Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report
(Announced)
Gower Medical Practice (Scurlage), Swansea Bay 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 Gower Medical Practice (Scurlage), Swansea Bay University Health Board on 10 July 2025.

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

During the inspection we invited patients 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 13 questionnaires were completed by patients 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.

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:

Our inspection found that Gower Medical Practice (Scurlage) demonstrated a strong commitment to person-centred, dignified, timely, and equitable care. All patients who completed a Healthcare Inspectorate Wales (HIW) questionnaire rated the service as either ‘very good’ or ‘good’, praising the knowledge, empathy, and professionalism of clinical staff. Comments reflected a consistently positive experience, with patients feeling well-supported and valued. However, one patient noted a disconnect between consultations and the communication of results, indicating an area for the practice to reflect on.

Health promotion at the practice was particularly well-developed, with up-to-date resources offered in various formats and through multiple channels. The winter vaccination campaign was a clear example of inclusive and well-structured communication, tailored to the needs of both digitally engaged and digitally excluded patients.

The practice’s approach supported patients in making informed decisions about their health, in keeping with the principle of person-centred care. Privacy and dignity were generally well-maintained during consultations, supported by appropriate physical arrangements and a written chaperone policy.

Access to timely care was another strength, with multiple routes available for patients to request appointments and an efficient triage system managed by GPs. The practice offered good availability of appointments, prioritised urgent needs, and made efforts to provide continuity of care by scheduling patients with their usual GP wherever possible. However, elements of the practice’s access policy referenced NHS England services, which should be amended to reflect the correct context for Welsh patients.

The practice also demonstrated strong equity of access through its inclusive communication strategies and accessible facilities. A wide range of formats and tools supported patients with communication difficulties, and staff were familiar with translation services. However, more consistent implementation of the Welsh Government’s ‘Active Offer’ would strengthen bilingual communication, as most signage was in English only.

Rights and equality were supported through practical measures such as an accessible building layout, workplace initiatives to promote staff wellbeing, and respectful practices towards transgender patients. Nonetheless, the practice must ensure all staff complete mandatory training in equality and diversity and maintain accurate records of training completion.

This is what we recommend the service can improve:

- Review and update the access policy to remove references to NHS England services and ensure alignment with the Welsh healthcare system
- Develop and implement a formal workflow policy for the management of incoming correspondence from secondary care, supported by an audit process to maintain oversight and reduce the risk of missed actions
- Ensure that all staff complete mandatory equality and diversity training and that training records are kept up to date to demonstrate compliance and support inclusive practice.

This is what the service did well:

- Delivered a well-coordinated and inclusive winter vaccination programme, utilising diverse communication methods to effectively engage all eligible patient groups, including those without digital access
- Maintained a strong commitment to accessible communication by providing health information in a wide range of formats and languages, ensuring equitable access for patients with varied communication needs.

Delivery of Safe and Effective Care

Overall summary:

The delivery of safe and effective care at Gower Medical Practice (Scurlage) was generally well managed, though several areas required improvement to ensure full compliance with national standards and to protect patient and staff safety.

The clinical environment was largely safe and appropriately maintained, but our inspection identified several issues that needed to be addressed. These included dust and cobwebs across all areas of the practice, outdated or unused medical equipment stored in clinical and non-clinical rooms, and visible water damage in a corridor ceiling. Such issues, though not immediately hazardous, pose risks to infection control and overall safety.

The presence of expired sharps containers and inconsistent waste storage practices, including an unsecured clinical waste bin, highlighted lapses in safe disposal procedures. Some of which were addressed during the inspection, but the service must ensure robust systems are in place to prevent recurrence.

Infection prevention and control (IPC) arrangements were partially compliant. While there was a clear policy framework and designated IPC leadership, some clinical areas still included fabric-covered furniture and carpeted flooring, both of which were contrary to best practice IPC guidelines. Additionally, cleaning schedules were not consistently completed and an up-to-date IPC audit was not available. To ensure effective infection control, the practice must conduct regular audits and address these environmental shortcomings.

Medicines were generally managed safely. Prescriptions and cold chain processes for vaccines were handled with care, and emergency equipment was in place and well maintained. However, staff had not been trained in the safe use of integrated valve medical gas cylinders from BOC, and expiry dates on emergency medicines were not routinely checked. These gaps must be addressed to maintain the integrity of emergency response capabilities.

Safeguarding practices were supported by current policies and multi-agency working, but improvements were needed. Not all staff had completed safeguarding training at the appropriate level, and the safeguarding policy lacked the name of the designated lead. Additionally, identifiable patient information had been inappropriately included in safeguarding meeting minutes. These concerns must be rectified to uphold data protection standards and ensure effective safeguarding procedures.

The practice supported effective care delivery through good clinical decision-making, team collaboration, and appropriate engagement with external services. Patient records were clear and generally well maintained, with evidence of person-centred care and appropriate coding. However, some discharge summaries were not fully coded, and medications were not always linked to a patient's clinical presentation. Furthermore, intimate examinations were not consistently documented with patient consent or chaperone offers, which must be standardised across all relevant encounters.

The practice demonstrated efficiency through strong multidisciplinary working and integration with local community services. Preventative health initiatives, such as the Diabetes Prevention Programme and wellbeing prescriptions, were effectively used to support patient health and reduce unnecessary hospital admissions. Mental health and vulnerable patient pathways were supported through regular access to clinicians and local support groups.

This is what we recommend the service can improve:

- Improve infection prevention and control measures by replacing fabric-covered furniture and carpeted flooring in clinical areas, completing regular IPC audits, and ensuring cleaning schedules are consistently followed

- Strengthen clinical governance by ensuring documentation of patient consent and chaperone offers during intimate examinations is complete and consistent across all records

- Enhance staff safety and training by ensuring all clinical staff receive appropriate safeguarding and medical gas cylinder handling training, and maintain up-to-date immunity checks for blood-borne viruses

- Ensure waste management protocols, including secure storage and correct use of sharps bins, are fully adhered to.

This is what the service did well:

- Maintained strong multidisciplinary working, including access to a mental health clinician, collaboration with community services, and participation in initiatives like the Diabetes Prevention Programme, which supported holistic and preventative patient care

- Implemented a robust home visit policy that included structured risk assessments for patient and clinician safety, reflecting a proactive and thoughtful approach to care delivery outside the practice setting

- Ensured secure handling of prescriptions and effective cold chain management for vaccines, with clearly documented processes that supported the safe and efficient delivery of medicines.

Quality of Management and Leadership

Overall summary:
Our inspection found that Gower Medical Practice (Scurlage) benefited from committed leadership and a positive working culture, with a clear focus on patient care, staff support, and service improvement.

Staff feedback was mostly positive, with all respondents indicating that they felt equipped for their roles, empowered to contribute ideas, and supported in delivering patient-centred care. Staff described a cohesive and pleasant working environment, with regular opportunities for professional development.

Leadership at the practice was visible and approachable, and the management team fostered a collaborative culture across both practice sites. Staff roles and responsibilities were clearly defined, supported by effective communication methods such as team meetings and digital messaging platforms. Designated leads were in place for key areas, including safeguarding, infection prevention and control, and nursing, ensuring staff had clear guidance and accountability.

The practice was actively engaged in clinical audit and service improvement, using patient feedback and audit data to identify trends and inform learning. Innovations such as the 'AskMyGP' digital platform and the use of artificial intelligence (AI) administrative tools highlighted a forward-thinking approach to improving efficiency and patient communication.

Participation in wider system-level initiatives, including cluster meetings and prescribing reviews, demonstrated a commitment to integrated care.

However, several governance and workforce-related areas required improvement. Our review of staff files revealed that some pre-employment documentation, including Disclosure and Barring Service (DBS) checks and references, was missing or incomplete. Additionally, the training matrix showed inconsistent compliance with mandatory training across both clinical and administrative staff, including gaps in safeguarding and Duty of Candour training. The practice must implement a robust system for monitoring and ensuring up-to-date training compliance for all staff.

While the practice had a whistleblowing policy and staff felt confident in raising concerns, the visibility of the complaints and 'Putting Things Right' process for patients needed to be improved within the practice environment.

Information governance systems were found to be robust, with secure storage of records and appropriate policies in place. The practice also demonstrated a strong commitment to partnership working, maintaining effective relationships with local health board partners and community services to support patient outcomes and system-wide care coordination.

This is what we recommend the service can improve:

- Ensure all staff complete and remain compliant with mandatory training, including safeguarding and Duty of Candour, and implement a system to monitor training compliance effectively

- Strengthen recruitment procedures by ensuring all necessary pre-employment checks are completed and documented, including DBS certificates and references for all staff

- Improve the visibility of the complaints and ‘Putting Things Right’ process within the practice to support patient awareness and accessibility.

This is what the service did well:

- Fostered a supportive and open working culture, where staff felt empowered to contribute to improvements and had access to a range of wellbeing resources, including national mental health support programmes

- Embraced innovation using digital tools such as ‘AskMyGP’ and AI-driven administrative support, enhancing patient communication and operational efficiency

- Actively engaged in partnership working with local health and care providers, contributing to coordinated, system-wide care and improving patient outcomes through collaborative pathways.

3. What we found

Quality of Patient Experience

Patient feedback

We received mostly positive feedback from the 13 patients who completed a HIW questionnaire. All respondents rated the service provided by Gower Medical Practice (Scurlage) as either 'very good' or 'good'.

Patient comments included:

> *"Fantastic service in every respect."*
>
> *"Always excellent service and advice."*
>
> *"[Doctor] is knowledgeable, caring and supportive. She has been incredibly gentle, kind and sensitive with my girls. Thank you."*
>
> *"There's a disconnect between seeing a Dr and receiving results."*

Person-centred

Health promotion

The practice offered a range of health promotion materials, including leaflets, workshops, and digital resources that were tailored to meet the specific needs of the local population. This included information on common illnesses, screening campaigns, mental health, and carers support. Information was of good quality and up to date.

Information about the practice was available on the practice website and within a leaflet distributed to patients upon registration. The practice's website provided accessible and relevant information, supporting patients in making informed decisions about their health and wellbeing.

Preparations by the practice to manage the annual winter vaccination programme were suitable and included a range of communication methods used to promote the programme and inform eligible patients, including letters, text messages, social media, a banner on the 'AskMyGP' app, and updates on the practice website.

Preparations for the programme were found to be well-organised and inclusive, with appropriate arrangements in place to support vulnerable patients and those without digital access.

Dignified and respectful care

There were satisfactory arrangements in place to promote patients' privacy and dignity. Doors to consulting rooms were closed when patients were being reviewed, and consulting rooms also had privacy curtains that could be used when patients were undressing or being examined. All but one respondent to the patient questionnaire felt they were treated with dignity and respect, and that measures were taken to protect their privacy.

An up-to-date written policy was in place in relation to the use of chaperones, and staff had completed formal chaperone training. A chaperone information notice was displayed in the waiting areas. However, we noted that the recording of the offer of a chaperone and whether this offer had been accepted or rejected by the patient, along with the details of any chaperone present, was not always entered into patient records.

The practice must ensure that the offer of a chaperone and the decision made by the patient, along with the details of any chaperone present, is entered into patient medical records in accordance with General Medical Council (GMC) guidelines.

Timely

Timely care

The practice had an up-to-date access policy in place, clearly outlining the arrangements for patients to access care in a timely manner. However, the policy included links to services provided by NHS England, which may not be applicable to patients in Wales.

The practice must review the policy to ensure all referenced services are appropriate for the Welsh healthcare context.

The practice offered patients multiple routes to access care, including telephone contact, digital requests via the ‘AskMyGP’ platform, and in-person visits to the reception desk. All appointment requests, regardless of the method of contact, were triaged by a GP who determined the most appropriate type and timing of appointment.

Patients could request either a face-to-face or telephone consultation, and these preferences were usually accommodated unless there was a clinical reason to advise otherwise. The practice demonstrated a strong commitment to continuity of care by aiming to allocate patients to their usual GP wherever possible. Urgent patients were seen on the same day, and most cases were prioritised to be seen either the same or next day.

When the 'AskMyGP' system approached capacity, the practice continues to accept requests via telephone, ensuring no patient is left without access to urgent advice and support. Signposting to alternative services such as direct access physiotherapy, optometry, and community pharmacy was also in place. The practice reported good appointment availability and believed there were no barriers to access for patients who were digitally excluded.

All patients who responded to the questionnaire reported being able to contact their GP practice when needed, either via telephone or the online booking system. All respondents also indicated that they were offered a choice of appointment type—whether in-person, via virtual video link, or by telephone. Of the 13 respondents, 11 stated they were able to access a same-day appointment when requiring urgent care.

Patients experiencing mental health concerns could access the practice through the same routes as other patients—via 'AskMyGP', telephone, or in person. The practice had access to a mental health liaison worker who supported the assessment and management of lower-level mental health needs, while urgent or emergency cases were referred to the crisis team.

A single point of access was used for referrals to secondary care, with the practice reporting generally good response times for urgent assessments. Overall, the practice reported good support from secondary care services and did not identify significant issues with access to mental health care.

Equitable

Communication and language

The practice demonstrated a strong commitment to accessible and inclusive communication. A range of health promotion materials were available in the waiting area, and new patients were provided with links to online resources to support their health and wellbeing.

All staff who completed a questionnaire said there were alerts on the patient records to inform them of any communication difficulties patients may have. To meet diverse communication needs, the practice offered patient information in multiple formats, including braille, audio CD, Easy Read, large print, and picture boards. A hearing loop and magnifying glass were also available to support patients with hearing or visual impairments.

The practice used a variety of communication methods—such as text messages, letters, telephone calls, the practice website, and a local Facebook page to inform patients about services and important updates. Banners were also displayed on the 'AskMyGP' platform and the practice website. Notice boards within the surgery were used to share key messages, and staff had received communication training, including Paul Ridd training sessions.

We were told there were no fluent Welsh speaking staff at the practice and that some staff were undertaking Welsh language training. As part of the Welsh Government's 'Active Offer' initiative, all practice information and signs should be bilingual. We saw that some signs and posters were available in Welsh, however, most were available in English only.

Although the number of Welsh-speaking staff was limited, this was considered appropriate for the language needs of the local population.

The practice must ensure that the 'Active Offer' of Welsh language is promoted to patients.

Staff reported that they were able to accommodate known language or communication needs and were familiar with translation services such as Language Line. Additionally, the practice website was available in both Welsh and English.

The practice had processes in place for the recording and sharing of information received from secondary care. Incoming correspondence, including clinical letters and discharge summaries, were allocated to the appropriate GP, who reviewed the content, coded relevant information, and marked any actions for administrative staff to complete.

The practice reported a typical turnaround time of 48 hours for processing incoming mail. However, there was no formal workflow policy in place to guide the consistent and effective management of this information. The development of such a policy would help ensure that all correspondence is handled in a timely and standardised manner, reducing the risk of missed actions or incomplete coding.

The practice must implement a workflow policy to provide clear guidance to staff.

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. The practice also had its own wheelchair that patients could use, if required. Patients were also able to request a home visit if access to the practice was an issue.

All patients who completed a questionnaire and attended the practice for their appointment said that the building was easily accessible, and that there were enough seats in the waiting area.

We saw evidence of an up-to-date equality and diversity policy in place; however, it was unclear whether all staff had completed equality and diversity training.

The practice must ensure that mandatory training in equality and diversity takes place for all staff, and a log of training completion is kept.

The practice has introduced several workplace initiatives to support equality, diversity and inclusion. These include flexible arrangements such as phased retirement and phased return-to-work practices. In recognition of the impact of menopause on staff wellbeing, the practice had also implemented supportive measures such as providing cooling fans and adopting a relaxed uniform policy.

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 environment was generally well maintained and appeared safe for patients and staff. During the inspection we observed dust and cobwebs in most areas of the building.

The practice must ensure the scheduled cleaning programme is being delivered in accordance with the cleaning contract. Cleaning schedules should be consistently followed, with six-monthly audits carried out regularly to monitor and maintain cleaning standards.

We observed that some rooms contained old and unused equipment. The storage of such items within treatment areas may pose a health and safety risk. In addition, the training room contained outdated medical textbooks and procedural documents.

The practice must undertake a review of all clinical and non-clinical areas to remove outdated materials and unused equipment.

We observed evidence of water damage on the ceiling in the corridor near the reception area. Although we were informed that the source of the leak had been repaired, staining and damage remained visible.

We reviewed the practice's business continuity plan; however, it did not include consideration of partnership risks or outline contingency arrangements in the event of a GP retirement.

The practice must update the business continuity plan to include a reference to partnership risk, specifically noting that while one partner is leaving, a replacement has already been identified.

The practice had an up-to-date home visit policy in place, which clearly outlined the procedures for triaging and prioritising home visit requests. Importantly, it also required a risk assessment to be completed prior to any visit, considering both patient and clinician safety. **This was an area of noteworthy practice.**

The practice had a process in place for managing patient safety alerts and significant incidents. The practice manager was responsible for receiving and

disseminating safety alerts to relevant staff members. While this system was functioning effectively, the responsibility currently rested with a single individual. To strengthen resilience and ensure continuity in the absence of the practice manager, it was advised that a second member of staff be nominated to support this function.

Infection, prevention and control (IPC) and decontamination

The practice had an appointed IPC lead, and staff were aware of their roles and responsibilities in maintaining IPC standards, recognising that IPC was a shared responsibility. A site-specific IPC policy was in place and available in the nurses' room, alongside an up-to-date blood-borne virus policy. Staff accessed current IPC guidance through online education platforms and email updates.

During our inspection, a portable radio was observed on the floor in the corridor outside the nurses' room, and it was noted to be dusty and a potential trip hazard. Our concern regarding this was dealt with during the inspection. Further information on the issues we identified, and the actions taken by the service, are provided in Appendix A.

Most clinical rooms were equipped with sinks with elbow-operated taps, hand hygiene products, and foot-operated bins. However, some rooms contained fabric curtains, pillows, and non-wipeable chairs, which did not meet IPC best practice standards. Additionally, while vinyl flooring had been installed in most clinical areas, some consulting rooms, potentially in use, still had carpet, which breached IPC best practice.

The practice must ensure that:

- **Fabric covered pillows and chairs in clinical areas are replaced within a reasonable timeframe**
- **Regular cleaning of fabric curtains occurs in accordance with current IPC guidelines or consider transitioning to disposable alternatives to support effective infection control. Clear documentation is maintained to evidence the frequency and dates of curtain changes or laundering.**
- **They continue to mitigate IPC risks related to carpet flooring and continue with the programme of carpet replacement for patient areas.**

The practice did not use reusable medical instruments and therefore did not require a sterilisation policy. Cleaning schedules were displayed on the backs of doors but were not consistently completed. At the time of the inspection, a

completed Infection Prevention and Control (IPC) audit was not available for review. This was subsequently provided following the inspection.

During our inspection, we found sharps boxes that were out of date. Sharps boxes should be disposed of either when they are three quarters full or after three months to minimise the risk of injury or cross contamination.

Our concern regarding this was dealt with during the inspection. Further information on the issues we identified, and the actions taken by the service, are provided in Appendix A.

The practice had appropriate waste management procedures, including the use of sharps containers, clinical waste bins, and recycling facilities. However, not all sharps bins were signed and dated as required.

Clinical waste, including sharps items, was appropriately segregated and stored in appropriate bins. These were not securely stored away from publicly accessible areas. One bin was found to have a faulty locking mechanism.

The practice must ensure that:

- **Sharps bin expiry dates are checked and dated in all rooms regularly**
- **Clinical waste is stored securely. This includes relocating bins to a secured area, ensuring all waste containers are fitted with functional locking mechanisms, and implementing regular checks to maintain compliance**
- **The unsecured bin must be removed from the premises to prevent further use**
- **Staff and cleaning teams are retrained on correct clinical waste handling and secure storage requirements.**

A review of staff records confirmed that, prior to the inspection, blood samples had been taken from some staff for Hepatitis B immunity screening, with results pending from the Health Board's Occupational Health Department. Other staff had documented evidence of immunity, while no testing records were available for a number of staff.

The practice must ensure that all staff members who may be at risk of exposure to blood-borne viruses, such as Hepatitis B, have up-to-date immunity

checks in place. This includes confirming results for those tested, arranging testing for staff without records, and maintaining clear documentation of immunisation status.

Medicines management

Processes were in place to ensure the safe prescribing of medication. The process for patients to request repeat medication was clear. Prescriptions could be collected at the reception desk, where a check of name, address and date of birth was conducted, and a record was kept. **This was an area of noteworthy practice.**

We saw that prescription pads were securely stored in a locked cupboard. Staff described to us the process in place to securely dispose of prescription pads when a GP left the practice.

There was a cold chain process in place for medications or vaccines that required refrigeration. There were two dedicated clinical refrigerators for certain items, such as vaccines. Daily temperature checks were completed and the documentation we reviewed confirmed this.

All necessary emergency equipment was in place. An automated external defibrillator (AED) was in place and was fully charged. A notice in reception stated where the emergency equipment was located. Staff at the practice had undertaken appropriate basic life support training.

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. However, the expiry dates of the emergency medicines were not documented as part of these checks, which may limit the effectiveness of the process in ensuring medicines remain in date and safe for use.

The practice must ensure expiry dates on emergency drugs are recorded during weekly checks.

During the inspection, we found that the practice used BOC integrated valve medical gas cylinders. However, staff had not received training in the safe handling and use of this equipment.

The practice must ensure BOC integrated valve medical gas cylinder training is completed by clinical staff.

Safeguarding of children and adults

Staff had access to up-to-date safeguarding policies and procedures, which did not include the contact details of the designated lead. Not all staff had completed safeguarding training at the required level.

The practice must ensure that:

- **All staff complete safeguarding training at the required level**
- **The safeguarding policy includes the name of the designated lead.**

We noted that the minutes of the safeguarding meeting included the full name of a patient.

The practice must ensure identifiable information should be replaced with a unique identifier or anonymised reference.

The practice had a 'Was Not Brought' policy to manage children and vulnerable adults who failed to attend their appointments. The policy included guidance on the process to follow when children or vulnerable adults missed their appointments. We were told that staff attended multi-agency meetings to discuss safeguarding concerns.

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. During our inspection, we identified some outdated medical examination equipment stored in a cupboard.

A review of all clinical and non-clinical areas must be undertaken to remove outdated materials and unused equipment.

Effective

Effective care

We found good processes in place to support the effective treatment and care of patients. We found examples of acute and chronic illness management, and clear narrative with evidence of patient centred decision making. This included multidisciplinary team working and engagement with external clinicians and agencies. Designated leads were in place for key areas such as safeguarding, IPC,

complaints, and nursing, ensuring staff had access to appropriate guidance and support.

There was an appropriate system in place for reporting incidents, and any shared learning was completed within team meetings.

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

Read codes were used appropriately and we found good examples where the reasons for discontinuing medication were present in a patient's medication record. However, we found examples where medication was not always linked to the patient's problem / presentation within their record.

The practice must ensure medication is appropriately linked to a patient's problem / presentation within the records.

We found examples where new medical conditions listed in incoming discharge summaries were not always coded within their record.

The practice must review its processes for handling incoming discharge summaries to ensure that new medical conditions are consistently identified and appropriately coded within patient records.

We found that new patient records were summarised by non-clinical administrative staff, with occasional random checks carried out to assess the quality of the summarising.

In three of the patient records reviewed, an intimate examination had been carried out. However, none of these records included documentation of the patient's consent for the examination. Additionally, in only one of the three cases was there a record that a chaperone was offered; in the remaining two cases, there was no record of a chaperone being offered.

The practice must ensure that consent for intimate examinations is clearly documented in the patient record. The offer of a chaperone must be made in all appropriate cases, with the offer, the patient's response, and the identity of

the chaperone (if present) clearly recorded in accordance with General Medical Council (GMC) guidelines.

Efficient

Efficient

The practice demonstrated effective multidisciplinary working and proactive use of community resources to support patients and reduce the risk of avoidable hospital admissions. Examples of this included participation in the Diabetes Prevention Programme, regular liaison with health visitors and midwives, and the presence of a mental health clinician in the surgery one day a week.

There was also good access to local support groups for patients with mental health needs and those considered vulnerable. Additionally, cluster wide initiatives were seen in use, including Bay Cluster Wellbeing prescriptions, which promoted prevention, self-care, and overall wellbeing.

Quality of Management and Leadership

Staff feedback

We received feedback from nine staff who completed a HIW questionnaire. Responses were mostly positive, with all staff telling us that they felt patients were involved in care decisions and receive timely care, and that they had appropriate training for their role. Most staff felt able to make suggestions to improve practices

One staff member commented:

> ***"I have worked here for many years. It has and remains a pleasant working environment that works extremely hard to provide best practice care. They provide opportunities for CPD to ensure we remain updated with current constantly changing guidelines."***

Leadership

Governance and leadership

We found that staff and managers were clear about their roles, responsibilities, and reporting lines, and understood the importance of working within their scope of practice.

Leaders were visible and approachable across both practice sites, with the leadership team primarily based at the practice at Scurlage and attending the practice at Pennard one afternoon per week. Staff rotated across both sites, supporting a consistent and cohesive team culture.

Regular team meetings were held, including monthly clinical and executive meetings, and nursing meetings every four to six months. Clinical meeting minutes were available, and staff were encouraged to contribute to agendas.

Information, including updates to policies and procedures, was shared through a range of channels such as email, direct conversations, and a WhatsApp group (for non-patient-related matters). A dedicated nurses group also supported communication within the nursing team.

Staff had access to wellbeing support through programmes such as Silvercloud (via the health board), Canopi Wales, and the REACT mental health awareness provider. These resources contributed to a supportive working environment.

Workforce

Skilled and enabled workforce

We spoke to staff across a range of roles throughout the inspection. Each had sound knowledge of their roles and responsibilities and appeared committed to providing a quality service to patients.

There were appropriate recruitment policies and procedures in place which described the required pre-employment checks for any new staff. This included checking of references and undertaking Disclosure and Barring Service (DBS) checks appropriate to their role. However, during our review of staff personnel files we did not see evidence to indicate that three staff members had suitable DBS certificates or annual DBS status checks in place. Additionally, references were not available on file for three staff members.

The practice must ensure that:

- **The recruitment policy is followed**
- **Relevant DBS checks are completed for all staff and evidence maintained on file**
- **All staff are required to complete a written annual certification to confirm there has not been a change that would affect their DBS status**
- **Relevant documentation such as written references are requested for new staff and kept on file.**

In addition, during the inspection we also asked to review the training records of clinical and administrative staff working at the practice. We were provided with a training matrix which identified poor compliance with mandatory training across all staff groups. Some of these training gaps have been highlighted already in this report.

The practice must:

- **Ensure all staff complete and remain compliant with mandatory training relevant to their roles, to maintain the safety of patients, staff and visitors**

- **Implement robust governance oversight to continuously monitor staff training compliance and promptly identify when updates are required.**

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.

Staff results from the HIW questionnaire confirmed that all staff agreed that the practice encouraged them to report errors, near misses or incidents and there was an appropriate skill mix at the setting.

Culture

People engagement, feedback and learning

The practice demonstrated a positive and open culture, where staff felt encouraged to raise concerns, share ideas, and contribute to service improvement.

The practice had a comprehensive complaints process in place. A complaints procedure and policy were aligned to the NHS Wales 'Putting Things Right' process, although information about the complaints process was not prominently displayed within the practice.

The practice must ensure that the complaints and 'Putting Things Right' process is prominently displayed at the practice to support patient awareness.

There were identified staff at the practice responsible for managing all complaints. Feedback was obtained via reception, the 'AskMyGP' app and the practice website. Complaints and concerns were monitored to identify any themes and trends, and any actions for improvement were communicated to staff.

Patient feedback was welcomed and acted upon, with a 'You Said; We Did' poster displayed in reception to demonstrate responsiveness. Learning from complaints and feedback was discussed during clinical meetings, and patients were encouraged to submit complaints in writing to support formal review.

A Duty of Candour policy was in place, but we were unable to find evidence that all staff had completed Duty of Candour training. We recommended training is undertaken to ensure staff were aware of their responsibilities as set out in the Duty of Candour Statutory guidance 2023.

Results from the HIW staff survey showed that all staff agreed that they knew and understood the Duty of Candour; they understood their role in meeting the

standards and they were encouraged to raise concerns when something had gone wrong and to share this with the patient.

The practice must ensure staff complete Duty of Candour training.

Information

Information governance and digital technology

An appropriate system was in place to ensure the effective collation, sharing and reporting of patient data, referrals and requests. All electronic and paper patient records were found to be securely stored. 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 demonstrated a commitment to continuous learning and improvement through regular clinical meetings, where complaints and concerns relating to clinical matters were discussed. Themes arising from feedback were shared with staff via meeting minutes and email communications, supporting a culture of shared learning.

Innovative approaches to service delivery were evident. The practice used the 'AskMyGP' platform to streamline communication with patients and deliver preset health information. Additionally, new health check materials were provided to encourage completion of new patient questionnaires.

The practice also explored innovative administrative support solutions, such as the use of "Heidi" artificial intelligence (AI) to assist with secretarial tasks.

There was evidence of clear accountability for service standards and improvement, supported by regular audits, including those related to referrals, Attention Deficit Hyperactivity Disorder (ADHD), and weight management interventions.

Whole-systems approach

Partnership working and development

The practice demonstrated a clear understanding of its role within the wider healthcare system and took account of the implications of its actions on other

services. Staff followed health board pathways and monitored referral patterns to support system efficiency and patient outcomes.

The practice actively engaged with system partners through regular attendance at cluster meetings, prescribing indicator reviews, and practice manager forums.

Collaborative relationships were maintained with a range of external partners, including the health board, other primary care providers, and cluster colleagues. These partnerships helped build a shared understanding of population needs and supported the delivery of coordinated responsive care.

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
We found sharps boxes that were out of date and more than ¾ full.	Sharps boxes should be disposed of either when they are ¾ full or after three months to minimise the risk of injury or cross contamination. Using a sharps container beyond its expiry date can also compromise its structural integrity and safety. Over time, the materials may degrade, increasing the likelihood of leaks, cracks or failure of the lid locking mechanism. This	Raised with the Practice Manager	Out of date or overfilled sharps containers were removed.

	deterioration poses a heightened risk of injury or contamination.		
A portable radio was observed on the floor in the corridor outside the nurses' room, and it was noted to be dusty.	Dust accumulation suggests the area or item may not be included in regular cleaning schedules, which indicate lapses in environmental hygiene. The radio could pose a trip hazard, particularly in an emergency or for individuals with mobility issues. It may obstruct access or egress routes, which is a concern under fire safety regulations.	Raised with the Practice Manager	The radio was removed during the inspection.

Appendix B - Immediate improvement plan

Service: Gower Medical Practice (Scurlage)

Date of inspection: 10 July 2025

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.	No immediate assurance issues were identified.					
2.						
3.						

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: Gower Medical Practice (Scurlage)

Date of inspection: 10 July 2025

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 recording of the offer of a chaperone and whether this offer had been accepted or rejected by the patient, along with the details of any chaperone present, was not always entered into patient records.	The practice must ensure that the offer of a chaperone and the decision made by the patient, along with the details of any chaperone present, is entered into patient medical records in accordance with General Medical Council (GMC) guidelines.	Health & Care Quality Standards (2023) - Information	The item has been discussed at a clinical meeting and will remain as a standing item to remind all clinicians. Specific reference has been made in the Locum and Registrar induction packs to the need for coding of chaperone offers/acceptance and consent. Hotkeys have been set up in Vision to make	Practice Manager to oversee but all clinicians responsible.	Audit in 3 months

				entering the codes easy. Current levels of recording will be established and searches conducted in 3 month to audit the process.		
2.	The Access policy included links to services provided by NHS England, which may not be applicable to patients in Wales.	The practice must review the policy to ensure all referenced services are appropriate for the Welsh healthcare context.	Health & Care Quality Standards (2023) – Timely	Access Policy reviewed and links to NHS England removed and links to NHS Wales verified.	Practice Manager	Complete
3.	As part of the 'Active Offer' for Welsh patients, all practice information and signs should be bilingual. We saw that some signs and posters were available in Welsh, however, most were available in English only.	The practice must ensure that the 'Active Offer' of Welsh language is promoted to patients.	Health & Care Quality Standards (2023) - Information.	Whilst the surgery has tried to support the 'Active Offer' of Welsh it can see improvements can be made. Using local Facebook groups, a message has been sent out to patients to ask for their help establishing a patient feedback group of Welsh	Practice Manager	First meeting within one month then ongoing.

				speakers that could advise the Surgery how it can improve this aspect.		
4.	There was no formal workflow policy in place to guide the consistent and effective management of incoming information.	The practice must implement a workflow policy to provide clear guidance to staff.	Health & Care Quality Standards (2023) – Timely; Equitable; Efficient; Information	A policy is in progress which will be reviewed by all staff to ensure it accurately reflects current processes and ensure all elements are included	Practice Manager	Policy to be in place by mid-September to be audited mid-December.
5.	We reviewed the mandatory training of five members of staff and noted that there were compliance issues for all.	The practice must: • Ensure all staff complete and remain compliant with mandatory training relevant to their roles, to maintain the safety of patients, staff and visitors • Implement robust governance oversight to continuously monitor staff training compliance and promptly identify when updates are required.	Health & Care Quality Standards (2023)– Safe; Workforce; Information	A spreadsheet exists of all staff training with a traffic light system to alert when revalidation is required. This is checked monthly by the Clinical Administration Manager who will advise staff. Mandatory training has been prioritised over the last year	Practice Manager	Levels of compliance to be reviewed fortnightly. Full compliance within 3 months.

				with effort made to ensure staff compliance. A new member of staff has been allocated a 'floating shift' which will enable cover to be supplied to allow staff time to complete their training. The importance of this training is now fully appreciated by all staff		
6.	We observed dust and cobwebs in most areas of the building.	The practice must challenge the cleaning service provider to ensure the scheduled cleaning programme is being delivered in full accordance with the cleaning contract. Cleaning schedules should be consistently followed, with six-monthly audits carried out regularly to monitor and maintain cleaning standards.	Health & Care Quality Standards (2023) – Safe		Practice Manager	

7.	Some rooms contained old and unused equipment. The storage of such items within treatment areas may pose a health and safety risk. The training room contained outdated medical textbooks and procedural documents.	A review of all clinical and non-clinical areas must be undertaken to remove outdated materials and unused equipment.	Health & Care Quality Standards (2023) – Safe		Practice Manager	
8.	The business continuity plan did not include consideration of partnership risks or outline contingency arrangements in the event of a GP retirement.	The practice should update the business continuity plan to include a reference to partnership risk, specifically noting that while one partner is leaving, a replacement has already been identified.	Health & Care Quality Standards (2023) – Information; Safe	This has now been amended, and a copy of the Partnership agreement is now kept with each keepers copy of the contingency plan as an appendix	Practice Manager	Business continuity plan amended.
9.	Some rooms contained fabric curtains, pillows,	The practice must ensure that:	Health & Care Quality Standards (2023) –Safe	All remaining fabric chairs removed. Pillows replaced with	Practice Manager	Chairs and pillows addressed.

	and non-wipeable chairs and carpets, which do not meet IPC best practice standards.	• Fabric covered pillows and chairs in clinical areas are replaced within a reasonable timeframe • Regular cleaning of fabric curtains occurs in accordance with current IPC guidelines or consider transitioning to disposable alternatives to support effective infection control. Clear documentation is maintained to evidence the frequency and dates of curtain changes or laundering • Continue with the programme of		wipeable waterproof covers. A program of carpet replacement is ongoing. 4 rooms were fitted with vinyl in February 2025, the remaining 4 in Scurlage are booked for October 2025. Although the fabric curtains are regularly laundered, they will be replaced with disposable curtains when next due.		Fabric curtains will be replaced by November 2025. Remaining carpeted consulting room floors will be replaced by November 2025

		carpet replacement for patient areas.				
10.	A completed IPC audit was not available at the time of inspection.	The practice must conduct IPC audits and ensure it is comprehensive and aligned with current, recognised IPC standards.	Health & Care Quality Standards (2023) –Safe	The audit from 13/05/2025 has been uploaded for review.	Practice Manager/Infection Control Lead	Uploaded for review.
11.	We observed that not all sharps bins were signed and dated as required. Clinical waste storage bins were positioned against the rear of the building in an unsecured external area. One bin was found to have a faulty locking mechanism. As a result, we could not be assured that adequate arrangements were in place for the	The practice must ensure that: • Sharps bin expiry dates are checked and dated in all rooms regularly • Clinical waste is stored securely. This includes relocating bins to a secured area, ensuring all waste containers are fitted with functional locking mechanisms, and implementing regular checks to maintain compliance	Health & Care Quality Standards (2023) –Safe	Clinical staff informed sharps bin not signed and dates and reminded of responsibility to do so every time. Weekly audits will be conducted for next 3 months to ensure compliance. Bin with faulty locking system has now been removed. Bins moved away from building and storage facility to be built. Contractor	Practice Manager/All clinical staff	Weekly audit for 3 months to ensure sharps boxes are signed and dated. Faulty bin removed. Storage facility completion by end September 2025

	secure storage of clinical waste.	• The unsecured bin must be removed from the premises to prevent further use • Staff and cleaning team retrained on correct clinical waste handling and secure Storage requirements.		identified, obtaining quote. Staff training on clinical waste handling and secure storage updated.		Staff walked through waste handling and storage audit as refresher training.
12.	Some staff had documented evidence of immunity from Hepatitis B, some were awaiting results, while no testing records were available some staff.	The practice must ensure that all staff members who may be at risk of exposure to blood-borne viruses, such as Hepatitis B, have up-to-date immunity checks in place. This includes confirming results for those tested, arranging testing for staff without records, and maintaining clear documentation of immunisation status.	Health & Care Quality Standards (2023) –Safe	3 Hep B status still outstanding, one has blood test booked.	Practice Manager	All status to be complete by the end Sept 2025

13.	Expiry dates of the emergency medicines were not documented as part of weekly emergency trolley checks.	The practice must ensure expiry dates on emergency drugs are recorded during weekly checks.	Health & Care Quality Standards (2023) –Safe	Column added to emergency trolley weekly checklist.	IPC Lead	Complete – column added.
14.	The practice uses BOC integrated valve medical gas cylinders. At the time, staff had not received training in the safe handling and use of this equipment.	The practice must ensure BOC integrated valve medical gas cylinder training is completed by clinical staff.	Health & Care Quality Standards (2023) –Safe	70% of clinical staff have now completed this course. This should reach 100% by end of August 2025	Practice Manager	100% training by end of August 2025
15.	The safeguarding policy did not include the contact details of the designated lead. Not all staff had completed safeguarding training at the required level.	The practice must ensure that: • The safeguarding policy includes the name of the designated lead. • All staff complete safeguarding training at the required level	Health & Care Quality Standards (2023) –Safe; Information	Designated Lead – Dr Tay Sahami added to policy. One member of staff left to complete their safeguarding training.	Practice Manager	All staff to complete by end August 2025

16.	Minutes of a safeguarding meeting included the full name of a patient.	The practice must ensure identifiable information should be replaced with a unique identifier or anonymised reference.	Health & Care Quality Standards (2023) –Safe; Information	Name removed, Unique identifier will be used going forward.	Practice Manager	PM to check all meeting minutes for compliance.
17.	Medication was not always linked to the patient's problem/ presentation within their record.	The practice should ensure medication is appropriately linked to a patient's problem/ presentation within the records.	Health & Care Quality Standards (2023) –Safe; Information	In Vision priorities are used to identify problems. GP's, registrars and locums reminded of coding. Highlighted in induction packs. Move to Emis early 2026 should aid with linking problems as this is done automatically in this clinical system.	Practice Manager	10 patients to be reviewed at random in 2 months' time to check for medications linked to problem.
18.	New medical conditions listed in incoming discharge summaries were not always coded within their record.	The practice should review its processes for handling incoming discharge summaries to ensure that new medical conditions are consistently identified and appropriately coded within patient records.	Health & Care Quality Standards (2023) –Safe; Information	To be addressed in workflow policy/protocol to ensure compliance by all read coders	Practice Manager	To be audited in 1 month to ensure workflow policy is being observed and coding

						taking place.
19.	In three of the patient records reviewed, an intimate examination had been carried out. However, none of these records included documentation of the patient's consent for the examination. Only one of the three cases was there a record that a chaperone was offered; in the remaining two cases, there was no record of a chaperone being offered.	The practice should ensure that consent for intimate examinations is clearly documented in the patient record. The offer of a chaperone should be made in all appropriate cases, with the offer, the patient's response, and the identity of the chaperone (if present) clearly recorded.	Health & Care Quality Standards (2023) – Information	Please see response to item 1. Which extends to this issue	Practice Manager	Audit in 3 months
20.	We reviewed the recruitment records of five members of staff and noted that	The practice must ensure that: • The recruitment policy is followed	Health & Care Quality Standards (2023) – Safe;	Reference and DBS checks were obtained for the 2 recently employed	Practice Manager	All DBS checks to be complete

	there was an absence of references kept on file for some staff. There were some checks made to ensure a person was suitable to work for the practice, such as their DBS status.	• Relevant documentation such as written references are requested for new staff and kept on file • Relevant DBS checks are completed for all staff and evidence maintained on file • All staff are required to complete a written annual certification to confirm there has not been a change that would affect their DBS status.	Workforce; Information	members of staff. All staff were also required to sign self-declarations at their appraisals in June 2025. All extended DBS checks for clinical staff have been applied for. 2 are in place. DBS checks of admin staff are in place for 70% of admin staff.		by end of August 2025
21.	Whilst the complaints procedure was displayed in the practice reception area, details of the NHS 'Putting Things	The practice must ensure that the NHS Putting Things right process is clearly displayed at the practice.	Health & Care Quality Standards (2023) – Culture	The Putting Things Right procedure and leaflets are now displayed prominently, central to the notice boards in the practices with	Practice Manager	Complete

	Right' procedure was not displayed.			leaflets available in English and Welsh.		
22.	We were unable to find evidence that all staff had completed Duty of Candour training.	The practice must confirm staff have completed Duty of Candour training.	Health & Care Quality Standards – Workforce	Whilst Duty of Candour training was covered in a PLTS, certificates were not supplied. Staff will now all complete Certified Duty of Candour training. £0% have completed the course. 100% to obtained by end of September 2025	Practice Manager	End Sept 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): **Lynne Palmer**

Job role: **Practice Manager**

Date: 13 August 2025