Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report
(Announced)

St Peter’s Surgery, Hywel Dda University Health Board

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

Our purpose

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

Our values

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

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

Our goal

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

Our priorities

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

Contents

1. What we did

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

Healthcare Inspectorate Wales (HIW) completed an announced inspection of St Peter's Surgery, Hywel Dda University Health Board on 09 September 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 or their carers to complete a questionnaire to tell us about their experience of using the service. Due to the notably low patient and carer response, it is not possible to include these findings within the report. We also invited staff to complete a questionnaire to tell us their views on working for the service, of which four were completed. Feedback and some of the comments we received appear throughout the report.

Where present, quotes in this publication may have been translated from their original language.

Note the inspection findings relate to the point in time that the inspection was undertaken.

2. Summary of inspection

Quality of Patient Experience

Overall summary:
The practice demonstrated a strong commitment to enhancing the quality of patient experience through person-centred care and accessible communication. Health promotion was embedded within the service, with patients benefitting from digital and personalised approaches, such as tailored resources delivered via mobile phones and a self-help hub on the practice website. Links to community-based professionals, including wellbeing advisors and social prescribers, further supported patients' health journeys. However, opportunities remain to strengthen visual health promotion materials within the practice environment itself.

Respectful and dignified care was evident during the inspection, with staff treating patients with professionalism and kindness. The availability and promotion of trained chaperones supported patient dignity, although one record reviewed lacked appropriate documentation regarding chaperone involvement during an intimate examination, which must be addressed to meet professional standards.

In terms of access, the practice offered flexible booking systems and accommodated patient preferences for appointment format. While this patient-led approach was generally effective, the absence of a formal access policy and triage system represents an area for improvement. Mental health needs were managed with responsiveness, including prompt access to support and onward referrals when necessary.

Communication methods were inclusive and wide-ranging, with a particular strength in bilingual services. Patients were kept informed through a combination of digital tools and non-digital methods, ensuring accessibility for all. Facilities and internal communication supported a well-coordinated care environment. Nonetheless, the lack of an emergency pull cord in the accessible toilet and the absence of a formal Equality, Diversity and Inclusion (EDI) policy require attention to ensure all patients are fully supported and safe within the practice.

Immediate assurances:
We identified areas which needed to be addressed through our immediate assurance process, where we wrote to the practice within two working days of our inspection requesting an immediate improvement plan. The issues included:

- The accessible toilet within the practice did not have an emergency pull cord fitted.

Details of the immediate improvements are highlighted in Appendix B.

This is what we recommend the service can improve:

- Ensure consistent documentation of chaperone offers and decisions in line with GMC guidelines, including whether the offer was accepted or declined and the identity of any chaperone present
- Create and adopt a clear access policy to define procedures for managing patient access, ensuring transparency and consistency in service delivery
- Develop and implement a formal EDI policy to underpin training and guide inclusive care delivery across the practice.

This is what the service did well:

- The practice demonstrated a strong commitment to promoting healthy lifestyles through a variety of accessible, patient-centred approaches
- The practice promoted equality and inclusion by supporting bilingual (English and Welsh) communication, providing accessible facilities, and respecting the rights and preferences of all patients.

Delivery of Safe and Effective Care

Overall summary:
The inspection found that the practice had established a range of systems and processes to protect the safety and wellbeing of patients, staff, and visitors. The premises were well maintained, with clear emergency exits and up-to-date risk assessments covering fire safety, environmental risks, and health and safety. A business continuity plan was in place, though it would benefit from further detail tailored to the specific risks and operational needs of the practice.

Arrangements for infection prevention and control (IPC) were robust, with a designated IPC lead and clear procedures in place. Staff demonstrated a good understanding of their roles, and daily cleaning routines were documented. While overarching IPC policies were in place, some were based on health board guidance rather than being tailored to the practice's specific context. Waste management and hand hygiene facilities were appropriate, and the use of single-use clinical equipment reduced the risk of cross-contamination.

Medicines management was generally well handled, with secure processes for prescribing and storing medication, and a highly responsive repeat prescription system.

Safeguarding arrangements included a designated lead and a policy, with staff trained to the appropriate level. However, the safeguarding policy required

updating to include essential contact information for key safeguarding stakeholders, such as the regional safeguarding board, the named GP for children, local social care services, and the police investigation team and accessible resources. The practice had systems to identify adults and children at risk but did not routinely monitor attendance at A&E or 'was not brought' incidents, which should be addressed to strengthen safeguarding oversight.

In terms of clinical effectiveness, the practice demonstrated good multi-disciplinary working and a clear commitment to keeping up with clinical guidance. Referrals and patient correspondence were managed efficiently, and records reviewed were of high quality and well maintained. While the reporting of incidents was in place, the absence of a structured approach to significant event analysis limited opportunities for reflective learning and service improvement. Addressing this gap will be essential to embedding a stronger learning culture across the team.

Immediate assurances:
We identified areas which needed to be addressed through our immediate assurance process, where we wrote to the practice within two working days of our inspection requesting an immediate improvement plan. The issues included:

- Prescription pads used by GPs for home visits were not kept in secure storage at the time of the inspection.
- We found the emergency trolley to be stored in a frequently used clinical area (nursing).

Details of the immediate improvements are highlighted in Appendix B.

This is what we recommend the service can improve:

- The business continuity plan should be revised and expanded to reflect the specific risks and operational context of the practice
- Safeguarding oversight must be strengthened. This includes updating the safeguarding policy to include complete contact details for key safeguarding stakeholders and accessible links and introducing a process to routinely monitor A&E attendances and 'was not brought' incidents
- The practice should implement a formal and structured approach to Significant Event Analysis (SEA).

This is what the service did well:

- The practice had effective infection prevention and control measures. Staff were knowledgeable about IPC protocols, cleaning routines were consistently documented

- The practice offered multiple convenient options for repeat prescription requests and maintained a 24-hour turnaround, supported by an on-site pharmacist
- The practice demonstrated strong collaboration across services, using regular multi-disciplinary team (MDT) meetings to plan and review care for patients with complex needs.

Quality of Management and Leadership

Overall summary:
The inspection found that the practice demonstrated a generally sound standard of management and leadership, with strengths in staff engagement, operational clarity, and collaboration with the wider healthcare system. Staff reported feeling positive about their roles and the care delivered, highlighting a visible and approachable leadership style that supported a clear understanding of responsibilities. The practice had designated leads for key areas and maintained a well-established communication framework, contributing to a cohesive and informed team environment.

The workforce was stable at the time of inspection, with evidence of continued professional development and appropriate training among clinical staff. However, the absence of a structured appraisal programme and an outdated recruitment policy were notable gaps.

The practice engaged positively with patients and staff, using surveys and displaying thank you cards and letters. However, there was no complaints register or system for routinely sharing patient feedback results.

Information governance was robust, with secure handling of patient data and the recent introduction of an electronic correspondence management system. The practice worked collaboratively with healthcare partners and neighbouring practices, participating actively in cluster meetings and multidisciplinary team discussions to support patient care and service improvement.

This is what we recommend the service can improve:

- Develop and implement a structured annual appraisal process for all staff
- Update the recruitment policy to ensure it is current and comprehensive
- Maintain a complaints register, display clear information on how to raise concerns, and implement a system to share patient feedback results with patients
- Develop a site-specific Duty of Candour policy to reinforce transparency and accountability in line with national guidance.

This is what the service did well:

- The practice had clear governance arrangements, with regular meetings, designated leads for key areas, and effective channels for sharing information and implementing safety notices or external recommendations
- The workforce was stable and skilled, with evidence of ongoing professional development and up-to-date training.

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

3. What we found

Quality of Patient Experience

Person-centred

Health promotion
The practice actively promoted healthy lifestyles through a range of accessible and patient-centred approaches. The practice website featured a self-help hub that included links to mental health support via NHS 111, guidance on healthy behaviours, and access to a variety of health and wellbeing resources. Patients were also directed to mobile applications designed to support improvements in health and lifestyle. The website further enabled self-referral for services such as physiotherapy and weight management. During consultations, both GPs and nurses were reported to support health promotion by printing relevant online leaflets or sending resource links directly to patients' mobile phones, thereby ensuring that information is tailored and easily accessible.

Patients benefit from access to a wide range of health and community services through the practice. These include established links with other healthcare professionals such as health and wellbeing advisors and physiotherapists based at St David's Park. In addition, a social prescriber attends the practice on a weekly basis and is available through referral by a GP or nurse. This service offers flexible engagement options, including home visits, telephone consultations, and face-to-face appointments.

While digital and personalised health promotion was well embedded within the practice, the physical environment of the practice offered limited health promotion material in the waiting area. Enhancing this space with a broader variety of health education displays could complement existing strategies and further support patient engagement during waiting times and for patient groups without digital access.

No Smoking signs were displayed confirming that the practice adhered to the smoke free premises legislation.

Preparations by the practice to manage the annual winter vaccination and immunisation programmes were suitable and included arrangements for vulnerable patients and those without digital access. Patients were made aware of these programmes through posters, online and via letter.

Dignified and respectful care

We found staff at the practice treated patients and their representatives with respect and kindness, and we saw staff greeting patients in a professional manner, both face to face and over the telephone.

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.

A current policy was in place regarding the use of chaperones, and staff had completed formal chaperone training. Chaperone information notices were displayed in the waiting area and within all clinical treatment rooms, indicating that this service was available. However, in one of the patient records reviewed, an intimate examination had been carried out without documentation of the offer of a chaperone, whether the offer was accepted or declined, or the identity of any chaperone present.

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 provides access to a breadth of clinical services, provided by a wide-ranging team of healthcare professionals. At the time of inspection, the practice did not have an access policy in place.

The practice should develop and implement a formal access policy to clearly outline procedures for managing patient access to services.

We were told that appointments could be made by telephone, online or in-person. The appointment system allowed for additional capacity when there were clinical concerns or when it was deemed necessary for a patient to be seen at an earlier opportunity.

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. Decisions regarding the format of appointments whether face-to-face or via telephone were primarily patient-led. We were told all patients under the age of 16 are automatically offered face-to-face appointments.

There were processes in place to support patients in mental health crisis. Individuals who contact the practice with urgent mental health concerns were appropriately prioritised to ensure they receive timely clinical attention. Where appropriate, patients are referred to the local Community Mental Health Team (CMHT), which included access to a Community Psychiatric Nurse (CPN) who can provide further assessment and support.

Equitable

Communication and language
The practice operated bilingually, incorporating the Welsh language into patient services. Most staff were Welsh speakers, and discussions between clinicians and patients could be conducted through the medium of Welsh. Visual aids, such as the 'Iaith Gwaith' badge were used to identify Welsh speaking staff and bilingual signage enabled patients to proactively communicate in their preferred language without needing to ask.

The practice employed a range of communication methods to ensure patients were kept informed of important changes. These included text messaging, telephone calls, updates via the practice website, and social media platforms.

The surgery had a hearing loop to support those with hearing difficulties.

The practice employed a multi-channel approach to ensure patients were kept informed of important updates and changes to the service. Digital communication was widely used, including text messaging, telephone calls, updates on the practice website, and posts via the practice's social media page.

To support patients who may be older or digitally excluded, the practice ensured equitable access to information by using alternative communication methods. These included written messages on the reverse side of prescriptions, postal letters, and direct telephone contact.

Internal communication between staff was managed efficiently through a combination of EMIS instant messaging for urgent, same-day matters and email for routine, non-urgent messages. This enables prompt information sharing and coordination among the clinical and administrative teams.

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 wheelchairs for patient use, if required.

However, during our inspection, we found that the accessible toilet did not have an emergency pull cord fitted. This cord is an important safety feature enabling patients to raise the alarm if they require assistance. This was addressed under our immediate assurance process at Appendix B.

Staff at the practice had completed Equality, Diversity and Inclusion (EDI) training. However, there was no formal EDI policy in place to underpin this training and guide consistent practice.

The practice must develop and implement a formal Equality, Diversity and Inclusion (EDI) policy to support its commitment to delivering inclusive care.

The practice actively upheld the rights of transgender patients. Staff reported that transgender individuals were treated with sensitivity, and it was confirmed that their preferred names and pronouns were consistently respected.

Delivery of Safe and Effective Care

Safe

Risk management
Arrangements were in place to protect the safety and wellbeing of staff and visitors to the practice. The premises were visibly well maintained both internally and externally, and all areas were free from obvious hazards. Emergency exits were clearly marked and a Health and Safety poster was displayed.

A general risk assessment was in place, covering fire safety, environmental risks and health and safety. This was current and subject to regular review.

A business continuity plan was in place, outlining general procedures for maintaining service delivery during periods of disruption. While the plan included reference to collaboration with neighbouring practices, it lacked sufficient detail tailored to the specific risks and operational context of the practice. For example, it did not address site-specific concerns such as the sustainability of the GP partnership or long-term workforce planning.

The practice should review and update its business continuity plan to ensure it is fully tailored to the specific needs and risks of the 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
During the inspection, it was evident that the practice had established clear structures and procedures to support infection prevention and control (IPC) and decontamination. An IPC lead had been designated, and staff demonstrated a clear understanding of their roles and responsibilities in relation to infection control.

An overarching IPC policy was in place; however, several key policies, including those addressing blood-borne viruses (BBVs), decontamination of equipment, personal protective equipment (PPE), hand hygiene, and needlestick injuries, were based on health board guidance and not specifically tailored to the practice.

The practice should review and, where appropriate, adapt key infection prevention and control policies to ensure they are tailored to reflect the specific procedures, risks, and context of the practice setting.

The practice maintained appropriate waste management procedures and provided suitable hand hygiene facilities and equipment to support effective infection control. No reusable clinical equipment is used, reducing the risk of cross-contamination.

Clinical rooms were subject to daily cleaning routines, which were documented accordingly, and the practice was trialling a new cleaning service provider over a three-month period.

The Hepatitis B immunisation register for staff was complete. A needlestick injury policy was available and stored in the practice's policy folder.

The practice must ensure that key information from this policy be displayed in all clinical rooms where staff may be exposed to the risk of a needlestick injury.

At the time of the inspection, there were no outstanding estates issues.

Medicines management
Processes were in place to ensure the safe prescribing of medication. The process for patients to request repeat medication was clear. Patients can request repeat prescriptions through various accessible channels, including an app, email, and pharmacy liaison. The practice operates a notably efficient system for prescription processing, with a 24-hour turnaround, and benefits from the support of an on-site pharmacist.

Prescriptions are managed securely, with computer prescriptions stored in locked facilities. However, it was noted that prescription pads used by GPs for home visits were not kept in secure storage at the time of the inspection. This issue has been addressed through immediate assurance, as detailed in Appendix B.

Vaccines and immunisations were managed by nursing staff, who maintain the cold chain effectively. Fridges used for vaccine storage are temperature-checked twice daily, and a policy is in place to guide staff in the event of fridge failure. All vaccines were appropriately stored and in date. One vaccine fridge was awaiting a replacement door seal at the time of the visit, which was due imminently.

Medicines and emergency drugs were checked weekly, with all found to be in date. Emergency equipment is checked daily, however, the location of and timely access

to the emergency trolley required review by the practice. This arrangement has been reviewed under our immediate assurance process (see Appendix B).

It was noted that the room housing the Automated External Defibrillator (AED) did not have clear signage.

The practice must ensure that AED signage is added to the door to improve visibility and access in an emergency.

No controlled drugs were stored on the premises.

Safeguarding of children and adults

The practice had a designated safeguarding lead and a safeguarding policy in place. However, the policy requires review to ensure it includes comprehensive and current contact details for key safeguarding stakeholders, such as the regional safeguarding board, the named GP for children, local social care services, and the police investigation team.

Annex B of the policy (Safeguarding Leaflet) lacks essential contact information and should be updated to reflect local safeguarding pathways. Annex C (Safeguarding Audit Tool) contains broken or missing hyperlinks, which compromises usability. All embedded links should be tested and made accessible to ensure staff can reliably access guidance and referral pathways.

The practice must ensure that the policy is revised to ensure completeness and accessibility of safeguarding resources.

All staff whose training records were reviewed had completed safeguarding training appropriate to their roles. The practice has systems in place to identify adults at risk, including regular multi-disciplinary team (MDT) meetings.

There was no evidence that the practice currently monitors attendance at accident and emergency (A&E) departments or 'was not brought' incidents for children, or for other vulnerable or at-risk individuals.

The practice must introduce a process to routinely monitor and review such information to strengthen safeguarding oversight.

The practice had a system to identify children on the child protection register. It is recommended that regular meetings be held between the safeguarding lead, the lead GP, and the practice manager to ensure consistent and informed management of these patients.

Management of medical devices and equipment

The practice demonstrated effective systems for the safe management of medical devices and equipment. Single-use equipment is utilised wherever possible, reducing the risk of cross-contamination. Portable appliances are tested regularly, and clinical staff carry out checks on equipment. These checks are documented appropriately.

All medical devices and equipment observed during the inspection appeared to be in good working order, with evidence of regular calibration. Staff were aware of the process for reporting faults or the need for replacement, with issues escalated to the practice manager.

Effective

Effective care

Overall, we found good processes in place to support the effective treatment and care of patients. This included MDT working and engagement with other healthcare professionals.

We found a timely and auditable process for dealing with referrals and other correspondence in and out of the practice for secondary care and/or other professionals.

The practice demonstrated a commitment to delivering effective care by keeping up to date with national and professional guidance. Updates are shared with staff through team meetings and email communications.

Incidents were reported using the Datix system; however, there was no formal process in place for the analysis of significant events.

The practice must implement a structured approach to Significant Event Analysis (SEA) to support reflective learning and continuous improvement.

Patient records

We reviewed seven electronic patient records, which were stored securely and were password protected from unauthorised access.

Overall, the records were clear, written to a good professional standard and complete with appropriate patient and clinical information. They were

contemporaneous and information was easy to understand for other clinicians reviewing the records and when providing care and treatment.

The practice demonstrated effective recall and management of patients with chronic conditions, supported by pharmacist-led medication reviews.

Efficient

Efficient
The practice worked collaboratively across services to coordinate care and reduce unnecessary hospital admissions. Multi-disciplinary team (MDT) meetings were used to plan and review care packages for patients with complex needs, supporting continuity and integrated care.

Quality of Management and Leadership

Staff feedback

Before our inspection we invited the practice staff to complete an online questionnaire to obtain their views of working for the practice. In total, we received four responses from staff at this practice. Some questions were skipped by some respondents, meaning not all questions had four responses.

The response to the staff survey was generally positive. Staff felt satisfied with the quality of care provided to patients and would be happy with the standard of care if provided to their own friends and family. All agreed that care of patients was the practice's top priority and that they were content with the practice's efforts to keep staff and patients safe.

Leadership

Governance and leadership
We found that the staff and manager were clear about their roles, responsibilities, and reporting lines, and understood the importance of working within their scope of practice. Leadership was described as visible and approachable, aided by the small team structure, an open-door policy, and shared use of communal spaces.

The senior partner holds clear responsibility for clinical oversight, ensuring that clinical standards and practices are maintained across the team. Information is shared effectively through multiple channels, including EMIS notes, email communication, regular meetings, and the distribution of meeting minutes.

Practice meetings are held fortnightly, with nursing and administrative teams meeting twice a year. Changes to policies and procedures are communicated via email or discussed in meetings where urgent. The practice also implements safety notices and external recommendations in a timely manner.

Designated leads are in place for key areas including safeguarding, infection prevention and control (IPC), complaints, and nursing. Staff wellbeing is supported through access to counselling services provided by an external provider.

Workforce

Skilled and enabled workforce

At the time of inspection, the practice reported a full complement of staff across general practitioners, nursing, and administrative roles. Staff demonstrated a commitment to professional development, with evidence of training certificates available for both nurses and GPs. Staff also reported attending training to expand their scope of practice and enhance their skills. All vaccinators were up to date with their annual immunisation and vaccination training.

While the practice has a recruitment policy in place, it has not been reviewed since 2005.

The practice must update the policy to reflect current recruitment practices, including procedures for pre-employment checks and occupational health checks.

All staff had submitted Disclosure and Barring Service (DBS) applications, although some were still awaiting results at the time of inspection.

The practice must introduce an annual self-declaration process for staff to confirm any changes to their DBS status.

There was no evidence of a structured programme of annual appraisals in place. Regular appraisals are a key component of workforce development and staff engagement. All staff who completed the HIW questionnaire reported not having received an appraisal within the past year.

The practice must develop and implement a structured programme of annual appraisals for all staff.

Culture

People engagement, feedback and learning

The inspection found that the practice demonstrated a generally positive approach to engaging with patients and learning from feedback, although there are areas where processes could be strengthened. At the time of the inspection, there had been no recent complaints available for review, and the practice did not maintain a register of complaints.

The practice should routinely monitor and record complaints and concerns, regardless of volume, using a register to support future analysis and learning.

The practice manager was responsible for overseeing complaints and concerns; however, the practice website had not yet been updated and still displayed the name of the previous manager. This should be corrected to ensure clarity and

accuracy for patients seeking assistance. The website included information about the NHS "Putting Things Right" (PTR) initiative, which provides patients with guidance on how to raise concerns. However, there was no information displayed in the waiting area about how to make a complaint or raise a concern, including details about the PTR process.

The practice must ensure that information about how to raise a concern or make a complaint, including Putting Things Right guidance, be displayed in the waiting area.

Patient feedback was obtained through an annual survey, and there was clear evidence of appreciation from patients, as demonstrated by a staff room notice board displaying numerous thank you cards and letters. However, we found that the results of patient feedback were not displayed or shared with people.

The practice should implement a suitable system to feedback to patients following their response to surveys.

Duty of Candour (DoC) information is available on the practice website, and staff whose records were reviewed had completed relevant DoC training. However, the practice did not have a Duty of Candour policy in place. While there have been no recent incidents requiring the application of DoC, the absence of a policy may limit clarity and consistency in future responses.

It is recommended that the practice develop and implement a site-specific Duty of Candour policy to support transparency, accountability, and compliance with national guidance.

Information

Information governance and digital technology

The practice understood its responsibility when processing information and demonstrated that data was managed in a safe and secure way. A current information governance policy was in place to support this, and we saw evidence that staff had completed training on this topic.

The practice had recently implemented an electronic system for managing incoming correspondence, supporting a structured and efficient workflow. There was a clear and systematic process in place for handling all incoming mail, with correspondence assigned to the appropriate clinician based on its content. Information from secondary care, including discharge summaries, is reviewed promptly upon receipt. Documents are coded and triaged accordingly: medication-related content is directed to the practice pharmacist, clinical issues are referred

to the relevant GP, and any urgent matters are flagged for immediate review by the on-call doctor.

The practice follows a systematic process to ensure that any patients requiring further investigations or follow-up tests are appropriately managed.

Learning, improvement and research

Quality improvement activities

There was evidence of clinical and internal audit in place to monitor quality. We were told learning was shared across the practice to make improvements.

Whole-systems approach

Partnership working and development

The practice demonstrated effective partnership working and engagement with the wider healthcare system. Regular multidisciplinary team (MDT) meetings are held with healthcare partners to coordinate care and support patients with complex needs, helping to prevent unnecessary hospital admissions.

The practice is an active member of its GP cluster and works collaboratively with neighbouring practices. This includes regular meetings to share ideas and improve service delivery. A cluster pharmacist supports the practice, contributing to medicines management and patient 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
No immediate concerns were identified on this inspection.			

Appendix B - Immediate improvement plan

Service: St Peter's Surgery

Date of inspection: 09 September 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.	During our inspection we found that the accessible toilet within the practice did not have an emergency pull cord fitted. This cord is an important safety feature to ensure patients can raise the alarm to summon help when they may require assistance.	An emergency pull cord should be fitted in the accessible toilet within the practice	Health & Care Quality Standards (2023) – Safe, Person-centred, Equitable.	Dyfed Alarms have been instructed to supply and install a disabled persons toilet alarm kit as soon as possible. Awaiting a date for this.	Wendy Williams	1 month

2.	During the inspection, HIW reviewed the processes in place to ensure the security of blank prescription forms used by GPs during home visits. It was found that there was no formal process or policy governing the management of these forms while stored at the practice or when in use by GPs on home visits. Practice leaders confirmed that no system was in place to monitor or record the movement of these prescription forms. Furthermore, there was no routine procedure for recording the serial numbers of blank prescription forms held by GPs for use during home visits. In the	The practice must implement a robust and safe system and policy to ensure the security of all blank prescription forms, including those held by GPs for home visits. This must include details of how the practice will • Prevent theft and misuse through secure storage • Develop an organisational policy outlining roles and responsibilities • Develop local action protocols outlining what actions to take in the case of loss, theft or missing prescription forms/paper. Control and record prescription form movement, including recording serial numbers.	Health & Care Quality Standards (2023) – Safe, Information.	Prescriptions are not taken on home visits with the GP's. If prescriptions are needed by the visiting GP, they are done when the GP is back in Surgery and sent to a pharmacy for delivery. A policy is being done to back this.	All GPs Wendy Williams	2 weeks

	absence of adequate controls, there is a risk of prescription form theft, fraud, and misuse.					
3.	During our inspection we found the emergency trolley to be stored in a frequently used clinical area (nursing). This clinical room is used for intimate examinations, which may result in delays in accessing the trolley in an emergency and could also lead to dignity issues for the patient in the room.	The practice must risk assess the location of the emergency trolley to ensure it is always readily accessible without impacting patient dignity or delaying emergency response.	Health & Care Quality Standards (2023) – Safe, Timely, Person-centred.	We will move the emergency trolley to room 10. This is a spare and used as a phlebotomy room for an hour 3 mornings a week. All signage will be redone and clear for all to be aware. Staff will all be informed also.	Wendy Williams	2 weeks

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): **Wendy Williams**

Job role: Practice Manager

Date: 18/09/2025

Appendix C - Improvement plan

Service: St Peter's Surgery

Date of inspection: 09 September 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.	All clinicians informed via email to ensure documentation showing this.	Wendy Williams	Completed
2.	The practice did not have an access policy in place.	The practice should develop and implement a formal access policy to clearly outline procedures for	Health & Care Quality Standards (2023) – Timely.	To implement ASAP	Wendy Williams	Six months

		managing patient access to services.				
3.	The practice did not have a formal EDI policy in place.	The practice must develop and implement a formal Equality, Diversity and Inclusion (EDI) policy to support its commitment to delivering inclusive care.	Health & Care Quality Standards (2023) – Equitable.	Policy developed and implemented.	Wendy Williams	Completed
4.	The business continuity plan lacked sufficient detail tailored to the specific risks and operational context of the practice.	The practice should review and update its business continuity plan to ensure it is fully tailored to the specific needs and risks of the practice.	Health & Care Quality Standards (2023) – Safe.	To discuss and review with Six months the Partners and update.	Wendy Williams	Six months
5.	Several key policies, including those addressing blood-borne viruses (BBVs), decontamination of equipment, personal protective equipment (PPE), hand hygiene, and needlestick injuries, were derived from health board guidance and not	The practice should review and, where appropriate, adapt key infection prevention and control policies to ensure they are tailored to reflect the specific procedures, risks, and context of the practice setting.	Health & Care Quality Standards (2023) – Safe.	These have been reviewed and tailored to our practice.	Heidi Jones Wendy Williams	Completed

	tailored specifically to the practice.					
6.	The needlestick injury policy was available and stored in the practice's policy folder.	The practice must ensure key information from this policy be displayed in all clinical rooms where staff may be exposed to the risk of a needlestick injury.	Health & Care Quality Standards (2023) – Safe.	Information in a poster format has been put on display in all clinical rooms	Wendy Williams Heidi Jones	Completed
7.	It was noted that the room housing the Automated External Defibrillator (AED) did not have clear signage.	The practice must ensure that AED signage be added to the door to improve visibility and access in an emergency.	Health & Care Quality Standards (2023) – Safe.	Signs bought and put on display at reception and on the room door.	Wendy Williams	Completed
8.	However, the safeguarding policy requires review and updating to include essential contact information. and ensure accessibility of embedded links.	The practice must ensure that the policy is revised to ensure completeness and accessibility of safeguarding resources.	Health & Care Quality Standards (2023) – Safe.	To be reviewed by GP /Health Visitor and Practice Manager	Wendy Williams Dr Robert Gravelle Claire Cox	Six months
9.	There was no evidence that the practice currently monitors attendance at	The practice must introduce a process to routinely monitor and review such	Health & Care Quality Standards (2023) – Safe.	Wendy to discuss with Joyce in admin to introduce monitoring of A&E attendance	Wendy Williams Joyce Walters	January 26

	accident and emergency (A&E) departments or 'was not brought' incidents for children, or for other vulnerable or at-risk individuals.	information to strengthen safeguarding oversight.		and not brought process for all u18. To set a code for continuous reporting and recording		
10.	There was no formal process in place for the analysis of significant events.	The practice must implement a structured approach to Significant Event Analysis (SEA) to support reflective learning and continuous improvement.	Health & Care Quality Standards (2023) – Effective.	Wendy to implement asap	Wendy Williams	Three months
11.	The practice has a recruitment policy in place; it has not been reviewed since 2005.	The practice must update the recruitment policy to reflect current recruitment practices, including procedures for pre-employment checks and occupational health checks.	Health & Care Quality Standards (2023) – Workforce.	Wendy Williams to update Policy asap	Wendy Williams	Three months
12.	All staff had submitted Disclosure and Barring Service (DBS) applications, although some were still	The practice must introduce an annual self-declaration process for staff to confirm any changes to their DBS status.	Health & Care Quality Standards (2023) – Workforce.	Wendy to incorporate in the self-declaration and any changes form into the recruitment policy. All staff to receive form yearly.	Wendy Williams	Three months

	awaiting results at the time of inspection.					
13.	No evidence was seen of a structured programme of annual appraisals. Regular appraisals are an essential component of workforce development and staff engagement.	The practice must develop and implement a structured programme of annual appraisals for all staff.	Health & Care Quality Standards (2023) – Workforce.	Wendy Williams & Debbie Brettle (lead Nurse) to implement a programme for appraisals and start the process asap	Wendy Williams Debbie Brettle	January 26 to start and ongoing
14.	The practice did not maintain a register of complaints.	The practice should routinely monitor and record complaints and concerns, regardless of volume, using a register to support future analysis and learning.	Health & Care Quality Standards (2023) – Culture.	Wendy Williams to create an excel spreadsheet for all complaints received	Wendy Williams	Ongoing and to continue
15.	There was no information displayed in the waiting area about how to make a complaint or raise a concern, including details about the Putting Things Right process.	The practice must ensure that information about how to raise a concern or make a complaint, including Putting Things Right guidance, be displayed in the waiting area.	Health & Care Quality Standards (2023) – Culture.	Putting things right policy displayed in waiting area	Wendy Williams	Completed

16.	We found that the results of patient feedback were not displayed or shared with people.	The practice should implement a suitable system to feedback to patients following their response to surveys.	Health & Care Quality Standards (2023) – Culture.	Notice board / area made available for Pt feedback in waiting area	Wendy Williams	Completed
17.	The practice did not have a Duty of Candour policy in place.	The practice must develop and implement a site-specific Duty of Candour policy to support transparency, accountability, and compliance with national guidance.	Health & Care Quality Standards (2023) – Culture.		Wendy Williams	Six months

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): **Wendy Williams**

Job role: **Practice Manager**

Date: **05/11/2025**