Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report (Announced)

Ashfield Surgery, Cwm Taf Morgannwg Health Board

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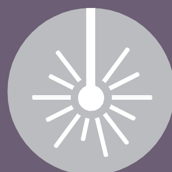

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

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

Our values

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

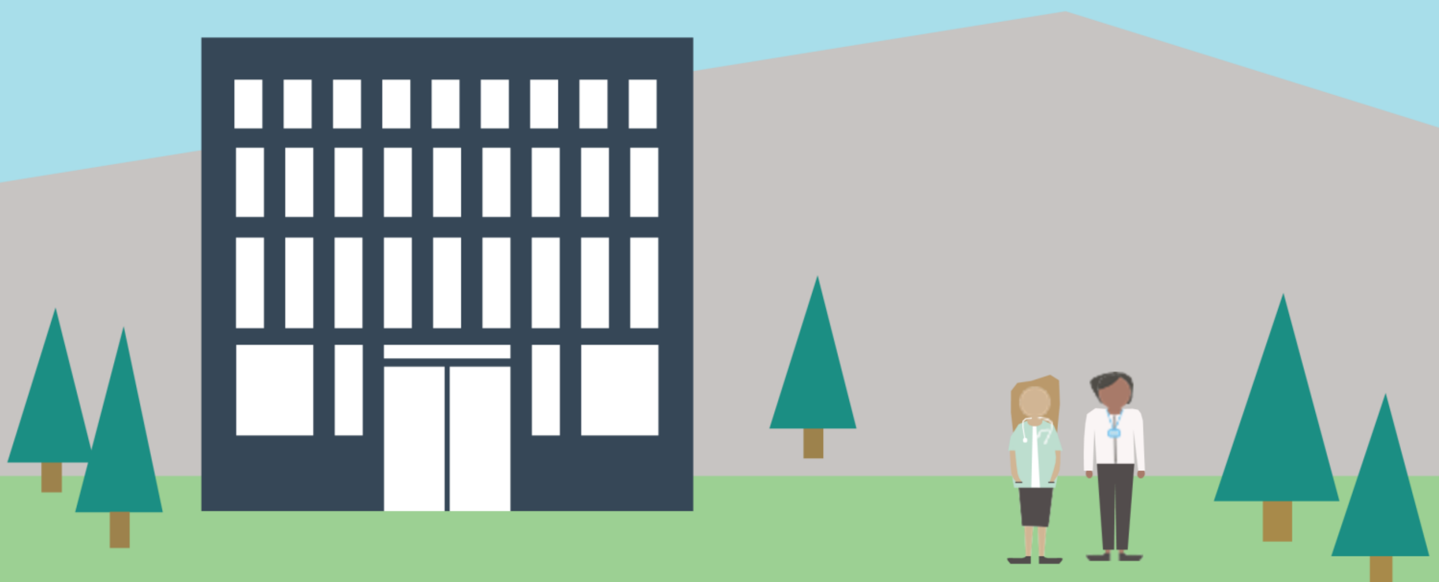
- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and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

Our goal

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

Our priorities

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



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1. What we did

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

Healthcare Inspectorate Wales (HIW) completed an announced inspection of Ashfield Surgery - Bridgend Group Practice, Cwm Taf Morgannwg University Health Board on 15 October 2024.

Our team for the inspection comprised of one HIW healthcare inspector and three clinical peer reviewers.

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 11 questionnaires were completed by patients or their carers and 7 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:
The findings from our patient questionnaires were overall, positive. All patients felt they were treated with dignity and respect, and all rated the service as 'good' or 'very good.' During our inspection we witnessed staff speaking to patients and their carers in a polite and positive manner.

There were processes in place that enabled patients to access the right service at the right time. The introduction of Mali, a digital assistant enables patients to complete tasks online without having to telephone the surgery, including requesting an appointment.

The practice has a 'VIP list' in place, to ensure vulnerable, housebound and palliative care patients can be prioritised in the queue when they telephone the surgery.

The practice should improve their offer of the chaperone service, with more notices in their clinical treatment areas and information on the website.

This is what we recommend the service can improve:

- Have more notices regarding the chaperone service, including on the website and in clinical treatment areas
- Have a hearing loop system to assist patients with reduced ranges of hearing
- Update the workflow policy to provide more information about the process, audits and delegation of responsibility

This is what the service did well:

- The introduction of Mali has provided an alternative way patients can access services and advice
- The VIP list is a good initiative that supports the practices' vulnerable patients in accessing services
- Patients felt they were treated with dignity and respect and had good service.

Delivery of Safe and Effective Care

Overall summary:
Our findings demonstrated a dedicated and enthusiastic clinical team who worked hard to provide patients with safe and effective care.

The practice displayed good cluster cooperation to ensure patient care could continue in the event of an extreme situation.

The patient medical notes were overall a good quality, containing clear and appropriate information.

Responses from staff who completed the questionnaire were generally positive. All staff felt that the care of patients was this practice's top priority, and they all were content with the efforts of the practice to keep staff and patients safe.

We issued an immediate assurance in relation to three areas, including infection prevention and control; emergency equipment and drugs checks and the storage of hazardous liquids.

Immediate assurances:

- Robust Infection prevention control procedures were not always in place at the practice
- Appropriate checks were not undertaken on resuscitation equipment and emergency drugs.
- Non-compliance with the Control of Substances Hazardous to Health (COSHH) Regulations 2002.

The details of the immediate improvements required and remedial action is highlighted in Appendix B.

This is what we recommend the service can improve:

- Compliance with all aspects of mandatory training
- Ensure policies and procedures are updated to reflect Welsh guidance and regulations
- Ensure reasons are documented on patient notes when medication is discontinued.

This is what the service did well:

- Good collaboration between the practice and the local GP cluster
- The practice employs a mental health nurse, providing timely support and care for patients.

Quality of Management and Leadership

Overall summary:

We found the management team supported a group of engaged and committed staff, all working in the best interests of their patients. We saw an appropriate skill mix across the teams to deliver the services required.

We found the dedicated development days in place which support staff with workforce planning and managing skill mix is a noteworthy initiative.

An appropriate recruitment and induction process was in place. Staff are working hard to address gaps in mandatory training and to ensure all staff have a current job description in place and appropriate records kept for Disclosure and Barring Service (DBS) checks.

Responses from staff who completed the questionnaire were generally positive. All staff felt that the care of patients is the practice's top priority. Overall, staff were content with the efforts of the practice to keep staff and patients safe.

This is what we recommend the service can improve:

- Ensure all staff are compliant with mandatory training requirements, and update the training matrix to monitor compliance
- Ensure policies and procedures are version controlled, and contain the author details, implementation date and review dates
- Ensure all meetings are minuted, and where appropriate implement an action log to keep monitor progress of actions.

This is what the service did well:

- Good collaboration between the practice and the local GP cluster
- Staff were friendly and engaging with patients and one another
- Well managed complaints process with minimal complaints.

3. What we found

Quality of Patient Experience

Patient feedback

HIW issued a questionnaire to obtain patient views on the care being provided at Ashfield surgery. In total, we received 11 responses from patients at this setting. Some questions were omitted by some respondents, meaning not all questions had 11 responses.

Person-centred

Health promotion
During our inspection we saw that the practice had a wide range of written health promotion information available for patients. The information was displayed in the patient waiting area, on the display screen and promoted through the practice website, and included smoking cessation, weight management, sepsis, menopause, mental health helplines, cancer support and carers information.

We were told that the practice engaged with several services to improve access to various healthcare professionals. A pharmacist attends on a weekly basis and a physiotherapist attends two days a week. The practice also employs a mental health nurse. These services enable patients to access help and support from other services in a timelier manner.

Care navigators worked to ensure patients received the right care from the right services upon initial contact with the practice. To ensure vulnerable patients receive timely care, the practice has a 'VIP' list. This enables patients on this list to jump to the front of the queue (via telephone) as their details are stored on the practices' system. These services support the provision of, and access to, high quality patient care.

All respondents to the patient questionnaire confirmed the health promotion information on display at the practice. All but one patient felt they were offered healthy lifestyle advice. All patients agreed that their GP explained things well to them and answered their questions. All patients felt listened to, and they were involved as much as they wanted to be in decisions about their healthcare.

Preparations by the practice to manage the annual winter vaccination programme were suitable and included arrangements for housebound, vulnerable and care

home residents. The practice was offering Saturday clinics to cater for patients who could not attend during the weekday.

Dignified and respectful care

We found patients were treated with dignity and respect throughout their patient journey. Clinical rooms provided patients with an appropriate level of privacy, with doors kept closed during consultations. Privacy curtains were also available in treatment and consulting rooms.

All respondents to the patient questionnaire felt they were treated with dignity and respect, and that measures were taken to protect their privacy.

Reception staff were observed welcoming patients in a professional and friendly manner. To protect confidentiality, telephone calls were taken in the administration office, away from the reception desk. The reception desk was partitioned by glass and the waiting area was separated from reception. On entering the surgery, a line on the floor and sign was displayed, asking patients to stand behind it. This offered some space to anyone at the reception desk.

For the patients who responded in the questionnaire regarding if their ability to talk to reception staff without being overheard; four agreed and four disagreed.

We saw one notice displayed offering a chaperone service. We were told that only health care professionals would do the chaperoning, which are mainly female staff, although male GPs could be asked if necessary. All patients who responded to the question confirmed that they were offered a chaperone.

The practice should consider having more notices regarding the chaperone service. These should be displayed in clinical treatment areas and on the website.

Timely

Timely care

There were processes in place to ensure patients could access the right service at the right time and in a timely manner. Appointments could be made via telephone, online booking and in-person. The practice also offers ‘Mali’, a digital assistant that enables patients to complete tasks online without having to telephone the surgery, including requesting a medical appointment. Staff felt this system has reduced call waiting times considerably, and we found the introduction of ‘Mali’ to be noteworthy practice.

Urgent appointments were appropriately triaged over the telephone by reception staff in consultation with a clinician. In addition, the practice has a 'VIP' list, whereby vulnerable, housebound and palliative patients on this list are jumped to the front of the queue.

Children requiring a face-to-face appointment are accommodated, and housebound patients will receive a home visit as appropriate.

We found the care navigators had a good pathway in place, assigning patients to the most appropriate person or service. The pathway was available to all staff in both electronic and written format. The care navigators were based with the duty doctor who was available to provide guidance as necessary. We found the practice made good use of cluster-based support services.

There were processes in place to support patients in a mental health crisis. Where appropriate, patients are referred to the mental health crisis team for urgent crisis support. Alternative support and signposting were also available for patients needing mental health support. The practice employed a mental health nurse who assesses and signposts patients to the most appropriate service and has emergency slots available each day. Having a mental health nurse as part of the clinical team is an area of noteworthy practice.

In response to the patient questionnaire, 64% felt able to have a same-day appointment when they need to see a GP urgently, 90% felt satisfied with the opening hours of the practice, 90% felt able to contact the practice when needed, and 80% said their appointment was on time.

Equitable

Communication and language

We found staff communicating in a clear manner and in a language appropriate to patient needs. They provided information in a way that enabled patients to make informed decisions about their care. The surgery did not have a hearing loop to support those hard of hearing, however, the practice has a deaf interpreter service which is accessed via an iPad.

The practice should ensure that a hearing loop system is available and have this displayed by the reception to indicate this service is available.

Patients are usually informed about the services offered at the practice through the website, social media, the surgery app, and by sharing information and updates via a text messaging service. Where patients are known not to have digital

access, letters would be sent to individuals, and communication through telephone calls.

We were told there were a few staff that spoke Welsh and included one reception staff member and two doctors. We saw a notice by reception informing patients they could communicate through the medium of Welsh, and some bilingual patient information was also available. The practice had access to translation services, if required.

There were appropriate processes in place for the recording and action of information from secondary care. Letters and documents are scanned onto patient notes and directed to the correct health care practitioner to action as required. From the notes observed, we saw health care staff had provided information to patients in a way that met their individual needs.

The practice ensured messages were communicated internally to the appropriate people, by using the practices communication and technology (ICT) systems, with read receipts and flagged tasks enabled for confirmation.

There were workflow processes and a policy in place, although the policy had limited information, and would benefit from being reviewed to ensure it is comprehensive and up to date.

We recommend the workflow policy is reviewed and updated to provide more information about the process, audits and delegation of responsibility.

Rights and equality

The practice offered good access with a small dedicated free car park, and on-street parking was also available. We noted that all patient areas including treatment rooms, and the accessible toilet were located on the ground floor.

All but two patients who responded to the questionnaire felt the building was easily accessible.

We saw evidence of an equality and diversity policy in place. Training had been arranged for all staff to complete equality and diversity training in November 2024. All patient who responded to our questionnaire said they had not faced discrimination when accessing or using this service.

The rights of transgender patients were also upheld, staff confirmed that preferred pronouns and names were used from the outset of transition.

The practice must ensure all staff complete equality and diversity training and provide HIW with evidence once complete.

Delivery of Safe and Effective Care

Safe

Risk management
The public facing areas of the practice appeared clean and tidy. However, we found cleaning equipment and materials being stored in the boiler room. Due to the potential dangers of storing cleaning chemicals/ materials close to electrical appliances, we asked the practice to relocate these promptly. This was dealt with under our immediate assurance process at Appendix B.

We reviewed the practice business continuity plan which was up-to-date and contained relevant information. We noted that partnership risk was not covered in the business continuity plan and recommend adding this to the document, even though there were currently eight partners. The business continuity plan was available to all staff via a shared drive.

The business continuity plan should be updated to include business partnership risk.

The practice demonstrated good cluster collaboration to ensure patient care could continue in the event of an extreme situation.

We saw how patient safety alerts were received and disseminated through the practice and communicated in meetings, and the process was robust.

Suitable mechanisms for calling for help urgently were evident. However, we found that emergency drugs and equipment were being stored in a nurse's room. We recommended that the drugs and equipment are moved to a more central location which would be easily accessible without compromising patient privacy and dignity.

We discussed the action taken when home visits were requested and found that staff were aware of when clinicians are attending house calls. However, there was no home visiting risk assessment in place, and recommend that an assessment is completed and any actions or mitigations to identified risks are implemented, to maintain the safety of lone working staff.

A home visiting risk assessment must be completed, and mitigations implemented and maintained as appropriate.

Infection, prevention and control (IPC) and decontamination

We were not assured that the practice environment and the governance arrangements in place uphold the required standards of IPC for maintaining the safety of staff and patients.

IPC training had lapsed for the appointed IPC nurse lead, and for the clinical team. The clinical curtains used to maintain privacy and dignity within clinical rooms were material/non disposable. There was no risk assessment in place nor evidence to demonstrate dates of curtain change, or evidence that the curtains are appropriately laundered. In addition, we were not assured that robust cleaning methods were in place. In one clinical treatment room we also identified clumps of dust under the treatment bed.

When we considered how the practice assures itself about staff immunity to hepatitis B, we found the register was not up to date. There were gaps when clinical staff were checked for their Hepatitis B status and when booster and immunity were last checked. Without evidence to demonstrate this during the inspection, we were not assured the practice could assure itself regarding the hepatitis B immunity status of all clinical staff. The issues identified were therefore dealt with under our immediate assurance process, highlighted in Appendix B.

The practice had an IPC and needlestick/sharps injury policies in place. These were available on the shared drive for all staff to access. The blood-borne virus and needlestick/sharps policies referenced English standards and outcomes and this needs to be reviewed and updated as applicable to reflect Welsh guidance and standards.

The blood-borne virus and needlestick/sharps policies must be reviewed and updated to include Welsh standards and guidance.

Suitable procedures were in place for the management and disposal of waste, including healthcare waste.

We found there were suitable facilities to allow for segregation of people to reduce the risk of healthcare acquired infections. A formal cleaning process was also in place after a room is used in this circumstance.

Personal Protective Equipment was used appropriately to maintain good IPC, and appropriate hand washing facilities were in place within treatment rooms.

In our questionnaires, most patients agreed there were signs at the entrance explaining what to do if they had a contagious infection. Eight out of 11 respondents felt there were hand sanitizers available and just over half felt healthcare staff washed their hands before and after being treated.

Of those patients who indicated they had received an invasive procedure at the practice, all noted that staff used gloves during the procedure. All but one respondent indicated that antibacterial wipes were used to clean the skin prior to a procedure and any equipment used was individually packages or sanitised.

Medicines management

The practice had processes in place to ensure the safe prescribing of medication. The process for patients to request repeat medication was clear. Staff told us that most patients order prescriptions through the prescribing hub. Prescriptions were processed in a timely manner by suitably trained clerks and authorised by a doctor.

Staff had undertaken training via the health boards medicine management course. Prescription pads were stored securely in a locked filing cabinet. There was a process in place to dispose of prescription pads when a GP left the practice.

There was a prescribing policy in place, however there was no information about the re-authorisation of certain medication for sign off by a GP.

The practice must update the prescribing policy to include re-authorisation of medication.

No controlled drugs are kept at the practice.

There was a medication cold chain policy in place for medications that required refrigeration, and clinical refrigerators were used for some medicines and vaccines. Daily temperature checks were completed and recorded. Nursing staff were aware of the required upper and lower temperature ranges, and what to do in the event of a breach to the cold chain.

We found that the vaccine refrigerator in the treatment room was overfilled. This could impede the flow of air and maintain appropriate temperatures. The practice should consider vaccine storage within the medical refrigerator to ensure appropriate air flow.

The practice must ensure that the medical refrigerators are not overfilled with vaccines and consider an additional fridge to ensure appropriate storage and cool air flow.

The drugs we checked during the inspection were all in date. The practice had a nominated person responsible for checking the drugs on a monthly basis, and the nursing staff were also aware of who this is. Records were kept evidencing the drugs and their expiry dates.

We were not assured that the emergency drugs and equipment were being checked appropriately. Records showed that monthly checks were being carried out and we recommend this is undertaken on a weekly basis in line with the Resuscitation Council UKs Quality Standards in Primary Care. Further details of the actions taken by HIW in respect of this matter are recorded in Appendix B of this report.

We also found that the emergency drugs and equipment were being stored in a treatment room. This is not appropriate because the room is used daily, including for intimate examinations. In addition, the equipment was not easily accessible as it was stored behind the fridge. This could cause delays in accessing the equipment and drugs in the event of a cardiac emergency.

The practice must ensure that emergency drugs and equipment are relocated to an area that allows ease and speed of access. The new location must be communicated to all staff.

We saw that oxygen cylinders were in date and with appropriate stock levels. All clinical staff were aware of how to use the oxygen and the arrangements in place for reporting any incidents. We recommended that all clinical staff are aware of the recent guidance and Welsh health circular relating to oxygen use and the requirement for training to be completed by clinicians dealing with portable oxygen therapy.

All clinical staff must obtain and update themselves with the recent guidance and Welsh health circular relating to oxygen use and implement any requirements that are recommended, including the online training.

Safeguarding of children and adults

We considered the safeguarding procedures in place at the practice and found a policy in place which included both adults and children. The policy referenced the national Wales safeguarding procedures and was available for all staff on the shared drive. The practice had a named safeguarding lead which was not recorded in the policy and some staff were unaware of who was the practices' safeguard lead.

The practice must ensure all staff are aware of the safeguarding lead for adults and children, and their details displayed more prominently for staff.

The safeguard policy should include the name of the safeguarding lead for both children and adults.

On review of patient records, we saw examples where people were appropriately flagged with any safeguarding concerns and followed a suitable safeguarding pathway.

Not all staff had the appropriate level of training in safeguarding. A training course has been arranged for November 2024 to ensure staff have an appropriate level of knowledge and understanding in the safeguarding of children and adults.

The practice must ensure all staff undertake the required level of safeguarding training (both children and adult) appropriate to their role, and a record should be kept to evidence this.

Management of medical devices and equipment

We found medical devices and equipment were correctly checked and in good condition. Suitable contracts were in place for the repair or replacement of this equipment. Single use items were used where appropriate and disposed of correctly.

Effective

Effective care

Suitable processes were in place to support the safe, effective treatment and care for patients. We were told that changes or new guidance is emailed to all staff and is discussed in practice meetings. A monthly newsletter also highlights key messages and information. In relation to clinical meetings, no minutes were being recorded for clarity on that discussed, or to share with those absent. These should be recorded along with an action log to track compliance with any actions.

Patient referrals were managed to a satisfactory standard, including those which are urgent. Referral rates are discussed in GP cluster meetings to establish any trends. The process for ordering and relaying test results to patients was robust, and an appropriate system was in place for reporting of incidents.

Patients in need of urgent medical help or those in a mental health crisis were provided with suitable information. As highlighted earlier, there is a dedicated mental health practitioner in post, enabling appropriate signposting. In addition, an on-call triage GP is also available daily, along with a process for patient follow-ups and ongoing reviews.

Patient records

We reviewed ten electronic patient records, and these were stored securely and were password protected from unauthorised access. Overall, the records were

clear, written to a good standard and complete with appropriate information. They were contemporaneous and information was easy to understand for other clinicians reviewing the records.

Read codes were used well, and all illnesses appeared to have appropriate Read coding.

From the notes reviewed we found that the patient's language choice was not obvious on the records, however, staff said this would pop up as an alert when a patient was provided with an appointment.

The practice would benefit from having an agreed standard for recording patient clinical observations, such as blood pressure, pulse and temperature, so auditing could be more effective. Any medications that are discontinued were not being recorded consistently in the records we reviewed.

The practice must ensure that:

- **Patient language preference is recorded and obvious on their clinical records**
- **A consistent method of recording observations is implemented to monitor an audit these as required**
- **Any medication that has been discontinued is documented in the patient records and the reason or rationale as too why.**

Efficient

Efficient

We found that services were arranged in an efficient manner and are person centred, to ensure people feel empowered in their healthcare journey.

A locally implemented physiotherapy service is available as well as referrals to an exercise scheme in the local leisure centres. Patient can also access a dietician, eye screening, diabetic education services and a seasonal vaccination service.

Nursing staff from across different branches of the practice meet regularly. Meetings are recorded and actions captured to ensure staff work across services to effectively coordinate care and promote best outcomes for patients.

Quality of Management and Leadership

Leadership

Governance and leadership
We were told there had been a lot of changes made in the practice, most recently within the last year, whereby several branch surgeries have joined Ashfield Surgery, Bridgend Group Practice. As a result, staff roles and responsibilities are becoming clearer, and we found a supportive and committed management team working in the best interests of staff and patients.

There was a clear process for sharing information with staff, such as changes in policies or procedures. All policies and procedures were on the shared drive and all staff were emailed when any changes have occurred. These emails required a read receipt. However, the policies and procedures in place were not all version controlled.

The practice must ensure that all policies and procedures are version controlled, contain a policy author and have implementation date and review dates.

Staff meetings were routine, however, not all were being recorded. We were told that lessons learnt would be discussed at clinical meetings, but there was no formal way of ensuring key messages were implemented as minutes were not recorded.

The practice must record all meeting minutes, and where applicable have an action log to ensure actions can be monitored and implemented.

The practice worked closely within the Health Board cluster group and worked collaboratively to lead projects, share learning and jointly manage initiatives.

Staff had access to wellbeing programmes, and information for the service was displayed on posters. The support services included counselling, which was independent of the practice, and confidential for staff to use.

Workforce

Skilled and enabled workforce
We spoke with staff across a range of roles working at the practice. They all had sound knowledge of their roles and responsibilities, and each appeared committed to providing a quality service to patients. Staff confirmed they worked within the

scope of their qualifications, skills and experience, and there was no expectation to work outside of that scope. We saw an appropriate skill mix across the teams to deliver the services required.

The practice holds development days twice a year, which are held outside of the practice. This gives staff dedicated time to discuss the workforce, staff skills set, training needs and skill mix. This process is noteworthy in demonstrating the practice’s commitment to developing its services.

Staff described the process for recruitment and conducting pre-employment checks. This included obtaining a Disclosure Barring Service (DBS) check, references, and issuing an offer letter and contract. A staff handbook was also available for new staff. There would also be a check of a healthcare professional's registration with their regulatory body to ensure it was current. Whilst the process described by senior staff was satisfactory, there was no recruitment policy in place to support this.

The practice must implement a recruitment policy.

We were told that due to changes in staff, some aspects of employment checks were not yet fully complete. We saw that whilst some staff had DBS checks completed and evidence in place, there were others at various stages of completion. This was being managed and a process was in place to address this. Also, the practice was in the process of updating job descriptions, therefore, not all staff had a job description on file.

The practice must ensure that all staff have an up-to-date job description

The practice must ensure that DBS checks are completed for all staff and that staff should make a declaration that there have not been any changes that would affect their DBS status.

We found an induction process and policy in place for newly appointed staff, trainees and medical students. Once complete, this would be approved and recorded by the practice manager or appointed staff member.

Some staff were compliant with mandatory training; however, our review of staff records highlighted several examples of non-compliance for both clinical and non-clinical staff, in particular IPC training as highlighted earlier. A programme of training had been arranged for November 2024. At the time of our visit a training matrix was being developed, to record all staff training, to ensure compliance can be monitored effectively, to ensure staff skills and knowledge are up to date in line with their role.

The practice must ensure staff are compliant with all mandatory training and provide HIW with evidence when completed.

We were assured that staff would be supported to raise a concern should the need arise, and we were provided with the practice whistleblowing policy.

All seven staff who completed a questionnaire said they had not faced discrimination within the last 12 months, and all but one felt they had fair and equal access to workplace opportunities. Additionally, all seven respondents felt their workplace was supportive of equality, diversity and inclusion.

All staff said they had access to appropriate ICT systems to support the provision of care and support for patients. In addition, staff felt there was an appropriate skill mix at the practice and the materials, supplies and equipment needed was available, to enable them to do their job. However, all seven respondents felt there was not enough staff to allow them to do their job properly, although all but one felt could meet all the conflicting demands on their time at work.

Culture

People engagement, feedback and learning
The practice had a complaints procedure which was aligned to the NHS Wales Putting Things Right process. The practice manager was responsible for managing all complaints and this was clear within the complaints policy and procedure documents. Complaints/concerns are also monitored to identify any themes and trends, in addition, they are discussed at meetings, and any actions for improvement are communicated to staff.

We saw complaints information displayed in the surgery, however, the practice webpage for complaints was not working.

The practice must review their website to ensure the complaints page is functional and ensure details of NHS Wales Putting Things Right process is easy to access.

There was no evidence to demonstrate that patient feedback is routinely collected by the practice to learn and inform service improvement. Staff told us that patients can submit an email or write to the practice to share feedback, however, a formal process should be implemented to ensure the patient voice is heard. Any feedback would be given to management staff for them to review and action as appropriately.

The practice must ensure that patients are informed how to share their experience feedback, to help inform service improvement and enhance the patient experience.

Staff felt comfortable to speak up regarding any concerns they may have, and a whistleblowing policy was in place to support this. In addition, staff felt comfortable to share any suggestions they might have and could provide these to their manager for consideration.

We spoke to senior staff about the arrangements in place regarding compliance with the Duty of Candour. A Duty of Candour policy was in place and staff were scheduled to complete training for this in November 2024.

Information

Information governance and digital technology
The practice understood its responsibility when processing information and demonstrated that data is managed in a safe and secure way. A current information governance policy was in place to support this.

The practice used the Digital Health and Care Wales (DHCW) service to support the data protection officer and the information governance lead. The practice's process for handling patient data was available for review on the website.

There were effective and secure sharing arrangements in place, to ensure that patient data or key notifications were submitted to external bodies as required.

Learning, improvement and research

Quality improvement activities
The practice engaged with quality improvement by developing and implementing innovative ways of delivering care. These included direct involvement in cluster projects, such as the online digital assistant 'Mali', which was introduced to help reduce appointment waiting times for patients and easier access to physiotherapy. There was also evidence of a programme of clinical and internal audit in place to monitor quality.

The practice engaged in learning from internal and external reviews, including mortality reviews, incidents and complaints. All learning was shared across the practice to make improvements, however, as highlighted earlier, there was no evidence of minutes and action logs to share with absent staff.

Whole-systems approach

Partnership working and development

The practice provided examples of how it as a stakeholder in patient care, impacts on other parts of the healthcare system. This included following health board clinical pathways. The practice also interacts and engages with system partners at various multi-disciplinary meetings, such as cluster meetings and practice manager meetings.

There were good collaborative relationships with external partners and within the cluster. The practice worked closely within the local GP cluster to build a shared understanding of the challenges and the needs of the local population, and to help integrate healthcare services for the wider area.

4. Next steps

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

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

The improvement plans should:

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

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

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

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

Appendix A – Summary of concerns resolved during the inspection

The table below 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
No immediate concerns were identified on this inspection			

Appendix B - Immediate improvement plan

Service: Ashfield Surgery - Bridgend Group Practice

Date of inspection: 15 October 2024

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

	Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	HIW is not assured that robust procedures are in place to ensure infection prevention and control (IPC) is being maintained at the practice. The clinical curtains used to maintain privacy and dignity within clinical rooms were material/ non disposable. There was no risk assessment in place nor evidence to demonstrate dates of curtain change, or evidence that the curtains are appropriately laundered.	The practice must: • Replace all privacy curtains in all clinical rooms with washable and/or disposable curtains. Where washable curtains are used, ensure records are maintained to evidence dates and appropriate laundering	Health & Care Quality Standards (2023) - Safe	All curtains in the clinical rooms in Ashfield Surgery have been replaced with disposable curtains.	Nurse Fricker	Completed Friday the 18th of October 2024
		• Ensure all staff complete the level of IPC training appropriate to their role. Records of training should be maintained to evidence staff compliance as appropriate		Training will be undertaken and records kept to evidence it has been completed.	Joanne Carter	We endeavour to ensure all staff have completed this by end of November 2024

	We identified a lapse in IPC training for the clinical team. The Hepatitis B register was not up to date and did not reflect the immunity status of staff. We were not assured that robust cleaning methods were in place, and in one clinical treatment room, we identified clumps of dust under the treatment bed.	• The Hepatitis B register must be kept updated to reflect the immunity status of all appropriate staff. Staff risk assessments must be completed where immunity is not evidenced. • A robust cleaning schedule must be implemented for of all areas within the surgery. Particular attention must be given to all clinical treatment rooms, to maintain a clean and dust free environment, to minimise the risk of cross infection.		We are currently in the process of putting together a new register to reflect the immunity status of all appropriate staff. We had already given notice to Albany Cleaning due to their poor cleaning standards. The new provider (Cleanmate) will take over all four sites on Monday the 9th of December 2024.	Nurse Fricker Joanne Carter	Currently being implemented. Full register will be available to evidence this action by end of November 2024 9th December 2024
2.	HIW is not assured that appropriate checks are undertaken on the emergency drugs and equipment. The records we reviewed showed monthly checks were being recorded, however, these should be carried out weekly, in	The practice must ensure all emergency drugs and equipment are checked and recorded on a weekly basis.	Health & Care Quality Standards (2023) - Safe; Timely; Information	We have now implemented a weekly check of emergency drugs and equipment.	Nursing Team	Action completed

	line with the Resuscitation Council UK; Quality Standards: Primary care equipment and drug list.					
3.	HIW is not assured that the practice is compliant with the Control of Substances Hazardous to Health (COSHH) Regulations 2002. During our observations, we found the boiler room was used to store various cleaning items including hazardous liquids. To minimise the risks to staff and patient safety, a separate and suitable area should be used to store hazardous cleaning equipment.	The practice must ensure an alternative storage area is sought for cleaning materials, to ensure any hazardous materials/liquids are stored securely and safely away from the boiler room.	Health & Care Quality Standards (2023) – Safe	Albany Cleaning have been contacted to ask them to remove all their cleaning materials from this room no later than 21st October 2024.	Joanne Carter	21st October 2024

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): **Joanne Carter**

Job role: **Managing Business Partner**

Date: **21st October 2024**

Appendix C - Improvement plan

Service: Ashfield Surgery - Bridgend Group Practice

Date of inspection: 15 October 2024

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 only saw one notice offering patients a chaperone service.**	**The practice should consider having more notices regarding the chaperone service. These should be displayed in clinical treatment areas and on the website.**	Health & Care Quality Standards - Person-centred	Notices will be put in all clinical treatment areas and a copy uploaded to the website.	Joanne Carter	Will be completed by 6th December 2024
2.	**There was no hearing loop available to assist patients with reduced ranges of hearing.**	**The practice should ensure that a hearing loop system is available and have this displayed by the reception to indicate this service is available.**	Health & Care Quality Standards - Safe; Person-centred	Hearing loop now available and positioned in Reception to indicate this service is available	Joanne Carter	Action Completed

3.	**The workflow policy had limited information and would benefit from being reviewed to ensure it contains how the process works, how and when audits take place and clear delegation of responsibility.**	**We recommend the workflow policy is reviewed and updated to provide more information about the process, audits and delegation of responsibility.**	Health & Care Quality Standards - Information	Workflow policy being reviewed and updated to provide more information about the process, audits and delegation of responsibility.	Joanne Carter	Policy will be completed by 31.12.24
4.	**Equality and diversity training had lapsed for staff. Training was scheduled for November 2024.**	**The practice must ensure all staff complete equality and diversity training and provide HIW with evidence once complete.**	Health & Care Quality Standards - Workforce	All staff completed Treat Me Fairly (Equality and Diversity) Training during November.	Joanne Carter	Action completed. All staff have completed this training and certificates are available to verify this
5.	**We noted that partnership risk was not covered in the business continuity plan and**	**The business continuity plan should be updated to include business partnership risk.**	Health & Care Quality Standards - Information	Business continuity plan will will be updated to include business partnership risk	Joanne Carter	This action will be completed by 31.12.24

	recommend adding this to the document					
6.	**We found that emergency drugs and equipment were being stored in a nurse's room. We recommended that the drugs and equipment are moved to a central location which would be easily accessible without compromising patient privacy and dignity.**	**The practice must ensure that emergency drugs and equipment are relocated to an area that allows ease and speed of access. The new location must be communicated to all staff.**	Health & Care Quality Standards - Safe; Timely	Emergency drugs and equipment have been relocated to an accessible area and the new area has been communicated to all staff so they know how to access them in an emergency	Joanne Carter	This action has been completed
7.	**We recommended that all clinical staff are aware of the recent guidance and Welsh health circular relating to oxygen use and the requirement for online training to be completed by clinicians dealing with**	**All clinical staff must obtain and update themselves with the recent guidance and Welsh health circular relating to oxygen use and implement any requirements that are recommended, including the online training.**	Health & Care Quality Standards - Safe; Workforce; Information	Clinical staff will be undertaking this training during December 2024	Joanne Carter	This action will be completed by 31.12.24

	portable oxygen therapy.					
8.	**There was no home visiting risk assessment in place.**	**A home visiting risk assessment must be completed, and mitigations implemented and maintained as appropriate.**	Health & Care Quality Standards - Safe; Workforce; Information; Culture	A home visiting risk assessment will be completed and mitigations implemented and maintained as appropriate	Joanne Carter	This action will be completed by 31.12.24
9.	**The blood-borne virus and needlestick/sharps policies referenced English standards and outcomes and this needs to be updated to reflect Welsh guidance and standards.**	**The blood-borne virus and needlestick/sharps policies needs to be reviewed and updated to include Welsh standards and guidance.**	Health & Care Quality Standards - Safe; Workforce; Information	The blood-borne virus and needlestick/sharps policies will be reviewed and updated to include Welsh standards and guidance	Joanne Carter	This action will be completed by 31.12.24
10.	**There was a prescribing policy in place, however there was no information about the re-authorisation of certain**	**The practice must update the prescribing policy to include re-authorisation of medication.**	Health & Care Quality Standards - Information	The prescribing policy will be updated to include re-authorisation of medication	Claire Arthur	This action will be completed by 31.12.24

	medication for sign off by a GP.					
11.	**We found that the vaccine refrigerator in the treatment room was overfilled. This could impede the flow of air and maintain appropriate temperatures. The practice should consider vaccine storage within the medical refrigerator to ensure appropriate air flow.**	**The practice must ensure that the medical refrigerators are not overfilled with vaccines and consider an additional fridge to ensure appropriate storage and air flow.**	Health & Care Quality Standards - Safe; Efficient	Stock in the fridge has been reduced and will be kept at low levels to ensure they are no overfilled	Joanne Carter	This action has been completed
12.	**The practice had a named safeguarding lead which was not recorded in the policy and some staff were unaware of who was the practices' safeguard lead.**	**The practice must ensure all staff are aware of the safeguarding lead for adults and children, and their details displayed more prominently for staff.**	Health & Care Quality Standards - Safe; Workforce; Information	Staff have been informed that Dr Clare Hughes is the safeguarding lead and her details have been circulated to all staff. The safeguard policy now contains Dr Hughes name as	Joanne Carter	This action has been completed

		The safeguard policy should include the name of the safeguarding lead for both children and adults.		safeguard lead for both children and adults		
13.	**We saw that not all staff had the appropriate level of training in safeguarding. A training course has been arranged for November 2024 to ensure staff have an appropriate level of knowledge and understanding in the safeguarding of children and adults.**	**The practice must ensure all staff undertake the required level of safeguarding training (both children and adult) appropriate to their role, and a record should be kept to evidence this.**	Health & Care Quality Standards - Safe; Workforce; Information	All staff completed Level 2 Safeguarding Training for both children and adults during November.	Joanne Carter	Action completed. All staff have completed this training and certificates are available to verify this
14.	**From the notes reviewed we found that the patient's language choice was not obvious on the records. We were told that this would pop up as an alert.**	**The practice must ensure that:** • **Patient language preference is recorded and obvious on their clinical records**	Health & Care Quality Standards - Safe; Information; Person-centred	• We are changing our new patient questionnaires to ask for preferred language. There is an	Joanne Carter	• The data capture will be over several months but the new patient questionnaire

	In addition, the practice would benefit from having an agreed use of recording observations, including blood pressure, pulse and temperature which can be auditable. We found some staff were using the templates and some were not. Therefore, collecting this type of data would be difficult. The reasons why medication has stopped was not being recorded consistently in the notes we reviewed.	• **A consistent method of recording observations is implemented to monitor an audit these as required** • **Any medication that has been discontinued is documented in the patient records and the reason or rationale as too why.**		option on our clinical system for preferred language but it defaults to English unless the patient states their preference. We will do a data capture to try and update as many records as possible. • All clinicians have been instructed to ensure they use the templates going forward to record observations • This has now been implemented		will be changed by 6th December 2024 • This action has been completed • This action has been completed

15.	**All policies and procedures must have full version control information.**	**The practice must ensure that all policies and procedures are all version controlled, contain a policy author and have implementation date and review dates.**	Health & Care Quality Standards - Information	All policies are being amended to add a version control	Joanne Carter	This action will be completed by 31.12.24
16.	**Staff meetings were routine, however, not all were being recorded. Where appropriate, an action log should also be kept as a way of ensuring key actions are implemented.**	**The practice must record all meeting minutes, and where applicable have an action log to ensure actions can be monitored and implemented.**	Health & Care Quality Standards - Information; Leadership; Effective	We ensure all minutes are now recorded and paper minutes produced and filed. Where applicable an action log is used to ensure actions can be monitored and implemented	Joanne Carter	This action has been completed
17.	The recruitment process described by senior staff was satisfactory, however, there was no recruitment policy in place to support this.	**The practice must implement a recruitment policy.**	Health & Care Quality Standards - Information; Leadership; Workforce	We will implement a recruitment policy to reflect the procedure we currently use	Joanne Carter	This action will be completed by 31.12.24

18.	**The practice was in the process of updating job descriptions, therefore not all staff had a job description on file.**	**The practice must ensure that all staff have an up-to-date job description**	Health & Care Quality Standards - Information; Workforce	We are continuing to update all job descriptions but this is quite an extensive piece of work	Joanne Carter	We are hoping to complete all job descriptions by early January 2025
19.	**We saw that whilst some staff had Disclosure and Barring Service (DBS) checks in place, there were others at various stages of completion.**	**The practice must ensure that DBS checks are completed for all staff and that staff are required to make a declaration that there have not been any changes that would affect their DBS status.**	Health & Care Quality Standards - Information; Leadership; Workforce	All staff have now had DBS checks. Next steps to produce a declaration and circulate to all staff to sign to confirm there have not been any changes that would affect their DBS status	Joanne Carter	Part one of this action has been completed and part two will be completed by 31.12.24
20.	**Whilst some staff had up to date mandatory training, our review of records highlighted large gaps for both clinical and non-clinical staff, including IPC training.**	**The practice must ensure staff are fully compliant with mandatory training and provide HIW with evidence when completed.**	Health & Care Quality Standards - Information; Leadership; Workforce	We have implemented a training matrix, set up online learning for all staff with e-Learning Wales. We have circulated all mandatory training courses we require staff to complete and utilised the next four	Joanne Carter	This action will be ongoing but all gaps are being address and reminders put in place to notify staff when they need to repeat the training

				PT4L sessions to schedule training		
21.	**The practices' website page for complaints was not working. The practice must review their website to ensure complaint information is available. Information about Putting Things Right should also be available on the website, in both Welsh and English.**	**The practice must review their website to ensure the complaints page is functional and ensure details of NHS Wales Putting Things Right process is easy to access.**	Health & Care Quality Standards - Information; Learning, improvement & research	A section is being added to our website to provide information on our complaints procedure	Joanne Carter	This action will be completed by 31.12.24
22.	**There was no evidence seen that patient feedback is collected and acted upon. Staff told us that patients can submit an email or write to the practice to submit feedback. Any feedback would**	**The practice must ensure that patients are informed how to share their experience feedback, to help inform service improvement and enhance the patient experience.**	Health & Care Quality Standards - Learning, improvement & research; Whole systems approach	An annual Patient Satisfaction Survey is undertaken every year. We have just completed this cycle and collected over 700 completed questionnaires in both paper and electronic format. We will put	Joanne Carter	This action has been completed

	be given to management staff for them to review and actioned as appropriately.			this information in to a powerpoint presentation to be shared with our Collaborative and also provide the information to Welsh Government as part of our QI Project. We act on this feedback provided by our patients		

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): Joanne Carter

Job role: Managing Business Partner

Date: 2nd December 2024