drugs to be stored appropriately.	Health and Care Quality Standard (2023) - Safe	The fridge has now been organised to ensure the drugs are not stored at the bottom and not touching the sides	Bev Davies	15/12/25
17.	The practice Cold Chain policy required updating.	The practice Cold Chain policy to be clear, up-to-date and scheduled for review at appropriate intervals.	Health and Care Quality Standard (2023) - Safe	I have updated the cold chain policy to meet requirements	Charmain Goldsworthy	15/12/25
18.	No ambient room temperature monitoring of areas used to store non-refrigerated drugs.	Ambient room temperature monitoring to be completed in all relevant areas and appropriate actions to be taken made clear should temperatures be recorded outside of acceptable limits.	Health and Care Quality Standard (2023) - Safe	A new thermometer to be ordered and room temperature to be monitored daily	Charmain Goldsworthy	1/4/26
19.	No formal log kept of drugs clinicians had administered or disposed of.	An inventory and logging system to be implemented to provide an audit trail of drugs taken into the practice, administered and disposed of.	Health and Care Quality Standard (2023) - Efficient	A new log will be put in place for the surgery	Charmain Goldsworthy	1/4/26

20.	The practice Safeguarding policy required a number of updates.	The practice Safeguarding policy to be reviewed to ensure that it: is personalised to the practice, includes the names of safeguarding leads within the practice and contact details for the local authority and other relevant agencies; correctly signposts to national guidance or other documents are correct to enable staff access to information; specifies clear training requirements for all staff based on national requirements.	Health and Care Quality Standard (2023) - Safe	The policy has now been updated also local contact numbers have been added to the reception waiting area and onto our website	Charmain Goldsworthy	15/12/25
21.	Not all staff had undertaken Safeguarding training appropriate to their role.	All staff to undertake safeguarding training relevant to their role.	Health and Care Quality Standard (2023) - Safe	All clinicians are booked onto the safeguarding course on the 24/2/26 safeguarding lead and deputy safeguarding have completed their level 2	All clinicians	1/3/26

22.	Use of digital flags within patient medical notes inconsistent and when used not always appropriately discontinued.	Use of digital flags within patients medical notes to be consistent and appropriate.	Health and Care Quality Standard (2023) - Safe	A process has been put in place to ensure patients' medical records are updated to reflect current information	All staff	1/4/26
23.	Documentation regarding consent and the offer of a chaperone not consistently documented with patient records.	Consent and the offer of a chaperone to be consistently documented within patient records as applicable and in line with General Medical Council guidelines.	Health and Care Quality Standard (2023) – Person centred	All clinical staff to ensure they code that patients have been offered a chaperone, HP to show all clinical staff a quick link to adding the information to ensure every patient who is offered a chaperone is documented onto the patient records	Charmain Goldsworthy	30/4/26
24.	Historic paper patient records not secured from unauthorised access.	All patient identifiable information to be securely stored to prevent unauthorised access.	Health and Care Quality Standard (2023) – Safe	Doors are now locked at all times to ensure no unauthorised access	Charmain Goldsworthy	15/12/25
25.	Several of the practice policies and procedures found not to be sufficiently specific to the	All practice policies and procedures to be specific to the practice and regularly reviewed and updated.	Health and Care Quality Standard (2023) – Effective	All policies have been updated to reflect specific policies and procedures	Charmain Goldsworthy	23/12/26

	practice or appropriately updated.					
26.	Recruitment policy in place but inconsistently applied.	Pre-employment checks to be undertaken for all new members of staff in line with published expectations for NHS employment.	Health and Care Quality Standard (2023) – Safe	A new pre-employment check is to be implemented for the new surgery	Charmain Goldsworthy	25/2/26

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): Charmain Goldsworthy

Job role: Practice Manager

Date: 9/2/26