Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report

(Announced)

Cwmaman Surgery, Cwm Taf 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 Cwmaman Surgery, Cwm Taf University Health Board on 06 November 2024.

Our team for the inspection comprised of one HIW healthcare inspectors 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 10 questionnaires were completed by patients or their carers and one was completed by staff. Feedback and some of the comments we received appear throughout the report.

Where present, quotes in this report 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 positive. All patients felt they were treated with dignity and respect, and all rated the service as '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 practice ensured vulnerable patients receive timely care. They have lists of patients that they call to make certain they have access to services specific to their needs.

There was good access into the premises allowing patients with impaired mobility and wheelchair users to easily access the facilities. The patient waiting room was clean and spacious, with separate rooms available for private discussions.

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:

- The practice must have notices regarding the chaperone service. These should be displayed in all patient areas including the clinical treatment areas and on the website.
- The practice must ensure that a process is documented for care navigation.

This is what the service did well:

- Good patient access
- Waiting area was pleasant with lots of patient information
- Ensured that patients felt they were treated with dignity and respect with good service.

Delivery of Safe and Effective Care

Overall summary:
The Infection Prevention and Control (IPC) arrangements were generally acceptable, but certain areas require improvement to consistently meet the required standards and ensure the safety of both staff and patients. Although staff

reported that IPC training for the clinical team was up to date, there was no evidence to confirm this.

A register for clinical staff immunity to hepatitis B is maintained, but it was found to be incomplete for two staff members.

Processes for safe medication prescribing were in place, but improvements are needed. Prescriptions were securely stored, but there was no record of their distribution.

Emergency equipment was checked, some items were near expiry date, and some oxygen masks needed replacing. A defibrillator was available and charged, but a spare battery is recommended. Missing emergency drugs were ordered immediately during inspection. Issues relating to the emergency equipment were addressed through our immediate assurance process.

Safeguarding procedures at the practice need updating to reflect Welsh guidance and legislation. There was confusion among staff about the named safeguarding lead, which was also not recorded in the policy. Improvement is also required with safeguarding training.

The review of ten electronic patient records revealed that they were securely stored and password protected, with clear and contemporaneous entries. However, there were issues with the use of clinical read codes, making it difficult to follow up on conditions. The patient record system made it challenging to link medications to diagnoses and to track when medications were started or stopped, along with the rationale.

The practice efficiently manages services in a person-centred manner, empowering patients in their healthcare journey. It can refer patients to health visitors, physiotherapy, mental health services, and the cluster wellbeing team.

Immediate assurances:

- Items of emergency equipment and medication were passed their expiry dates or needed replacing
- Staff compliance with safeguarding training, alignment of the safeguarding policy to the Wales Safeguarding Procedures, and staff knowledge of the practice safeguarding lead.

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
- Services were arranged in an efficient manner and are person centred to ensure people feel empowered in their healthcare journey
- Procedures were in place for the management and disposal of waste, including healthcare waste.

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. All staff work across two branch surgeries and cover absences, and challenges were reported with staff retention. This was impacting the ability of senior staff to take leave.

The practice had established processes to support governance, leadership, and accountability, to help sustain delivery of safe and effective care. Staff are clear about their roles, responsibilities, and reporting lines, and understand the importance of working within their scope of practice.

Information sharing processes were in place for staff, with policies and procedures accessible on a shared drive and updates communicated verbally or via WhatsApp. Staff meetings are routine, but there was no evidence of clinical meeting minutes, which may leave some staff unaware of key information and required actions.

Recruitment processes include pre-employment checks such as DBS checks, references, and professional registration verification. However, the recruitment policy needs updating to mandate DBS checks, and some pre-employment checks were incomplete, including DBS. This was addressed through our immediate assurance process.

A Patient NHS Experience survey showed mainly positive results, but feedback was not available to patients. A local feedback system should also be implemented to allow ongoing patient input for service improvement.

A complaints process was in place but was not aligned with the NHS Wales Putting Things Right process, in addition, the complaints process needs updating to ensure consistency in response timescales.

The practice demonstrated its role as a stakeholder in patient care by following health board clinical pathways and engaging with system partners through multidisciplinary meetings, such as cluster and practice manager meetings. It maintained strong collaborative relationships with external partners and within the local GP cluster. This collaboration helped build a shared understanding of local challenges and needs, facilitating the integration of healthcare services for the wider area.

We issued an immediate assurance letter regarding the recruitment process regarding Disclosure and Barring Service checks and safeguarding training.

Immediate assurances:

- Disclosure and Barring Service checks had not been completed for all staff

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

This is what we recommend the service can improve:

- Ensure all staff are compliant with mandatory training requirements, and implement a training matrix to monitor compliance
- Ensure policies and procedures are updated and specific to the practice as well as including version control
- 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
- The practice understood their responsibility when processing information and demonstrated that data is managed in a safe and secure way.

3. What we found

Quality of Patient Experience

Patient feedback

HIW issued a questionnaire to obtain patient views on the care being provided at Cwmaman surgery. In total, we received 10 responses from patients at this setting. Some questions were not answered by some respondents, meaning not all questions had 10 responses.

Patient comments included:

> *"Warm and caring staff. Excellent automatic check-up and called in rather than having to make appointments"*

Person-centred

Health promotion

The practice had a wide range of written health promotion information available for patients. The information was displayed in the patient waiting area and promoted through the practice website. We saw health promotion information on a variety of topics including smoking cessation, weight management and carers information. The information screen in the waiting room was not on during the visit. All respondents to the questionnaire felt there was health promotion information on display at the practice, and all but two felt they were offered healthy lifestyle advice.

We were told that the practice engaged with several agencies to improve access to various healthcare professionals. A pharmacist attends on a weekly basis as does a mental health counsellor. Patients can access physiotherapy services at another practice and there are good links with the community wellbeing team and access to the mental health crisis team. This enables patients to access help and support from other agencies in a timelier manner.

Staff at the practice work closely with their patient group to ensure they receive the right care from the right services. To ensure vulnerable patients receive timely care, the practice has lists of patients they call to ensure they have access to services specific to their needs. The practice also uses an alert on patient records to easily identify those requiring access to additional services.

All patients agreed that staff explained things well to them and answered their questions. In addition, they 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.

Dignified and respectful care
We found patients were treated with dignity and respect. Clinical rooms provided an appropriate level of privacy, with doors kept closed during consultations. Privacy curtains were also available. All respondents to the questionnaire said they were treated with dignity and respect, and for those who answered the relevant question, all confirmed that measures were taken to protect their privacy.

Reception staff were observed welcoming patients in a professional and friendly manner. The reception desk was partitioned by glass and situated within the large waiting area. All patients responding to the questionnaire felt they could talk to reception staff without being overheard.

There were four trained chaperones at the practice, and others were due to receive training for this. There were no visible posters advertising the chaperone service, therefore better signage of the patients right to request this service is needed.

The practice must display notices regarding the chaperone service. These should be displayed in all patient areas including the 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.

Urgent appointments were appropriately triaged over the telephone by reception staff in consultation with a clinician when required. Children requiring a face-to-face appointment are accommodated when required. Following triage, patients are signposted to the most appropriate service to manage their needs. This included accessing GP cluster-based services, such as the cluster pharmacist, mental health counsellor and physiotherapist.

Whilst a clear process was described for care navigation this was not in written format, therefore a written process should be developed and implemented support staff and ensure consistency in their approach.

The practice must ensure that a written process for care navigation is implemented.

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, including extended face to face consultations.

In response to the questionnaire, all patients agreed:

- they were able to have a same-day appointment when they need to see a GP urgently
- they were satisfied with the opening hours of the practice
- they were able to contact the practice when needed, by telephone, or the online booking system
- their appointment was on time.

Equitable

Communication and language

We found that staff communicated 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. We were told a hearing loop was available, which were present at reception and in the clinical rooms.

Patients are usually informed about the services offered at the practice through the website, practice information leaflet 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 communicated through telephone calls.

We were told there were no Welsh speaking staff at the practice, however, the practice had access to translation services, if required. We saw some patient information was available bilingually.

There were processes in place for the recording and actioning of information from secondary care. Letters and documents are directed to the correct health care practitioner to action as required.

The practice ensured messages were communicated internally to the appropriate people, mainly verbally, but supported by their communication and technology systems, and read receipts are requested.

Rights and equality
The practice offered good access with a dedicated free car park and on-street parking available. We noted that all patient areas including treatment rooms and accessible toilet were located on the ground floor. All patients who responded to the questionnaire felt the building was easily accessible.

An equality and diversity policy was in place, and staff had completed equality and diversity training. All respondents to the questionnaire said they had not faced discrimination when accessing or using this health service.

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

Delivery of Safe and Effective Care

Safe

Risk management
There were processes in place to protect the health, safety and wellbeing of all who used the service, including within clinical rooms. The practice was clean and tidy, free of clutter and in a good state of repair.

A business continuity plan (BCP) was in place but requires review and updating to reflect Welsh guidance and legislation, where applicable. In addition, the plan should be specific and relevant for both branch surgeries. We recommend that the BCP is available to all staff at both surgeries for clarity on responsibilities and contact details in the event of an urgent or emergency situation impacting the business.

The business continuity plan should be updated to reflect Welsh guidance and legislation. The plan should also be specific and relevant for both surgeries and shared with all staff.

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

We saw how patient safety alerts were received and disseminated to the practice and communicated in meetings. The process in place for managing patient safety alerts and significant incidents was robust.

We saw the stock room was cluttered and found items that were past their expiry date, posing a risk to patient safety. This included gloves, syringes and masks. These must be removed to prevent their use when undertaking patient care.

The practice must review the stock room contents and remove all equipment/personal protective equipment which have past their expiry date.

We discussed the action taken when home visits are requested and found that staff triage all home visits before attending. A home visiting risk assessment was in place.

Infection, prevention and control (IPC) and decontamination
Overall, the IPC arrangements in place were acceptable, but some arrangements need strengthening to ensure the practice always upholds the required standards of IPC to maintain the safety of staff and patients.

The practice had an appointed IPC lead and staff were aware of this. Staff told us they understood their roles and responsibilities in upholding IPC standards. Staff told us that IPC training was up to date for the clinical team, however, we did not see evidence to support this.

The practice must ensure evidence is recorded to ensure all clinical staff are up to date with IPC training.

A current blood borne virus policy was in place, and a process to manage any incidents of needlestick injuries. To support staff further, we suggested the practice displays a needlestick injury poster within treatment areas. Policies were in place for IPC and needlestick or sharps injuries

The practice should consider displaying a needlestick injury management poster in treatment rooms to support staff following any sharps injuries.

Suitable procedures were in place for the management and disposal of all waste, and a policy was in place to support this. However, the waste, IPC and sharps injury polices require review to ensure completeness of information, and reference to Welsh guidance and legislation where appropriate. In addition, policies should also be localised to a specific surgery if any details differ.

The practice must ensure that the policies for waste management, IPC and sharps injuries are reviewed and updated to include Welsh standards and guidance. Where applicable the information in each policy must be specific to each surgery.

The practice had a register in place for staff immunity to hepatitis B. We found the register was up to date apart from two members of staff, and the practice was waiting for their results to be submitted.

The practice must ensure evidence is kept for all clinical staff regarding hepatitis B immunity. Where immunity is not confirmed, a risk assessment must be completed for the relevant staff members.

Suitable arrangements were in place to segregate people with transmissible infections to reduce the risk of cross infection. All patients responding to the questionnaire agreed there were signs at the entrance explaining what to do if they had a contagious infection.
Personal Protective Equipment (PPE) was available and used appropriately to maintain good IPC, and appropriate hand washing facilities were in place within clinical areas. The patients responding to the questionnaire felt there were hand

sanitizers available, and that healthcare staff washed their hands before and after being treated.

The patients who indicated they had received an invasive procedure at the practice, said that staff used PPE during the procedure, that antibacterial wipes were used to clean the skin prior to a procedure, and any equipment used was individually packages or sanitised.

Appropriate cleaning schedules were in place. However, the cleaning schedule should be updated to include the dignity screens and the practice wheelchair to minimise the risk of cross infection.

The practice must update the cleaning schedule to include sanitisation of dignity screens and the practice wheelchair.

Medicines management
Processes were in place to ensure the safe prescribing of medication, however, some aspects required improvement. We saw prescriptions were kept securely, but there was no record kept of where and when they are distributed to clinical rooms or the other branch surgery.

Manual prescription pads were kept securely and used by only the senior partner and salaried GP. We were told any unused prescription pads would be returned to the health board for appropriate disposal and prevention of unauthorised use. In this circumstance, we recommended records should be kept of what pads are returned to the health board to avoid the risk of incorrect or unauthorised use, if any clinician had left the practice.

Whilst a prescription storage and security policy was in place, which referenced the presence of a record for storage and distribution of prescriptions, this was not being followed.

The practice must ensure compliance with the prescription storage and security policy. In addition, a record should be kept for tracking the issuing of prescription pads, and when returning unused pads to the health board.

A medication cold chain policy was in place for medicines and vaccines that require refrigeration, and clinical refrigerators were used to store them as appropriate. 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.

The emergency equipment we checked were appropriate and staff completed regular checks of this. However, the process was not robust to ensure items remain within their expiry dates. Whilst most items were within their expiry dates, some oxygen face masks needed replacing. An automated external defibrillator (AED) was in place and was fully charged, we suggested staff consider storing a spare battery. When checking the emergency drugs, we noted some items were missing. This was raised at the time of the inspection and an order placed for the missing items and was addressed through our immediate assurance process. Further details are recorded in Appendix B of this report.

We saw that the emergency drugs and equipment were stored separately, albeit in the same room. Both equipment and drugs should be stored together to minimise the risk of delays in accessing the kit in the event of an emergency, such as cardiac emergency.

The practice must ensure that emergency drugs and equipment are located together, in an area that allows ease 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.

There were up to date Patient Group Directions (PGDs) in place. However, the PGD folder requires review to remove the out-of-date information we found, to ensure nurses are working to the most up-to-date directions. In addition, we found there was no PGD in place for travel vaccines and Hepatitis A vaccines. The nursing staff must ensure a prescription is generated by a prescriber and documented in the patient record.

The practice must ensure the PGD folder is reviewed, and any outdated directions must be removed and should only contain current information.

The practice must ensure a PGD is in place for travel vaccines, including Hepatitis A. Until this is complete, nurses must ensure a prescription is generated by a prescriber and documented in the patient record.

No controlled drugs are kept at the practice.

Safeguarding of children and adults
We considered the safeguarding procedures in place which included the policy for both safeguarding adults and children. The policy referenced English guidance and legislation and needs to be updated to reflect the national Wales safeguarding

procedures. There was also confusion amongst staff regarding who was the practices' named safeguarding lead, which was not recorded in the policy either.

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 safeguarding policy for children and adults must be updated to include:

- **current Welsh guidance and legislation**
- **the name of the safeguarding lead at the practice**
- **contact details/ important numbers of organisations staff might need**
- **a local process to guide staff of their responsibilities when faced with any safeguarding concerns.**

During the inspection we did not see evidence that all staff had completed safeguarding training at the required level. We addressed this issue under our immediate assurance process. Further are recorded in Appendix B of this report.

On review of patient records, we found no formal system for identifying any children at risk. We were told that the lead doctor is confident they can identify all active safeguarding cases due to the practice being small. However, we recommended that children at risk should be easily identifiable to relevant clinicians accessing their records. In particular, during the absence of the senior partner.

The practice must ensure that children at risk are clearly identifiable within the patient record system.

Management of medical devices and equipment

We found medical devices and equipment were in good condition, safe to use and had been appropriately checked. Suitable contracts were in place for the repair or replacement of relevant 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 any changes or new guidance is emailed to all staff and the information is stored on the shared drive where all staff can access.

Patient referrals were managed to a satisfactory standard, including those which are urgent. Most patient records contained investigation/ test results; however,

three records had no narrative as to why investigations were requested in the first instance.

Patients in need of urgent medical help or those in a mental health crisis were provided with suitable information. The practice has access to a mental health nurse once a week who refers patients to a relevant clinician, or appropriate signposting to other service providers.

Patient records
We reviewed ten electronic patient records, which were stored securely and were password protected from unauthorised access. Overall, the records were clear, written to a good standard and contemporaneous.

We found there was a poor use of clinical read codes, which makes the follow-up of conditions difficult. In addition, we found the follow-up of urgent suspected cancer (USC) referrals were left to the patient's discretion to call the practice. This is a concern since some patients may not be aware of this process or may forget that this is required. Therefore, a process should be implemented to ensure patients are aware of what action to take, if they have not received confirmation from their local hospital or received an appointment date in a timely manner.

The practice must ensure that all patients referred to the local health board with urgent suspected cancer are aware of what action they should take, if applicable, whilst they wait for correspondence regarding an appointment.

The patient record system used made it difficult to link medication to a diagnosis. In addition, it was difficult to establish the rationale when medication had been commenced or discontinued. We were told that a new system is planned for implementation, but no date has been given to the practice for this.

From the notes reviewed we found that the patient's language choice was not obvious on the records.

The practice must ensure that:

- **Improvement is made with the use of clinical read codes**
- **Any medication that has been commenced and/or discontinued is documented in the patient records and the rationale recorded**
- **Patient language preference is recorded and easily identified in their clinical records.**

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.

The practice can refer to health visitors, physiotherapy, mental health services and the cluster wellbeing team as appropriate. Patients can also access a diabetic service at the surgery and a seasonal vaccination service.

Health visitors attend the practice on a weekly basis for child immunisation clinics. We were told there were good working relationships with the health visitor team and any safeguarding concerns are communicated appropriately and in a timely manner.

Quality of Management and Leadership

Leadership

Governance and leadership
There were processes in place to support effective governance, leadership and accountability, to ensure a sustainable delivery of safe and effective care. Staff were clear about their roles, responsibilities and reporting lines and the importance of working within their scope of practice.

The practice had a process in place for sharing information with staff, such as changes in policies or procedures. All policies and procedures were on the shared drive and all staff would be told about any changes verbally or via the practices' WhatsApp group. The document control on the polices we saw included author, date of publication and a review date. Not all the policies and procedures were version controlled. In addition, we saw that many policies required updating to ensure the information was specific to the practice and based on Welsh legislation and guidance, where applicable.

The practice must ensure that all policies and procedures are:

- **Version controlled**
- **Are specific to the practice and where applicable, relate to Welsh guidelines and legislation.**

We were told staff meetings were routine and we saw minutes of the last meeting. However, we saw no evidence of clinical meeting minutes, which suggests those not present are not aware of key information, messages action required.

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

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

Staff could access wellbeing programmes through their professional registrations or through their own GP. There was no wellbeing programme in place for staff within the practice.

The practice should consider what initiatives or programmes can be implemented, to support staff with their wellbeing.

Workforce

Skilled and enabled workforce
We spoke with staff across a range of roles. They all had sound knowledge of their roles and responsibilities, and each appeared committed to providing a quality service to patients.

Despite there being an appropriate skill mix across the teams to deliver the services required, the practice reported difficulty in retaining staff. All staff work across two branch surgeries and cross cover any absences. The practice manager who is also a registered nurse was also covering nursing activities in addition to their own role. These included supporting the winter vaccine roll out and the diabetic clinic. The difficulties in recruiting and retaining staff makes it difficult for the senior partner and practice manager to take annual leave.

The practice must review their workforce plans, assess the gaps and consider if there are any opportunities for upskilling staff to help fulfil the practices' strategic direction.

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. There would also be a check of a healthcare professional's registration with their regulatory body to ensure it was current. An induction process was available for new staff. A recruitment policy was in place but requires updating to include DBS checks.

The practice must update the recruitment policy to include DBS checks as mandatory.

We saw some aspects of employment checks were not yet complete and included staff DBS checks. This was addressed through our immediate assurance process. Further are recorded in Appendix B of this report.

Some staff were compliant with most aspects of mandatory training; however, our review of staff records highlighted several examples of non-compliance with safeguarding children and adult training as highlighted earlier. At the time of our visit, we recommended a training matrix is developed and implemented. This will enable the practice to record all staff training, to ensure compliance can be monitored effectively and to ensure staff skills and knowledge are up to date in line with their role.

The practice must ensure all staff are compliant with all mandatory training relevant to their role and provide HIW with evidence once completed.

We found no evidence that clinical supervision or annual appraisals were taking place. Clinical supervision is a requirement set by the Nursing and Midwifery Council (NMC) and is an essential part of professional practice for nurses. In addition, annual appraisals are mandatory for GPs in the UK, and for nurses as part of their revalidation process.

The practice must ensure annual appraisals and clinical supervision is undertaken for all clinical staff, and evidence recorded.

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, however it must be updated with reference to Welsh Guidance and legislation, and with the correct contact details for HIW, for those who wish to raise a whistleblowing concern.

The practice must update the whistleblowing policy with Welsh guidance and legislation, and that staff are aware of the correct contact details for HIW.

Only one staff member completed a questionnaire, and felt they had fair and equal access to workplace opportunities. Additionally, they felt their workplace was supportive of equality, diversity and inclusion, and they had not faced discrimination within the last 12 months.

Staff had access to appropriate ICT systems to support the provision of care and support for patients. The survey respondent felt there was an appropriate skill mix at the practice, along with enough staff to allow them to do their job properly, and they could meet all conflicting demands on their time at work. In addition, they felt all relevant materials, supplies and equipment was available, to enable them to do their job.

Culture

People engagement, feedback and learning

Of those who responded to our survey, six out of 10 patients confirmed they had been asked by the practice about their experience of the service provided. All respondents knew how to make a complaint about the service, and all agreed that the service they had received was ‘very good’.

The practice had a patient complaints procedure and policy; however, it was not 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 monitored to identify any themes and trends, and any actions for improvement are communicated to

staff. We found that the timescales listed in the policy and complaints process leaflet were different, and these need to be corrected.

The practice must update their complaints policy and procedures by:

- **Aligning them with the NHS Putting Things Right process**
- **Ensuring the timescales listed in all complaint information is consistent**
- **Displaying details of Putting Things Right in an area easily accessible to patients.**

A Patient NHS Experience survey had been undertaken in line with the General Medical Services (GMS) Wales Contract. We were told the results were mainly positive, but no feedback was available to patients on the website or at the practice. In addition, a patient feedback system should be implemented locally, so patients can share their feedback about the service.

The practice must ensure that the Patient NHS Experience feedback is available to people who use the practice. In addition, patients should be informed how to share their experience on an ongoing basis, to help inform service improvement and enhance the patient experience.

Staff felt able to speak to the practice manager regarding any concerns they may have, in addition, they felt comfortable to share any suggestions they might have with the practice manager for their consideration.

We spoke to staff about the arrangements in place regarding compliance with the Duty of Candour. A Duty of Candour policy was in place, however the records we reviewed showed no staff had completed training on this topic. The member of staff who completed a questionnaire agreed that they knew and understood their role in line with Duty of Candour.

The practice must update the Duty of Candour policy to reflect Welsh legislation and guidance. In addition, the practice must consider staff access to training regarding the Duty of Candour.

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's process for handling patient data was available for review on the website.

Learning, improvement and research

Quality improvement activities
The practice engaged with quality improvement by developing and implementing innovative ways of delivering care. 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 incidents and complaints. We were told learning was shared across the practice and via the cluster group to make improvements.

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 multidisciplinary meetings, such as cluster meetings and practice manager meetings.

There were good collaborative relationships in place 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			

Appendix B – Immediate improvement plan

Service: Cwmaman Surgery

Date of inspection: 6 November 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.	During our inspection HIW found not all staff had a Disclosure and Barring Service (DBS) check in place. This was partly due to the length of service of some staff at the practice. To ensure the wellbeing and safety of patients, a DBS check should be undertaken, and systems should be implemented for staff to confirm that no changes have occurred to their DBS status.	A robust system must be implemented in relation to the completion and monitoring of DBS checks for all staff. • Relevant DBS checks must be completed for all staff and maintained on file • Staff must annually confirm that the information on the DBS check remains accurate and that there have been no changes since this check.	Health and Care Quality Standards – Safe	• Staff who have been employed in Cwmaman Surgery for longer than 10 years will undertake a DBS check • Staff who have completed DBS checks will sign an annual declaration that no changes have taken place since the original DBS was Taken , this will be	Sharon Rao	30/11/2024

				undertaken annually		
2.	During the inspection we were unable to find evidence to confirm that all staff had completed safeguarding training at the required levels. Additionally, the safeguarding policy did not identify the designated safeguarding lead. The policy needs to reflect current Welsh guidance and legislation and needs to identify local safeguarding contacts. This information must be shared with all staff.	The practice must: • Ensure that all staff complete the relevant mandatory safeguarding training • Implement a robust system for the monitoring of ongoing training compliance • Review, update and communicate safeguarding policies and processes with all staff to ensure all are aware of how to raise a safeguarding concern.	Health and Care Quality Standards - Safe	• GP asked to provide certificates of level 3 safeguarding training for Adults and Children • Copies of all staff Safeguarding eLearning for adults and children to be placed in folder on G Drive and not in staff training records • Posters will be displayed in surgery to identify Safeguarding Lead • Computer link for relevant Adult and Children Forms to be Identified on safeguarding poster.	Sharon Rao	30/11/2024

				Discuss with staff and ensure sign compliance of surgery Policy on safeguarding of adults and children		
3.	During the inspection HIW found items missing from the emergency drugs. This was raised at the time of the inspection and an order placed for the items. Confirmation is required to ensure all the recommended emergency drugs and equipment listed by the Resuscitation Council UK are available at the practice.	The practice must: • Ensure all the required emergency drugs and equipment are available at the practice for use in an emergency	Health and Care Quality Standards – Safe	• Health Inspectorate Wales has clarified guidelines for Emergency equipment and drugs which is Resuscitation Council Uk (8/11/2024). On visit 06/11/2024, stock was requested as per English Guidelines as recommended by the inspector and emergency order placed. However, drugs ordered were found to be in addition to Resuscitation Council Uk guidelines. Only change required was dextrose liquid in place of	Sharon Rao	Immediately 8/11/24 Awaiting delivery Glucose Gel and cefotaxime expected delivery due to supply chain and availability 11/11/24

				tablets that were stocked instead, adrenaline was already in place. • List of emergency drugs and standard equipment to be produced for use in an emergency • List of emergency drugs and equipment to be placed with weekly drug and Defib check • Staff to recheck if any equipment is used in emergency situation and stock replaced		

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): Sharon Rao

Job role: Practice Manager

Date: 08/11/2024

Appendix C - Improvement plan

Service: Cwmaman Surgery

Date of inspection: 6 November 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.	There were no visible posters advertising the chaperone service, therefore better signage of the patients right to request this service is needed.	The practice must display notices regarding the chaperone service. These should be displayed in all patient areas including the clinical treatment areas and on the website.	Health & Care Quality Standards - Person-centred	Poster was only displayed in surgery waiting room in main and Branch surgery, posters have been placed in all clinical rooms, Doctors and Nurses and information displayed on surgery website	Sharon Rao	Complete
2.	Whilst a clear process was described for care navigation this was not documented. There was a need for a clearly documented	The practice must ensure that a written process for care navigation is implemented.	Health & Care Quality Standards - Information	Written Process for Care Navigation available for staff Staff aware of how to READ Code - Care navigation and	Sharon Rao	Ongoing training refresher Audit appointments to ensure

	care navigation process for staff to follow to ensure consistency in their approach.			appropriate MDM team referred to.		appropriate Care Navigation
3.	A business continuity plan (BCP) was in place. We found that the BCP requires review and updating to reflect Welsh guidance and legislation, where applicable. In addition, the plan needs to be specific and relevant for both branch surgeries. We recommended that the BCP is available to all staff at both surgeries to ensure everyone is aware of their responsibilities and contact details of necessary services	The business continuity plan should be updated to reflect Welsh guidance and legislation. The plan should also be specific and relevant for both surgeries and shared with all staff.	Health & Care Quality Standards – Information	Business Continuity Plan updated Hard copies available in both surgeries	Sharon Rao	Complete

	should an emergency or situation arise.					
4.	We found the stock room was cluttered and contained out-of-date equipment, including gloves, syringes and face masks.	The practice must review the stock room contents and remove all equipment/personal protective equipment which have past their expiry date.	Health & Care Quality Standards – Safe	All items Destroyed	Sharon Rao	Complete
5.	We were unable to locate safeguarding training certificates for all staff	The practice must ensure evidence is recorded to ensure all clinical staff are up to date with IPC training.	Health & Care Quality Standards – Workforce	Spreadsheet of staff training and dates of updates available. Posters visible, displayed on practice website	Sharon Rao	complete
6.	There were no needlestick injury posters displayed in treatment areas to show staff the steps to be taken following a sharps injury.	The practice should consider displaying a needlestick injury management poster in treatment rooms to support staff following any sharps injuries.	Health & Care Quality Standards – Information	Posters displayed in all clinical rooms Doctors and Nurses	Sharon Rao	Complete
7.	The waste, IPC and sharps policies need to be updated to	The practice must ensure that the policies for waste management, IPC and	Health & Care Quality Standards – Information	Posters and policies updated	Sharon Rao	Complete

	reference Welsh guidance and legislation. Policies should be localised to a specific surgery if any details differ.	sharps injuries are reviewed and updated to include Welsh standards and guidance. Where applicable the information in each policy must be specific to each surgery.				
8.	The practice had a register in place for staff immunity to hepatitis B. We found the register was up to date apart from two members of staff, and the practice was waiting for their results to be submitted.	The practice must ensure evidence is kept for all clinical staff regarding hepatitis B immunity. Where immunity is not confirmed, a risk assessment must be completed for the relevant staff members.	Health & Care Quality Standards – Safe; Workforce; Information	All clinical staff records available	Sharon Rao	Complete
9.	The cleaning schedule must be updated to include dignity screens and the practice wheelchair.	The practice must update the cleaning schedule to include sanitisation of dignity screens and the practice wheelchair.	Health & Care Quality Standards – Information	Cleaning of wheelchair and portable curtains added to cleaning schedule	Sharon Rao	complete

10.	We saw prescriptions were kept in a locked storage area, but there was no computer log for the prescriptions. Therefore, no log of where and when they are distributed to rooms or different branches.	The practice must ensure compliance with the prescription storage and security policy. In addition, a record should be kept for tracking the issuing of prescription pads, and when returning unused pads to the health board.	Health & Care Quality Standards – Information	Log available for all computer scripts and room allocation Logbook kept with logbook for handwritten scripts which was in place	Sharon Rao	Complete
11.	We saw that the emergency drugs and equipment were stored separately, albeit in the same room. Both equipment and drugs should be stored together to minimise the risk of delays in accessing the kit in the event of an emergency, such as cardiac emergency.	The practice must ensure that emergency drugs and equipment are located together, in an area that allows ease of access. The new location must be communicated to all staff.	Health & Care Quality Standards – Safe; Timely	Drugs were stored above resus equipment in cupboards and drawers, all items labelled on door fronts, all staff are aware of location, which is also part of induction process	Sharon Rao	Complete
12.	The Patient Group Directions (PGDs) folder needs	The practice must ensure the PGD folder is reviewed, and any outdated directions	Health & Care Quality Standards – Safe; Information	All old PGD stored in separate folder, for reference only. Only	Sharon Rao	Complete

	reorganising to remove the out-of-date information, to ensure nurses are working to the most up to date PGD.	must be removed and should only contain current information.		up to date PGD is in folder		
13.	There was no PGD in place for travel vaccines, Hepatitis A. Nurses need to ensure a prescription is generated by a prescriber and documented in the patient record.	The practice must ensure a PGD is in place for travel vaccines, including Hepatitis A. Until this is complete, nurses must ensure a prescription is generated by a prescriber and documented in the patient record.	Health & Care Quality Standards – Safe; Workforce; Information	HEP A PGD in place, surgery only generates a prescription for Hep A, as surgery does not keep stock	Sharon Rao	Complete
14.	There was confusion from staff regarding who was the practices' named safeguarding lead, which was not recorded in the policy.	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 – Information	Poster Displayed with name of safeguarding Lead and contact address and computer link	Sharon Rao	Complete

15.	The policy referenced English guidance and legislation and needs to be updated to reflect the national Wales safeguarding procedures. There was confusion amongst staff regarding who was the practices' named safeguarding lead, which was not recorded in the policy.	The safeguard policy for children and adults must be updated to include: • current Welsh guidance and legislation • the name of the safeguarding lead at the practice • contact details/ important numbers of organisations staff might need • a local process to guide staff of their responsibilities when faced with any safeguarding concerns.	Health & Care Quality Standards – Information	Staff aware of safeguarding Lead Contact details for important numbers and links displayed in surgery Policy and procedure in place	Sharon Rao	Complete
16.	On review of patient records, we found no formal system for identifying any children at risk. We were told that the lead doctor is	The practice must ensure that children at risk are clearly identifiable within the patient record system.	Health & Care Quality Standards – Information	Already in place. When Surgery is aware that children are on chid protection register appropriate READ Code is placed in child's journal and	Sharon Rao	Was in place

	confident they can identify all active safeguarding cases due to the practice being small. However, we recommended that children at risk should be easily identifiable to relevant clinicians accessing their records. In particular, during the absence of the senior partner.			siblings who may be registered in the surgery. When children are removed from child Protection register this is documented READ code is placed in parents journal so that there is a record that children are on child protection register. Unborn babies are READ coded in maternal mother's records Children in Foster Care are appropriately READ Coded as well as foster parents Adopted children have appropriate READ Codes Policy and Procedure Looked after children VISION search undertaken on		

				10/12/2024 and indicates numbers of patients currently on register or past Register		
17.	we found the follow-up of urgent suspected cancer (USC) referrals were left to the patient's discretion to call the practice. This is a concern since some patients may not be aware of this process or may forget that this is required. Therefore, a process should be implemented to ensure patients are aware of what action to take, if they have not received confirmation from	The practice must ensure that all patients referred to the local health board with urgent suspected cancer are aware of what action they should take, if applicable, whilst they wait for correspondence regarding an appointment.	Health & Care Quality Standards – Safe; Timely; Information	Information Sheet will be given to patients by referring Dr in relation to who to contact if they don't receive an appointment for appropriate referral	Sharon Rao	Complete

	their local hospital or received an appointment date in a timely manner.					
18.	Findings from the review of patient records.	The practice must ensure that: • Improvement is made with the use of clinical read codes • Any medication that has been commenced and/or discontinued is documented in the patient records and the rationale recorded • Patient language preference is recorded and easily identified in their clinical records.	Health & Care Quality Standards – Safe; Information; Person-centred	Staff made aware of importance of READ coding during consultations. When medication commenced and discontinued. Patients language preference to be documented if not already READ Coded	Sharon Rao	Ongoing
19.	Not all the policies and procedures were version controlled.	The practice must ensure that all policies and procedures are: • Version controlled	Health & Care Quality Standards – Information	All policies and Procedures updated November 2024	Sharon Rao	Complete

	Many policies required updating to ensure the information was specific to the practice and based on Welsh legislation and guidance, where applicable.	• Are specific to the practice and where applicable, relate to Welsh guidelines and legislation.				
20.	We had no evidence of any clinical meeting minutes.	The practice must record all meeting minutes, and where applicable implement an action log to ensure actions can be implemented and monitored.	Health & Care Quality Standards – Information	Logbook maintained of clinical meeting and staff meetings	Sharon Rao	Ongoing
21.	There was no wellbeing programme in place for staff working at the practice.	The practice should consider what initiatives or programmes can be implemented, to support staff with their wellbeing.	Health & Care Quality Standards – Workforce; Culture	Regular Staff meetings, discuss with staff any health issues or concerns and give appropriate support	Sharon Rao	ongoing
22.	The practice reported difficulty in retaining staff. All staff work across the two branch surgeries and cover	The practice must review their workforce plans, assess the gaps and consider if there are any opportunities for upskilling	Health & Care Quality Standards – Workforce	Advert Place for Practice Nurse, Staff in current positions in process of being upskilled in	Sharon Rao	Ongoing

	for absences. The practice manager was covering nursing activities as well as overseeing the practice manager role. The difficulties in recruiting staff were making it difficult for the senior partner and practice manager to take annual leave.	staff to help fulfil the practices' strategic direction.		their roles with competencies		
23.	A recruitment policy was in place but requires updating to include DBS checks.	The practice must update the recruitment policy to include DBS checks.	Health & Care Quality Standards – Workforce	DBS was in place for new staff, introduced annual disclaimer for staff who have been employed for more than 1 year	Sharon Rao	Complete
24.	Our review of staff mandatory training records highlighted several examples of non-compliance for both clinical and non-clinical staff	The practice must ensure staff are compliant with all mandatory training and provide HIW with evidence when completed.	Health & Care Quality Standards – Information; Leadership; Workforce	E Learning record of mandatory and clinical requirements depending on role, Forms part of induction process	Sharon Rao	To review monthly as training dates expire

25.	We found no evidence that clinical supervision or annual appraisals were taking place. Clinical supervision is a requirement set by the Nursing and Midwifery Council (NMC) and is an essential part of professional practice for nurses. In addition, annual appraisals are mandatory for GPs in the UK, and for nurses as part of their revalidation process.	The practice must ensure annual appraisals and clinical supervision is undertaken for all clinical staff, and evidence recorded.	Health & Care Quality Standards – Leadership; Workforce	Dr's annual appraisal via NHS Wales appraisal site GP (https//gp.mars wales.org) Practice Nurses appraisal inline with NMC revalidation every 3 Years	Sharon rao	As per Appraisal via GP Mars Website December 2024
26.	Whistleblowing policy needs updating.	The practice must update the whistleblowing policy with Welsh guidance and legislation, and that staff are aware of the correct contact details for HIW.	Health & Care Quality Standards – Information	Policy updated	Sharon Rao	complete

27.	Complaints policy and process need updating and aligning to Welsh standards/guidance.	The practice must update their complaints policy and procedures by: • Aligning them with the NHS Putting Things Right process • Ensuring the timescales listed in all complaint information is consistent • Displaying details of Putting Things Right in an area easily accessible to patients.	Health & Care Quality Standards – Information; Learning, improvement & research	Information Displayed on surgery website Posters Displayed in Surgery	Sharon Rao	complete
28.	The practice should consider having their own patient feedback system in place so patients can share their feedback about the service.	The practice must ensure that the Patient NHS Experience feedback is available to people who use the practice. In addition, patients should be informed how to share their experience on an ongoing basis, to help inform service improvement and	Health & Care Quality Standards – Learning, improvement & research; Whole systems approach	Annual survey completed and displayed on practice website. Undertaken at different periods. Suggestion Box for patient feedback placed in main and Branch Surgery	Sharon Rao	complete

		enhance the patient experience.				
29.	Duty of Candour policy needs to be localised and based on Welsh guidance, where applicable. No duty of candour training was evidenced for any staff members.	The practice must update the Duty of Candour policy to reflect Welsh legislation and guidance. In addition, the practice must consider staff access to training regarding the Duty of Candour.	Health & Care Quality Standards – Information; Leadership; Workforce	Staff who had not completed Duty of Candour Training asked to complete, added to staff induction programme Policy and Procedure In place	Sharon Rao	31/01/2025

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): Sharon Rao

Job role: Practice Manager

Date: 08/01/2025