Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report

(Announced)

Meddygfa Canna Surgery, Cardiff and Vale University Health Board

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

Our purpose

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

Our values

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

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

Our goal

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

Our priorities

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

Contents

1. What we did

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

Healthcare Inspectorate Wales (HIW) completed an announced inspection of Meddygfa Canna Surgery, Cardiff and Vale University Health Board on 10 December 2024.

Our team for the inspection comprised of two HIW healthcare inspectors and three clinical peer reviewers. The inspection was led by a HIW healthcare inspector.

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of 28 questionnaires were completed by patients or their carers and nine 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.

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 in our patient questionnaires were positive. All patients felt they were treated with dignity and respect, and all rated the service as 'good' or 'very good,' and we witnessed staff speaking to patients in a polite and respectful manner.

We found the practice emphasised health promotion and wellbeing to patients. A wide range of information was displayed, which included mental health awareness, screening services and smoking cessation.

There were processes in place to ensure patients could access care in a timely manner, and with the most appropriate person. The practice has also implemented a telephone 'call back' system, which gives patients the option to receive a call back when they are at the front of the telephone queue.

Access to the premises was generally good, providing patients with impaired mobility and wheelchair users with easy access while inside the building. However, we were told that access through the main doors to the building caused some patients with impaired mobility and wheelchair users difficulties due to the width of the doors. The practice a patient buzzer system in place if they need support to gain access into the building.

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

This is what we recommend the service can improve:

- Informing patients of Welsh speaking staff
- Formalise arrangements for patients accessing the building who may need assistance
- Have more notices regarding the chaperone service, including in clinical treatment areas

This is what the service did well:

- Patients felt they were treated with dignity and respect and had good service
- Good health promotion information available
- Patient call back system has been implemented with positive feedback received from patients

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.

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

The infection, prevention and control (IPC) arrangements in place were acceptable, but strengthening in some aspects is needed to ensure the practice always upholds the required standards of IPC. These included updating key policies and procedures with practice specific information in particular, improvements to the needlestick injury flowchart, the waste management system and contractual cleaning schedules.

Processes were in place to ensure the safe prescribing of medication, and the process for patients to request repeat medication was clear. However, there was no general prescribing policy in place and it was not clear who was acting as the prescribing lead at the practice.

A cold chain process was in place for medications or vaccines that required refrigeration. Twice daily cold chain and medication checks were completed, with a clear pathway to follow.

There were appropriate resuscitation equipment and emergency drugs in place to manage a patient emergency, such as cardiac arrest. These were located in an area where staff could access and locate promptly in an emergency.

Appropriate safeguarding procedures were in place supported by a policy, however, some staff required updating of their safeguarding training. On review of patient records, we found it difficult to identify those subject to the child protection register.

The patient records were of a good quality and were stored securely and were password protected from unauthorised access. The records were clear, written to a good standard and completed with appropriate information, demonstrating safe and effective management of acute and chronic illness. However, audits are needed to ensure the accuracy of summarisation by non-clinical coders.

Responses from staff who completed the questionnaire were 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.

This is what we recommend the service can improve:

- There was no general prescribing policy in place and it is not clear who the prescribing lead for the practice is
- An annual audit of the child protection register and coding accuracy for the individual and family members, and to ensure those who are no longer on the register are removed
- All staff need to have up to date safeguarding training, appropriate to their role
- An annual audit of summarisation to ensure the summarisation is of a high standard and accurate and relevant coding to support clinical staff with newly registered patients.

This is what the service did well:

- High quality clinical care and record keeping
- Good quality patient medical notes.

Quality of Management and Leadership

Overall summary:
The quality of management and leadership was satisfactory, with clear reporting lines and a dedicated and committed practice management and senior team. Staff were also clear about their roles and responsibilities.

The policies and procedures we saw had been reviewed and updated regularly. These were accessible to all staff via the practices shared drive or hardcopies within the practice managers office. However, work is needed to implement some key policies that were absent.

Regular staff meetings are held, however, minutes and/ or actions are recorded, to share with staff across the practice.

Most staff were compliant with mandatory training, and plans were in place for those not compliant. Annual staff appraisals had also been completed, and any additional training needs were identified to support staff professional development.

The practice sought patient feedback. Information was displayed in the waiting area on how people could feedback on their experiences and included a suggestion box.

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.

This is what we recommend the service can improve:

- Monitoring system for mandatory training
- Formalise staff meetings and consider adding an action log to meeting minutes
- Ensure all key policies and procedures are put in place

This is what the service did well:

- Quality control and review system for policies and procedures
- Nursing staff felt very supportive by the GP's and all staff that we spoke to stated they were happy to escalate any concerns.

3. What we found

Quality of Patient Experience

Patient feedback

HIW issued a questionnaire to obtain patient views on the care at Meddygfa Canna Surgery prior to the inspection that took place in December 2024. In total, we received 28 responses. Responses were overall positive, all respondents who answered rated the service as 'very good' or 'good.'

Some of the comments included the following:

> *"The care provided to my two small children has been consistently first class. This includes treatment from doctors and routine appointments with nurses. As a parent, I have always been able to access swift and full medical advice for both children, and medical professionals have been sensitive to my health and well-being as a mother. Excellent all round. Thank you to the heroes at Canna Surgery!"*

> *"I have always been happy with the level of care I have received from the midwives, nurses and doctors."*

> *"Canna surgery is fantastic, and we are so lucky to have them. My kids call [Doctor] 'the best doctor in the world.' Even when they are really busy, we always feel looked after and that we get the best possible care. Speaking to my Welsh speaking children in Welsh is feels like an example of patient centred care we always get."*

> *"At all times I am treated with respect and care by the doctor, nurses and receptionists. The doctor takes time to listen and also to explain any results or needs. I have written to the Minister of health, in the past to congratulate the practice."*

> *"The service at these surgeries is particularly good. Everyone is affectionate and shows respect, everyone has time to listen to you. Explanation given by the doctor in an understandable manner. Special care is given."*

> *"Great service from all staff."*

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 areas, on the display screens and promoted through the practice website, and included smoking cessation, mental health awareness, screening services, weight management, flu vaccine and dementia.

Responses to our patient questionnaire confirmed that health promotion and patient information material was on display at the practice. Additionally, respondents to our staff questionnaire said the practice offered health promotion advice and information about chronic conditions to patients.

The practice was offering the winter flu vaccination service and this had commenced in September 2024. The service was promoted within the practice, on social media, the practice website, and by text messaging. For those patients without digital access, the campaign was promoted at the practice and staff would also telephone eligible patients.

Dignified and respectful care

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

In our questionnaire, all respondents agreed that:

- Staff treated them with dignity and respect
- Measures were taken to protect their privacy
- Staff listened to them
- They were involved in decisions about their healthcare.

Reception staff were observed welcoming patients in a professional and friendly manner. To protect confidentiality, some telephone calls were taken in the administration office, away from the reception desk. The reception desk was partitioned by glass, which offered some level of privacy from the waiting area.

The practice offered chaperones in all appropriate circumstances, and there was a chaperone policy in place. A chaperone information notice was displayed on the front reception desk, however, not all clinical treatment rooms had notices indicating that this service was available.

The practice must ensure that information is available to patients regarding the option of a chaperone in all clinical treatment rooms

Timely

Timely care
There were processes in place to ensure patients could access care in a timely manner, and with the most appropriate person.

Staff described the arrangements for patients to access services. Appointments can be made via telephone and in-person. Appointments comprised of urgent appointments or routine bookable appointments.

The practice has implemented a telephone ‘call back’ system, which allows patients to request the practice to call them back when they are at the front of the queue, instead of waiting on hold.

The on-call doctor triages patients via telephone, and same day appointments are offered for all urgent cases if needed. We were told that children would be seen face to face on the same day. Patients can also book routine appointments 72 hours in advance, which can be delivered face to face or via a telephone appointment.

The practice also has an 'overspill' list for patients who can be triaged when all ‘on the day’ appointments have been used. A duty doctor is available every afternoon to deal with urgent queries.

There were processes in place to support patients in mental health crisis. Where appropriate, patients are referred to the mental health crisis team/ child and adolescent mental health team for urgent crisis support. Alternative support and signposting were also available for patients needing mental health support.

Equitable

Communication and language
We found that staff communicated in a clear manner and in a language appropriate to patient needs. They also provided information in a way that enabled patients to make informed decisions about their care. The surgery had a hearing loop to support those with hearing difficulties.

Patients are usually informed about the services offered through the website, social media and by sharing information and updates via a text messaging service.

Where patients were known not to have a mobile phone, letters would be sent to individuals and communicated through telephone calls.

There were processes in place with medical oversight of incoming mail relevant to specific patients. Information is appropriately reviewed and recorded promptly in the patient's medical summary. Staff described how mail would be scanned and coded with actions set for clinicians and forwarded appropriately. We reviewed an appropriate workflow policy and saw that tasks were appropriately documented. This included appropriate actions in relation to logging of interactions and follow up for practice staff if a patient interacts with Out of Hours GP services.

There are Welsh speaking GPs within the practice, however, there was an absence of notices to inform patients that Welsh speaking staff are available.

The practice should ensure that the active offer of Welsh language is promoted to patients.

Rights and equality
The practice offered good access for patients. We noted that patient areas, including treatment rooms and an accessible toilet were all located on the ground floor.

Access to the premises was generally good, providing patients with impaired mobility and wheelchair users with easy access while inside the building. However, we were told that access through the main doors to the building caused some patients difficulties, due to the width of the doors.

The practice has a buzzer system in place where patients can call for help to enter the premises. The practice also has its own wheelchair that patients can use if necessary'

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

The practice was proactive in upholding the rights of transgender patients. We were told transgender patients were treated with sensitivity and it was confirmed that their preferred names and pronouns would always be used.

Delivery of Safe and Effective Care

Safe

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

We reviewed the business continuity plan (BCP). This adequately covered the business partnership risk, pandemic risk and appropriately detailed contingencies for long-term sickness absence. We recommend that the BCP is available to all staff for clarity on responsibilities and contact details in the event of an urgent or emergency impacting the business.

The business continuity plan must be shared with all staff and a hardcopy made available to support staff in urgent or emergency situations impacting the business.

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

The process in place for managing patient safety alerts and significant incidents was robust. The deputy practice manager was responsible for receiving patient safety alerts, and we saw how these were received and disseminated to staff and communicated in meetings. Patient safety alerts were also printed and placed in a manual folder however, we suggest all alerts should also be stored on the practices electronic shared drive for easy access for staff.

The practice should store patient safety alerts on the practice's electronic shared drive for easy access for all staff.

The emergency drugs and equipment were stored appropriately, and staff were able to locate this in an emergency.

We discussed the action taken when patient home visits are requested and found staff triage all home visits before attending.

We found some items that were past their expiry date, posing a risk to patient safety. This included syringes and needles. 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 passed their expiry date.

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.

There was no specific IPC policy in place and were told that this was incorporated into the needle stick policy. The practice also has a named IPC lead, which was checked and confirmed by staff members. We recommended a local IPC policy is implemented which includes the named IPC lead.

The practice must implement an IPC policy specific to the practice and ensure the named IPC lead is included within.

The training matrix included IPC training as a mandatory for staff. All staff had completed IPC training relevant to their roles.

On review of human resource files and documentation, we found an appropriate system in place to check that all staff have immunity and/or are protected against the transmission of hepatitis B.

Suitable procedures were in place for the management and disposal of all waste, however, only a brief section was included in the Health and Safety policy to support this. We recommended that a policy is implemented specific to the practice. We noted that clinical waste was secure, with no public access. Staff told us that there had been no issues to date regarding this, but there was no formal risk assessment in place to ascertain if the security of the clinical waste collection is satisfactory.

The practice must ensure that a policy for waste management is implemented and is regularly reviewed and updated and is specific to the practice.

The practice must ensure that the security of the clinical waste is included in a formal risk assessment.

Although we were told IPC audits took place, we recommended that a more thorough IPC audit programmes is implemented to monitor against standards.

The practice must update its IPC audit to ensure it is comprehensive and aligned with current, recognised IPC standards.

There was no formal arrangement in place to segregate people with transmissible infections to reduce the risk of cross infection, although we were told that a door at the pharmacy side of the building is available, which could be utilized for reducing contact with other patients. We were also told that during Covid a small room was used as an isolation room.

The practice should formalise arrangements to segregate people with suspected transmissible infections to reduce the risk of cross infection.

Notices were displayed in the treatment rooms with information regarding sharps and waste disposal, however, we found sharps boxes in clinical treatment rooms were not closed properly or put into safety mode, therefore posing a risk for a spill hazard or needlestick injury. A needle stick injury and blood borne virus policy was in place, however, the needle stick flow chart was not in staff sight and was displayed inside of a cupboard door. To support staff further, we suggested the practice displays a needlestick injury poster clearly within treatment areas.

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

We were told that the practice had recently employed new subcontractors to provide the cleaning. On the day of the inspection there were no weekly cleaning schedules available. However, we found that the public areas, treatment rooms/consulting rooms and reception were all clean and tidy.

The practice must ensure weekly cleaning schedules are implemented.

The patients responding to the questionnaire felt there were hand sanitizers available, and that healthcare staff washed their hands before and after being treated. All respondents described the practice as ‘very clean’ or ‘clean’.

Medicines management
Processes were in place to ensure the safe prescribing of medication. The process for patients to request repeat medication was clear.

Most prescriptions were directed straight to the adjoining pharmacy. A log is maintained of all prescriptions that are managed in this way. Prescriptions can also be collected at the reception desk, where a check of name, address and date of birth is conducted, and a record is kept.

Staff had undertaken training via the health boards medicine management course.

We saw that prescription pads were securely stored in a locked cupboard. We were told there was a process in place to securely dispose of prescription pads when a GP leaves the practice.

The practice had staff trained in repeat prescribing which is supervised by one senior member of staff. The GP's authorise any actions or reauthorisations.

There was a cold chain process in place for medications or vaccines that required refrigeration. There were dedicated clinical refrigerators for certain items, such as vaccines. Daily checks were completed and the documentation we reviewed confirmed this. Conversations with staff confirmed that they were aware of the upper and lower temperature and what to do in the event of a breach to the cold chain. We were told there was a rotation system for vaccines, the new medications are put at the back of the fridges and older stock at the front. They also spread-out stock between four fridges.

The GP's complete the medication reviews which we were told was tied in with re-authorising. The practice has a repeat prescribing policy in place but no general prescribing policy at present.

The practice should ensure there is a general prescribing policy in place.

No controlled drugs were kept at the practice.

Safeguarding of children and adults
The practice had a named safeguarding lead for adults and children. Staff had access to practice safeguarding policies and procedures, which were ratified, up to date and included contact details of designated leads. However, not all staff had completed safeguarding training at the required level.

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.

On review of patient records, we saw examples where people were appropriately flagged subject to any safeguarding concerns and followed a suitable safeguarding pathway. However, it was not easy for all relevant staff to identify children subject to the child protection register.

The practice must ensure a process is implemented to ensure relevant staff are aware of children subject to the child protection register, and for those removed from the register and that this is appropriately coded in child records.

Management of medical devices and equipment
The practice had processes in place to safely maintain equipment. We found all equipment was in a good condition, well maintained with appropriate electrical checks had been carried out. There were contracts in place for maintenance and calibration of equipment as appropriate, and for any emergency repairs and replacement.

There were appropriate resuscitation equipment and emergency drugs in place to manage a patient emergency, such as cardiac arrest. We saw evidence that the checking of the drugs and emergency equipment was being recorded appropriately and this was completed weekly. These met the primary care equipment standards as outlined by the Resuscitation Council UK guidance.

We found that staff had completed appropriate training for medical emergencies, and all clinical staff had undertaken appropriate basic life support training.

Effective

Effective care
Processes were in place to support safe and effective care, and this included the process for receiving treatment or care across the GP cluster and wider primary care services. We found good examples of acute and chronic illness management, and clear narrative with evidence of patient centred decision making.

There was an appropriate system in place for reporting incidents, and any shared learning was completed within team meetings. However, these were often informal meetings, and no minutes or actions were taken.

Staff meeting minutes should be recorded and actions documented, and shared with all staff

We were told that any changes or new guidance is shared with staff via email and discussed with staff as appropriate, and the information is stored on the shared drive for all staff to access.

Appropriate processes were in place for reporting incidents, including discussions at internal clinical meetings and logs kept.

Patient referrals were managed to a good standard, including those which are urgent. Patient records contained investigation/ test results and had narrative as to why investigations were requested.

Patient records

We reviewed 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 complete with appropriate information. They were contemporaneous and information was easy to understand for other clinicians reviewing the records.

We found good and consistent use of clinical read codes, which makes analysis and audit easier. The patient records where chronic disease was recorded contained a full summary of conditions, including all past and continuing problems, as well as the medication being taken. However, medication review rates were poorly documented.

The practice must ensure that medication review coding and linkage of medications to clinical conditions is improved, and annual medication reviews are completed.

We were told that non-clinical staff are used to summarise patient information, and 'on the job' training is provided to new staff responsible for summarising. However, there is no formal training process in place or documents to support staff with coding, nor is there a formal audit of summarising accuracy.

The practice should implement formal training for summarising and coding, and annual audits completed on the accuracy of that summarised and coded.

The continuity of care was good, with close oversight and supervision of patients and patients records by all the GPs. The records we reviewed, evidenced good quality patient consultations.

When considering patient language preference, the only language able to record was Welsh, therefore making it difficult to ensure patients are support in their language of choice.

The practice must ensure that all patient language preferences are recorded and easily identified in their clinical records.

Efficient

Efficient

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

The practice can refer patients to physiotherapy and mental health services, however, there is currently no counselling service available via the cluster group.

The practice should engage with the cluster to ensure timely access to patient counselling services to support their mental health and wellbeing.

The pharmacy service within the cluster offers advice and support with patient medication queries.

Quality of Management and Leadership

We engaged with staff throughout our inspection and sought feedback through a staff questionnaire. Some comments included:

> *"Excellent surgery to work in. Supportive caring colleagues both in reception staff to nurses to doctors to admin and management. Lovely place to work."*

> *"I love this job and the colleagues I work with we all wish this was our own gp practice. We are a great work family here. We work well together and we offer our patients a safe efficient and well managed surgery. The best work environment I have worked in"*

Leadership

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

Leaders confirmed that there was an open-door policy for staff to share concerns and ideas for the practice.

We were told staff meetings were routine, however, minutes were not formally recorded. Where appropriate, nursing and non-clinical staff should also be involved in staff meetings. Recording and sharing meeting minutes has been highlighted and addressed earlier in the report.

We reviewed a comprehensive suite of policies and procedures. They were reviewed and updated regularly and were accessible to all staff via the shared drive. There was an effective document control system in place.

Workforce

Skilled and enabled workforce
All staff we spoke with confirmed they had opportunities to attend relevant training. We were provided with evidence that most staff had completed mandatory training, and plans were in place for staff to renew their training where applicable.

We found evidence that annual appraisals for most staff had been completed, and any additional training needs were identified to support professional development. Whilst a system was in place to monitor most individual staff training compliance, this was not collated within a training matrix for the GP's, to easily identify who had completed training (or not).

The practice should include the GPs training records and all other staff within a training matrix to monitor mandatory training compliance.

There were appropriate recruitment policies and procedures in place, and the practice manager described the required pre-employment checks for any new members of staff before they joined the practice. This included checking of references and undertaking Disclosure and Barring Service (DBS) checks appropriate to their role. However, on review of the practices recruitment policy there was no reference made on safe recruitment checks, such as how many references, evidence of hepatitis B immunity and professional qualifications. However, a review of three staff records showed that no information was missing from their files.

The practice must ensure all employment information is collected and saved within each staff members personal file.

Culture

People engagement, feedback and learning
The practice sought patient feedback. Information was displayed detailing how people could feedback on their experiences as well as a comments, feedback and suggestions box in the patient waiting area. However, there was no evidence to demonstrate that patient feedback is routinely used by the practice to learn and inform service improvement.

The practice must ensure that any patient experience feedback is used to help inform service improvement and enhance the patient experience.

A complaints procedure and policy was in place which 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. An effective complaints tracking system was in place to monitor, review and resolve complaints and feedback. However, we did not see any evidence of shared learning via meetings and appraisals.

The practice should consider how learning and improvement from complaints is shared with all staff.

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, however the records we reviewed showed not all staff had completed training on this topic, training was scheduled for November 2024. The members of staff who completed a questionnaire agreed that they knew and understood their role in line with Duty of Candour.

The practice must ensure all staff are supported to access training for the Duty of Candour.

Information

Information governance and digital technology

We considered the arrangements in place for patient confidentiality and compliance with Information Governance and the General Data Protection Regulations (GDPR) 2018. We saw evidence of patient information being stored securely.

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.

Learning, improvement and research

Quality improvement activities

The practice engaged in learning from internal and external reviews, including incidents and complaints. We were told learning was shared across the practice via regular staff meetings to make improvements, however, as highlighted earlier, there was no evidence of minutes and action logs taken.

Whole-systems approach

Partnership working and development

We found evidence of partnership working with the practice's collaboration within a GP cluster. Medical staff attended cluster meetings and provided services on a cluster wide basis.

4. Next steps

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

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

The improvement plans should:

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

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

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

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

Appendix A – Summary of concerns resolved during the inspection

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

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

Appendix B - Immediate improvement plan

Service: Meddygfa Canna Surgery

Date of inspection: 10 December 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
No immediate concerns were identified on this inspection					

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

Service representative:

Name (print):

Job role:

Date:

Appendix C - Improvement plan

Service: Meddygfa Canna Surgery

Date of inspection: 10 December 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.	The practice offered chaperones in all appropriate circumstances, and there was a chaperone policy in place. A chaperone information notice was displayed on the front reception desk, however, not all clinical treatment rooms had notices indicating that this service was available.	**The practice must ensure that information is available to patients regarding the option of a chaperone in all clinical treatment rooms**	Health & Care Quality Standards – Information	Ensure chaperone notices are displayed in each clinical room (already put in place following inspection visit).	Mr C Wiliams	Already completed

2.	There are Welsh speaking GPs within the practice, however, there was an absence of notices to inform patients that Welsh speaking staff are available.	**The practice should ensure that the active offer of Welsh language is promoted to patients.**	Health & Care Quality Standards – Information	Notices advising of availability of Welsh speaking staff put in Reception. (Completed on day of inspection)	Mr C Wiliams	Already completed
3.	We reviewed the business continuity plan (BCP). This adequately covered the business partnership risk, pandemic risk and appropriately detailed contingencies for long-term sickness absence. We recommend that the BCP is available to all staff for clarity on responsibilities and contact details in the event of an urgent or emergency impacting the business.	**The business continuity plan must be shared with all staff and a hardcopy made available to support staff in urgent or emergency situations impacting the business.**	Health & Care Quality Standards – Information	Ensure BCP is available on staff shared drive. Hard copy available to all staff in Reception. Hard copy available in Safe	Mr C Williams	By 31.03.25

4.	The process in place for managing patient safety alerts and significant incidents was robust. The deputy practice manager was responsible for receiving patient safety alerts, and we saw how these were received and disseminated to staff and communicated in meetings. Patient safety alerts were also printed and placed in a manual folder however, we suggest all alerts should also be stored on the practices electronic shared drive for easy access for staff.	**The practice should store patient safety alerts on the practice's electronic shared drive for easy access for all staff.**	Health & Care Quality Standards – Information; Safe	Ensure all alerts are stored on the shared drive. Paper copies available at Reception in case of computer issues.	Mr C Williams	By 31.03.25
5.	We found some items that were past their expiry date, posing a	**The practice must review the stock room contents and remove all**	Health & Care Quality Standards – Information; Safe	Process put in place to check all stock in each clinical room when	Mrs A Rogers	Already completed

	risk to patient safety. This included syringes and needles. These must be removed to prevent their use when undertaking patient care.	**equipment/personal protective equipment which have passed their expiry date.**		checking emergency drugs and resus equipment. (Added to checklist on day of inspection)		
6.	There was no specific IPC policy in place and were told that this was incorporated into the needle stick policy. The practice also has a named IPC lead, which was checked and confirmed by staff members. We recommended a local IPC policy is implemented which includes the named IPC lead.	**The practice must implement an IPC policy specific to the practice and ensure the named IPC lead is included within.**	Health & Care Quality Standards – Information; Safe	IPC being obtained from Lead Nurse at LHB. Once available this will be adopted.	Mrs A Rogers	By 31.03.25
7.	Suitable procedures were in place for the management and disposal of all waste,	**The practice must ensure that a policy for waste management is implemented and is**	Health & Care Quality Standards – Information; Safe	Waste Management Policy and 3 monthly audits will take place	Mr C Williams	By 31.03.25

	however, only a brief section was included in the Health and Safety policy to support this. We recommended that a policy is implemented specific to the practice.	**regularly reviewed and updated and is specific to the practice.**		following inspection visit. Separate policy to be adopted.		
8.	We noted that clinical waste was secure, with no public access. Staff told us that there had been no issues to date regarding this, but there was no formal risk assessment in place to ascertain if the security of the clinical waste collection is satisfactory.	**The practice must ensure that the security of the clinical waste is included in a formal risk assessment.**	Health & Care Quality Standards – Information; Safe	Undertake risk assessment.	Mr C Williams	By 24.02.25
9.	Although we were told IPC audits took place, we recommended that a more thorough IPC	**The practice must update its IPC audit to ensure it is comprehensive and aligned**	Health & Care Quality Standards – Information; Safe	Audit will be in place once IPC policy has been updated. (As per 6 above)	Mrs A Rogers	By 31.03.25

	audit programmes is implemented to monitor against standards.	**with current, recognised IPC standards.**				
10.	There was no formal arrangement in place to segregate people with transmissible infections to reduce the risk of cross infection, although we were told that a door at the pharmacy side of the building is available, which could be utilized for reducing contact with other patients. We were also told that during Covid a small room was used as an isolation room.	**The practice should formalise arrangements to segregate people with suspected transmissible infections to reduce the risk of cross infection.**	Health & Care Quality Standards – Information; Safe	Adopt policy and disseminate to staff with a copy added to shared drive.	Mr C Williams	By 31.03.25
11.	Notices were displayed in the treatment rooms with information regarding	**The practice should consider displaying a needlestick injury management poster in**	Health & Care Quality Standards – Information; Safe	Poster to be displayed in all clinical rooms.	Mrs A Rogers	Done

	sharps and waste disposal, however, we found sharps boxes in clinical treatment rooms were not closed properly or put into safety mode, therefore posing a risk for a spill hazard or needlestick injury. A needle stick injury and blood borne virus policy was in place, however, the needle stick flow chart was not in staff sight and was displayed inside of a cupboard door. To support staff further, we suggested the practice displays a needlestick injury poster clearly within treatment areas.	**treatment rooms to support staff following any sharps injuries.**				
12.	We were told that the practice had recently employed new	**The practice must ensure weekly cleaning schedules are implemented.**	Health & Care Quality Standards – Information; Safe	New contractors instructed to provide weekly cleaning	Mr C Williams	By 31.03.25

	subcontractors to provide the cleaning. On the day of the inspection there were no weekly cleaning schedules available. However, we found that the public areas, treatment rooms/consulting rooms and reception were all clean and tidy.			schedules and monthly audit/spot check reports to PM for inclusion in cleaning logbook.		
13.	The GP's complete the medication reviews which we were told was tied in with re-authorising. The practice has a repeat prescribing policy in place but no general prescribing policy at present.	**The practice should ensure there is a general prescribing policy in place.**	Health & Care Quality Standards – Information; Safe	New policy to be adopted.	Partners	By 31.03.25
14.	The practice had a named safeguarding lead for adults and	**The practice must ensure all staff undertake the required level of**	Health & Care Quality Standards –	All staff have completed training to the required levels	Mr C Williams	Done

	children. Staff had access to practice safeguarding policies and procedures, which were ratified, up to date and included contact details of designated leads. However, not all staff had completed safeguarding training at the required level.	**safeguarding training (both children and adult) appropriate to their role, and a record should be kept to evidence this.**	Information; Safe; Workforce	and are included in the mandatory training log. Certificates have been added to staff files.		
15.	On review of patient records, we saw examples where people were appropriately flagged subject to any safeguarding concerns and followed a suitable safeguarding pathway. However, it was not easy for all relevant staff to identify children subject to the child protection register.	**The practice must ensure a process is implemented to ensure relevant staff are aware of children subject to the child protection register, and for those removed from the register and that this is appropriately coded in child records.**	Health & Care Quality Standards – Information; Safe; Workforce	Partners to ensure appropriate coding of children on the register.	Partners	Ongoing

16.	There was an appropriate system in place for reporting incidents, and any shared learning was completed within team meetings. However, these were often informal meetings and no minutes or actions were taken.	**Staff meeting minutes should be recorded and actions documented, and shared with all staff**	Health & Care Quality Standards – Information; Workforce	Formal meetings and sharing of incidents, outcomes and learning points minutes on shared drive going forward.	Mr C Williams	Ongoing
17.	We found good and consistent use of clinical read codes, which makes analysis and audit easier. The patient records where chronic disease was recorded contained a full summary of conditions, including all past and continuing problems, as well as the medication being taken. However, medication review	**The practice must ensure that medication review coding and linkage of medications to clinical conditions is improved, and annual medication reviews are completed.**	Health & Care Quality Standards – Information; Safe;	All clinicians to ensure medication is linked to a problem. PM to review settings for new staff to ensure this happens automatically.	Partners Mr C Williams	Ongoing

	rates were poorly documented.					
18.	We were told that non-clinical staff are used to summarise patient information, and 'on the job' training is provided to new staff responsible for summarising. However, there is no formal training process in place or documents to support staff with coding, nor is there a formal audit of summarising accuracy.	**The practice should implement formal training for summarising and coding, and annual audits completed on the accuracy of that summarised and coded.**	Health & Care Quality Standards – Information; Safe; Workforce	Summarising audit protocol to be adopted and assigned clinician to carry out regular audit of notes summarising.	Mr C Williams	By 31.03.25
19.	When considering patient language preference, the only language able to record was Welsh, therefore making it difficult to ensure patients are support in	**The practice must ensure that all patient language preferences are recorded and easily identified in their clinical records.**	Health & Care Quality Standards – Information	All language preferences are recorded on the yellow flag within the patient record.	All staff	Ongoing

	their language of choice.					
20.	The practice can refer patients to physiotherapy and mental health services, however, there is currently no counselling service available via the cluster group.	**The practice should engage with the cluster to ensure timely access to patient counselling services to support their mental health and wellbeing.**	Health & Care Quality Standards – Information; Timely	This has been raised at cluster level and due to lack of available funding. All counselling requests are triaged by PMHSS and then added to counselling waiting lists accordingly. Practice has fully engaged and worked with cluster as utilitises community connectors and wellbeing officers provided across the cluster.	N/A	N/A
21.	We found evidence that annual appraisals for most staff had been completed, and any additional training needs were identified to support professional	**The practice should include the GPs training records and all other staff within a training matrix to monitor mandatory training compliance.**	Health & Care Quality Standards – Information; Workforce	All GPs will be added to training matrix.	Mr C Williams	Ongoing

	development. Whilst a system was in place to monitor most individual staff training compliance, this was not collated within a training matrix for the GP's, to easily identify who had completed training (or not).					
22.	There were appropriate recruitment policies and procedures in place, and the practice manager described the required pre-employment checks for any new members of staff before they joined the practice. This included checking of references and undertaking Disclosure and Barring Service (DBS) checks	**The practice must ensure all employment information is collected and saved within each staff members personal file.**	Health & Care Quality Standards – Information; Workforce	Policy to be reviewed to include those items highlighted. Ensure references and Hep B status are recorded for all staff.	Mr C Williams	By 31.03.25

	appropriate to their role. However, on review of the practices recruitment policy there was no reference made on safe recruitment checks, such as how many references, evidence of hepatitis B immunity and professional qualifications. However, a review of three staff records showed that no information was missing from their files.					
23.	The practice sought patient feedback. Information was displayed detailing how people could feedback on their experiences as well as a comments, feedback	**The practice must ensure that any patient experience feedback is used to help inform service improvement and enhance the patient experience.**	Health & Care Quality Standards – Information;	All patient feedback is discussed at practice meetings and used to inform service improvements. Results of patient surveys have recently	N/A	N/A

	and suggestions box in the patient waiting area. However, there was no evidence to demonstrate that patient feedback is routinely used by the practice to learn and inform service improvement.			been discussed at cluster level. All patient comments are discussed and where improvements can be made, they are implemented. (Recent recommendation to improve outdoor bike storage has been completed in last few weeks).		
24.	A complaints procedure and policy was in place which 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	**The practice should consider how learning and improvement from complaints is shared with all staff.**	Health & Care Quality Standards – Information;	All complaints and compliments will be shared with the appropriate members of staff and learning points added to the shared drive.	Partners Mr C Williams	Ongoing

	procedure documents. Complaints/concerns are monitored to identify any themes and trends, and any actions for improvement are communicated to staff. An effective complaints tracking system was in place to monitor, review and resolve complaints and feedback. However, we did not see any evidence of shared learning via meetings and appraisals.					
25.	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, however the records we reviewed showed not all staff	**The practice must ensure all staff are supported to access training for the Duty of Candour.**	Health & Care Quality Standards – Information; Workforce	All staff have completed awareness training since the inspection visit. All records updated on the training matrix.	Mr C Williams	Completed

had completed training on this topic, training was scheduled for November 2024. The members of staff who completed a questionnaire agreed that they knew and understood their role in line with Duty of Candour.					

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): **Mr C Williams**

Job role: **Practice Manager**

Date: **03.02.2025**