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Healthcare Inspectorate Wales

General Practice Inspection Report (Announced)

St Andrews Surgery, Cwm Taf Morgannwg University Health Board

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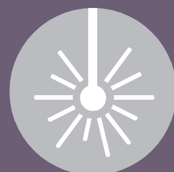

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

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:

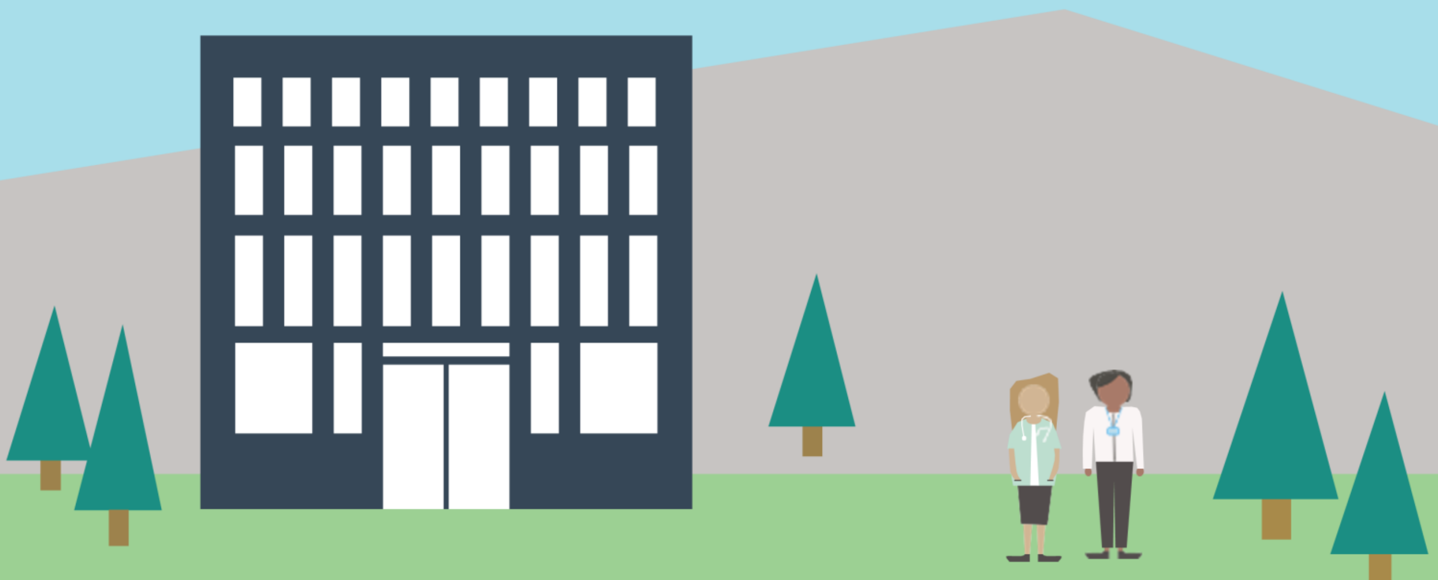
- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and 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.



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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 St Andrews Surgery, Cwm Taf Morgannwg University Health Board on 28 January 2026.

Our team for the inspection comprised of one HIW Healthcare Inspector and two clinical peer reviewers, and a practice manager reviewer. The inspection was led by a HIW Healthcare Inspector.

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 ten questionnaires were completed by patients. 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:
Overall, patient feedback was generally positive with most patients agreeing that the clinicians explained things well to them, that they felt listened to, and that they were treated with dignity and respect.' However, patients did raise issues about privacy at reception and accessing routine appointments.

Staff worked hard to provide a caring and professional service for patients. We found a good range of information was available both within the practice and on the website to help patients improve their health and wellbeing.

In general, we considered there was good access to service. The appointment system enabled effective clinical assessment and prioritisation of appointments. Incoming documents and secondary care letters were handled appropriately and work flowed in a timely manner.

A chaperone service was available with relevant policies in place, although there were no notices displayed to make patients aware of this service. One patient record that we reviewed did not contain a record that a chaperone was offered despite an intimate examination taking place.

There was ramp access into the premises allowing patients with impaired mobility and wheelchair users easy access to facilities. The patient waiting rooms were clean and spacious.

This is what we recommend the service can improve:

- Ensure patients speaking at reception could do so in a way that upheld their privacy and confidentiality
- Develop an up-to-date care navigation pathway document
- To implement the Active Offer of providing care in the medium of Welsh
- Ensure all staff complete Equality and diversity training.

This is what the service did well:

- Good engagement with the local cluster to provide healthcare initiatives
- Access to appropriate translation service for patients whose first language was not English.

Delivery of Safe and Effective Care

Overall summary:
Whilst clinical treatment rooms were spacious and clean, overall, the premises required redecoration to create a more welcoming environment. We noted a damp corridor upstairs due to a partially repaired roof leak while poorly fitting carpets created potential trip hazards for staff.

Overall, the infection prevention and control (IPC) arrangements were considered acceptable, although some arrangements needed improvement including replacement of damaged bins and fabric covered chairs. We found one sharps bin to be unsecured and within easy reach of patients.

There was an appropriate arrangement for handling and monitoring repeat prescriptions. Vaccines were suitably stored and there was an up-to-date cold chain policy in place, which enabled a recent breach to be managed effectively.

There were comprehensive safeguarding procedures in place at the practice that aligned with the Wales Safeguarding guidelines. Appropriate alerts within medical records identified children and vulnerable adults at risk. However, training records suggested several staff had not completed safeguarding training at the appropriate levels.

We reviewed a sample of 10 patient records and found them clear and up to date with a high standard of note keeping. However, use of clinical Read codes needed improvement, although it is expected that this will improve when the practice switches to the EMIS clinical records system.

This is what we recommend the service can improve:

- Repairs to be carried out on the roof and office carpets require replacement
- To implement an appropriate system for the management of prescription pads and for logging prescriptions for home visits
- Signs to be displayed to indicate the location of emergency equipment
- Emergency equipment to be checked weekly instead of monthly.

This is what the service did well:

- Sharps injury flowcharts displayed in each surgery
- Medicines fridge managed well with evidence of twice-daily temperature checks
- Patient records were clear with easy-to-follow care plans and evidence of safety netting.

Quality of Management and Leadership

Overall summary:
St Andrews Surgery was a training practice with clear leadership and an open-door culture. While staff meetings occur, they have become ad-hoc. Information was shared through targeted emails, and policies are available both digitally and in hard copy, though several lack version control, review dates, or sufficient detail.

The practice followed a structured recruitment process and provided fully documented inductions for new staff. Although they used regular locums for continuity, the practice lacked a locum pack and a standardised induction process for temporary staff.

We were told that training compliance was monitored. However, we discovered lots of gaps in mandatory training across the whole practice team. Staff appraisals were conducted but not formally documented.

The practice had a complaint policy that was largely in line with the NHS 'Putting Things Right' process although timeframes needed to be amended. We saw that complaints were fully investigated and documented.

The practice had a good relationship with the local health board's multi-disciplinary team. It had also built close links within the local GP cluster to support integrated services across the Rhondda area.

Immediate assurances:
We identified several areas which needed to be addressed through our immediate assurance process. The issues included:

- Poor compliance with mandatory training across all staff groups
- Lack of effective system to provide clear oversight of mandatory training.

This is what we recommend the service can improve:

- Ensure policies are completed and have appropriate version control
- To implement a formal process of annual staff appraisals that is documented
- Display the complaint procedure and 'Putting Things Right' in patient areas.

This is what the service did well:

- Approachable senior team including management and GP partners
- Complaints were well documented
- Evidence of improvements made because of complaints reviews

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

3. What we found

Quality of Patient Experience

Patient feedback

Before our inspection we invited the practice to hand out HIW questionnaires to patients to obtain their views on the service provided at the practice. Responses were mostly positive, with the main issue being accessing routine appointments and lack of privacy at reception. All respondents rated the service as 'very good' or 'good'. The one comment we received about the service and how it could improve was:

> *"As a patient who attends the GP rarely, the reception staff were exceptional in the advice and signposting given."*

Person-centred

Health promotion
During our inspection, we saw a good range of relevant written health promotion information available for patients within the practice waiting areas. Staff informed us that specific and targeted information would be provided during consultation with the GPs and clinicians.

We saw some healthcare posters in both Welsh and English and saw there were information display screens in the waiting area although these were not operational at the time of the inspection. We noted that a lot of notices were photocopied in black and white and were therefore not engaging or easily seen. We also found the practice website contained some useful information, although some areas required updating. We were told that the staff member responsible was no longer employed at the practice.

The practice should review:

- **How their healthcare information is provided to patients with the aim to make it more visible and easily accessible**
- **Their website to ensure patients are provided with up-to-date information.**

The practice provided access to physiotherapy, drug and alcohol counsellors, MIND mental health practitioners and the All-Wales diabetes prevention programme. There were plans to implement additional cluster funded initiatives such as

wellbeing co-ordinators, a cardio-vascular advice service and the ‘PIPYN’ programme which aims to support children and families to make healthier eating choices.

We were told that the practice reviewed instances when patients did not attend appointments, with appropriate discussions with health visitors for children who were not brought. The practice offered alternative appointments outside of clinic times and telephone reminders the day before appointments to encourage patient attendance.

Whilst we were told that the winter vaccinations for over 65-year-olds was at 78 per cent, for other age groups there had been a lot of patients who declined the offer. Despite a proactive approach to RSV vaccinations, the practice noted a poor turnout and suggested that patients were suffering from vaccine fatigue post Covid-19.

Dignified and respectful care

During the inspection, we observed reception staff welcoming patients in a professional and friendly manner. We were told that some telephone calls were taken in the upstairs administration office to protect confidentiality, although calls were also answered at the reception desk where privacy was limited. We did not see any signage at reception to inform patients of any additional privacy arrangements if required. Four of the respondents who answered the HIW questionnaire felt that they were unable to speak with a member of reception staff without being overheard by others in the patient waiting area.

The practice should ensure that patients speaking at the reception desk are enabled to do so in a way that upholds their privacy and confidentiality.

Treatment rooms were closed and privacy curtains were in place to maintain patient’s privacy and dignity. There was a practice chaperone policy in place for intimate examinations, although there were no notices displayed advertising this service to patients. In one patient record that we reviewed where an intimate examination had taken place, neither the offer of a chaperone nor the patient response was recorded.

The practice must ensure:

- **That the offer of chaperones is displayed in clinical rooms so that patients are aware of the service**
- **That the offer of a chaperone and the response of the patient is entered into patient notes, in line with guidelines set out by the General Medical Council (GMC).**

Most patients who answered the HIW questionnaire felt they were treated with dignity and respect and said measures were taken to protect their privacy. Similarly, most said the GP explained things well, felt listened to and were involved in decisions about their healthcare.

Timely

Timely care

The surgery was open between 8:00am and 6:30pm Monday to Friday with out-of-hours cover over evening and weekends. Patients were informed of options for accessing appointments via the practice website.

Access to appointments was predominantly via telephone from 08:00am.Telephone consultations and GP led triage appointments were also available. Patients were offered same day face-to-face assessments based on urgency, clinical judgement and patient preference. Photographs for certain conditions could be emailed to the practice for remote triage. We discussed that the practice considers offering electronic booking of advance appointments to strengthen workload and patient access.

Staff appeared familiar with the care navigation pathways with non-clinical navigators able to seek guidance from senior clinical colleagues if required. However, the practice was unable to provide us with a documented care navigation pathway that provided a consistent approach for staff to follow.

The practice should ensure a documented care navigation pathway is available to staff.

Most of the patients who answered the HIW questionnaire stated they were able to get a same-day appointment when they need to see a GP urgently. All confirmed that they were content with the type of appointment they were offered. However, three respondents disagreed that they could get routine appointments when they needed them.

We recommend the practice reflects on the issues raised in this feedback to ensure patients receive treatment in a timely manner.

Equitable

Communication and language

The practice informed patients about services and any changes primarily via the practice website and notices displayed in the patient waiting areas. We found that there were no practice information leaflets available for patients without digital

access. We were told this had also been picked up on a health board annual review.

The practice should have a written patient information leaflet available to ensure information is also available to patients who do not have digital access.

We were provided with the practice consent policy. This ensured that all patients were able to give informed consent and those patients without capacity were appropriate protected.

We found effective handling of incoming documents and secondary care letters which were recorded and work flowed to the doctor who actioned matters in a timely manner. However, we found that these were added to patient records without editing meaning that some jargon remained that was not always person-centred. There was good evidence of detailed discussions with patients about their condition and care management options. We were told that there was occasional weekend work to catch up on any backlog of letters, and we discussed monitoring this to prevent this becoming more commonplace.

We saw a limited amount of bilingual information and signage in the practice. We were told that one staff member spoke Welsh while staff had access to an appropriate translation service to aid patients whose first language was not English. We found the Active offer of providing treatment in Welsh was not promoted and found that most staff were unaware of the 'Active Offer'.

The practice must ensure all staff are made aware of the 'Active Offer' to provide services in the medium of Welsh and that this is promoted to patients.

Almost all patients who answered the HIW questionnaire felt that the GP explained things well to them and answered their questions and most felt involved in decisions about their healthcare.

Rights and Equality
The practice offered good access for patients with impaired mobility and wheelchair users. We noted that all patient areas including treatment rooms were located on the ground floor with ramp access from the street. The waiting areas were spacious, while corridors and doorways appeared wide enough for wheelchairs. There was an accessible toilet available although it did not have an emergency pull cord fitted.

The practice should install an emergency pull cord so that patients can summon help if they require assistance.

We saw an equality and diversity policy was in place. However, this lacked version control and indicated alignment with CQC in England rather than Welsh standards. We also found that mandatory training in this subject had not been completed, although we were told that the practice was in the process of arranging this via the local health board. The mandatory training issue was addressed under our immediate assurance process at Appendix B.

The practice must review their equality and diversity policy to ensure it aligns with the Welsh standards and contains appropriate version control.

The practice was proactive in upholding the rights of transgender patients. We were told transgender patients were treated with sensitivity and it was confirmed preferred names and pronouns would always be used. We were told that was providing a gender dysphoria enhanced service in collaboration with the Welsh Gender Service.

All patients who answered the question thought the building was easily accessible and said they had not faced discrimination when accessing or using this health service.

Delivery of Safe and Effective Care

Safe

Risk Management
We found the clinical treatment rooms were spacious, visibly clean, and well-lit although we considered the premises needed redecorating to make the practice more welcoming to patients and staff alike. We were shown an upstairs corridor which was damp and had a strong mouldy smell caused by a roof leak that had only been partially repaired by the landlord. We also found carpets in offices that were poorly fitted with raised areas and taped down edges which presented potential trip hazards to staff.

The practice must explore with the building owner repair of the roof and carpets within a reasonable timeframe to ensure the health and safety of staff using these areas.

We were provided with a copy of the practice business continuity plan which was in draft form and under review. This required completion to ensure all procedures and relevant emergency contact details were available in the event of an extreme situation. However, we found it contained reference to CQC and that it also lacked appropriate version control.

The practice should complete their business continuity plan to ensure it is appropriate for the practice and contains appropriate version control.

We were told that an emergency call bell system was not currently available as the practice were awaiting the imminent installation of the EMIS clinical software, which will feature a built-in emergency call button.

Discussions with senior staff demonstrated that patient safety alerts and significant events were dealt with appropriately with any medication alerts forwarded to the prescribing team for action. Learning from significant event analysis was shared with the wider practice through team meetings.

Infection, Prevention, Control (IPC) and Decontamination
Overall, the IPC arrangements in place were considered acceptable, but some arrangements needed strengthening to ensure the practice always upholds the necessary standards of IPC to maintain the safety of staff and patients.
There were appropriate up-to-date practice IPC and Blood Borne Virus (BBV) policies in place. We saw needlestick injury posters available in clinical treatment rooms to advise staff of the course of action to follow in the event of a sharps

injury. However, in one surgery we found a sharps bin unsecured on the corner of the desk next to the patient seat and in easy reach of children.

The practice must ensure sharps bins are stored securely or appropriately located, so that they are not accessible to patients and children.

During our tour of the practice, we saw soap was available in patient and staff toilets and that hand washing posters were displayed in the treatment areas and toilets. However, we found that toilet paper and paper hand towels were left on cisterns instead of in the dispensers that were fitted, leaving them susceptible to contamination. We also found cleaning fluids were easily accessible next to all toilets which could pose a danger to patients with learning difficulties and mental health issues, despite having child-proof lids.

Our concerns regarding this were dealt with at the time of the inspection. Further information on the issues we identified, and the actions taken by the service, are provided in Appendix A.

The practice should ensure toilet roll and paper hand towels are placed in the appropriate dispensers to protect them from contamination.

We saw a cleaning contract was in place and cleaning schedules were available. An IPC audit was last completed in November 2025 which reflected the current condition of the practice, with areas for improvement noted but not yet acted upon. Issues that we found included broken bins and cluttered surfaces within surgeries. Whilst some chairs in surgeries had easily wipeable coverings, others were upholstered with non-wipeable fabric. We saw a privacy curtain that was dated 2017.

The practice should take action to ensure:

- **Damaged bins are repaired or replaced within surgeries, preferably with foot operated systems**
- **Clutter is removed from surfaces in surgeries**
- **Privacy curtains to be replaced or laundered at appropriate intervals**
- **Resolve areas for improvement as raised within the audit action plan.**

All patients that answered the IPC questions in the HIW questionnaire said the practice was clean or very clean. Most told us that hand sanitisers were always available for them in the practice and agreed that staff washed their hands before and after delivering care. Just one respondent said that they had an invasive procedure and confirmed that the equipment used was individually packaged and appeared sanitised, and that staff wore gloves during the procedure.

Medicines Management
The process for repeat prescriptions was described with appropriate arrangements for managing requests that involved the practice prescribing clerk, GPs and pharmacist. Overuse was actively monitored and discussed the GP.

The practice had a prescribing policy in place, which referred to a prescription pad register that would provide an audit trail, including if a doctor leaves the practice. However, this had not been implemented at the time of the inspection. We also found that controls for storing and logging manual prescriptions for home visits was not in place.

The practice must implement and maintain appropriate systems to enable effective management of prescription pads and for storing and logging prescriptions for home visits.

Vaccines were stored within dedicated vaccine fridges which we saw had annual maintenance checks. A suitable up-to-date cold chain policy was in place to ensure safe storage of refrigerated medicines, and we saw evidence that a recent cold chain breach was managed effectively. Evidence of twice daily temperature checks were provided.

Non-vaccine drugs were stored securely and subject to appropriate checks. We inspected these and found them to be in date. We were told that expired drugs were taken to the local pharmacy and destroyed.

Management of Medical Devices and Equipment
Medical devices and equipment were found to be in good working order. There was evidence of calibration and appropriate contracts in place with relevant manufacturers and suppliers.

Emergency equipment including oxygen and a defibrillator were available. We were told that practice nurses took turns to check the emergency equipment monthly, rather than weekly. We found oxygen cylinders were serviced and both adult and child defibrillator pads available and in date. We found that emergency drugs were stored in a locked cupboard, which could hinder access in an emergency. Whilst there were signs indicating the location of the oxygen, there were no signs to indicate the location of emergency drugs and equipment.

The practice should ensure that:

- **Emergency equipment is check on a weekly basis in line with the Resuscitation Council guidelines.**
- **Appropriate signage is displayed to indicate the location of emergency equipment**

- **Emergency drugs are always easily accessible to staff in the event of an emergency.**

Safeguarding of Children and Adults

We inspected the safeguarding procedures in place at the practice and found a policy in place which included both adults and children. The policy referenced the Wales Safeguarding Procedures and was available for all staff as hard copy and on the practice shared drive. We saw that a named safeguarding lead was recorded in the policy and confirmed that staff were aware who the lead was.

A process was in place to ensure the medical records of children and vulnerable adults with a safeguarding status, were identifiable to staff by way of an alert marker within the patient records.

During a review of staff training, although we were told that some staff had completed safeguarding training the previous week, we did not see evidence that all staff had completed this training at the required levels. The mandatory training issue was addressed under our immediate assurance process at Appendix B.

Effective

Effective Care

We found the practice had a dedicated team that worked hard to provide patients with effective and safe care. There were appropriate systems in place for reporting incidents including Significant Event Analysis reviews and the Duty of Candour process.

Patient referrals to secondary care were managed appropriately via the Welsh Clinical Communications Gateway (WCCG). Referrals were suitably categorised as routine, urgent and urgent suspected cancer. We were informed that whilst GP activity data was submitted, there was no current analysis to compare referral rates against other practices in the area.

The practice should consider implementing a review of referral rates to help highlight key themes and trends.

The practice telephone answer service directed callers with emergency conditions to their nearest Emergency Department, while signage within the waiting rooms directed patients to alternative healthcare options where appropriate.

Arrangements for assessment and referral to mental health services were described. This included access to a mental health support nurse and self-referral to health and wellbeing services. We were told that patients who contacted the practice in crisis would be referred to the duty doctor. However, we found that staff had no specific mental health awareness training. The mandatory training issue was addressed under our immediate assurance process at Appendix B.

Patient records

We reviewed a sample of ten patient medical records. These were stored securely and protected from unauthorised access. Overall, we considered the patient records to be clear with a high standard of note keeping that included easy-to-follow care plans and evidence of safety netting which we considered to be good practice.

All records appeared up to date, complete and easy to understand should other clinicians need to review the records. Where relevant, we found evidence of appropriate systems for monitoring and managing patients with chronic diseases. However, we did note that the use of clinical Read codes needed improvement, although it is expected that this will improve with the imminent move to the EMIS clinical records system.

Quality of Management and Leadership

Leadership

Governance and leadership

St Andrews Surgery was operated by three GP partners and is an active member of the Rhondda Cluster of Cwm Taff Morgannwg University Health Board. The practice is a training practice that supports medical and pharmaceutical students.

We found staff were clear about their roles and responsibilities and there were clear lines of accountability in place at the practice, with clinical oversight carried out by the senior partner. Management and staff alike confirmed there was an open-door policy with partners being available and approachable to all. However, there was no evidence of formal clinical supervision for staff.

The practice should adopt a formal approach to clinical supervision that is suitably evidenced.

The practice held formal staff meetings, but these had become ad-hoc in nature, based on when issues or events arise. These meetings enabled shared learning from discussions about significant events or updates to clinical guidelines. Management said there were plans for these to be more regular again. We discussed implementing a structured programme of meetings to help achieve this goal.

We were told that information, such as policies and procedural changes or safety notices were shared with staff via targeted emails to ensure that the right information went to the relevant people and to provide an audit trail.

The practice had a wide range of policies and procedures held both on the practice IT system and as hard copy within the staff room. We were told that these were reviewed regularly by the practice manager. However, we noted that several policies lacked any version control and review dates. In particular, we found the Information Handover, Consent and Recruitment policies lacked detail whilst the Home Visit policy was incomplete.

The practice should ensure that:

- **All policies contain version history, review dates and person responsible for reviewing the procedure**
- **All policies are completed and contain sufficient detail to establish the principles, scope and accountability of that policy**

- **All staff have read and understood relevant practice policies to ensure compliance with practice processes**
- **Provide HIW with evidence once completed.**

We were told the practice were experiencing several operational pressures, including the absence of a deputy practice manager and an increased need for stronger governance arrangements in line with approaches adopted by other practices. The building required roof repairs, redecoration and replacement of carpets, putting additional strain on resources. Rising patient demand has also led to the need for additional administrative support while awaiting the introduction of electronic prescribing.

Workforce

Skilled and enabled workforce
We spoke with staff across a range of roles working at the practice. It was clear that they all knew their roles and responsibilities and were committed to providing a quality service to patients. Staff felt that the workload allocation was appropriate and within their scope of practice. We were told that annual staff appraisals along with vacant positions provided the leadership team with opportunities to review the skill mix at the practice.

The practice had a suitable recruitment policy that included a pre-employment checklist. Newly appointed staff were required to undertake a comprehensive induction programme which was documented and signed off by the supervising staff member. However, we noted this did not include coverage of IPC processes.

The practice should review the induction programme to include infection prevention and control processes.

The practice had recently employed a salaried GP and had GP registrars reducing the staff retention risk. Where locums were used, the practice tried to use the same individuals to provide continuity of care. However, we found there was no locum pack available or standardised induction process for locums or agency staff, if used.

The practice should consider producing a GP locum pack specific for the practice.

We reviewed staff training records which highlighted several gaps in mandatory training for both clinical and non-clinical staff including IPC, safeguarding and fire safety training. Evidence of up-to-date annual resuscitation training was provided

for approximately half of the staff at the practice. The mandatory training issue was addressed under our immediate assurance process at Appendix B.

We were assured that staff would be supported in raising a concern should the need arise and we were provided with the practice whistleblowing policy. This had been recently reviewed and was available to all staff. Despite staff confirming that they had annual appraisals, the practice was unable to provide us with evidence that these were documented. It was confirmed by the practice manager that these had been conducted as an informal conversation, rather than as a documented process.

The practice should consider implementing a formal process of annual staff appraisals that is appropriately documented.

Culture

People engagement, feedback and learning
The practice had in place an appropriate complaint policy and procedure which was recently reviewed. Whilst this was largely in line with the NHS 'Putting Things Right' process, we noted that acknowledgement of a complaint was seven working days instead of the required five working days. In addition to this, neither the complaint procedure nor the 'Putting Things Right' poster were seen displayed in the waiting area.

The practice must:

- **Ensure that the complaint policy is aligned with the NHS Wales Putting Things Right process**
- **Display a copy of the complaint procedure in an area where it can be clearly seen by patients**
- **Display 'Putting Things Right' posters in an area where they can be clearly seen by patients.**

We reviewed the practice complaints file and saw the process to be fully documented and applied in line with the policy timescales. We were told that complaints were discussed in team meetings and at one-to-one discussions, with themes and learnings identified. We saw evidence of action taken as a result of this process.

We saw QR codes displayed in the waiting area indicating how a patient can submit feedback. Only one respondent to the HIW questionnaire stated they had been asked to provide feedback on the service experience. However, several respondents who answered said they would know how to complain about poor service if they wanted to do so.

We were told that staff felt comfortable to speak up regarding any concerns they may have, and a whistleblowing policy was in place to support this. In addition, staff were happy to share any suggestions they might have to improve services, although this was done verbally, with no formal process in place. We discussed options for introducing a process for recording staff suggestions.

We saw an up-to-date Duty of Candour policy was in place that met the requirements of the guidance. However, the practice was unable to provide any evidence that staff had completed training on this topic. The mandatory training issue was addressed under our immediate assurance process at Appendix B.

Information

Information governance and digital technology

The practice understood its responsibility when processing information and demonstrated that data is managed in a safe and secure way. A current information governance policy was in place to support this. We saw that the practice used the Digital Health and Care Wales (DHCW) service as its data protection officer. This service handled non-routine information requests to ensure compliance with the relevant regulations. We saw little evidence that staff had completed training on information governance. The mandatory training issue was addressed under our immediate assurance process at Appendix B.

Learning, improvement and research

Quality improvement activities

We were told that the practice engaged in periodic research projects. The practice manager was actively engaged with the local health board learning disability working group, that was exploring how to better communicate with this patient group and their carers. Learning from internal and external reviews, including incidents and complaints was shared across the practice via staff meetings and emails to make improvements.

Whole system approach

Partnership working and development

We reviewed the processes in place to identify how the practice worked with wider healthcare teams and external partners to develop a whole system approach to achieving effective outcomes that met the evolving needs of the community.

We were told the practice had an effective working relationship with the local health board multi-disciplinary home service team to support the delivery of services. This helps in keeping patients to receive care at home, where admission to hospital can be avoided.

The practice appeared to have developed a close relationship with other practices within the local GP cluster to build a shared understanding of the challenges and the needs of the local population and to help integrate healthcare services for the wider Rhondda area.

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
The Practice had cleaning fluids which were accessible to patients in all the toilets.	These cleaning chemicals posed a potential risk to patient safety.	We raised this with senior management on the day of the inspection.	Items were removed immediately and stored securely.

Appendix B - Immediate improvement plan

Service: St Andrews Surgery

Date of inspection: 28 January 2026

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.	During the inspection, complete and coherent staff training records were not available for review. We reviewed a sample of five staff records and found gaps in basic training, including safeguarding, infection prevention and control, and fire safety. We were informed that a training matrix was not in use and found partial evidence of mandatory training	The practice must take immediate action to strengthen staff training governance arrangements. This includes identifying training requirements for both clinical and non-clinical staff, considering national and professional guidelines, individual roles and responsibilities. All staff must complete and provide evidence of completed mandatory training.	Health and Care Quality Standards (2023)	Organise training matrix for live monitoring of mandatory training for all staff including doctors, at St. Andrews Surgery - please see attached. Central access for training certificates for easy access and monitoring rather than in separate places. Provide evidence of completed training so far as of 05/02/2026 - please see training certificates attached.	Dr. John Boby Thomas - Senior Partner, Karen Jones - Practice manager	Completed as of 05/02/2026 Complete Complete Started and almost complete

	kept in staff folders and various policy files, while we were told that other training evidence, including for GPs, were held in personal training accounts which we were unable to access during the inspection. This meant we could not determine that staff had completed the required training to maintain the safety of patients, staff and visitors to the surgery.	The practice must implement robust systems to monitor, record, and assure compliance with staff training, including refresher training.		Ensure mandatory training at least for fire safety, infection control, safeguarding and resuscitation completed. Next safeguarding training for Cwm Taff is on 18/03/2026. One of our members of staff is on maternity leave. Training matrix will be monitored by the Practice Training Champion on a 2 monthly basis and assure compliance with mandatory training requirements. All mandatory training to be completed by all staff and evidence to be provided.		except for the staff on annual leave. To be completed by 19/02/26. Evidence to be emailed to inspector. Monitoring has already started on 02/02/2026 01/04/2026

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): Dr John Boby Thomas

Job role: Senior Partner

Date: **05/02/2026**

Appendix C - Improvement plan

Service: St Andrews Surgery

Date of inspection: 28 January 2026

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 found information display screens in the waiting area were not operational and a lot of notices were photocopied in black and white and were therefore inconspicuous. We also found the practice website required updating.	The practice should review: • how their healthcare information is provided to patients with the aim to make it more visible and easily accessible • Their website to ensure patients are provided with up-to-date information.	Health and Care Quality Standards - Person Centred	We will remove the non-working display screens Notices will be printed in colour We will update the practice website	GP Partners GP Partners Practice Manager	1 month 1 months 6 months

2.	Almost half of the respondents who answered the question felt that they were unable to speak with a member of reception staff without being overheard by others in the patient waiting area.	The practice should ensure that patients speaking at the reception desk are enabled to do so in a way that upholds their privacy and confidentiality.	Health and Care Quality Standards - Person Centred	The practice will ensure clear signage how this can be achieved - alternatively we will point patients towards making a phone call as opposed to in person	Practice manager	3 months
3.	There were no notices displayed advertising the chaperone service to patients. In one patient record that we reviewed where an intimate examination had taken place, neither the offer of a chaperone nor the patient response was recorded.	The practice must ensure: • That the offer of chaperones is displayed so that patients are aware of the service • That the offer of a chaperone and the response of the patient is entered into patient notes, in line with guidelines set out by the General Medical Council (GMC).	Health and Care Quality Standards - Person Centred General Medical Council (GMC): Intimate examinations and chaperones	The practice will ensure that chaperone service signs are placed throughout the building and especially in consultation rooms. The Clinical staff will be reminded to enter "chaperone offered/declined" in medical notes.	Practice manager Senior partner	Completed Completed

4.	The practice was unable to provide us with a documented care navigation pathway that provided a consistent approach for staff to follow.	The practice should ensure a documented care navigation pathway is available to staff.	Health and Care Quality Standards – Timely	Pathways to be developed by GPs and nurses. Liaise with neighbouring practices regarding the use of pathways. Implement the pathways to staff.	Practice Manager/all staff	1 month
5.	Three respondents to the HIW questionnaire said that they could not get routine appointments when they needed them.	We recommend the practice reflects on the issues raised in this feedback to ensure patients receive treatment in a timely manner.	Health and Care Quality Standards – Timely	The practice has recently undertaken a patient questionnaire regarding access and will be reviewing the results to improve further access for patients.	Practice Manager	6 months
6.	We found that there were no written practice information leaflets available for patients without digital access. We	The practice should have a written patient information leaflet available to ensure information is also available to patients who do not have digital access.	Health and Care Quality Standards – Equitable	The Practice will ensure there is provision of practice information online and in leaflets.	Practice Manager	3 months

	were told this had also been picked up on a health board annual review.					
7.	We found the Active offer of providing treatment in Welsh was not promoted and found that most staff were unaware of the 'Active Offer'.	The practice must ensure all staff are made aware of the 'Active Offer' to provide services in the medium of Welsh and that this is promoted to patients.	Health and Care Quality Standards - Equitable Social Services and Wellbeing (Wales) Act 2014	The practice will ensure that leaflets are in Welsh and English. The practice will continue to offer Welsh language courses and encourage them to wear badges or lanyards to show that they are Welsh speakers or learning Welsh.	Practice Manager	Completed
8.	There was an accessible toilet available although it did not have an emergency pull cord fitted.	The practice should install an emergency pull cord so that patients can summon help if they require assistance.	Health and Care Quality Standards - Equitable	The GP Partners will install an emergency pull cord.	GP Partners	6 months
9.	The equality and diversity policy lacked version control and	The practice must review their equality and diversity policy to ensure it aligns	Health and Care Quality Standards - Equitable	The Practice will ensure that version controls are updated	Practice Manager	3 months

	indicated alignment with CQC in England rather than with the Welsh standards.	with the Welsh standards and contains appropriate version control.		in all practice policies. The Practice manager will ensure that the equality and diversity policy aligns with the Welsh standards.		
10.	There was a roof leak that had only been partially repaired, and carpets were poorly fitted with raised areas and taped down edges which presented potential trip hazards to staff.	The practice must explore with the building owner repair of the roof and carpets within a reasonable timeframe to ensure the health and safety of staff using these areas.	Health and Care Quality Standards - Safe	The GP partners will liaise with the landlords to ensure the roof repairs are prioritised following which new carpets will be sourced, and decorating will be carried out.	GP Partners	6 months
11.	The practice business continuity plan required completion to ensure all procedures and relevant emergency contact details were available in the event of an extreme situation. It also	The practice should complete their business continuity plan to ensure it is appropriate for the practice and contains appropriate version control.	Health and Care Quality Standards - Safe	The business continuity plan will be reviewed to ensure all procedures and relevant emergency contact details are available in the event of an extreme situation and will be	GP Partners/Practice manager	2 months

	contained reference to CQC and lacked appropriate version control.			appropriately version controlled.		
12.	In one surgery we found a sharps bin unsecured on the corner of the desk next to the patient seat and in easy reach of children.	The practice must ensure sharps bins are stored securely or appropriately located, so that they are not accessible to patients and children.	Health and Care Quality Standards - Safe	Daily practice nurse checks will be implemented to ensure sharps boxes are not within reach of children	Practice manager	Completed
13.	Toilet paper and paper hand towels were left on cisterns instead of in the dispensers that were fitted, leaving them susceptible to contamination.	The practice should ensure toilet roll and paper hand towels are placed in the appropriate dispensers to protect them from contamination.	Health and Care Quality Standards - Safe	The GP Partners will purchase new dispensers and installing in all toilets	GP Partners	1 month
14.	We found included broken bins and cluttered surfaces within surgeries, whilst some chairs were upholstered with non-wipeable fabric. We saw a	The practice should take action to ensure: • Damaged bins are repaired or replaced within surgeries, preferably with foot operated systems	Health and Care Quality Standards - Safe	The practice has purchased new bins. New privacy curtains will be purchased and old ones replaced. All cluttered surfaces have been cleared.	GP Partners	1 month

	privacy curtain that was dated 2017.	• Clutter is removed from surfaces in surgeries • Privacy curtains to be replaced or laundered at appropriate intervals • Resolve areas for improvement as raised within the audit action plan.		The GP Partners purchase wipeable chairs.		
15.	The practice had a prescribing policy in place, which referred to a prescription pad register. However, this had not been implemented at the time of the inspection. We also found that controls for storing and logging manual prescriptions for home visits was not in place.	The practice must implement and maintain appropriate systems to enable effective management of prescription pads and for storing and logging prescriptions for home visits.	Health and Care Quality Standards – Safe	The practice will implement a prescription pad register and ensure that controls are in place for prescriptions issued at home.	Practice manager/GP Partners	1 week

16.	We were told that practice nurses took turns to check the emergency equipment monthly, rather than weekly. Emergency drugs were stored in a locked cupboard, which could hinder access in an emergency, whilst there were no signs to indicate the location of emergency drugs and equipment, other than oxygen.	The practice should ensure: • Emergency equipment is check on a weekly basis in line with the Resuscitation Council guidelines. • Appropriate signage is displayed to indicate the location of emergency equipment • Emergency drugs are always easily accessible to staff in the event of an emergency.	Health and Care Quality Standards - Safe	The emergency equipment will be checked weekly in line with the Resuscitation Council guidelines. Signs about emergency drug locations will organised. Emergency adrenaline is already easily accessible to staff in event of an emergency in each room. Some drugs are locked and this is necessary for safety. A few years ago a patient barricaded themselves in our treatment room and if the emergency drug cupboard was not	Practice nurses	Completed

				locked, they could have easily opened it.		
17.	We were informed that there was no current analysis to compare referral rates against other practices in the area.	The practice should consider implementing a review of referral rates to help highlight key themes and trends.	Health and Care Quality Standards - Effective	The practice will ask other neighbouring practices about how they analyse their referral rates.	Practice manager	6 months
18.	There was no evidence of formal clinical supervision for staff.	The practice should adopt a formal approach to clinical supervision that is suitably evidenced.	Health and Care Quality Standards - Workforce	The practice will organise annual appraisals and audits to demonstrate formal evidence of supervision of nursing staff.	Practice manager Senior Partner	6 months
19.	Several policies lacked any version control and review dates. Others were found to lack detail whilst others were incomplete.	The practice should ensure that: • All policies contain version history, review dates and person responsible for reviewing the procedure • All policies are completed and contain sufficient detail to establish	Health and Care Quality Standards - Leadership	The Practice will ensure that version controls; review dates etc are updated in all practice policies. The Practice manager will discuss with the partners the purchase of Practice Index access to help the Practice Manager	Practice Manager	6 months

		the principles, scope and accountability of that policy • All staff have read and understood relevant practice policies to ensure compliance with practice processes Provide HIW with evidence once completed.		maintain high standards with regards to written policies and procedures		
20.	The induction programme for new staff did not include coverage of IPC processes.	The practice should review the induction programme to include infection prevention and control processes.	Health and Care Quality Standards - Workforce	The practice will review its induction programme to ensure IPC processes are included	Practice Manager	6 months
21.	We found there was no locum pack available or standardised induction process for locums or agency staff, if used.	The practice should consider producing a GP locum pack specific for the practice.	Health and Care Quality Standards - Workforce	The practice will produce a GP locum pack specific for the practice.	GP Partners/Practice Manager	6 months
22.	Despite staff confirming that they had annual appraisals, the practice	The practice should consider implementing a formal process of annual	Health and Care Quality Standards - Workforce	The practice will implement a formal process of annual staff appraisals that is	Practice Manager	6 months

	confirmed that these had been conducted as an informal conversation, rather than as a documented process.	staff appraisals that is appropriately documented.		appropriately documented		
23.	Whilst the complaint policy was largely in line with the NHS 'Putting Things Right' process, we noted that acknowledgement of a complaint was seven working days instead of the required five working days. Neither the complaints procedure nor the 'Putting Things Right' poster were seen displayed in the waiting area.	The practice must: • Ensure that the complaint policy is aligned with the NHS Wales Putting Things Right process • Display a copy of the complaint procedure in an area where it can be clearly seen by patients • Display 'Putting Things Right' posters in an area where they can be clearly seen by patients.	Health and Care Quality Standards - Culture	The practice will align its complaints policy in line with the NHS Wales process and will display the process as well as the putting things right posters in the patient areas	Practice Manager	2 months

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): **Dr. John Boby Thomas**

Job role: **Senior Partner**

Date: **13/04/2026**