Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report (Announced)

Cross Hands and Tumble Medical Partnership, Hywel Dda 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 Cross Hands and Tumble Medical Partnership, Hywel Dda University Health Board on 11 May 2023.

Our team for the inspection comprised of two HIW Healthcare Inspectors and two clinical peer reviewers. The inspection was led by a HIW Healthcare Inspector.

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. A total of 58 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.

This (full) report is designed for the setting, and describes all findings relating to the provision of high quality, safe and reliable care that is centred on individual patients.

A summary version of the report, which is designed for members of the public can be found on our website.

2. Summary of inspection

Quality of Patient Experience

Overall summary:
We found staff at Cross Hands and Tumble medical practice to be committed to providing a caring, professional, and positive experience to patients. Throughout the inspection we witnessed staff speaking to patients and their carers in a kind and helpful manner.

There was a range of health promotion information available for patients in the waiting area, the majority of which was displayed bilingually. There were also arrangements in place for patients wishing to communicate through the medium of Welsh, however we recommended that staff wear 'Iaith Gwaith' badges to advertise this service further.

The practice offered good access with a patient car park, level access, a hearing loop system and telephone translation service provided by the local health board.

This is what we recommend the service can improve:

- Practice manager to provide evidence of receipt of privacy screens to ensure these are available in all treatment rooms
- The practice must ensure that all relevant staff complete chaperone training and remain up to date with this at all times
- Practice manager to order 'Iaith Gwaith' badges for all Welsh speaking staff to wear.

This is what the service did well:

- The practice offered good access with a patient carpark, level access, a hearing loop installed and the availability of a translation service
- Staff were proactive in upholding patient's rights, such as, arranging for patients with ASD to attend appointments at quieter times and ensuring preferred names and pronouns were used when treating transgender patients
- The majority of patients who completed HIW questionnaires felt they could access the right healthcare at the right time.

Delivery of Safe and Effective Care

Overall summary:
We were assured that patients attending Cross Hands and Tumble Medical Partnership received safe and effective care. All clinical rooms were an appropriate size and generally kept tidy. However, we did identify environmental hazards, which required immediate action by the practice to promote patient safety.

We reviewed a sample of patient records. All were legible and of a good quality. Our review of the practice's risk assessments showed us an environmental risk assessment, a health and safety risk assessment and an infection prevention and control (IPC) risk assessment needed to be developed for the practice.

Immediate assurances:

- The floor in the male patient toilet was very uneven and should be repaired or replaced
- The flooring in the corridor and all consultation rooms should be changed to ensure adequate cleaning.

This is what we recommend the service can improve:

- Arrangements should be made for the damp in certain treatment rooms and the broken light fixture to be fixed imminently
- An environmental risk assessment, a health and safety risk assessment and an IPC risk assessment for the practice must be completed
- All treatment rooms must have an effective and easily accessible panic alarm system in place.

This is what the service did well:

- Our review of patient records showed that they were maintained to a good standard
- The practice had comprehensive and up to date safeguarding policies and procedures in place.

Quality of Management and Leadership

Overall summary:
From discussions with practice staff, it was clear they were committed to providing good patient care and were eager to carry out their roles effectively.

We saw evidence of regular staff meetings taking place and minutes being recorded. The practice also had a comprehensive register of policies in place. All were in date and easily accessible for staff through a shared drive.

We identified improvement was needed in relation to aspects of the recruitment process and staff training compliance, which required immediate action by the practice.

Immediate assurances:

- Pre-employment checks for all staff must include a Disclosure and Barring Service (DBS) check appropriate to their roles and all current staff must have an up to date DBS check on file
- Basic Life Support training must be booked imminently for all staff and evidence of completed training kept in staff files.

This is what we recommend the service can improve:

- Staff complete and be up to date with all mandatory training I
- Staff to complete a clinical waste audit and IPC audit for the practice.

This is what the service did well:

- We saw evidence of a clear management structure in place at the practice.

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

3. What we found

Quality of Patient Experience

Patient Feedback

Before our inspection we invited the practice to hand out HIW questionnaires to patients to obtain their views on the service provided at the practice. On the day of the inspection our inspectors also spoke with patients to find out about their experiences at the practice. Patient comments included the following:

> *"Online services for all patients."*

> *"Service depends on who is on duty and who you speak to/see".*

We asked what could be done to improve the service. Comments included the following:

> *"Parking is often really difficult, especially if coming with children."*

> *"Waiting time to see GP too long."*

Person Centred

Health Promotion
During our inspection, we saw that the practice had a wide range of written health promotion information available for patients.

Staff informed us that health promotion information was provided by the health board and third sector organisations. Such information was displayed in the practice waiting area and promoted through the practice's Facebook page and website. Staff were also able to promote this information via the MySurgery app.

We were told that a social prescriber was employed by the GP cluster group and worked from the practice once a week. This individual met with patients and signposted to relevant community groups depending on the needs of the patient. The social prescriber also hosted coffee mornings twice a month for patients to attend.

Of the 58 patients who completed a HIW questionnaire, 30 told us that they either 'agree' or 'strongly agree' that there is health promotion information on display at the practice. However, 2 patients disagreed with this statement, 4 answered with 'not applicable' and 21 patients skipped this question.

Staff told us a physical form was available for podiatry referrals, which could be completed in the practice. Referrals for physiotherapy were made via an online form only, however staff would assist patients to complete this form if necessary.

We were informed of the process in place to manage the winter vaccination program. A local hall was hired over two days in order to work through as many flu and COVID-19 vaccinations as possible. Nurses would also free up afternoons to hold catch-up clinics when needed. Staff told us that patients would receive phone calls, text messages and posts shared on social media to promote the vaccination program.

Dignified and Respectful Care
We observed reception staff welcoming patients in a professional and friendly manner. Staff informed us that all calls were taken in the administration office, situated away from the reception desk. This ensured no conversations were overheard by patients in the waiting area.

Most of the patients who answered the questions in the HIW questionnaire, felt they were treated with dignity and respect (47/51) and most of the patients who answered said measures were taken to protect their privacy (24/32). The remaining patients did not provide an answer to these questions.

During our tour of the practice, we noted that, although all treatment rooms were lockable, some did not have privacy screens to maintain patient's privacy and dignity. We raised this will staff and asked that all treatment rooms have privacy screens installed as soon as possible. Since our inspection, the practice manager has confirmed that additional screens have been ordered, however we have not yet seen evidence of receipt of these.

The practice is required to provide evidence of receipt of privacy screens to ensure they are available in all treatment rooms.

We saw that the practice offered a chaperone service, which was clearly advertised for patients in the waiting area. However, staff informed us that administration staff will be used as chaperones if clinical staff are not available, despite admin staff not receiving the appropriate training.

The practice must ensure all relevant staff complete chaperone training and remain up to date with this at all times.

Timely

Timely Care

Cross Hands and Tumble Medical Partnership was open between the hours of 8am to 6:30pm Monday to Friday. Patients were able to access appointments at the surgery via telephone or in person at the reception desk.

Of the patients that completed the questions in the HIW questionnaire, around half told us that they were able to get a same-day appointment when they need to see a GP urgently (27/54). Of the 50 patients who answered, 31 said they could get routine appointments when they need them and around half of the respondents were offered the option to choose the type of appointment they preferred (26/53). On all of these questions, a number of patients did not provide a response.

Some comments received were:

> *"Service depends on who is on duty and who you speak to/see".*
> *"Waiting time to see GP too long."*

Patients contacting the practice for an appointment would initially be screened by a member of the reception team. Staff would talk to the patient about the most suitable type of appointment for them and then signpost or transfer as appropriate. We were told that staff had completed care navigation training and a laminated flow chart was clearly displayed in the administration office for reference.

We were told there were good opportunities for non-clinical triaging staff to speak with clinical staff if they were unsure about the best options for a patient. Reception staff confirmed there was a good relationship between clinical and non-clinical staff at the practice.

Equitable

Communication and Language

Staff informed us of the methods of communication used to convey information to patients. As well as face-to-face, staff would call and text patients with specific information if necessary and social media platforms were constantly updated.

It was clear that staff were proactive in ensuring individual patient's needs were met. The practice manager told us they always try and accommodate

appointments during quieter times for patients with ASD. The advanced nurse practitioner also offered home visits for patients in assisted living accommodation. Staff also informed us of the allowances made to ensure a deaf patient and their children were always able to access appointments. This individual was permitted to email when they require an appointment and offered a face-to-face appointment on the day, without triage. The same was also offered for their children.

The majority of patient information in the practice was available bilingually. There was a hearing loop installed and staff told us that large print documents would be made available on request. The practice also had access to a translation service through the local health board.

Of the 14 questionnaire respondents who answered, 9 told us they were actively offered the opportunity to speak Welsh whilst attending their appointment. The majority of patients who answered the question felt that the GP explained things well to them and answered all of their questions (44/52) and told us that felt listened to generally whilst at the practice (43/50).

Although it was confirmed that there were a number of Welsh speakers working at the practice, we witnessed no one wearing 'Iaith Gwaith' badges for patients to identify the Welsh speaking staff. We asked the practice manager to ensure the relevant individuals wear these badges going forward.

The practice is required to provide all Welsh speaking staff with 'Iaith Gwaith' badges.

Rights and Equality
The practice offered good access. There was a dedicated free car park and cars were also able to pull up right outside the main doors to allow patients with impaired mobility to access the building easily. The waiting area and treatment rooms were spacious, however due to the layout of the patient toilets, these did not offer full access.

We saw evidence of a comprehensive equality and diversity policy in place, as well as an age discrimination policy. Both were in date and had been reviewed in the last 12 months.

The practice was proactive in upholding the rights of transgender patients. We found that transgender patients were treated sensitively, and staff confirmed that preferred pronouns and names were always used. The electronic record system flagged the preferred pronouns and names of transgender patients.

Of the HIW questionnaire respondents, 42 patients felt they could access the right healthcare at the right time, 6 patients stated they couldn't access the right healthcare and the right time, and 9 patients did not provide an answer.

Delivery of Safe and Effective Care

Safe

Risk Management
We found the practice premises to be generally clean, tidy and free from clutter. All questionnaire respondents who answered (37/37) felt the practice was either 'very clean' or 'clean'.

During our tour of the setting, we witnessed flooring in the male patient bathroom, which had been taped over due to damage. Despite this, the floor was still very uneven and posed a significant risk to patient safety. There were also no signs displayed to inform patients of the damage. We raised this as an immediate concern with staff and insisted measures were put in place immediately to reduce the risk.

Our tour of the practice also highlighted issues with damp developing in some of the practice treatment rooms. A light fixture in the administration office was also broken. We raised these issues with staff and asked that these issues be fixed as soon as possible.

The practice is required to arrange for the damp problems to be solved and the light fixture to be fixed as soon as possible.

We reviewed the practice business continuity plan. This was up-to-date and contained all relevant information.

The practice manager told us the practice received patient safety alerts. When received, the practice manager told us these are distributed appropriately amongst staff via email. We were informed that any patient safety alerts received are discussed in clinical team meetings and any learning from alerts shared.

Whilst reviewing practice risk assessments, we confirmed that an environmental risk assessment, a health and safety risk assessment and an IPC risk assessment were yet to be completed.

The practice is required to complete an environmental risk assessment, a health and safety risk assessment and an IPC risk assessment for the practice imminently.

We noted there was no easily accessible mechanism in place for staff to be able to call for help urgently. Staff informed us that they have experienced problems with

the telephone lines in the practice, whereby they no longer provide an effective panic alarm. We were told that staff are currently negotiating with a new telephone provider who will provide a panic button.

The practice is required to ensure panic buttons are available in consultation rooms as soon as possible.

Infection, Prevention, Control (IPC) and Decontamination
Of the patients that responded to our questionnaire, 29 told us that hand sanitizer was always available for them in the practice, 3 patients disagreed with this and 23 did not respond. In addition, 27 patients agreed that healthcare staff washed their hands before and after treating them, 5 responded with 'not applicable' and 26 patients did not respond.

Soap was available in both patient and staff toilets. We also saw hand washing posters displayed in the waiting area and signs displayed in the toilets. All bins in the practice were foot operated and surfaces in both clinical and non-clinical rooms were wipeable to allow effective cleaning. We also saw evidence of detailed cleaning schedules in place. All cleaning was undertaken by an external company.

Although the two treatment rooms in the practice had suitable, hard flooring, the consultation rooms and corridor leading to all clinical rooms were carpeted. The carpet in these rooms posed an infection prevention and control risk, due to the difficulty in properly cleaning carpet, in comparison to hard clinical floors. We raised this as an immediate concern with staff.

Our review of staff records highlighted a lack of Hepatitis B vaccination documentation. Staff confirmed on the day of our visit that no official record was in place to record this information. Since our inspection the practice manager has confirmed that all staff have either provided evidence of their Hepatitis B status of had a blood test to obtain the results.

The practice is required to provide HIW with evidence of a record in place showing Hepatitis B status for all relevant staff once results for all individuals are received.

Medicines Management
Requests for repeat prescriptions could be made online via the practice website or in person at the practice. There was also a clinical pharmacist working at the practice who could re-authorise repeat prescriptions if needed.

Staff informed us of the arrangements in place to ensure prescription pads are stored securely at the practice. All are stored away from patient access and locked away

at the end of each day. In the event a GP left the practice, relevant prescription pads are shredded in house to prevent future use.

Safeguarding of Children and Adults
We saw evidence of comprehensive safeguarding policies and procedures in place at the practice. There were also clear flow charts in place to identify an individual at risk.

Our review of safeguarding training highlighted non-compliance of some staff members working at the practice. Members of the reception team had not yet completed the required level of safeguarding training. The safeguarding lead had also only completed level 3 safeguarding training, instead of the required Level 4.

The practice must ensure staff complete the level of safeguarding training relevant to their role as soon as possible.

The practice had an effective system in place to monitor the patients who do not attend appointments. We were also provided with evidence of effective multi-disciplinary team (MDT) working. Monthly MDT meetings were held with the lead GP, palliative care team and district nurses to discuss care packages for relevant patients.

Management of Medical Devices and Equipment
The practice nursing team held responsibility for the checking of devices and equipment. On the day of our visit, we found that all were well maintained and in a good state of repair.

On the day of our visit, we saw evidence of checks on emergency drugs and equipment being carried out monthly. We raised this with staff and informed them checks are required to be carried out weekly. Since our inspection staff have provided evidence of weekly checks being completed.

The practice had an automatic external defibrillator (AED) available with defibrillator pads for both adults and children. This was found to be appropriately charged and ready for use.

Effective

Effective Care
It was clear that the practice had a dedicated and caring staff team that strived to provide patients with safe and effective care.

The practice ensured staff were kept up to date with best practice, national and professional guidance, and new ways of working. Changes to guidance would be sent via email to staff, with a read receipt to show staff members had read the message. Information regarding changes would also be communicated in weekly staff meetings. We saw any incidents were reported via the NHS Datix system.

Senior staff informed us of the practice procedure for patient referrals. We were told that it was the responsibility of the GPs to write the referrals, then secretarial staff would prioritise accordingly. We were told that routine referrals were sent electronically via the Welsh Clinical Communications Gateway (WCCG). We were told that urgent referrals were always acted upon promptly.

Patient Records
We reviewed a sample of 10 electronic patient medical records. These were stored securely and protected from unauthorised access.

Our review indicated that patient records were clear and maintained to a good standard. However, we found a number of medication reviews were overdue. We raised this with staff and asked that these be updated imminently.

The practice must ensure all medication reviews in patient records are kept up to date going forward.

Quality of Management and Leadership

Leadership

Governance and Leadership
Cross Hands and Tumble Medical Partnership is part of the Amman Gwendraeth Cluster area and owned and operated by three GP partners. It was evident that all staff were clear about their roles, responsibilities and there were clear lines of accountability in place at the practice.

We saw evidence of weekly staff meetings held and detailed minutes recorded. Information was also shared amongst staff via a WhatsApp group, email, verbal correspondence and printed documents, which staff sign once read.

The practice kept a comprehensive register of policy and procedures. All were in date and reviewed annually and staff had easy access to these via a shared drive. Any policy or procedural changes were communicated to staff promptly either digitally or verbally and all were required to complete a signing sheet once they had read the updated document.

The practice manager informed us of the staff engagement and wellbeing programmes for staff. All had access to a phone app, through which they could access counselling and a 24/7 phone line should they need to call for support.

Staff informed us that, at the time of our visit the main challenges and pressures being faced by the practice were staffing levels and retention of salaried GPs. The practice manager told us that they actively advertise job roles.

Workforce

Skilled and Enabled Workforce
We spoke with staff across a range of roles working at the practice. It was clear that they were all knowledgeable of their roles and responsibilities and committed to providing a quality service to patients.

Our review of staff records highlighted several gaps in mandatory training for both clinical and non- clinical staff. Fire safety training had not been completed by all staff and some clinical staff could not provide evidence of completed IPC training. Also, no equality and diversity training had been completed by staff. We raised this with the practice manager and asked that all staff be fully compliant with mandatory training as soon as possible.

The practice must ensure staff are fully compliant with mandatory training.

Our review of staff records also highlighted that all staff were out of date with BLS training. The practice manager told us that they have attempted to book training for staff through the local health board on multiple occasions but had been unable to do so. We raised this as an immediate concern with staff and insisted training be arranged imminently.

Whilst reviewing staff records, we also noted that the majority of staff both clinical and non-clinical, did not have DBS checks on file. The assistant practice manager confirmed that, prior to the current practice manager coming into post in September 2022, DBS checks were not routinely undertaken. We were informed that plans were in place to meet with all staff members to obtain the relevant documents to complete DBS applications, however this had not yet started.

Staff told us that they felt comfortable to raise a concern if required. The practice had a whistleblowing policy in place that had been recently reviewed and this was available to all staff.

Culture

People Engagement, Feedback and Learning

The practice had in place an appropriate complaints policy and procedure. This was in line with the NHS Putting Things Right process, which was clearly displayed in the waiting area.

We reviewed the practice's complaints file which contained copies of written complaints and letters sent in pursuit of resolution. We saw that complaints were dealt with in a robust manner and in line with the agreed complaints timescales stated within the policy.

We saw evidence of the practice gaining feedback via patient surveys. These were available in paper copy from the practice and also digitally via social media. Staff provided us with a copy of the latest patient feedback summary, which is published annually. We were told that an action plan was made from the feedback provided, with a target to complete all action by the end of the year.

We spoke to senior staff about the arrangements in place to ensure compliance with the Duty of Candour requirements. The practice had a Duty of Candour policy in place that met the requirements of the guidance. We were told that all staff would be undertaking training to ensure full understanding of the policy and staff roles and responsibilities, however the training course was still unavailable online.

The assistant practice manager ensured us that they would be chasing this up as soon as possible.

Information

Information Governance and Digital Technology
We saw evidence of systems in place to ensure the effective collection, sharing and reporting of high-quality data and information. The practice had use of 'Vision' and were also signed up for 'Access System' for reporting data. We were informed that there was also a dedicated Data Protection Officer for the practice.

Learning, improvement and research

Quality Improvement Activities
We reviewed clinical audits carried out by the practice. Our review highlighted that staff were yet to carry out a waste management audit or IPC audit for the practice. We raised this with staff and asked that these be completed as soon as possible.

The practice is required to carry out relevant audits as soon as possible.

Whole system approach

Partnership Working and Development
Staff informed us that various multi- disciplinary team meetings took place to ensure effective interaction and engagement with healthcare partners. We were told that the practice works closely within the GP cluster to build a shared understanding of challenges within the system and the needs of the population.

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 summaries 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
On the day of our visit, we saw evidence of checks on emergency drugs and equipment being carried out monthly. Guidance issued by the Resuscitation Council UK recommends checks are caried out at least weekly.	This meant equipment and drugs for use in the event of an emergency may not be available and suitable to use when needed.	We raised this with staff and informed them checks are required to be carried out weekly.	Since our inspection staff have provided evidence of weekly checks being completed.

Appendix B - Immediate improvement plan

Service: Cross Hands and Tumble Medical Partnership

Date of inspection: 11/05/2023

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

Risk/finding/issue	Improvement needed	Service action	Responsible officer	Timescale
During our tour of the setting, we witnessed flooring in the male patient bathroom which has been taped over, due to damage. Despite this, the floor was still very uneven and posed a significant risk to patient safety.	The flooring should be repaired in the male patient toilet.	Clear visual signs – "Caution uneven floor" are displayed on the door and inside the toilet. Staff are aware that the signs must be in-situ at all times. Risk assessment written and attached. 8th June 23- email sent to [REDACTED] for update- [REDACTED] has been asked to complete a CAPITAL BID for the flooring issue to be fixed. No further confirmation on a start date can be given.	PM/APM	3 months from funding being granted. (Sept 2023)

		12th June 23- email sent to [REDACTED] asking if there is a way to improve the temporary fix that is in place now- [REDACTED] confirmed that Estates Dept will send someone to improve the temp fix that is already in place. [REDACTED] confirms that once funding Is approved the work will be completed within 3 months.		
Although the two treatment rooms in the practice had suitable, hard flooring, the consultation rooms and corridor leading to all clinical rooms were carpeted. The carpet in these rooms poses an infection prevention and control risk, due to the difficulty in properly cleaning carpet, in comparison to hard clinical floors.	The flooring in the corridor and all consultation rooms should be changed to hard flooring, to ensure adequate cleaning.	Email sent to Hotel Services 9th June 2023 requesting deep cleaning plan of carpeted areas-awaiting response Risk assessment completed RE- risk of infection which is attached.	PM/APM	3 month from funding being granted. (Sept 2023)

		Clinical staff are aware of risk assessment, and procedures in place.		
During our inspection, we reviewed all staff files. We noted that the majority of staff both clinical and non-clinical, did not have DBS checks on file. The assistant practice manager confirmed that, prior to the current practice manager coming into post in September 2022, DBS checks were not routinely undertaken. We were informed that plans were in place to meet with all staff members to obtain the relevant documents to complete DBS applications, however this had not yet started.	The practice must ensure that pre-employment checks for all staff include a DBS check appropriate to their roles. Staff must ensure that all current staff have an up-to-date DBS check on file.	Of the 12 outstanding staff members, 5 remaining need to complete forms and return them. I have requested that all outstanding forms are retuned by 19th June. All should be sent off by 23rd June and based on the current turnaround time, all certificates should be back within 3 months' time. I am also in contact with staff at NWSSP who keep me updated with certificates being posted out etc.	APM	asap
Our review of staff records highlighted that all staff were	The practice manager must ensure that Basic Life Support training is booked imminently for all staff and	BLS training has been booked with Lifeline Training and Operations for all clinical staff	PM	08/06/23

out of date with Basic Life Support (BLS) training.	that evidence of completed training is kept in staff files.	on Thursday 8th June 2023, at 4pm.- all clinical staff have completed this. Practice Index e-learning training for admin staff has been sent via email with a deadline of 8th June. Plan – All practice staff will have completed this mandatory training by 8th June.		

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

Service representative:

Name (print):

Job role:

Date:

Appendix C - Improvement plan

Service: Cross Hands and Tumble Medical Partnership

Date of inspection: 11/05/2023

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	Service action	Responsible officer	Timescale
We noted not all treatment rooms had privacy screens to maintain patients' privacy and dignity	The practice is required to provide evidence of receipt of privacy screens to ensure they are available in all treatment rooms.	All Treatment Rooms have privacy screens in place.	Practice Manager	Completed
Staff told us that both clinical and administration staff act as chaperones if required. However only clinical staff have received appropriate training.	The practice must ensure all relevant staff complete chaperone training and remain up to date with this at all times.	All staff have completed or are scheduled to complete E-learning training, accept 5 people who all have had a deadline to complete by 11th August. In-house training by Practice Nurse has been organised for 11th August	Practice Manager	11th August 2023
Despite several staff members being Welsh speakers, no staff members wore 'Iaith Gwaith'	The practice is required to provide all Welsh speaking staff with 'Iaith Gwaith' badges.	All staff who are Welsh Speakers now wear "Iaith Gwaith" badges.	Practice Manager	Completed

badges to inform patients of this.				
During our tour of the practice, we noted damp developing in some of the practice treatment rooms. A light fixture in the administration office was also broken.	The practice is required to arrange for the damp problems to be solved and the light fixture to be fixed as soon as possible.	Damp was reported to the Estates Department on 12th May and is still outstanding. (Risk assessment has been completed) Light fixtures have been replaced.	Practice Manager	02/10/2023 Completed
Whilst reviewing practice risk assessments, we confirmed that an environmental risk assessment, a health and safety risk assessment and an IPC risk assessment were yet to be completed.	The practice is required to complete an environmental risk assessment, a health and safety risk assessment and an IPC risk assessment for the practice imminently.	All assessments are now in place.	Practice Manager	Completed
We noted there was no easily accessible mechanism in place for staff to be able to call for help urgently.	The practice must ensure panic buttons are available in consultation rooms as soon as possible.	We have installed a panic alarm system from Vision on every PC in every room.	Practice Manager	Completed
Our review of staff records highlighted a lack of Hepatitis B vaccination documentation.	The practice is required to provide HIW with evidence of a record in place showing Hepatitis B status for all relevant staff once results for all	All relevant staff have had a blood test to determine immunity. 2 GP's were identified as requiring a	Practice Manager	Completed

	individuals are received. showing Hepatitis B status of all relevant staff members.	booster and appointments organised for their vaccinations.		
Our review of safeguarding training highlighted non-compliance of some staff members working at the practice.	The practice must ensure staff complete the level of safeguarding training relevant to their role as soon as possible.	All staff have now completed the relevant training for their role. We have been unable to source specific level 4 training for our GP Lead, but level 3 training has been completed and this is on par with other practices within our Cluster.	Practice Manager	Completed .
During our review of patient records, we noted several medication reviews were overdue.	The practice must ensure all medication reviews in patient records are kept up to date going forward.	This is an ongoing process post covid and we are aware that moving forward, this is a priority. 2 prescription clerks have been appointed and we are working towards the role to highlight and arrange necessary appointments to ensure reviews are completed	Practice Manager	01/11/2023
Our review of staff records highlighted several gaps in	The practice must ensure staff are fully compliant with mandatory training.	All staff have now completed BLS and all staff have completed or have scheduled access to the relevant courses	Practice Manager	Completed

mandatory training for both clinical and non- clinical staff.		to complete the mandatory training.		
Our review highlighted that staff were yet to carry out a waste management audit or IPC audit for the practice.	The practice is required to carry out relevant audits as soon as possible.	The waste management audit was already in place and IPC audit has been implemented.	Practice Manager	Completed

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): Emma Davies

Job role: Assistant Practice Manager

Date: 04th August 2023