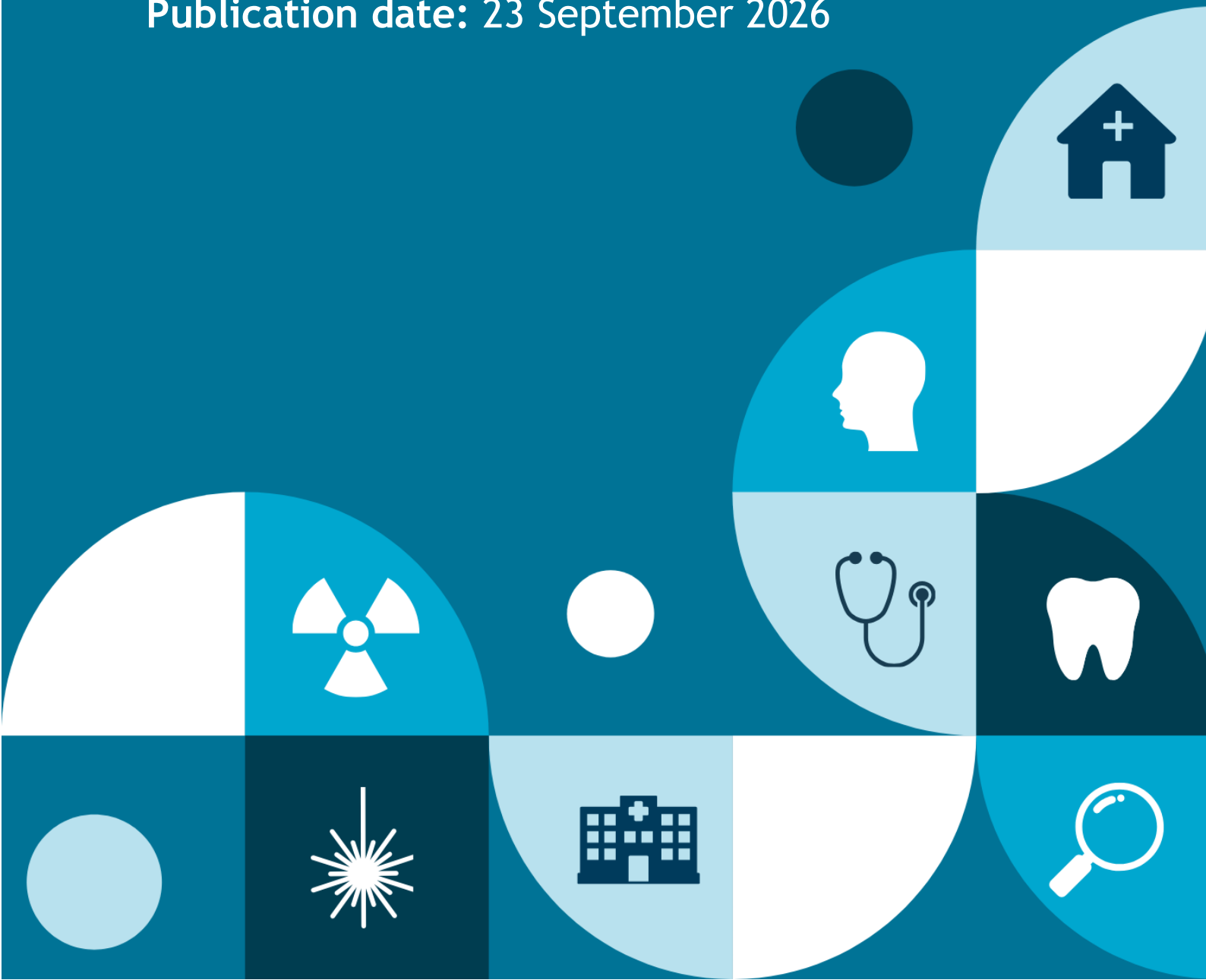
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General Practice Inspection Report (Announced)

Old School Surgery, Cwm Taf Morgannwg University Health Board

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

Our Purpose

We check the safety and quality of healthcare across Wales.

Our Vision

A future where healthcare in Wales is safe, effective, and high-quality for everyone.

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 Priorities

Putting People First - We will focus on the biggest risks facing people and communities as they access healthcare services now and in the future.

Learning and Working Together - We will collaborate with partners to share learning and drive lasting improvements.

Investing in Our People - We will ensure our people feel supported, valued, and empowered.

Taking Action That Matters - We will take action to improve the quality and safety of healthcare for the future of Wales.



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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 Old School Surgery, Cwm Taf Morgannwg University Health Board on 23 June 2026.

Our team for the inspection comprised of one HIW healthcare inspectors, two clinical peer reviewers and one practice manager peer reviewer.

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of 18 questionnaires were completed by patients or their carers and 5 were completed by staff. Feedback and some of the comments we received appear throughout the report.

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

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

2. Summary of inspection

Quality of Patient Experience

Overall summary:

Overall, patients provided positive feedback about their experiences at the practice. All respondents who completed the questionnaire reported that they felt listened to and were treated with respect by staff. However, some patients expressed concerns regarding access to appointments and long telephone queues.

The practice promoted health and wellbeing through a range of health promotion initiatives, information resources and services. Patients had access to a variety of support services, including physiotherapy, mental health support and social prescribing.

We found patients were treated with dignity and respect. Appropriate arrangements were in place to maintain privacy and confidentiality, and patients could request a chaperone where required. However, information regarding the availability of chaperones was not displayed within patient areas.

The practice demonstrated a commitment to providing equitable care and had made reasonable adjustments to support patients with differing needs, including those with mobility, communication and language requirements. Although accessible facilities were available, improvements were required to ensure staff understood and responded appropriately to emergency alarm systems

This is what we recommend the service can improve:

- Ensure information on the practice website is accurate, up to date and accessible
- Ensure staff understand the purpose and operation of emergency alarm systems.

This is what the service did well:

- Offered information through multiple channels, including SMS messaging, social media and printed materials
- Promoted patients' rights by recording and respecting preferred names and pronouns and supporting transgender patients appropriately.

Delivery of Safe and Effective Care

Overall summary:

The practice had arrangements in place to support the delivery of safe and effective care. The practice environment was generally clean, tidy and well maintained, and business continuity arrangements supported service resilience. However, improvements were required in relation to environmental cleaning, the storage of cleaning materials, significant event management and home visit risk assessments.

Appropriate infection prevention and control measures were in place, including staff training, waste management processes and suitable decontamination facilities. However, IPC leadership, staff awareness, audit activity and monitoring of staff Hepatitis B immunisation status required strengthening. Medicines management systems were generally effective, with appropriate repeat prescribing processes, medication reviews and accessible emergency equipment, although improvements were needed in medicines storage and prescription monitoring arrangements.

Staff demonstrated a good understanding of safeguarding responsibilities and referral processes, and patient records were generally comprehensive and well maintained. However, the practice needed to strengthen safeguarding training compliance, document workflow processes and aspects of clinical record keeping to further enhance patient safety and quality of care.

Immediate assurances:

- Cleaning schedules required reviewing due to issues with dust in clinical rooms
- System required for managing prescription stationary to ensure accurate tracing and ensure prescriptions are stored securely within clinical rooms at all times
- Infection Prevention and Control (IPC) audit programme to be implemented.

This is what we recommend the service can improve:

- Improve vaccine storage, temperature monitoring and cold chain management
- Implement a protocol to follow in the event of a patient contacting experiencing a mental health crisis
- Strengthen patient document workflow and records management processes.

This is what the service did well:

- Maintained accessible emergency equipment and medicines with routine checking arrangement
- Kept patient records that were generally comprehensive, contemporaneous and well coded

- Robust referral processes were in place, including daily auditing of referrals.

Quality of Management and Leadership

Overall summary:

Overall, we found the practice had established governance and leadership arrangements, with staff describing managers as visible, approachable and supportive. Staff feedback was positive, and respondents told us they felt able to contribute ideas and participate in decision-making.

Regular staff and clinical meetings were held, supporting communication, the sharing of learning and discussion of service developments. However, we found several policies required review or were not in place and accountability for improvement actions following audits were not formally documented.

The practice demonstrated a commitment to staff wellbeing and provided opportunities for staff development through appraisal, training and protected learning time. Clear recruitment and induction processes were in place, although improvements were needed to ensure recruitment records and staff training documentation were complete and effectively monitored.

Appropriate arrangements were in place for information governance, complaints management and the review of safety alerts. The practice also engaged in collaborative working and quality improvement activities. However, the practice needed to implement mechanism to allow patients to leave feedback when in practice and demonstrate how feedback had been used to inform service improvements.

Immediate assurances:

- We found a number of policies and procedures were missing or required reviewing.

This is what we recommend the service can improve:

- Improve governance and clinical oversight arrangements for nursing staff
- Increase opportunities for patient feedback and demonstrate changes made in response
- Ensure all staff recruitment records are complete and maintained in line with policy.

This is what the service did well:

- Strong arrangements were in place for information governance and data security

- The practice worked effectively with cluster, health board and multidisciplinary partners
- Staff felt involved in decision-making and able to suggest improvements.

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

HIW issued questionnaires to patients and carers who attend the practice to gather their views on the services provided. In total, we received 18 responses from patients at this setting. Some questions were skipped by some respondents, meaning not all questions had 18 responses. Responses were generally positive, with all respondents reporting they felt listened to and were treated with respect by staff.

Patient comments included:

> "... I have been looked after admirably during my frequent spell of poor health by GP, practice Nurses and receptionists...."
>
> "Lack of available appointments is an ongoing issue."
>
> "...There is never a problem getting through for an appointment and reception staff always go the extra mile to accommodate patients- they are extremely helpful and kind..."
>
> "There is no flexibility with regards to booking an appointment. Calling at specific times of the day is not suitable."
>
> "...On the day is a long telephone queue and non on the day appointments are allocated just once a week and go very quickly"
>
> "... I have nothing but praise for old school surgery, I can get an appointment, speak to a GP. I am more than happy with my service here."

Person-Centred

Health promotion

The practice promoted healthy lifestyles through a range of approaches. Information was available on the practice website and within the waiting area, and patients could also receive information via SMS messaging. However, we noted that some areas of the website were missing information and some website links did not work.

The practice must ensure information is up-to-date and accessible on the practice website.

A variety of health promotion information was displayed within the waiting room, including topics such as bereavement support for young people, maternal wellbeing, musculoskeletal self-referral, bowel cancer symptoms, menopause support, foot care, carers' support, falls prevention, and access to wellbeing programmes and screening services. We were told patients without digital access were able to obtain information through posters, printed materials and by contacting the practice directly. They could also access appointments by attending in person or phoning the practice.

The practice provided access to a range of healthcare professionals and services. These included a physiotherapist available through the cluster arrangement, a mental health service operating from the branch surgery, and clinics for skin lesions. We were told patients were able to self-refer to for these services.

The practice promotes health and wellbeing through public health campaigns such as smoking cessation and screening initiatives, as well as access talking therapies for children aged over five, a social prescribing service, and drug and alcohol support services.

Childhood immunisations were co-ordinated through the child health team, with appointments arranged by the practice. The practice confirmed it did not provide Respiratory Syncytial Virus (RSV) or COVID-19 vaccinations, and patients were directed to the health board for these services. Communication regarding vaccination clinics was primarily issued by letter, which supported patients without digital access. We were told posters were also displayed within the practice to inform patients of vaccination programmes taking place.

Dignified and respectful care

We observed that clinical rooms provided patients with appropriate levels of privacy. Doors were kept closed during consultations, and conversations could not be overheard. Privacy curtains were available in all treatment rooms and rooms with external windows had blinds in place, which were kept closed to maintain confidentiality.

We found that staff were discreet and sensitive when speaking with patients. The reception area was positioned away from the main waiting area and separated by a door, which supported private conversations. A separate room was available for confidential discussions if required. Telephone calls were taken in a room on the first floor, away from patient areas, reducing the risk of conversations being overheard.

The practice offered both male and female chaperones, and staff confirmed that requests for a chaperone could be recorded on the appointment system. We were told staff had received chaperone training during induction, and an up-to-date chaperone policy was in place. Where applicable, most (6/7) respondents to the HIW questionnaire who answered the question confirmed they were offered a chaperone for intimate examinations or procedures. However, we found that there was no information displayed in waiting or clinical areas to inform patient of the option of a chaperone, which may limit patient awareness of the service.

The practice must ensure chaperone information is displayed within the practice in an area easily seen by patients.

Timely

Timely care

We found information about appointment options and services was available on the practice website, in patient leaflets and via reception staff. Additional information was also displayed within the waiting area. Staff told us that patients could book appointments through the NHS Wales app or directly with reception, and all patients were offered face-to-face consultations where required. For urgent on-the-day appointments, patients were required to contact the practice by telephone or attend in person. We were told the practice gathered patient feedback on access through an annual survey, which was shared via social media, text message links and paper copies.

We noted the practice did not have a formal access policy in place, however information about accessing services was available on the website. Further information regarding this is available in Appendix B.

Reception staff supported to signpost patients to appropriate services and had completed relevant care navigation training. However, the care navigation process was not fully formalised and did not clearly include all available services, such as wider cluster-based options. Further information on this can be found in Appendix B.

Staff were clear that they did not undertake clinical triage and could seek advice from the duty doctor if urgent support was needed.

Arrangements were in place to support vulnerable patients, including identifying

individuals on the system and offering longer or more flexible appointments where needed. The practice operated a system where appointments were released on the day, with an on-call GP supporting patients when capacity was reached. Patients could update the practice on their condition during consultations or via email, which was monitored during the day.

Equitable

Communicating and language

We found the practice communicated information about services through its website, patient information leaflets and reception staff. New patients were provided with a practice leaflet, which was available in both paper and digital formats, and additional information was displayed within the waiting area. The practice also used social media, SMS messages, posters and telephone communication to inform patients of changes to services. Staff told us that information could be provided in alternative formats, such as large print or easy read, to meet individual needs, and a hearing loop was available at reception.

Staff understood the importance of communicating with patients in their preferred language and told us they would support patients to communicate in Welsh where possible, using Welsh-speaking colleagues or interpretation services if required. We observed that some bilingual information was displayed in the waiting area, and positively 'Cymraeg' identifiers were used on treatment room doors where staff spoke Welsh. Several GPs were Welsh speaking, and some Welsh speakers were available within the administrative team.

Rights and equality

We found that the practice promoted equality and diversity through staff training and policies, which were available within the staff handbook. Staff told us they treated all patients fairly and understood the importance of providing equitable care.

The practice was accessible to patients with mobility needs, with ramp access, ground floor patient areas and designated disabled parking spaces available. Accessible toilet facilities were in place. However, whilst on inspection, we raised the alarm within the accessible toilet. We found staff within the practice did not respond to this alert; being told by the practice manager they did not know what the sounding alarm was for.

The practice must ensure all staff are aware of the purpose and location of alarm systems, ensure regular testing of safety alarms and understand their responsibilities in responding to emergency alerts.

A hearing loop was available at reception, and an electronic system was used to call patients. Where required, staff would collect patients from the waiting area.

Reasonable adjustments were made to meet patients' individual needs. For example, records were flagged to identify communication needs, bariatric seating was in place, appropriate weighing scales were available, and we were told patients were offered quieter areas if they experienced anxiety. The practice also offered flexibility with appointment arrangements and would signpost patients to a sister practice where additional support for mobility needs was required.

Systems were in place to uphold the rights of transgender patients. Staff recorded patients' preferred names and pronouns within medical records and confirmed these were respected in practice.

Delivery of Safe and Effective Care

Safe

Risk management

We found the practice was generally clean, tidy and in a good state of repair. Clinical and treatment rooms were free from clutter and hazards. However, we noted areas beneath treatment couches, on shelving and on windowsills required cleaning. This was immediately raised to the practice manager, and further information can be found in Appendix B. We also noted cleaning fluids and cleaning equipment were not stored appropriately within an electrical room.

The practice must ensure cleaning materials are stored within Control of Substances Hazardous to Health (COSHH) guidelines, and cleaning equipment is stored appropriately.

The practice had an up-to-date Business Continuity Plan (BCP), which was available on the pc where all staff could access it, with copies also held by practice partners and the practice manager. The BCP included arrangements for significant health emergencies; however, we noted there was no information present on business partnership risks.

The practice must update the Business Continuity Plan to include business partnership risks and appropriate contingency arrangements.

The practice worked with local cluster arrangements and maintained a support arrangement with a neighbouring practice to help ensure continuity of service in exceptional circumstances. Processes were in place to manage workforce pressures, including the use of regular locum clinicians to support continuity of care.

Patient safety alerts were received by the practice manager, with access also available

to the deputy practice manager, providing cover during periods of absence. Staff described a process for discussing significant events through clinical meetings, email communications and protected learning time. However, there was no formal policy or standardised documentation in place, and significant events were not routinely reviewed after implementation of actions to ensure improvements had been effective.

The practice must implement a formal significant event policy and recording process, including arrangements for reviewing incidents and evaluating the effectiveness of actions taken.

Staff had access to an electronic alert system to summon urgent assistance when required and were aware of the location of emergency drugs and equipment. Sharps containers were stored appropriately, securely assembled and had not been overfilled.

We found the practice did not have a documented risk assessment for home visits. While alerts were used to identify patients who may present additional risks, there was no practice-specific assessment outlining the arrangements and mitigations in place for staff undertaking home visits.

The practice must develop and implement a documented home visit risk assessment that reflects the needs of the practice population and identifies controls to mitigate risks to staff.

Infection prevention and control (IPC) and decontamination

The practice had a cleaning contract in place with an external cleaning company, which had recently commenced following a change of supplier. Cleaning schedules were available; however, we observed dust within some clinical areas as previously mentioned in the report. There were also outstanding estates issues, including a leaking roof which effected the patient toilet ceiling and a broken staff room air conditioning unit within a staff area.. Of those who responded to the HIW questionnaire, all stated the practice was very clean or clean.

Appropriate handwashing and decontamination facilities were available throughout the practice. We observed suitable sinks, foot-operated bins, wipeable flooring and surfaces, and wipeable examination couches. Staff were observed to be bare below the elbows.

We asked staff who the IPC lead was for the practice and found uncertainty amongst staff regarding who held responsibility for IPC matters. While it appeared that a nurse prescriber had undertaken the role of IPC lead, staff were not consistently aware of this. We also found a general lack of staff knowledge relating to IPC arrangements and found no evidence that IPC audits had been undertaken. Further information regarding this can be found in Appendix B.

The practice must ensure staff are aware of who the infection prevention and control lead is in the practice.

Staff completed annual IPC training, and we found appropriate waste management arrangements in place, supported by a waste management policy and monthly waste audits. The practice had an isolation room available for the segregation of patients where required. However, there was no supporting guidance outlining how the room should be cleaned and managed following use.

We found an IPC policy in place; however, it was not specific to the practice. Further information regarding this can be found in Appendix B.

The practice must ensure it implements supporting guidance outlining how the isolation room should be cleaned and managed following use.

We found that blood-borne virus and needlestick injury guidance was not specific to the practice and required updating. Further information regarding this can be found in Appendix B. In addition, we were not assured that adequate arrangements were in place to monitor staff Hepatitis B immunisation status. Records reviewed did not provide assurance that all relevant staff had received appropriate vaccination follow-up boosters.

The practice must strengthen its arrangements for managing and recording staff Hepatitis B immunisation status.

Medicines management

We found prescription stationery was stored in locked areas within the practice when not in use. Staff described an appropriate process for returning named prescription pads to Shared Services when a GP left the practice. We also found evidence of good practice, with the collection of individual prescriptions recorded in patients' medical records, providing an audit trail when prescriptions were collected. However, there was no log in place to monitor the allocation of prescription pads or prescription stationery, including those used for home visits. We observed, on two separate occasions, the door to a clinical room was left open and unattended. Further information regarding this can be found in Appendix B.

Repeat prescribing arrangements were in place, with prescription clerks processing requests and referring queries to a pharmacist or GP when required. Medication reviews were undertaken by the practice pharmacist, and training needs were identified through audits, appraisals and the review of prescribing errors.

We found four vaccine refrigerators in use within the practice. Records available showed temperatures were maintained within the recommended range and vaccine stock was organised, rotated and in date. However, we found temperature checks had

not always been completed consistently, particularly when no nursing staff were on duty. We also found vaccines were stored on the base of refrigerators restricting air circulation. In addition, the cold chain policy was not specific to the practice and required updating.

The practice must strengthen its vaccine management arrangements by ensuring refrigerator temperatures are monitored consistently, vaccines are stored in accordance with national guidance, and a practice-specific cold chain policy is implemented.

We found medicines requiring refrigeration were mostly appropriately stored; however, room temperatures were not monitored despite the practice policy stating that medicines should be stored below 25°C. During our inspection, we identified an expired supply of medical drugs and blood collection tubes within clinical storage areas.

The practice must ensure all medicines are regularly checked and that expired medicines are removed from stock promptly.

Emergency medicines and resuscitation equipment, including an Automated External Defibrillator (AED) and oxygen, were available and accessible within the practice. We found the AED was charged, appropriately signposted and ready for use, and we reviewed detailed records of emergency equipment checks, expiry dates and stock levels.

Staff were aware of the location of emergency equipment, and weekly and monthly checking arrangements were in place. However, we found no formal protocol for replacing emergency medicines or equipment following use.

The practice must ensure formal procedure for the replenishment of emergency medicines and equipment following use is implemented.

Safeguarding of children and adults

We found the practice had a named safeguarding lead in place, and staff were aware of who to contact if they had a safeguarding concern. Staff demonstrated an understanding of the process for raising concerns and we were told safeguarding matters were overseen by two GPs. We were told by staff that they had access to the All-Wales Procedures.

We found a safeguarding policy was available; however, this was a national policy and had not been tailored to reflect local practice arrangements and responsibilities. Further information can be found in Appendix B.

The practice monitored A&E attendances and reports relating to patients who did not attend or were not brought to appointments. Staff reviewed this information and brought any concerns to the attention of a GP for further action.

We found evidence of multi-disciplinary working through safeguarding meetings involving GPs, the practice manager and health visitors, where available. We were also told that quarterly meetings were held with district nurses and palliative care teams to discuss patients requiring additional support.

Staff described systems for identifying adults at risk through daily clinical discussions, information received from family members and concerns identified by staff during routine contact with patients.

We saw evidence that most staff had safeguarding training in place to the level required for staff roles. We found most GPs had completed Level 3 safeguarding training and administrative staff had completed Level 1 training. However, of the five staff files reviewed, one clinical staff member did not have safeguarding children training in place and, for two staff members, we were unable to obtain assurance that safeguarding training had been completed at the appropriate level.

The practice must ensure all staff complete safeguarding training at a level appropriate to their role and maintain clear records to demonstrate compliance.

Management of medical devices and equipment

We found medical devices and equipment appeared to be in good condition, were stored appropriately and were fit for purpose. Equipment observed during the inspection appeared to have been maintained and calibrated where required. We also found evidence that the practice used single-use equipment whenever possible.

The practice manager held responsibility for maintaining records relating to electrical testing and equipment calibration. We saw contracts were in place for the servicing and maintenance of medical devices through an external provider.

Effective

Effective care

We found the practice had arrangements in place to keep up to date with best practice and national guidance. Clinical staff told us they accessed National Institute for Health and Care Excellence (NICE) guidance and received updates through GP collaborative meetings, practice manager meetings and Digital Health and Care Wales communications. New information was circulated to staff through EMIS and NHS email systems. We were told significant events were reviewed within the practice and incidents were reported through the Datix system when appropriate.

Reception staff demonstrated a good understanding of how to identify patients requiring urgent care and were able to signpost patients to appropriate services,

including NHS 111 and 999. Staff had access to guidance documents containing information on common conditions, referral pathways and support services. Reception staff described how they would respond to patients whose condition appeared to deteriorate whilst in the waiting area and would seek support from clinicians where necessary.

We found clear processes were in place for managing patient tests and results. Nurses requested tests for patients with long-term conditions, with results reviewed by a GP. Patients were advised to contact the practice for results or access them through the NHS App, with telephone access available for patients who were unable to use digital services. GPs contacted patients directly where results required further discussion or action.

The practice demonstrated a compassionate approach to supporting people experiencing poor mental health or those in crisis. Staff described examples of escalating concerns to clinicians and accessing support from local crisis services. The practice also had access to a mental health practitioner, and referrals could be made by GPs when appropriate. We were told that information relating to patients who had received crisis intervention was shared with the practice to support ongoing care and follow-up.

However, we found that reception staff had not received specific mental health awareness training, and while guidance was available for managing patients experiencing mental health difficulties, there was no dedicated protocol to support staff when responding to patients expressing suicidal thoughts or presenting in immediate mental health crisis.

The practice should develop a clear protocol for managing patients who present with suicidal thoughts or are experiencing a mental health crisis and ensure staff are familiar with its use.

We found referrals were managed through the Welsh Clinical Communications Gateway (WCCG). Urgent, routine and suspected cancer referrals were all submitted electronically through this system. We noted an effective process whereby all referrals were coded and subject to a daily audit to ensure they had been completed and sent. Locum GPs were provided with information regarding referral processes through a practice handbook.

The practice had adapted to changes in death certification arrangements and told us that processes were now operating more effectively following initial implementation challenges. Mortality reviews were undertaken where concerns had been identified and were reviewed through the significant event process.

The practice had systems in place to communicate with patients and manage information, including recorded telephone lines and electronic messaging systems. Callers were informed that calls were recorded, and access to recordings were

restricted. However, we identified potential risks in the management of incoming correspondence, as hospital letters were sometimes circulated within the practice before being scanned onto patient records.

The practice must ensure a process is implemented to ensure patient documents received are scanned onto patient records prior to moving onto the relevant clinician.

We also found there was no overarching workflow policy in place to support the consistent handling and tracking of documents. Further information can be found in Appendix B.

The practice used structured processes to communicate clinical information to patients, including electronic messaging and patient information leaflets to support understanding of conditions and treatment options. A results tracking system was in place to monitor follow-up investigations, which we identified as good practice.

Patient records

We found the practice used EMIS as its clinical system. We reviewed a sample of seven patient records and found they were generally of a good clinical standard. Records reviewed were contemporaneous, comprehensive and contained clear documentation of consultations, clinical findings, decisions made and action plans. We also found good use of clinical coding, including the coding of examination findings, which supported effective audit trails and clinical oversight.

Records demonstrated that allergies and adverse reactions were recorded appropriately, and most patients had received regular medication reviews. We also noted examples of good practice, including the use of recognised clinical prediction tools to support assessment and decision-making.

However, we identified inconsistencies in the way medicines were linked to patients' diagnosed conditions. While some records demonstrated good practice, others contained medications that were not linked to any condition. In addition, one record showed that a medication review was overdue by 16 months. We also found that information provided to support patients' understanding of their condition and treatment options was not consistently documented within records reviewed.

The practice must ensure the following:

- **Medicines are consistently and accurately linked to the relevant diagnosed condition within patient records.**
- **Medication reviews are completed within appropriate timescales and monitored effectively.**
- **The problem list and associated clinical codes are maintained and reviewed regularly to ensure they remain accurate and up to date**.

Efficient

Efficient

We found the practice had arrangements in place to support efficient movement through care and treatment pathways. Patients were able to self-refer to physiotherapy services and access first contact clinicians where appropriate, helping to ensure timely assessment and treatment. The practice also had access to a mental health practitioner, with referrals generally made by GPs.

These arrangements supported patients in accessing the most appropriate service for their needs and helped reduce the need for unnecessary GP appointments. The availability of community-based services within or alongside the practice promoted a coordinated approach to care and enabled patients to receive support closer to home.

Quality of Management and Leadership

Staff Feedback

In total, we received five responses from staff at this setting. Some questions were skipped by some respondents, meaning not all questions had five responses. Overall, the responses from staff were positive. The majority of staff felt able to suggest improvements and involved in decisions.

Staff comments included:

> " This surgery is very well run- the team are all very responsive to patient's needs"

Leadership

Governance and leadership

We found the practice had operational systems and processes in place to support effective governance, leadership and accountability. Staff and managers were clear about their roles and responsibilities, and staff spoken with understood the importance of working within their scope of practice.

The practice management team were visible and approachable. Staff told us managers maintained an open-door approach and were available to provide support and guidance when required.

Practice-wide staff meetings were held quarterly during protected learning time. Staff were encouraged to contribute agenda items and provide feedback ahead of meetings. Topics discussed included fire safety, prescribing, appointments, safeguarding and significant events. Minutes were recorded and shared with all staff via email, including those who were unable to attend.

Changes to policies, procedures and important operational information were communicated by email to ensure staff received consistent information. However, we noted there were numerous policies that were not in place or required review. Further information regarding this can be found in Appendix B.

Safety alerts issued by organisations such as the Medicines and Healthcare products Regulatory Agency (MHRA) and Welsh Government were reviewed by the practice manager and deputy practice manager before being disseminated to relevant staff.

The practice demonstrated a commitment to staff wellbeing. Return-to-work discussions were undertaken following periods of sickness absence, and managers discussed available support options with staff where required. We also heard examples of wellbeing initiatives being delivered by GPs to support staff during challenging periods.

Clinical oversight was provided jointly by named GP leads and the practice manager. Clinical meetings were held twice each month, with minutes maintained and stored in a shared folder accessible to staff. Learning from significant events was discussed within these meetings and shared across the wider practice team.

The practice participated in cluster and collaborative working arrangements and had been involved in initiatives to support improvements.

We found responsibilities for service quality and improvement was shared between the GP partners and practice manager; however, we found that accountability for improvement actions was not formally documented or monitored through a structured action plan.

The practice should implement a formal improvement plan to record, allocate and monitor actions arising from audits, significant events, inspections and service improvement activities.

The main challenges identified by the practice included financial pressures, increasing workload transferred from secondary care services and ongoing contractual pressures within primary care.

Workforce

Skilled and enabled workforce

We found the practice had clear processes in place for recruitment and pre-employment checks. We found an up-to-date recruitment policy and induction programme in place, and induction records were available for review. Vacancies were advertised through NHS Jobs and other appropriate channels, and recruitment included shortlisting and interview processes. Pre-employment checks included proof of identity, references, employment history, occupational health clearance, Disclosure and Barring Service (DBS) checks, evidence of qualifications and professional registration. We also saw evidence of job descriptions and professional registration checks and staff told us they worked within their competence and only saw patients they were appropriately trained to manage. However, when reviewing five staff records, we found the following:

- Two of five records did not contain evidence of identity checks.
- Three of five records did not contain DBS checks.
- One of five records did not contain references.
- One of five records did not contain a full employment history.
- One of five records did not contain evidence of a professional registration check.
- Evidence of individual scope of practice documentation, qualification certificates or records demonstrating regular review of competencies was missing for some clinical staff.

This was discussed with the practice manager, who advised that references had not previously been obtained consistently; however, a process was now in place to address this. We were also told that the staff member whose record did not contain a full employment history had worked at the practice for over 20 years.

The practice must ensure all staff files going forward contain complete and up-to-date recruitment records in line with its recruitment policy and regulatory requirements.

Staff suitability to work within the practice was monitored through annual appraisals, and staff were required to notify the practice of any changes that could affect their ability to undertake their role. Staff were encouraged to undertake continuing professional development through e-learning, external courses and protected learning sessions.

We reviewed five staff records and found evidence that staff had completed a range of essential training, including safeguarding, infection prevention and control, fire safety and information governance. However, training records were incomplete in several areas. We found:

- Two of five records did not contain certification for equality and diversity training.
- Two of five records did not contain certification for health and safety training.
- One of five records did not contain certification for resuscitation training.
- Two of five records did not contain certification for portable oxygen cylinder training.
- Two of five records did not contain certification for mental capacity training.
- Two of five records did not contain certification for duty of candour training.

In addition, two safeguarding certificates did not clearly identify the level of training completed, preventing assurance that staff had received safeguarding training appropriate to their role. We also found no clear system in place to identify when mandatory training required renewal.

The practice must implement a robust training monitoring system to ensure all staff complete mandatory training appropriate to their role and that training records and certificates are maintained.

Workforce planning was managed through regular discussions between GP partners and managers, supported by staff rotas to manage annual leave and unexpected absences. Although there was no formal workforce plan, we found the practice maintained oversight of staffing levels and skill mix. Staff competencies were reviewed through annual appraisals and ongoing discussions throughout the year. Appropriate indemnity arrangements were in place for clinicians, and occupational health screening and health clearance processes had been completed prior to employment.

The practice employed a nurse independent prescriber; however, we found limited evidence of clinical oversight or routine auditing of prescribing practice beyond annual reviews. We were told regular nurse meetings took place; however, we found no evidence of regular nursing team meetings, formal clinical supervision sessions or documented peer support arrangements.

The practice should ensure scope of practice documentation is maintained and regularly reviewed for all relevant clinical staff.

The practice should strengthen governance arrangements for supporting nursing staff by implementing regular documented nursing team meetings, maintaining records of clinical supervision and undertaking routine audits of non-medical prescribing practice.

Culture

People engagement, feedback and learning

We found the practice had arrangements in place to obtain, manage and respond to patient feedback and complaints. Concerns and complaints could be raised informally or managed through the formal Listening to People process. Complaints were acknowledged within five working days, and we saw evidence that complaints and responses were maintained within a dedicated complaints folder. The practice manager was responsible for managing formal complaints, with clinical concerns being managed by a GP and the deputy practice manager providing cover during periods of absence. We were also told that an annual review of complaints was completed and discussed with GPs.

We found an up-to-date complaints policy in place which aligned with the NHS Listening to People process. However, although information regarding complaints was available within the complaints leaflet, we found limited opportunities for patients to provide feedback within the practice. We found there was no suggestions box available, information about the Listening to People procedure was not displayed in the waiting area, and the feedback link on the practice website was not working.

The practice should ensure mechanisms are in place to allow patients to leave feedback when in practice, and information regarding the NHS Listening to People procedure is clearly displayed and easily accessible to patients.

The practice had introduced a patient experience questionnaire in November 2025 to gather feedback from patients. However, we found no information available to demonstrate how patient feedback had been used to improve services, such as a 'You Said, We Did' display or similar mechanism.

The practice should implement a process to inform patients of changes made in response to feedback received.

We saw evidence that complaints were discussed during staff meetings and that learning was shared with staff where appropriate. Staff told us they felt able to raise concerns, suggest new ideas and contribute to service improvements through training afternoons, meetings and discussions with managers and GP partners. Staff also

confirmed they would feel comfortable raising concerns about colleagues' conduct and were aware of the whistleblowing arrangements contained within the employee handbook.

We found an up-to-date Duty of Candour policy in place, and staff were aware of their responsibilities under the statutory guidance. Records reviewed demonstrated that most staff had completed Duty of Candour training and were aware of the actions required should a notifiable safety incident occur.

Information

Information governance and digital technology

We found the practice had an up-to-date information governance policy in place, which was scheduled for review in June 2026. Paper records were stored securely within locked offices, and electronic patient records were managed using EMIS Web with individual password-protected user accounts.

The practice used Digital Health and Care Wales (DHCW) as its Data Protection Officer service. Staff were aware of this arrangement, and we were assured that appropriate expertise was available to support the practice in meeting its data protection responsibilities.

We found appropriate arrangements in place to ensure patients were aware of how their information was managed. A privacy notice was available within the waiting area and on the practice website.

The practice used clinical templates to support consistency and accuracy in record keeping. We were told data quality was monitored through a range of audits, including prescribing and medicines management audits, and medication reviews. GP activity data was monitored and reported monthly, and annual prescribing audits were undertaken to support service improvement and oversight.

We found effective arrangements in place to enable the sharing of information with external organisations where appropriate. Data sharing agreements were in place, including arrangements to support the use of anonymised data through Secure Anonymised Information Linkage (SAIL) audit tools and information sharing with the health board.

Learning, improvement and research

Quality improvement activates

We found the practice engaged in activities to support continuous quality improvement. Staff described how ideas for service improvements were discussed at partnership meetings, with new initiatives considered and progressed where appropriate. The GP partners and practice manager also held an annual planning session to discuss future developments and priorities for the practice.

We reviewed quality improvement documentation and found it aligned with the requirements of the Quality Assurance and Improvement Framework (QAIF). Some clinical audits were undertaken to monitor the quality and safety of care. Examples included prescribing audits, and we were told GP registrars were encouraged to participate in audit activity as part of their training. Audit findings and any resulting actions were discussed at clinical meetings, enabling learning to be shared across the practice team. However, we found no audits were undertaken for infection prevention and control. Further information on this can be found in Appendix B.

We were told complaints and concerns were recorded and reviewed, with an annual complaints summary produced for consideration by the GP partners. However, evidence of this annual review was not available during the inspection.

Learning from incidents, complaints and other reviews was discussed during clinical meetings, with minutes recorded and stored within a shared folder accessible to staff. This helped ensure learning was shared across the practice and supported ongoing service improvement.

Whole-systems approach

Partnership working and development

We found the practice worked collaboratively with a range of partners to support the delivery of patient care and ensure services met the needs of the local population. Staff told us they followed health board pathways and guidance when planning and delivering care, helping to ensure consistency across the wider healthcare system.

The practice engaged with a range of system partners through health board meetings, GP collaborative meetings and multi-disciplinary team (MDT) meetings. We were told safeguarding and palliative care MDT meetings were held to support care and improve outcomes for patients with complex needs.

The practice also participated in cluster projects and initiatives aimed at improving services for the local population. This included involvement with Vitality talking therapies and other initiatives designed to support patient wellbeing and improve

access to care.

These collaborative arrangements enabled the practice to develop a shared understanding of local healthcare challenges and patient needs, whilst supporting continuity of care through effective partnership working with primary care, secondary care, health board and third-sector organisations.

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
There were no immediate concerns resolved during the inspection.			

Appendix B – Immediate improvement plan

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	We were not assured that appropriate systems were in place to ensure the safe and secure management of prescription stationery within the practice. During the inspection, we found a lack of effective security measures in place for paper prescriptions, with no system to monitor or identify if any prescriptions were missing. In addition, we observed on two occasions that a consulting room door was left open and unattended, while patients were present in the waiting area and not under direct supervision by staff. This lack of oversight meant that patients could potentially have accessed prescription stationery and potentially other sensitive information without detection, increasing the risk of misuse or loss.		
Improvement needed		**Standard / Regulation**	
1.	The practice must implement a clear system for managing prescription stationery, including maintaining an accurate log prescription reference numbers to allow accurate tracing. Prescription forms must be stored securely at all times, and unattended rooms containing prescription stationery must not be accessible to patients.	Health & Care Quality Standards (2023) – Safe, Effective	
Service Action:		**Responsible officer**	**Timescale**
We have now generated logbooks for both the computer prescriptions (boxes) and individual GP pads. We have a protected learning afternoon on 17th July where the team will have the new system explained to them. The system will then be implemented from this date. Each GP consulting room will be allocated a whole box of prescriptions to make it easier for us to trace any missing ones. GPs will be responsible for the security of these boxes.		Lead Prescribing GP and Practice Manager	Meeting on 17.7.26 and new policy will be explained to the Practice team and implemented from this date.

Due to the layout of the practice, patients can access clinical rooms directly from the open waiting area, making it impractical to ensure unattended rooms are always inaccessible. To mitigate this risk blank individual GP named prescription pads will be stored in locked storage or carried by clinicians, with electronic prescribing used wherever possible. Staff have been reminded of the requirement to secure prescription stationery before leaving a room unattended.		Checks on log books will be included in our monthly information security audit (from August 2026)

Findings	We were not assured that robust procedures were in place to ensure that infection prevention and control (IPC) was consistently maintained at the surgery. There was a lack of IPC audit activities completed, which limited assurance that IPC risks were being routinely identified, monitored, and managed. In addition, observations of the environment identified areas within treatment rooms where robust cleaning had not been completed.		
Improvement needed		**Standard / Regulation**	
2.	The practice must take immediate action to ensure effective and sustainable infection prevention and control arrangements are in place. This includes: • Implement a documented IPC audit programme to ensure infection risks are routinely identified, monitored and managed. This must include completion of a comprehensive IPC audit at least annually, supported by a schedule of targeted audits throughout the year (e.g. hand hygiene & aseptic non-touch technique) • Reviewing cleaning schedules to ensure that clinical areas are maintained to a consistent standard.	Health & Care Quality Standards (2023) – Safe, Effective, Learning, Improvement and Research	
Service Action:		**Responsible officer**	**Timescale**

Our IPC Policy will be updated in line with current NHS guidelines We will implement monthly IPC audits which will cover ANTT, hand hygiene, waste management and cleaning standards (in clinical and non-clinical areas) First annual IPC Audit will be scheduled for August 2026 alongside our annual cold chain audit Continuation of staff training at induction and two yearly intervals. Cleaning schedules will be checked as part of the monthly audit and inconsistency of cleaning will be fed back to external organisation. However, if something is noted before the monthly audit is carried out it will be reported and corrected.	GP Partner and Nurse Manager Practice Manager	A new IPC policy has been written and will be fully discussed with Nurse Manager following her return from annual leave on 29th July 2026 Audits to start from August 2026 after a review of IPC Policy to ensure we are following the correct procedures/guidelines Annual IPC audit will be completed (August 2026)

Findings	We were not assured that the practice had appropriate, up-to-date and practice-specific policies to support the safe delivery of care. A number of policies were either missing, out of date, or not tailored to the practice, including those relating to medicines management, resuscitation, workflow, care navigation, 'was not brought', practice access, and a general prescribing policy. Existing policies, including consent and safeguarding, were not localised from national or Health Board templates, and lacked review details. In addition, the IPC policy had not been reviewed since 2020 and did not include guidance on blood borne viruses or sharps injuries specific to the practice.

Improvement needed	**Standard / Regulation**

3.	The practice must develop, implement and maintain a comprehensive range of up-to-date, practice-specific policies and procedures to support the safe and effective delivery of care. This must include, but is not limited to: • Implementing policies for medicines management, resuscitation, workflow processes, care navigation, 'was not brought', practice access, and general prescribing. • All existing policies must be reviewed, appropriately localised from national or Health Board templates, and include clear practice roles, responsibilities, relevant points of contact, and issue and review dates. • The IPC policy must be updated to include current, practice-specific guidance, including on blood borne viruses and the management of sharps injuries.	Health & Care Quality Standards (2023) – Safe, Effective, Leadership, Information

Service Action:	Responsible officer	Timescale
We did not have a policy in the following areas these will be available for the team to read by 7th August 2026 (resus, access, did not attend/was not brought, care navigation, medicine management (to include general prescribing), workflow processes) Current policies will be reviewed (although this is already an ongoing process using DPO, Health Board and Welsh Government templates as guides) IPC policy as above (section 2)	GP Partner Assistant Practice Manager	New policies will be written by 7th August 2026 Review of current policies will take place during the month of August 2026, and the review will be completed by 28th August 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): Rachael Baker

Job role: Practice Manager **Date: 14.07.2026**

Appendix C – Improvement plan

Service: **Old School Surgery**

Date of inspection: **23 June 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 noted that some areas of the website were missing information and some website links did not work.	The practice must ensure information is up-to-date and accessible on the practice website.	Health and Care Quality Standards 2023 Information	Website in the process of being changed to new provider	Practice Manager	We hope to be on our new platform by the end of August 2026

2.	We found that there was no information displayed in waiting or clinical areas to inform patient of the option of a chaperone, which may limit patient awareness of the service.	The practice must ensure chaperone information is displayed within the practice in an area easily seen by patients.	Health and Care Quality Standards 2023 Information, Equitable	The practice believes this requirement is already being met, as chaperone information is displayed in patient facing areas within the surgery. We will nevertheless review the location and prominence of the notices to ensure they remain easily visible and accessible to patients. Clinical staff will be reminded to offer chaperone	Practice Manager	Completed
3.	Whilst on inspection, we raised the alarm within the accessible toilet. We found staff within the practice did not respond to this alert; being told by the practice manager they did not know what the sounding alarm was for	The practice must ensure all staff are aware of the purpose and location of alarm systems, ensure regular testing of safety alarms and understand their responsibilities in responding to emergency alerts.	Health and Care Quality Standards 2023 Safe	We have a protected educational meeting planned in September 2026 when both clinical and non-clinical staff will be in attendance and we will go through all the alarms used for emergency situations	Practice Manager	By end of September 2026

4.	We noted cleaning fluids and cleaning equipment were not stored appropriately within an electrical room.	The practice must ensure cleaning materials are stored within Control of Substances Hazardous to Health (COSHH) guidelines, and cleaning equipment is stored appropriately.	Health and Care Quality Standards 2023 Safe	As we were had only just changed cleaning companies, we were still in the process of making changes and working together to ensure rooms are cleaned to a high standard The practice has reviewed its arrangements and has ensured that cleaning materials are stored in accordance with COSHH requirements and that cleaning equipment is kept in designated storage areas. Staff have been reminded of the importance of maintaining these standards, and compliance will be monitored through routine environmental checks. This will form part of our monthly IPC audit	Practice Manager and Nurse Manager	Completed

				being carried out by Nurse Manager		
5.	The BCP included arrangements for significant health emergencies; however, we noted there was no information present on business partnership risks.	The practice must update the Business Continuity Plan to include business partnership risks and appropriate contingency arrangements.	Health and Care Quality Standards 2023 Safe	This was in our previous BCP but omitted in error when we moved to the DHCW format Policy to be amended	Assistant Practice Manager	September 2026
6.	There was no formal policy or standardised documentation in place, and significant events were not routinely reviewed after implementation of actions to ensure improvements had been effective.	The practice must implement a formal significant event policy and recording process, including arrangements for reviewing incidents and evaluating the effectiveness of actions taken.	Health and Care Quality Standards 2023 Learning, Improvement and Research	We did not have a formal policy in place and will implement this Datix incidents are kept in a folder in PM office alongside SEA and discuss annually	Assistant Practice Manager	By end of December 2026

7.	While alerts were used to identify patients who may present additional risks, there was no practice-specific assessment outlining the arrangements and mitigations in place for staff undertaking home visits.	The practice must develop and implement a documented home visit risk assessment that reflects the needs of the practice population and identifies controls to mitigate risks to staff.	Health and Care Quality Standards 2023 Safe	We are aware of our "risky" patients and alerts are added to medical records No formal policy in place at the time of HIW visit	Assistant Practice Manager	Completed July 2026
8.	We asked staff who the IPC lead was for the practice and found uncertainty amongst staff regarding who held responsibility for IPC matters.	The practice must ensure staff are aware of who the infection prevention and control lead is in the practice.	Health and Care Quality Standards 2023 Safe	Meeting held between Lauren and Joanne in July to address this issue and put an action plan in place	Nurse Manager and Assistant Practice Manager	In the process of being completed
9.	There was no supporting guidance outlining how the isolation room should be cleaned and managed following use.	The practice must ensure it implements supporting guidance outlining how the isolation room should be cleaned and managed following use.	Health and Care Quality Standards 2023 Safe	To be discussed with Practice team as this will be their responsibility during the working day – they will need to follow cleaning schedule	Nurse Manager and Practice Manager	Add to agenda 10.11.26

10.	Records reviewed did not provide assurance that all relevant staff had received appropriate vaccination follow-up boosters.	The practice must strengthen its arrangements for managing and recording staff Hepatitis B immunisation status.	Health and Care Quality Standards 2023 Workforce	We have a folder documenting Hep B status and moving forward all non-clinical members of staff will be offered a Hep B	Practice Manager	To be completed by end of December 2026
11.	We found temperature checks had not always been completed consistently, vaccines were stored on the base of refrigerators restricting air circulation, and the cold chain policy was not specific to the practice and required updating.	The practice must strengthen its vaccine management arrangements by ensuring refrigerator temperatures are monitored consistently, vaccines are stored in accordance with national guidance, and a practice-specific cold chain policy is implemented.	Health and Care Quality Standards 2023 Safe	We do hold a practice specific cold chain policy and an audit is carried out annually in August. We are in the process of purchasing data loggers for 7 Fridges	Nurse Manager and Practice Manager	To be completed by end of September 2026
12.	We identified an expired supply of medical drugs and blood collection tubes within clinical storage areas.	The practice must ensure all medicines are regularly checked and that expired medicines are removed from stock promptly.	Health and Care Quality Standards 2023 Safe	This was an oversight by the Practice Nursing team who had checked the stock the previous week Out HCA is responsible for checking clinical rooms but currently on maternity leave	Practice Manager	completed

13.	We found no formal protocol for replacing emergency medicines or equipment following use.	The practice must ensure formal procedure for the replenishment of emergency medicines and equipment following use is implemented.	Health and Care Quality Standards 2023 Safe	Formal procedure was not in place, and this will be implemented	Nurse Manager	By end of September 2026
14.	Of the five staff files reviewed, one clinical staff member did not have safeguarding children training in place and, for two staff members, we were unable to obtain assurance that safeguarding training had been completed at the appropriate level.	The practice must ensure all staff complete safeguarding training at a level appropriate to their role and maintain clear records to demonstrate compliance.	Health and Care Quality Standards 2023 Safe, Workforce	It was identified that the Croner Safeguarding course completed was not adequate as it did not have a Level on it for non-clinical staff. The members of staff who completed this training course will be asked to complete the NHS Wales e-learning modules I have since checked with the Health Board Safeguarding Lead and my HCA/Phlebotomists do not need to complete Level 3 (Level 2 is adequate)	Practice Manager	By end of December 2026

15.	There was no dedicated protocol to support staff when responding to patients expressing suicidal thoughts or presenting in immediate mental health crisis.	The practice should develop a clear protocol for managing patients who present with suicidal thoughts or are experiencing a mental health crisis and ensure staff are familiar with its use.	Health and Care Quality Standards 2023 Effective	We held a staff meeting on 23rd July whereby we discussed how to deal with patients presenting with Mental Health issues	Senior Partner and GP Partner	Completed

16.	We identified potential risks in the management of incoming correspondence, as hospital letters were sometimes circulated within the practice before being scanned onto patient records.	The practice must ensure a process is implemented to ensure patient documents received are scanned onto patient records prior to moving onto the relevant clinician.	Health and Care Quality Standards 2023 Effective	We agree that all patient documents should be incorporated into the patient record in a timely manner. However, we do not believe it is appropriate or safe to require all documents to be scanned onto the patient record *prior* to being reviewed by the relevant clinician. Our process is that documents are received, reviewed and clinically prioritised where necessary, and then filed/scanned to the patient record as part of the workflow. Requiring scanning before clinician review could introduce delays in the assessment of urgent information and does not necessarily improve patient safety	GP Partners	Completed

17.	We found some records contained medications that were not linked to any condition, one record showed a medication review was overdue by 16 months, and information provided to support patients' understanding of their condition and treatment options was not consistently documented within records reviewed.	The practice must ensure the following: Medicines are consistently and accurately linked to the relevant diagnosed condition within patient records. Medication reviews are completed within appropriate timescales and monitored effectively. The problem list and associated clinical codes are maintained and reviewed regularly to ensure they remain accurate and up to date.	Health and Care Quality Standards 2023 Effective	The practice recognises the importance of ensuring medicines are linked to the relevant diagnosed condition, medication reviews are completed within appropriate timescales, and problem lists remain accurate and up to date. We have implemented processes to support these objectives, including regular medication reviews, ongoing maintenance of problem lists, and the use of clinical coding to link medicines to diagnosed conditions wherever possible. However, despite these measures, it is not always possible to achieve this consistently across all patient records. This	GP Partners	Completed

				may be due to factors such as historical records containing incomplete information, medicines initiated by external providers without a clearly coded diagnosis, legacy coding issues, or changes in clinical circumstances that require subsequent review and updating. The practice continues to undertake opportunistic reviews during patient contacts and structured searches where feasible to improve data quality and coding accuracy. We will continue to monitor and refine our processes to maximise compliance, recognising that maintaining complete and fully up to date		

				records is an ongoing process rather than a one time exercise.		
18.	We found that accountability for improvement actions was not formally documented or monitored through a structured action plan.	The practice should implement a formal improvement plan to record, allocate and monitor actions arising from audits, significant events, inspections and service improvement activities.	Health and Care Quality Standards 2023 Learning, Improvement and Research	We take on board your guidance and will formalise our documentation and have a central place of storage	GP Partners and Practice Manager	End of December 2026

19.	we found the following: •Two of five records did not contain evidence of identity checks. •Three of five records did not contain DBS checks. •One of five records did not contain evidence of a professional registration check. •Evidence of individual scope of practice documentation, qualification certificates or records demonstrating regular review of competencies was missing for some clinical staff.	The practice must ensure all staff files going forward contain complete and up-to-date recruitment records in line with its recruitment policy and regulatory requirements.	Health and Care Quality Standards 2023 Workforce	We had a discussion with Shared Services regarding DBS checks prior to HIW visit as we wanted clarification on whether or not GP Partners should renew their DBS documentation and what level of DBS is needed for some administrative staff For non-clinical staff where a DBS had not been completed as they had been in employment for 10+ years, DBS applications were completed. At the time of the HIW visit these certificates were still being processed by Shared Services and not available to view One of the records checked was for a new member of staff and we were still in the process of obtaining information	Practice Manager	Completed but to be double checked to ensure compliance

				from them Identity checks – staff were asked to provide information but slow to respond despite several reminders Professional registration documentation had been requested, and Practice Manager was waiting for member of staff to provide this		

20.	We found: •Two of five records did not contain certification for equality and diversity training. •Two of five records did not contain certification for health and safety training. •One of five records did not contain certification for resuscitation training. •Two of five records did not contain certification for portable oxygen cylinder training. •Two of five records did not contain certification for mental capacity training. •Two of five records did not contain certification for duty of candour training.	The practice must implement a robust training monitoring system to ensure all staff complete training appropriate to their role and that training records and certificates are maintained.	Health and Care Quality Standards 2023 Workforce	The practice recognises the importance of ensuring all staff complete training appropriate to their role and that training records are maintained. We have processes in place to monitor mandatory and role-specific training requirements and encourage staff to complete training within the recommended timescales. However, the practice operates within significant operational and service delivery pressures, which can affect the timing of training completion and administrative updates to training records. Protected learning time can be difficult to secure due to clinical demand, staff	Practice Manager	By the end of December 2026

				shortages, annual leave, and competing priorities. Despite these challenges, the practice maintains oversight of training requirements, regularly reviews training compliance, and supports staff to complete outstanding training as soon as practicable. We continue to work towards strengthening our monitoring processes while balancing the need to maintain safe and effective patient care.		

21.	We found limited evidence of clinical oversight or routine auditing of prescribing practice beyond annual reviews.	The practice should ensure scope of practice documentation is maintained and regularly reviewed for all relevant clinical staff.	Health and Care Quality Standards 2023 Workforce	We take on board your comments and we will ask our ANP and Pharmacist to provide us with a scope of practice document and carry out a review of their prescribing	GP Partners	By end of December 2026

22.	We found no evidence of regular nursing team meetings, formal clinical supervision sessions or documented peer support arrangements.	The practice should strengthen governance arrangements for nursing staff by implementing regular documented nursing team meetings, maintaining records of clinical supervision and undertaking routine audits of non-medical prescribing practice.	Health and Care Quality Standards 2023 Leadership	The practice recognises the importance of effective governance arrangements for nursing staff and has existing mechanisms in place to support communication, clinical oversight and safe prescribing practices. Whilst formal documented nursing team meetings, recorded clinical supervision sessions and routine audits of non-medical prescribing are desirable, implementation can be challenging due to workforce capacity, clinical commitments and competing operational priorities within the practice. Nursing staff have access to advice and	Nurse Manager	ongoing

				support from clinical colleagues on an ongoing basis, and governance issues are discussed through established practice meetings and day-to-day clinical interactions. Where concerns or learning needs are identified, these are addressed appropriately. The practice will continue to explore opportunities to strengthen and formalise these arrangements, including increasing the frequency of documented nursing meetings, improving the recording of clinical supervision activities, and undertaking non-medical prescribing audits where resources allow. However, this will need to be		

				balanced alongside the delivery of safe and effective patient care.		

23.	We found there was no suggestions box available, information about the Listening to People procedure was not displayed in the waiting area, and the feedback link on the practice website was not working.	The practice should ensure mechanisms are in place to allow patients to leave feedback when in practice, and information regarding the NHS Listening to People procedure is clearly displayed and easily accessible to patients.	Health and Care Quality Standards 2023 Culture	The practice recognises the importance of obtaining patient feedback and ensuring patients are aware of the avenues available to raise concerns or share their experiences. Patients are currently able to provide feedback through a range of established channels, including direct contact with the practice, the practice website, and formal complaints procedures. The practice reviews patient feedback regularly and uses it to inform service improvements. Whilst we do not currently intend to reintroduce the suggested in-practice feedback mechanism, we will continue to	Practice Manager	By end of December 2026

				review the effectiveness and accessibility of the feedback routes available to patients to ensure they remain appropriate and responsive to patient needs. Information regarding the NHS Listening to People procedure and other relevant patient information will continue to be made available through patient facing communication channels and reviewed periodically to ensure accessibility. Our new website should allow patients to send us feedback and suggestions		

24.	we found no information available to demonstrate how patient feedback had been used to improve services, such as a 'You Said, We Did' display or similar mechanism.	The practice should implement a process to inform patients of changes made in response to feedback received.	Health and Care Quality Standards 2023 Culture	The practice acknowledges this recommendation. However, due to resource and capacity constraints, it is not always feasible to operate a formal process to inform patients of every change made in response to feedback. The practice already considers patient feedback as part of its service development and communicates significant changes through existing patient communication channels where appropriate. We will continue to review opportunities to enhance this within available resources.	GP Partners	By end of December 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: RL Baker

Name (print): Rachael Baker

Job role: Practice Manager **Date: 26.8.26**