Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report

(Announced)

Cyncoed Medical Centre, Cardiff and Vale University Health Board

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

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our values

We place people at the heart of what we do.
We are:

- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

Our goal

To be a trusted voice which influences and drives improvement in healthcare

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.

Contents

1. What we did

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

Healthcare Inspectorate Wales (HIW) completed an announced inspection of Cyncoed Medical Centre, Cardiff and Vale University Health Board on 25 March 2026.

Our team for the inspection comprised of one HIW healthcare inspector, 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. A total of six were completed. We also spoke to staff working at the service during our inspection. 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:
Of the small number of respondents to the HIW patient questionnaire, patient feedback was positive, with all respondents rating the service as good or very good. Patients reported they could access GP services when they required them and described staff as supportive, professional and attentive. We observed dignified and respectful interactions.

Practice premises were accessible to patients with a range of needs and health promotion information was visible.

While many systems supported person-centred care, opportunities were identified to strengthen care navigation, signposting to mental health support, and provision of the Welsh language active offer.

This is what we recommend the service can improve:

- Better promote self-check-in and the offer of a private room for in-depth discussions between patients and reception staff
- Develop clearer care navigation pathway documents for non-clinical staff and improve signposting to NHS 111 press 2 for mental health support
- Review the consent policy to ensure it provides appropriate guidance to all professionals working at the practice and regarding supporting patients who are unable to make decisions regarding their healthcare in line with the Mental Capacity Act (2005).

This is what the service did well:

- Supported equitable access through digital and non-digital contact routes
- Routinely provided face to face appointments, having found that telephone appointments had led to more duplicate consultations and reduced efficiency
- Clinicians worked together to ensure an appropriate degree of flexibility to offer same day consultations even once appointment slots had already been fully allocated.

Delivery of Safe and Effective Care

Overall summary:
We found systems of information sharing supported safe and effective care for patients. Patient records were generally considered to provide a high quality

narrative and allergy history was consistently recorded. However, records could be strengthened in relation to safety netting for patients requiring some risk management in relation to their medical condition. Read codes were suitably allocated except regarding the offer or use of a chaperone. The EMIS electronic system was still relatively new to the practice and we discussed further formal training for relevant staff to cascade and support the embedding of the system.

Patients reported a clean environment. However, we found some clutter and maintenance needs within the premises. A number of other risks required immediate assurance to be provided.

Immediate assurances:

- Patient Group Directions had not been appropriately authorised such that the practice was not meeting the required professional and legal obligations
- Security procedures required strengthening with respect to items that could cause harm to patients or were open to misuse
- Medical equipment and devices were not suitably maintained, including empty oxygen cylinders stored in the same location as other emergency drugs and equipment, emergency equipment checks only completed on a monthly basis and not comprehensively documented, no recent calibration or other formal servicing of clinical fridges or other medical devices.

This is what we recommend the service can improve:

- Strengthen Infection Prevention and Control governance and embed IPC and waste management principles in practice
- Create suitable cold chain policy and procedures and monitor room temperature in areas where non-refrigerated drugs are stored
- Strengthen safeguarding arrangements.

This is what the service did well:

- Emergency call buttons were available to rapidly summon assistance if required for staff and patient safety
- Communication with the wider multidisciplinary team supported continuity of care and contributed to avoidance of admissions into secondary care.

Quality of Management and Leadership

Overall summary:
Leaders demonstrated commitment to visible leadership and staff described an open and supportive culture and clear day-to-day teamwork. Practice partners and management met frequently for oversight of clinical and operational aspects of the

practice and worked together to complete required quality framework, clinical governance and information governance reports.

Clinical role development required by the practice was underpinned by appropriate training. However, several gaps in key safety training were identified across staff groups. We also found no evidence of formal supervision or appraisal for nursing staff over a period of years and limited delegation of leadership or designated time for the completion of safety activities such as IPC audits and medical device maintenance.

Mechanisms for patients to provide feedback or raise concerns or complaints were in place. However, not all respondents to the HIW patient questionnaire were aware of these and documentation of complaint handling we reviewed did not evidence structured complaints handling and response processes. Duty of Candour was also not well understood within the practice.

Immediate assurances:

- HIW was not assured that robust systems were in place to ensure staff received consistent, effective general training relevant to their roles, including effective oversight of staff training and competence.

This is what we recommend the service can improve:

- Make policy version control clearer to ensure only the most up-to-date versions of policies are used. Priority should be given to creating and reviewing the policies named in the improvement plan following this inspection
- Improve recruitment, induction and staff file management processes
- Reflect on current systems of audit and other continuous development activity to ensure the practice remains in line with current best practice.

This is what the service did well:

- Fostered effective teamwork, supporting a calm environment for staff and patients
- Minuted clinical meetings provided opportunities for information exchange with clinical staff and discussions around any recent Significant Adverse Events.

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

As the HIW patient questionnaire received a low number of responses, findings should be interpreted with care and may not be considered representative of the wider practice patient population. However, it was noted that all respondents were generally positive about the service they received and rated the practice as 'good' or 'very good' overall.

Patient comments included:

> *"Lots of care and support for my mother recently during a fall and follow up issues with home visits by GP and support via pharmacy too. I have been listened to and supported"*

> *"All staff and doctors in Cyncoed Medical Centre are fantastic, extremely helpful and professional. It is a great surgery."*

Person-centred

Health promotion
We saw a range of health promotion materials and information regarding support services available to patients. These included information regarding specific symptoms and conditions, the role of emergency and primary care services and signposting to third sector mental health and carers support services. Information on the practice premises was available in posters or leaflets to take away and a newly installed digital information screen also provided information and interactive health education and lifestyle opportunities such as a health check quiz accessed through a QR code. The digital screen also provided patients with practice specific information. A patient information leaflet was available on request.

A recent practice self-assessment indicated that the practice aimed to meet the needs of the local population and promote health and healthy lifestyles through a Making Every Contact Count (MECC) approach to patient interactions. One respondent to our patient questionnaire indicated that they had not received specific healthy lifestyle information during their consultation.

The practice worked within a cluster which offered physiotherapy, and with other health board services, such as respiratory clinics, midwives and health visitors. However, we were informed that some mental health provision, wound care and minor surgery services had recently reduced in line with funding.

Dignified and respectful care
We observed patients being treated with dignity and respect by all staff and that measures were in place to preserve patient confidentiality at reception and during consultations. A room separate from reception was available for patients to have more in depth discussions on arrival at the surgery if this was required and a self-check-in screen was also available. However, neither of these were promoted to patients.

The practice should ensure that the offer of self-check-in or a separate room for more in-depth discussions with reception staff are better promoted as options to preserve confidentiality.

Notices regarding the offer of a chaperone for examinations were clearly visible within the practice premises, website, and explained within the patient information leaflet. Chaperone training was provided in house and staff we spoke with were clear that they would only undertake the chaperone role once suitably trained.

Timely

Timely care
We were told that administrative and clinical staff worked together to offer patients the right care at the right time. A new telephone system was also being introduced which would also assist with timely call answering and directing patients to appropriate professionals. However, it was too soon for information to be available regarding how effective this system was for patients and staff experience.

Non-clinical staff confirmed that they could seek advice from more experienced colleagues or clinicians if they were unsure regarding signposting or offering an appointment and care navigation training was available in line with roles. Quick guides were in place to inform reception staff of appropriate actions should appointments be unavailable and reception staff were also able to directly book appointments with a community pharmacist if appropriate and with patient consent. However, further developing pathway documents would more fully support non-clinical staff in signposting and supporting patients through care navigation.

The practice should ensure that care navigation is supported via provision of standard pathway documents as a resource for non-clinical staff.

Staff informed us that most patients contacting the practice would be offered an appointment within the practice. The default option had recently returned to face to face appointments as the practice had found offering telephone appointments had led to more duplicate consultations and reduced efficiency. Telephone appointments would be offered on patient request. Clinicians worked together to ensure an appropriate degree of flexibility to offer same day consultations even once appointment slots had already been fully allocated. Home visit requests were triaged by GPs if patients were not coded on their patient record as housebound or unable to access the practice due to disability.

All respondents to our patient questionnaire expressed satisfaction with practice opening hours and access to GP and out of hours services and appointments, though some patients reported their appointments had taken place later than scheduled.

Patients presenting with acute mental health symptoms were referred via telephone for urgent mental health assessment. Letter referrals were made to mental health services for patients considered to be experiencing lower risk needs. There was concern expressed by the practice regarding the availability of mental health support for patients and we were told that to compensate GPs were active in monitoring the responses to referrals to ensure appropriate escalation of referrals or would contact patients to provide advice should there be a wait for mental health assessments. We saw that NHS 111 press 2 was not promoted on the practice website or premises. Signposting patients to this service would be another option to reduce pressure on specialist mental health services and primary care support.

The practice should ensure that staff and patients requiring mental health support are aware of the NHS 111 press 2 service.

Once patients had been seen by mental health services summary information received would determine any further practice action. Counselling services were available if appropriate to need and patients consented.

Equitable

Communication and language

We were told that practitioners knew their patients well and would tailor communication according to individual needs. We saw that a hearing loop was

available. The self-check-in screen could be used in different languages and a language line and other translation options were also available.

The practice was aware of the 'More than just words' Welsh language plan for health and social care and some staff members were seen wearing Iaith Gwaith badges to indicate a level of Welsh proficiency. However, clearer signage and a more proactive approach to establishing and recording a patient's language choice was required to underpin person-centred communication and robustly implement the Welsh language active offer.

The practice should ensure that they:

- **Establish patients language preference on registration or further contacts**
- **Record language preferences within patient records to inform on going person-centred communication**
- **Consider how to better promote the Welsh language active offer.**

Rights and equality

Patients could contact the surgery via digital platforms or by phone or in person to support the less digitally enabled. Text messages were sent to remind patients of upcoming appointments and we were told that reception staff would offer assistance to patients who required help with navigating digital information.

A consent policy and a dignity and respect policy were available within the staff handbook and we were told that the practice aimed to ensure that protected characteristics were responded to in a respectful and confidential manner. However, no reference was made to the Mental Capacity Act or supporting patients unable to make decisions regarding their healthcare within the consent policy. The consent policy also needed reviewing to ensure it was suitable to support all professionals working within the practice.

The practice should review their consent policy to ensure it provides appropriate guidance to all professionals working at the practice and regarding supporting patients who are unable to make decisions regarding their healthcare.

We saw that the practice was committed to maintaining accessible premises. An automatic door enabled access to the property from outside and internal flooring and thresholds were level and secure throughout. The lift in place to enable any required access to upstairs was fixed during the inspection visit. Various seating options in the waiting area, the self-check-in screen, disabled toilet and availability of a wheelchair were available to support patients of varying mobility needs while on the practice premises. All respondents to our patient questionnaire agreed that the practice premises were accessible and suitable to a range of needs.

We were told that the practice provided weekly local care home visits, supporting these patients to receive the healthcare they required without them needing to be able to attend the practice.

Delivery of Safe and Effective Care

Safe

Risk management
We observed that the practice was spacious and had a calm ambience. Fire escape routes and action plans were easily seen and we were told that the practice team undertook regular fire drills. However, we saw that one fire door was wedged open which would render this fitting ineffective should a fire occur.

The practice should ensure that fire precautions are followed at all times.

Some clutter and maintenance needs were seen. Items were found left out on worktops in clinical areas and a large number of old fire extinguishers were awaiting collection stored next to a fire escape. The boiler was also leaking and in need of maintenance.

The practice should ensure that:

- **All areas are kept free of clutter, with items appropriately stored or disposed of immediately after use. Old equipment should be promptly removed from areas where they could be used in error and fully disposed of as soon as possible**
- **The boiler is appropriately maintained.**

Although staff were able to tell us where emergency equipment was kept, signage was required to highlight the location of all medical gases and the defibrillator to patients, staff and emergency service personnel in the event of an emergency.

The practice should ensure that the locations of hazardous items and emergency equipment are fully signposted for staff, patients and other professionals attending in the event of an emergency.

A Business Continuity Plan (BCP) was available to all staff to refer to should major service disruption occur. However, this was only accessible via the computer system on the premises. Arrangements for staff absence cover and contingency in the event that the building could not be used for service provision also lacked detail, being based on informal agreements.

The practice should:

- **Formalise arrangements for sourcing alternative staff and accommodation in the event of major disruption and incorporate these into the BCP**

- **Ensure that the BCP is accessible to key personnel both on and off the practice premises.**

Suitable processes were in place for practice management to receive patient safety alerts and cascade to relevant members of the team. Minuted clinical meetings also provided opportunities for information exchange with clinical staff and discussions around any recent Significant Adverse Events. We were informed that NICE guidance had not been recently discussed. Practitioners may wish to add best practice to the regular clinical meeting agenda to ensure timely practice updates.

Emergency call buttons were available to rapidly summon assistance if required for staff and patient safety. We were told that procedures to support patients noted to be becoming acutely unwell while at the practice had recently been required and had worked effectively. A home visit policy raised staff awareness of safety precautions while working in the community.

Infection, prevention and control (IPC) and decontamination
All respondents to our patient questionnaire felt practice facilities were very clean and that staff implemented relevant IPC measures. We saw that suitable hand hygiene facilities were available throughout the practice for staff and patients to use. A separate room away from the main waiting area was also available for patients attending the practice with suspected transmissible illnesses to prevent the spread of infections. All flooring and couches and chairs within treatment areas were wipeable.

IPC and cleaning policies were available to staff within the staff handbook. However, we found that these lacked clarity in relation to latest guidance. No IPC lead was in place and staff were not clearly able to articulate their roles and responsibilities with respect to IPC. There was no mechanism for receiving and implementing IPC updates from the health board or other sources, no IPC or waste management audits had been undertaken and IPC training was out of date. We also noted that there was no documentation confirming the cleaning of medical devices or collection of waste from the premises. Not all posters displayed in clinical areas were laminated and we saw that mop and bucket storage needed attention to prevent the growth of bacteria within these cleaning items.

The practice should ensure that:

- **IPC and cleaning policies are reviewed to ensure they contain sufficient detail and reflect the latest IPC guidance to support staff to implement IPC procedures**
- **All staff have undertaken IPC training relevant to their role**

- **Comprehensive records are maintained indicating when contracted cleaners and clinical staff have undertaken cleaning of clinical areas and equipment and what this has involved**
- **Waste collection records are maintained**
- **IPC and waste management audits are undertaken at suitable intervals and improvements identified are implemented**
- **All posters in clinical areas are laminated**
- **Mops and buckets to be stored separately with mop heads up and buckets inverted or on shelving.**

A needlestick policy was available within the staff handbook. However, this lacked detail and posters were only displayed in some clinical areas.

The practice should ensure that comprehensive needlestick and blood-borne virus policies are available and action plans clearly displayed in all clinical areas to support staff in the event in the event that implementation is required.

We saw evidence of clinical staff Hepatitis B vaccination and antibody levels. However, there was no overall staff vaccination database or register to enable robust monitoring for staff safety.

The practice should ensure that a comprehensive staff Hepatitis B and vaccination register is maintained.

Medicines management
A medicines management policy was in place. However, we found that Patient Group Directions had not been appropriately authorised such that the practice was not meeting the required professional and legal obligations. Our concerns regarding these issues were dealt with under our immediate assurance process. More details can be found in Appendix B.

Suitable processes were in place for the appropriate and timely processing of repeat prescription requests. Prescription clerks had completed health board training and undertook annual appraisals with practice managers. The practice may wish to consider redelegating these appraisals to ensure they are aligned more closely to a relevant practitioner who can advise on safe prescribing practices and new developments.

Patients signed when collecting prescriptions from the practice which is noteworthy practice. However, no formal procedures were in place for the safe storage of prescription pads and forms. This issue formed part of a larger finding regarding security procedures within the practice which was dealt with under our immediate assurance process. More details can be found in Appendix B.

Safeguarding of children and adults
We considered the safeguarding procedures in place at the practice.

Digital flags within the patient record identified patients living with safeguarding concerns and their relevant contacts. Flags were removed once concerns had been resolved. Regular safeguarding meetings and informal contact with health visitors were in place to protect children at risk.

A safeguarding policy was in place. This provided staff with relevant contact details. However, some of this information needed checking for accuracy. The policy indicated that a safeguarding lead was in place at the practice. However, there was confusion within the staff group as to who the safeguarding lead was. No quick reference safeguarding posters or flow charts were available to support staff to follow appropriate safeguarding processes if required. The policy in place to follow-up with patients who had missed primary or secondary care appointments was also not consistently implemented and relied on clinician discretion.

The practice must:

- **Comprehensively review their safeguarding arrangements in line with national standards, including Royal College of GP Safeguarding Standards (2024)**
- **Ensure staff are clearly informed of the practice safeguarding arrangements.**

Management of medical devices and equipment
We reviewed the drugs, equipment and medical devices kept on the practice premises. All drugs could be accounted for and suitable vaccination stock rotation practices were in place. However, some items intended for named patient use were found within the emergency drugs and equipment.

The practice should ensure that emergency drugs and equipment stocks are ordered separately from items intended for individual patients.

Emergency drugs appeared in date. However, a bottle of Calpol had not been dated on opening to guide use and disposal. Opened single use items required replacing and expired defibrillator pads were also noted.

The practice should indicate the date of opening of any liquid drugs to ensure appropriate use and disposal. Single-use items which have been opened and expired items should be replaced.

We were told emergency drugs and equipment stocks and expiry dates were checked on a monthly basis. However, this was not in-line with Resuscitation

Council UK guidelines and documentation was not dated or clear enough to evidence the frequency or nature of checks undertaken. An empty oxygen cylinder was found stored alongside full cylinders, posing a patient safety risk.

We saw records of twice daily medication fridge temperature monitoring and the monthly use of data loggers to confirm appropriate fridge temperatures were maintained. However, fridges had not been serviced or formally calibrated within the last 12 months.

These issues formed part of a larger finding regarding the suitable maintenance of medical equipment and devices which was dealt with under our immediate assurance process. More details can be found in Appendix B.

Nursing staff were clear on the action to take should a temperature breach occur. However, no formal cold chain policy or procedure was in place. We also found that room temperature monitoring was not undertaken in areas where non-refrigerated drugs were stored.

The practice should ensure that:

- **A cold chain policy and flow chart are available to support all staff in taking appropriate action should a temperature breach occur**
- **Room temperature is monitored in areas where non-refrigerated drugs are stored.**

Oxygen cylinders available for use were not securely stored. Staff were also unable to demonstrate the safe use of oxygen cylinders and no evidence was seen that staff had completed training regarding the use of oxygen cylinders in line with Patient Safety Notice 041.

The practice should ensure that:

- **Oxygen cylinders are securely stored**
- **All staff who may be required to administer oxygen in the course of patient care undertake training to underpin the safe use of oxygen cylinders in line with Patient Safety Notice 041.**

Effective

Effective care

Information sharing supported the safe and effective care of patients. Auditable processes were used to confirm incoming information was received and responded to and ensure that outgoing referrals were completed. Quick guides were available to ensure staff were knowledgeable regarding administrative processes. However,

due to a backlog with the processing of letters we suggested workflow procedures may benefit from being reviewed and updated.

Suitable processes were in place for reviewing test results and coding new diagnoses within patient records. Specific appointment slots were allocated for discussing test results and follow-up care options with patients.

Patient records
We examined a sample of ten electronic patient records.

Records were generally considered to provide a high quality narrative. Allergy history was consistently recorded. Read codes were suitably allocated except regarding the offer or use of a chaperone. Verbal consent regarding the use of a chaperone was recorded when appropriate.

Records could be strengthened in relation to safety netting for patients requiring some risk management in relation to their medical condition.

Structured audit outside of the scope of this inspection would be appropriate to the further development chronic disease management practice and documentation. Formal audit of medical notes summaries is also recommended. Summarising was completed by experienced administrative staff. However, no formal audit of these summaries had been completed.

The practice should ensure that:

- **Appropriate clinical Read codes are used throughout patient records**
- **Records and summaries are regularly audited to underpin further practice and documentation development.**

Electronic patient records were kept within the secure IT system and historical paper notes kept on the premises were also stored securely.

Efficient

Efficient
Communication with the wider multidisciplinary team supported continuity of care between the practice and out of hours services, palliative care and other attached teams and contributed to avoidance of admissions into secondary care. The involvement of Health Care Assistants within diabetes reviews supported the prudent use of nurse prescriber time.

Quality of Management and Leadership

Leadership

Governance and leadership
We found practice partners and management provided visible leadership and were recognised as having an open door policy so that staff were able to approach leaders with ideas, suggestions and concerns both formally and informally. Staff we spoke with were clear about their roles and told us that teamwork ensured a calm and supportive environment within which workloads were effectively prioritised.

Practice partners and management met frequently for oversight of clinical and operational aspects of the practice and worked together to complete required quality framework, clinical governance and information governance reports. However, there was limited further delegation of leadership or designated time for the completion of some safety activities such as IPC or the checking and maintenance of medical devices, equipment and drugs.

The practice should review their delegated leadership structure and time allocation for patient safety activities.

Practice policies were compiled within a staff handbook which all members of the team could access. However, some additional policies were needed and the content and version control of a number of existing policies required reviewing. Practice management would benefit from the use of a matrix or other system to ensure a regular programme of timely, scheduled policy review.

The practice should ensure that all policies and procedures are regularly reviewed at timely, scheduled intervals. Version control should be clear to ensure only the most up-to-date versions of policies are used. Priority should be given to creating and reviewing the policies named in the improvement plan following this inspection.

Staff told us that new processes were communicated verbally, followed up by email for reference. We discussed whole practice team meetings as another helpful forum for sharing updates.

Workforce

Skilled and enabled workforce
Staff told us they were able to work within their scope of practice. Practice managers undertook administrative staff annual appraisals and GPs engaged with an annual appraisal with an external reviewer. However, we found no evidence of formal supervision or appraisal for nursing staff over a period of years. Non-medical prescribers' self-declarations had also not been reviewed by a suitable manager.

The practice should ensure that appropriate supervision, appraisal and governance oversight is provided to all members of staff.

Clinical role development required by the practice was underpinned by appropriate training. For example, nursing staff had been enabled to develop expertise with respect to the management of some chronic conditions and prescribing. However, we were not assured that robust systems or oversight were in place to ensure staff received consistent, effective general training relevant to their core roles. Gaps were noted in core safety training, including in Basic Life Support, IPC and Safeguarding. This was dealt with under our immediate assurance process. More details can be found in Appendix B.

We saw that a recruitment policy outlining pre-employment checks was in place. However, review of five staff files indicated that this policy was not consistently implemented. We also noted that staff files needed streamlining as two contained information regarding other individuals.

The practice should ensure that:

- **Recruitment policy and pre-employment checks are consistently implemented**
- **Staff files clearly evidence staff are fit to work at the practice on recruitment and on an on-going basis, and do not contain information of any other applicants or other individuals.**

New members of staff were supported through side-by-side working until they felt comfortable to take on more autonomy within their role. Locums were provided with information to support their integration to the practice. However, formal induction processes focused on health and safety information so did not provide clear role specific information or development milestones.

The practice should review their induction processes to ensure that clear role specific information is available to new temporary and permanent members of the team.

Culture

People engagement, feedback and learning
We examined practice feedback and complaint mechanisms and records of recent patient complaint handling.

We saw that a suggestion box was available on site for patients and that patients could provide feedback or raise concerns or complaints to practice management in person, via email or written letter. However, some respondents to our patient questionnaire were aware of how to raise a complaint but others were not. Documentation of complaint handling that we reviewed did not evidence structured complaints handling and response processes.

We were told that an annual away day provided an opportunity for complaints and other incidents to be discussed as a whole practice team to support staff in implementing any changes to practice processes or procedures identified. However, no information was provided to patients to highlight how themes from feedback or complaints had led to practice development. Providing this information may reassure patients that they are listened to and reduce what practice staff described as 'survey fatigue' within the patient population.

The practice should ensure that:

- **Processes for providing feedback and raising concerns or complaints are readily available to patients**
- **Records of feedback, concerns and complaints received, investigation and responses are maintained to underpin practice learning**
- **Patients are provided with information regarding how the practice has learnt from feedback, concerns and complaints. This could be via a 'You said, we did' board within the practice or on the website or other means.**

The practice complaints policy was in line with Putting Things Right. This would require review upon the introduction of Listening to People in place of Putting Things Right in April 2026. We also found that a new Duty of Candour (DoC) policy was required as DoC was not well understood within the practice management or wider team and therefore could not be appropriately implemented.

The practice should develop appropriate local policies and procedures to embed the principles of DoC.

The practice was able to access Datix and the Yellow Card Scheme to report incidents or adverse drug reactions.

Leaders told us that they aimed to foster a collaborative and positive working environment for all team members through regular and open staff engagement.

Information

Information governance and digital technology

A suitable Data Protection Officer was in place to oversee data protection and information governance arrangements and ensure any queries were appropriately handled. We found that staff were aware of their obligations with respect to confidentiality, data protection and GDPR regulations. Information governance and privacy notices were available to patients on the practice website. However, the privacy notice also required displaying within the practice premises. This could be well-placed on the digital information screen within the practice waiting area.

The practice should ensure that their privacy notice is displayed both online and within the practice premises.

Templates were being developed to create consistency within the electronic records system and enable data to be more easily pulled for reviews of clinical practice or focused audits. The EMIS electronic system was still relatively new to the practice and we discussed further formal training for relevant staff to cascade and support the embedding of the system.

The practice should continue to develop its approach to data capture and audit using the EMIS system. This could include agreeing a practice wide approach to the use of Clinical Read codes in the problem line.

Learning, improvement and research

Quality improvement activities

The practice contributed to the development of the broader healthcare professional workforce by offering opportunities to GP registrars and pharmacy students. The practice had been previously involved with a Health and Care Research Wales study. However, the practice should reflect on their current systems of audit and other continuous development activity to ensure they remain in line with current best practice.

Whole-systems approach

Partnership working and development

The practice engaged with regular neighbourhood care network, cluster and practice manager meetings to share ideas and innovations to enhance the delivery of primary care services. We discussed drawing on supportive relationships

practice leaders had with other settings for assistance with implementing improvements from this inspection.

4. Next steps

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

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

The improvement plans should:

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

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

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

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

Appendix A – Summary of concerns resolved during the inspection

The table below summarises the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns Identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns were identified on this inspection			

Appendix B – Immediate improvement plan

Service: Cyncoed Medical Centre

Date of inspection: 25 March 2026

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

Findings

HIW was not assured that robust systems were in place to ensure staff received consistent, effective training relevant to their roles, including effective oversight of staff training and competence. Our review of a sample of five staff training records and discussions with staff from clinical and non-clinical professional groups highlighted the following issues:

- No evidence of recent training was available for clinical staff regarding key safety topics including Basic Life Support, Infection Prevention and Control or Safeguarding. Historical Safeguarding training was not completed to levels appropriate to roles in line with Royal College of General Practitioners guidelines. There were also gaps in Information Governance, Equality, Diversity and Inclusion, Health and Safety and Fire Safety
- Some non-clinical staff had completed some training, but this was not consistent
- There was no evidence that staff who would be required to use oxygen cylinders within routine or emergency care had undertaken training regarding the safe use of oxygen cylinders.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
1.	The practice must take immediate action to strengthen staff training governance arrangements. This includes implementing robust systems to determine training needs, and to monitor, record, and assure on-going compliance with staff training, including refresher training.	Health and Care Quality Standards (2023) - Safe	**Response / Plan:** • A Training Needs Analysis (TNA) will be completed for all staff to identify mandatory and role-specific training requirements. • The existing centralised training register will be updated and enhanced to provide the information and records required to effectively monitor staff training compliance. This will include recording completion dates, expiry dates, and refresher requirements for all mandatory and role-specific training, and will allow the practice to track outstanding training and generate reports to assure ongoing compliance. • Staff will be reminded of training requirements, and completion will be actively	Practice Manager / Deputy Practice Manager	Timescale: Actions will be fully implemented within 6–8 weeks from the date of this notice.

			monitored by the Deputy Practice Manager. • Regular audits of training compliance will be carried out to assure ongoing adherence. • Refresher training will be scheduled in accordance with guidance and tracked through the register.		

Findings

HIW was not assured regarding security procedures within the practice with respect to items that could cause harm to patients or were open to misuse. Our inspection highlighted the following issues:

- Waste bins kept outside the practice building were not locked or secured. This meant that members of the public could access clinical and sharps waste which would pose an infection prevention and control, health and safety, and environmental risk
- Clinical rooms found to be left open and unattended while patients were accessing the building. Drugs cupboards within these rooms could not be locked and computer access cards were kept inserted into computers. This meant that members of the public could access drugs and information which would pose health and safety risk and data protection risks
- Prescription pads kept within areas with access restricted to staff only. However, they were not secured within these areas.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
1.	The practice must ensure that waste bins, drug cupboards, prescription pads and forms and computer systems are secured and locked at all times to prevent unauthorised access or misuse of resources.	Health and Care Quality Standards (2023) - Safe	**Clinical Waste Management - Revised Protocol** The practice has taken immediate action to strengthen the management of clinical waste. Clinical waste bins are now required to be kept locked at all times to prevent unauthorised access. Bins are stored securely within the basement car parking area, accessible only via locked doors, and are placed externally solely when required for collection. External cleaning staff have been informed of the revised protocol and	Clinical Waste Management Revised Protocol – Practice Manager Responsibility for overseeing adherence - Reception Managers	Immediate effect - 31/03/2026

			updated procedures. A notice outlining these requirements, along with the key, is securely held within the cleaning supplies room. An additional notice detailing the process has been prominently displayed on the clinical waste bin. The clinical waste collection provider, Stericycle, has been notified of the revised arrangements, and confirmation has been requested to ensure collection personnel have the appropriate means to unlock and safely empty the bins during collection. All staff have been made aware of the updated protocol. Responsibility for the collection and disposal of clinical waste from clinical areas has been clearly assigned to the cleaning staff. **Prescription Storage and Monitoring Protocol – Revised** The practice has implemented a revised protocol to ensure the secure storage and accurate monitoring of prescription stationery, including boxes of prescriptions and individual clinician prescription pads. **Storage of Prescription Boxes**	Prescription Storage and Monitoring - Revised Protocol – Practice Manager Responsibility for overseeing adherence – Prescriptions Clerks	Immediate effect – 31/03/2026 Prescription Log Version 1.0 (March 2026) has been uploaded as evidence of implementation

			All boxes of prescriptions are stored in the locked clinical supplies room. An asset register of full prescription boxes is maintained, recording the box reference numbers and associated details. Any box removed from the central store is recorded by its reference number, the allocated clinician or location, and/or the clinical room. This information is logged on the prescriptions register to maintain a complete audit trail. **Prescription Requests and Record-Keeping** All prescription requests must be processed through the Prescriptions Clerks. Clerks update both the paper records (kept with the stock) and the electronic copy of the prescriptions log, which is maintained on the S:Drive. This ensures consistency and accountability across all records. **Individual Clinician Prescription Pads**		

			Individual clinician prescription pads are retained in the clinical rooms in locked drawers when not in use. Clinical rooms are kept locked when clinicians are not present, maintaining the security of prescription pads and reducing the risk of unauthorised access. **Monitoring and Oversight** The Practice Manager is responsible for overseeing compliance with this protocol, including the accurate logging of prescriptions, secure storage, and ensuring all staff are aware of and adhere to these procedures. **Drugs Cupboard – Revised Protocol** The practice has implemented a revised protocol to ensure the secure storage, monitoring, and safe access to drugs, excluding those contained within the emergency drugs kit. **Storage and Security**	Drugs Cupboard – Revised Protocol – Practice Manager Responsibility for overseeing adherence – Nursing Team	Lock installed with Immediate effect – 31/03/2026 The Drugs Stock Register is to be implemented and fully completed by 07/04/ 2026 and thereafter maintained and updated on an ongoing basis.

			All drugs (excluding emergency drugs) are stored in a locked cupboard within the clinical room. The cupboard is accessible only to authorised clinical staff. The clinical room is kept locked when not in use, preventing unauthorised access to medication. **Stock Monitoring and Record-Keeping** A drugs stock register is maintained, recording the type, quantity, batch number, and expiry date of all drugs stored in the cupboard. Any removal of drugs is recorded in the register by date, quantity, and name of the staff member accessing the cupboard. Regular stock checks are conducted by a designated staff member to ensure accuracy of the register and identify expired or missing items promptly. **Access and Accountability** Only authorised clinicians are permitted to access the cupboard.		Drug Stock Register – Clinical Room Cupboard Version 1.0 (March 2026) has been uploaded as evidence of implementation.

			Any concerns regarding stock discrepancies, damaged packaging, or expired drugs are reported immediately to the Practice Manager. The Practice Manager is responsible for monitoring adherence to this protocol and ensuring that staff are informed and compliant. **Additional Safety Measures** Emergency drugs are stored separately in the emergency drugs kit and are subject to their own monitoring protocol. All staff are reminded of infection control and safe handling procedures when accessing drugs. The cupboard is checked daily to ensure it remains securely locked and the keys are kept in a secure location.		

Findings

HIW was not assured that robust systems ensured the suitable maintenance of medical equipment and devices. During the inspection we found:

- Empty oxygen cylinders stored in the same location as other emergency drugs and equipment. This meant that oxygen may not be readily available when required within an emergency situation and causing a delay to appropriate care
- Emergency equipment checks were only completed on a monthly basis and were not comprehensively documented. Checks should be completed on a weekly basis according to Resuscitation Council UK guidance. The documentation of checks in place at the practice did not support a robust checking or recording
- No recent calibration or other formal servicing of clinical fridges or other medical devices. Some electrical equipment had been PAT tested but this had not been completed for all appliances. There was also no ring-fenced time for visual inspections or other in-house checks to be completed prior to or following use or on a regular basis. Lack of clear delegation of responsibility for medical equipment and devices meant that maintenance issues may not readily identified posing a patient safety risk.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
1.	The practice must implement robust processes for the regular checking and maintenance of medical equipment and devices. This includes regular, documented visual inspection and in-house checks, clear arrangements for the removal, repair or replacement of faulty or otherwise unsuitable equipment, formal calibration, servicing and PAT	Health and Care Quality Standards (2023) - Safe	**Action Plan – Medical Equipment and Devices Compliance** **Objective:** To implement robust processes for the regular checking, maintenance, and monitoring of all medical equipment and devices, ensuring safety, compliance, and readiness for use. **Asset Register Creation** **Action:** Develop a comprehensive Asset Register of all medical	Responsibility for overseeing adherence – Practice Manager/Deputy Practice Manager **Responsible Person:** Practice Manager/ Deputy Practice Manager	**Timescale:** Completed within **2 weeks**

	testing of electrical devices, including clinical fridges.		equipment, including electrical and non-electrical devices. **Details to include:** Equipment name, location, manufacturer/model, serial number, date acquired Calibration requirements Servicing schedule PAT testing requirements (for electrical equipment) Notes on condition/status **Visual Inspection & Regular In-House Checks** **Action:** Implement documented weekly visual inspections and functional checks of all equipment. **Guidelines for Documentation:** Use a **Weekly / Monthly Check Log** cross-referenced to the Asset Register Record date, staff member, equipment checked, condition, and any actions taken	**Responsible Person:** Authorised clinical staff for weekly checks; Practice Manager/Deputy Practice Manager to review monthly	**Timescale:** Process to start **immediately**; documentation format agreed within **1 week**

			Removal, Repair, and Replacement of Faulty Equipment **Action:** Faulty or unsuitable equipment to be tagged and removed from use immediately Arrangements to be made for repair or replacement Actions recorded in the check log and Asset Register **PAT Testing of Electrical Devices** **Action:** Arrange PAT testing for all electrical equipment, and portable devices. **Clinical Fridge Service** **Action:** Arrange service of clinical fridges, ensuring compliance with manufacturer guidance and safety standards. **Calibration of Medical Equipment** **Action:** Identify equipment requiring formal calibration (e.g., blood pressure monitors, thermometers) Schedule calibration as per manufacturer guidance	**Responsible Person:** Practice Manager/Deputy Practice Manger to oversee escalation and follow-up Responsible Person: Practice Manager to arrange with an approved contractor Responsible Person: Practice Manager to coordinate service Responsible Person: Practice Manager / Authorised staff	**Timescale:** Immediate for any current faulty equipment **Timescale:** As soon as possible; completion recorded in Asset Register and Check Log **Timescale:** As soon as possible; record service completion and next scheduled service in Asset Register **Timescale:** Within 4 weeks **Timescale:** Ongoing

			Record completion and next scheduled calibration in Asset Register **Ongoing Monitoring and Governance** **Action:** Practice Manager/Deputy Practice Manager to review logs and Asset Register every periodically Audit compliance, outstanding maintenance, calibration, and PAT testing Escalate any unresolved issues immediately Documentation: Weekly / Monthly Check Log + Asset Register + PAT/Service/Calibration records		
2.	Documented checks of emergency drugs and equipment to be completed in accordance with Resuscitation Council UK guidelines.	Health and Care Quality Standards (2023) - Safe	**Weekly Emergency Drugs & Equipment Check Protocol - Revised** **Storage** Emergency drugs are stored with the resuscitation equipment in a designated, secure, and easily accessible location. **Frequency of Checks** Weekly Checks: Clinical staff perform weekly checks to ensure that	Weekly Emergency Drugs & Equipment Check – Revised Protocol Practice Manager Responsibility for overseeing adherence – Nursing Team	Immediate effect – 31/03/2026 Weekly Emergency Drugs & Equipment Check Version 1.0 (March 2026) has been uploaded as evidence of implementation.

			emergency drugs are present, in date, and stored correctly, and that all equipment is present and functional. **Note:** A **detailed stock and equipment check** is completed separately in a dedicated document, which records full inventory, expiry dates, batch numbers (for drugs), and detailed equipment functionality. **Monthly Oversight** The Practice Manager reviews the completed weekly logs at the end of each month to ensure all records are complete and any issues have been addressed. **Documentation** All checks are recorded in the Emergency Drugs & Equipment Check Log, including: • Date of check • Staff member completing the check • Confirmation that drugs and equipment are present and functional • Notes or actions taken if any discrepancies are identified • Staff signature **Accountability**		

			The Practice Manager ensures that weekly checks are completed consistently and that monthly review of records is carried out. Any missing, expired, or faulty drugs/equipment are addressed immediately and recorded in the notes. **Audit** Logs are maintained for inspection and reviewed regularly to ensure compliance.		

Findings

HIW was not assured that the practice was meeting the professional and legal obligations associated with Patient Group Directions (PGDs).

We reviewed a sample of PGDs and found missing countersignatures on all of these. One PGD for pneumonia was not signed at all.

1.	The practice must ensure that PGDs are appropriately signed and authorised.	The Human Medicines Regulations 2012 / NICE Guideline MPG2	The practice has ensured that all Patient Group Directions (PGDs) are appropriately authorised and signed by a GP Partner. Each PGD has been reviewed to confirm it is current, within its validity period, and compliant with relevant national guidance	PGD – Revised Protocol – Practice Manager Responsibility for overseeing adherence – Nursing Team/ GP Partners	Immediate effect – 30/03/2026 Patient Group Directions (PGD's) Protocol Version 1.0 (March 2026) has been uploaded as evidence of implementation.

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: **Sarah Thomas** Cyncoed Medical Centre

Name (print): SARAH THOMAS

Job role: Practice Manager **Date:** 31/03/2026

Appendix C - Improvement plan

Service: Cyncoed Medical Centre

Date of inspection: 25 March 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.	Self-check-in and a separate room for more in-depth discussions with reception staff available but not promoted to patients.	Self-check-in or a separate room for more in-depth discussions to be better promoted as options to preserve confidentiality.	Health and Care Quality Standard (2023) - Person centred	A self-check-in notice has been displayed in the main reception area, together with a notice informing patients that a separate private room is available for confidential discussions if required.	Louise Tucker – Reception Manager	Action Complete 01/06/2026
2.	No standard pathway documents available to support non-clinical staff in care navigation.	Care navigation to be supported via provision of standard pathway documents as a resource.	Health and Care Quality Standard (2023) - Safe / Timely	Standard pathway documents have been developed and implemented to support effective care navigation. All staff have been notified of the resource and a direct link to the central resource location has been added to each staff member's desktop to facilitate access.	Resource– Sarah Thomas Practice Manager Implementation - Natalie Bridgeman Deputy Practice Manger	Action Complete 01/06/2026

3.	No signposting information seen regarding NHS 111 press 2 for patients requiring mental health support.	Information to be provided on the practice website and premises regarding NHS 111 press 2 as a mechanism for mental health support.	Health and Care Quality Standard (2023) – Safe / Timely	Information regarding available mental health support services and how to access them has been displayed on the reception information screen and published on the practice website.	Resource - Sarah Thomas Practice Manager Implementation - Natalie Bridgeman Deputy Practice Manger	Action Complete 01/06/2026

4.	Practice staff were aware of mechanisms available to support patient communication. However, language preference not routinely established or recorded to inform support mechanisms required. The Welsh language active offer also poorly promoted.	• Patients language preference to be identified and recorded on registration or further contacts to inform patient care • Welsh language active offer to be better promoted.	Health and Care Quality Standard (2023) – Person centred	Patients' language preferences are routinely collected as part of the new patient registration questionnaire and recorded in the patient's EMIS record during the registration process. Staff use a registration template embedded within EMIS to ensure this information is consistently captured. Information regarding the availability of Welsh-speaking GPs has been updated on the practice website. In addition, a notice is displayed in the reception office to remind staff of the availability of Welsh-speaking GPs and to support patients in accessing consultations in their preferred language.	Resource - Sarah Thomas Practice Manager Implementation - Natalie Bridgeman Deputy Practice Manger Ongoing oversight Louise Tucker – Reception Manager	Action Complete 01/06/2026

5.	Consent policy specifically aimed at physiotherapists and did not make any reference to the Mental Capacity Act (2005) or supporting patients unable to make decisions regarding their healthcare due to impairment or disturbance of mind or brain.	Consent policy to be reviewed to ensure it provides appropriate guidance to all professionals working at the practice and regarding supporting patients who are unable to make decisions regarding their healthcare.	Health and Care Quality Standard (2023) – Person centred	The consent policy has been reviewed and revised to ensure compliance with relevant guidance and regulatory requirements. CMC & CCR Policies and Procedures V3:1 Section 59 Pg 159-164	Resource– Sarah Thomas Practice Manager	Action Complete 01/06/2026
6.	A fire door was observed to be wedged open.	Fire precautions to be followed at all times to protect patients, staff and facilities.	Health and Care Quality Standard (2023) – Safe	Fire drills are completed in accordance with requirements. Staff and patients have been reminded of the importance of keeping fire doors closed and not wedging them open.	Implementation - Natalie Bridgeman Deputy Practice Manger Ongoing oversight Louise Tucker – Reception Manager	Action Complete 01/06/2026

7.	We found items left out after use and clutter within practice areas.	All areas to be kept tidy and free of clutter with items appropriately stored or disposed of immediately after use. Old items should be promptly removed from areas where they could be mistaken for items suitable for use and used in error and fully disposed of as soon as possible.	Health and Care Quality Standard (2023) – Safe	All areas to be maintained in a tidy and clutter-free condition, with items stored appropriately or disposed of immediately after use. Obsolete or unused items will be removed promptly to prevent them being mistaken for equipment suitable for use. Empty oxygen cylinders have been removed from the premises. Staff have been reminded of the importance of maintaining a safe, organised, and clutter-free working environment, with ongoing monitoring to ensure compliance.	Implementation - Natalie Bridgeman Deputy Practice Manger Ongoing oversight Louise Tucker – Reception Manager	Ongoing 01/06/2026
8.	The boiler required maintenance.	Boiler to be appropriately maintained.	Health and Care Quality Standard (2023) – Safe	The boiler was serviced on 06/11/2025 and was confirmed to be in full working order. The contractor was contacted regarding the water egress and provided assurance that it was not a cause for concern. This will be highlighted for review during the next routine service.	Sarah Thomas Practice Manager	Completed 01/06/2026

9.	Insufficient signage seen indicating the locations of medical gases and emergency equipment.	Suitable signage to indicate the location of medical gases and emergency equipment to inform patients, staff and other professionals attending in an emergency.	Health and Care Quality Standard (2023) – Safe	Suitable signage has been created and displayed to clearly indicate the location of medical gases and emergency equipment, ensuring that patients, staff, and visiting healthcare professionals can readily locate these items in an emergency.	Resource– Sarah Thomas Practice Manager Ongoing oversight Louise Tucker – Reception Manager	Completed 01/06/2026
10.	Business Continuity Plan (BCP) lacked detail and was not accessible to key personnel both on and off the practice premises.	• BCP to be reviewed to ensure formalised arrangements for sourcing alternative staff and accommodation are available in the event of major disruption to these aspects of service delivery • BCP to be accessible to key personnel both on and off the practice premises to refer to when required.	Health and Care Quality Standard (2023) – Effective	The Business Continuity Plan has been comprehensively reviewed and updated to ensure that all arrangements are clearly documented and fit for purpose. Copies of the current plan are held off-site by key personnel, including the Senior Partner, Practice Manager, and Deputy Practice Manager, to facilitate an effective response to any disruption in service.	Resource– Sarah Thomas Practice Manager Natalie Bridgeman Deputy Practice Manger	Completed 01/06/2026

11.	IPC policies lacked clarity and IPC and waste management practices were not embedded.	• IPC policies to be reviewed to ensure suitable details are included to reflect the latest IPC guidance and clearly support staff to implement IPC procedures • All staff to undertake IPC training relevant to their role • Comprehensive records to be maintained indicating when contracted cleaners and clinical staff have undertaken cleaning of clinical areas and equipment and what this has involved	Health and Care Quality Standard (2023) – Safe	Infection Prevention and Control (IPC) policies have been reviewed and updated to reflect current IPC guidance and best practice. Staff are currently completing the IPC training relevant to their roles to ensure compliance with required standards. An IPC audit has been undertaken by Rebecca Gill, and all recommendations are being reviewed and actioned. A follow-up review is scheduled to take place within the next 2–3 months to assess progress and identify any further improvements. IPC records and monitoring documentation are being introduced incrementally and will be maintained by both clinical staff and contracted cleaning personnel to support ongoing compliance and effective infection prevention and control practices. Waste collection records are maintained, with	Sarah Thomas Practice Manager Natalie Bridgeman Deputy Practice Manger Ongoing oversight Sister Maggie Bowden Sister Heather Chappell	Ongoing 2-3 months

		• Waste collection records to be maintained • IPC and waste management audits to be undertaken at suitable intervals and improvements identified implemented • All posters in clinical areas to be laminated • Mops and buckets to be stored separately with mop heads up and buckets inverted or on shelving.		Monthly reports provided by the contracted clinical waste collection service. IPC and waste management audits will be undertaken on a monthly basis by the Healthcare Assistant (HCA). Findings will be reviewed, and any identified improvements will be implemented and monitored. All posters displayed within clinical areas have been laminated to support effective cleaning and infection prevention measures. Contracted cleaning staff have been informed of the requirement to store mops and buckets appropriately, with mop heads stored upright and buckets inverted or placed on shelving. Reminder notices have been displayed within the cleaning storage rooms to reinforce this practice. CMC & CCR Policies and Procedures V3:1 Section 38 Pg 88-99		

12.	Needlestick policy lacked detail and a blood-borne virus policy was not seen. Posters to support staff in the event of a needlestick injury were displayed in some clinical areas but not all.	Comprehensive needlestick and blood-borne virus policies to be available and action plans clearly displayed in all clinical areas.	Health and Care Quality Standard (2023) – Safe	The Needlestick Injury and Blood-Borne Virus (BBV) policies have been comprehensively reviewed and updated to reflect current guidance and best practice. Clear action plans and management procedures are displayed in all clinical areas to ensure staff can respond promptly and appropriately in the event of an incident. CMC & CCR Policies and Procedures V3:1 Section 38 Pg 88-99	Resource– Sarah Thomas Practice Manager Ongoing oversight Sister Maggie Bowden Sister Heather Chappell	
13.	No staff Hepatitis B register or records of other staff vaccinations available.	A comprehensive staff Hepatitis B and vaccination register to be maintained.	Health and Care Quality Standard (2023) – Safe	Up-to-date records of Hepatitis B vaccination and immunity status are maintained for all clinical staff in accordance with occupational health requirements.	Natalie Bridgeman Deputy Practice Manger	Register complete 01/06/26 Periodic review ongoing

14.	Safeguarding policy needed reviewing for accuracy. Staff unsure who was the practice safeguarding lead.	• Practice safeguarding arrangements to be comprehensively reviewed in line with national standards, including Royal College of GP Safeguarding Standards (2024) • Staff to be clearly informed of the practice safeguarding arrangements.	Health and Care Quality Standard (2023) – Safe	The practice safeguarding policy has been reviewed and updated in line with current guidance and best practice. Staff are currently undertaking safeguarding training appropriate to their roles and responsibilities. All staff have access to the updated safeguarding policy and are aware of the designated safeguarding lead and the process for raising safeguarding concerns. CMC & CCR Policies and Procedures V3:1 Section 68 Pg 206-221	Resource– Sarah Thomas Practice Manager Ongoing oversight of training needs – Natalie Bridgeman Deputy Practice Manager	Ongoing 2-3 months

15.	Some items intended for named patient use were found within the emergency drugs and equipment.	• Emergency drugs and equipment stocks to be ordered separately from items intended for individual patients.	Health and Care Quality Standard (2023) – Equitable	A review of emergency drugs and equipment identified that some items intended for named patient use had been stored within emergency stock. Processes have been reinforced to ensure that emergency drugs and equipment are ordered, stored, and managed separately from items intended for individual patients. Staff have been reminded of the requirement to maintain clear segregation of stock to reduce the risk of error and ensure emergency equipment remains readily available and appropriately managed.	Ongoing oversight Sister Maggie Bowden Sister Heather Chappell	Periodic review ongoing

16.	Some emergency drugs were not dated on opening to guide use and disposal. Single use items of emergency equipment had been used and required replacement and expired defibrillator pads found.	• The date of opening of any liquid drugs should be recorded to guide use and disposal • Single-use items which have been opened should be replaced • Expired items should be replaced.	Health and Care Quality Standard (2023) – Safe	The findings of the review have been acknowledged, and actions have been implemented to strengthen the management of emergency drugs and equipment. A process has been introduced to ensure that all liquid medications are dated upon opening to support appropriate use and disposal in accordance with manufacturers' guidance. Staff have also been reminded that all single-use items must be replaced immediately after use to ensure emergency equipment remains complete and ready for use. The expired defibrillator pads have been replaced. In addition, more comprehensive checking and recording systems have been implemented to provide improved oversight of emergency drugs and equipment, support stock rotation, and ensure that any expired, used, or missing items are identified and addressed promptly.	Resource– Sarah Thomas Practice Manager Ongoing oversight Sister Maggie Bowden Sister Heather Chappell	Periodic review ongoing

17.	No formal cold chain policy or flow chart available.	Cold chain policy and flow chart to be available to support all staff in taking appropriate action should a temperature breach occur.	Health and Care Quality Standard (2023) – Safe	A current Cold Chain Policy is maintained within the nursing room and is accessible to staff to support compliance with vaccine storage and handling requirements.	Ongoing oversight Sister Maggie Bowden Sister Heather Chappell	Periodic review ongoing
18.	Room temperature not monitored in areas where non-refrigerated drugs are stored.	Room temperature to be monitored in areas where non-refrigerated drugs are stored.	Health and Care Quality Standard (2023) – Safe	Arrangements have been made for the purchase of a thermometer.	Sarah Thomas Practice Manager Ongoing oversight Sister Maggie Bowden Sister Heather Chappell	1-2 weeks

19.	Oxygen cylinders not securely stored and not all staff aware of their safe use.	• Oxygen cylinders to be securely stored • All staff who may be required to administer oxygen in the course of patient care to undertake training regarding the safe use of oxygen cylinders in line with Patient Safety Notice 041.	Health and Care Quality Standard (2023) – Safe	Oxygen cylinders are stored with the emergency drugs and equipment, and all staff have been made aware of their location. Non-clinical staff have received training to ensure they understand the basic safety checks required, including how to identify whether a cylinder is full, recognise signs of damage, and report any concerns. Staff who may be required to administer oxygen as part of patient care are currently undertaking training on the safe use of oxygen cylinders in accordance with Patient Safety Notice 041. Training completion is being monitored to ensure all relevant staff achieve the required level of competence.	Sarah Thomas Practice Manager Ongoing oversight – Natalie Bridgeman Deputy Practice Manager Ongoing responsibility of Administration staff Louise Tucker – Reception Manager	Ongoing Training needs completion 2-4 weeks

20.	Patient records reviewed considered to be of a generally high quality. However, some areas could be strengthened: • The application of Read codes for the offer and use of a chaperone • Details of safety netting for condition risk management Further structured audit of chronic disease management and documentation and record summaries would also be beneficial to practice development.	• Appropriate clinical Read codes to be used throughout patient records • Records and summaries are regularly audited to underpin further practice and documentation development.	Health and Care Quality Standard (2023) – Safe	A robust auditing process for patient records and clinical summaries is being developed to monitor the quality and consistency of documentation, identify areas for improvement, and support the ongoing development of record-keeping standards. Regular audits will be introduced to provide assurance that records and summaries are accurate, complete, and maintained in accordance with best practice and professional guidance.	Sarah Thomas Practice Manager Natalie Bridgeman Deputy Practice Manager	Ongoing 4-6 weeks

21.	Limited delegation of leadership or designated time for the completion of some safety activities such as IPC or the checking and maintenance of medical devices, equipment and drugs.	Consideration to be given to formally delegating leadership and allocating time for patient safety activities.	Health and Care Quality Standard (2023) – Safe	Consideration has been given to formally delegating leadership responsibilities and allocating dedicated time for patient safety activities. The following leads have been identified to provide oversight and support continuous improvement in key areas: • Infection Prevention and Control (IPC): Sister Heather Chappell and Sister Maggie Bowden • Fire Safety: Natalie Bridgeman, Deputy Practice Manager • Maintenance of Medical Devices and Equipment: Natalie Bridgeman, Deputy Practice Manager, and Louise Tucker, Reception Manager • Drugs Monitoring and Management: Sister Heather		Ongoing

				Chappell and Sister Maggie Bowden These responsibilities have been incorporated into existing roles to ensure appropriate oversight, accountability, and ongoing monitoring of patient safety activities across the practice.		

22.	Some new policies needed and a number of existing policies content and version control required updating.	• All policies and procedures to be in place, up-to-date and regularly reviewed at timely, scheduled intervals. • Version control to be clear and any old versions of policies archived. • Priority should be given to creating and reviewing the policies named in this inspection.	Health and Care Quality Standard (2023) – Effective	A comprehensive review of all practice policies and procedures is currently underway. A more robust and systematic process for policy review, monitoring, and updating is being developed to ensure all documentation remains current, compliant, and aligned with best practice. The review programme is being guided by the findings of the HIW inspection, which identified policies requiring attention, together with the recommendations arising from the Welsh Information Governance Toolkit Audit completed by the Data Protection Officer (DPO). These assessments have provided a structured foundation from which to prioritise and implement the required improvements.	Sarah Thomas Practice Manager Natalie Bridgeman Deputy Practice Manager	Ongoing 8-12 weeks

23.	No evidence of supervision or appraisal for nursing staff over a period of years.	Appropriate supervision, appraisal and governance oversight to be provided to all members of staff.	Health and Care Quality Standard (2023) – Safe	The lack of documented supervision and appraisal for nursing staff has been acknowledged, and action has been taken to address this. A programme of appraisals is being implemented for all nursing staff. Self-appraisal forms will be distributed and completed in advance of formal appraisal meetings to support meaningful discussion, reflection, and personal development planning. A structured appraisal process is being established to ensure regular review of performance, training needs, professional development, and wellbeing. Appropriate records of appraisals and supervision will be maintained to provide assurance that all staff receive the support and oversight required for their roles.	Dr John Jones – Senior Partner Sarah Thomas Practice Manager	4-6 weeks

24.	Recruitment policy and pre-employment checks not consistently implemented and staff files not sufficiently organised to demonstrate staff were fit to work at the practice on recruitment and on an on-going basis. Some staff files also contained information relating to other individuals. This information should be stored elsewhere.	• Recruitment policies and pre-employment checks to be consistently implemented • Staff files to clearly evidence staff are fit to work at the practice on recruitment and on an on-going basis and must not contain information of any other applicants or other individuals.	Health and Care Quality Standard (2023) – Safe	The findings have been acknowledged, and actions are underway to strengthen recruitment and personnel record management processes. A pre-employment checklist has been developed to ensure all required recruitment checks are completed and documented consistently. In addition, recruitment policies are currently being reviewed and updated to reflect current guidance and best practice. A systematic review of all staff files is being undertaken to ensure they contain the appropriate documentation required to demonstrate that staff were fit to work at the time of recruitment and continue to meet the necessary requirements on an ongoing basis. Any information relating to other individuals will be removed from personnel files and stored appropriately in accordance with data protection and	Sarah Thomas Practice Manager Natalie Bridgeman Deputy Practice Manager	4-6 weeks

				confidentiality requirements. A more robust filing and monitoring process is being implemented to ensure staff records are complete, organised, and regularly reviewed for compliance. CMC & CCR Policies and Procedures V3:1 Section 5 Pg 11-12 Section 6 Pg 13-15		

25.	No role specific induction programmes in place.	Induction processes to ensure that clear role specific information is available to new temporary and permanent members of the team.	Health and Care Quality Standard (2023) – Safe	The current induction process, associated policies, and induction checklists are being comprehensively reviewed and updated to ensure a more robust, consistent, and effective approach for all new starters. The review will ensure that all mandatory training, role-specific requirements, organisational policies, health and safety information, safeguarding responsibilities, and information governance requirements are incorporated into the induction process. Standardised documentation and checklists are being developed to provide clear evidence of completion and competency, while supporting managers to monitor progress and identify any additional training or support needs. The revised process will help ensure that all staff are appropriately inducted, supported, and equipped to	Resource– Sarah Thomas Practice Manager Ongoing oversight - Natalie Bridgeman Deputy Practice Manager	4-6 weeks

				undertake their roles safely and effectively from the outset of employment.		

26.	Not all respondents to the HIW patient questionnaire aware of mechanisms for raising feedback, concerns or complaints with the practice. Records of feedback, concerns and complaints and complaints handling lacked detail. Themes and learning from feedback and complaints was not shared with patients.	• Processes for providing feedback and raising concerns or complaints to be readily available to patients • Comprehensive records of feedback, concerns and complaints received, investigation and responses to be maintained to underpin practice learning • Information regarding how the practice has learnt from feedback, concerns and complaints to be shared with patients, for example through a 'You said, we did' board.	Health and Care Quality Standard (2023) – Effective	The findings have been acknowledged, and steps have been taken to improve patient awareness of the mechanisms available for providing feedback, raising concerns, or making a complaint. Information explaining how patients can provide feedback or raise concerns is available on the practice website, and details have also been added to the reception information display screen to increase visibility and accessibility. Comprehensive records are maintained for all feedback, concerns, compliments, and patient contacts. These records include details of the issue raised, investigations undertaken, actions implemented, responses provided, and any learning identified. This enhanced documentation supports transparency, governance, and continuous improvement within the practice.	Resource– Sarah Thomas Practice Manager Ongoing oversight - Natalie Bridgeman Deputy Practice Manager	Ongoing

				The practice recognises the importance of demonstrating how patient feedback influences service development and will therefore implement a 'You Said, We Did' communication process. This will enable themes, learning, and resulting improvements arising from patient feedback, concerns, and complaints to be shared with patients on a regular basis, helping to promote engagement and confidence in the practice's commitment to continuous improvement. CMC & CCR Policies and Procedures V3:1 Section 19 Pg 37-40		

27.	Duty of Candour (DoC) not understood or implemented within the practice.	Appropriate local policies and procedures to be developed to embed the principles of DoC.	Health and Care Quality Standard (2023) – Effective	The practice acknowledges the need to further embed the principles of the Duty of Candour (DoC) within everyday practice. Staff have received refresher information regarding the requirements and principles of the Duty of Candour, including the importance of openness, honesty, and transparency when things go wrong. Appropriate local policies and procedures are being reviewed and developed to ensure the Duty of Candour is clearly embedded within practice processes and governance arrangements. Ongoing reminders, training, and discussion will be provided to staff to reinforce understanding and ensure continued awareness and compliance with Duty of Candour requirements. CMC & CCR Policies and Procedures V3:1 Section 47 Pg 114-116	Resource– Sarah Thomas Practice Manager Ongoing oversight - Natalie Bridgeman Deputy Practice Manager	Ongoing

28.	Privacy notice not displayed on the practice premises.	Privacy notice to be displayed both online and within the practice premises.	Health and Care Quality Standard (2023) – Person Centred	The Practice Privacy Notice is available on the practice website and is also displayed within the reception area, ensuring that patients can readily access information regarding how their personal information is collected, used, stored, and protected. CMC & CCR Policies and Procedures V3:1 Section 36 Pg 80-84	Resource– Sarah Thomas Practice Manager Ongoing oversight - Natalie Bridgeman Deputy Practice Manager	Complete 01/06/26

29.	Little formal training completed to underpin the embedding of the EMIS electronic records system.	Structured approach to developing data capture and audit practice using the EMIS system to continue to be developed.	Health and Care Quality Standard (2023) – Effective	The practice acknowledges that limited formal training has been undertaken in relation to EMIS searches and reporting functionality. As the practice remains relatively new to the EMIS clinical system, efforts have been made to develop knowledge and skills through collaboration with other Practice Managers, sharing resources, experience, and best practice approaches. The cost of formal EMIS training has been recognised as a consideration; however, the practice has actively engaged with the free training opportunities provided by Optum, including one-hour focused training sessions covering specific functions and queries. These sessions have supported the development of knowledge and confidence in using the system effectively. The practice remains committed to further developing EMIS skills and	Sarah Thomas Practice Manager Natalie Bridgeman Deputy Practice Manager	Ongoing

				will continue to explore additional training opportunities to enhance the use of searches, reporting, and data management functions to support clinical governance, quality improvement, and service delivery.		

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

Service representative:

Name (print): SARAH THOMAS

Job role: Practice Manager **Date: 02/06/2026**