Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report
(Announced)

Estuary Group Practice – Gowerton Medical Centre, Swansea Bay University Health Board

Inspection date: 14 October 2025
Publication date: 14 January 2026

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Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager
Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

Or via

Phone: 0300 062 8163
Email: hiw@gov.wales
Website: www.hiw.org.uk

Digital ISBN 978-1-80633-927-3

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 Estuary Group Practice – Gowerton Medical Centre, Swansea Bay University Health Board on 14 October 2025.

Our team for the inspection comprised of a HIW healthcare inspector, two clinical peer reviewers and a 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. A total of 79 were completed. We also spoke to staff working at the service during our inspection. 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 clear commitment to treating patients with dignity, promoting health, and supporting timely and equitable access to care. Staff consistently demonstrated respectful and professional behaviour, and the environment was suitably arranged to maintain patients' privacy and comfort during consultations. The practice's use of chaperones was well communicated and underpinned by current policy.

Patients had access to numerous specialist clinics and were signposted to self-help and lifestyle resources. However, while digital health promotion was well established, the waiting area lacked sufficient physical health education materials, limiting engagement opportunities for patients without digital access. Carers were supported through a dedicated information board. Patients could independently monitor key health indicators in the reception area.

Patients could access care through multiple channels. A structured contingency system ensured urgent cases were managed appropriately when appointments were unavailable. Specific pathways were in place to support those in mental health crisis, including referrals and cluster-funded counselling services.

The practice communicated information effectively through various formats, and efforts had been made to address the needs of patients facing digital exclusion. While some bilingual signage was present, further promotion of the Welsh Government's 'Active Offer' would enhance inclusivity. Translation services and paper-based alternatives supported equitable access.

The practice premises were accessible and inclusive, with facilities to support patients with mobility needs and neurodivergent individuals. An Equality, Diversity and Inclusion policy was in place, and the practice had taken practical steps to promote fairness in both patient care and staff support.

This is what we recommend the service can improve:

- Enhance physical health promotion materials in the waiting area
- Strengthen the Welsh Language 'Active Offer'.

This is what the service did well:

- Respectful and dignified care

- A wide range of enhanced clinical services and specialist clinics were available
- Accessible and timely care pathways.

Delivery of Safe and Effective Care

Overall summary:
The practice demonstrated commitment to patient safety and effective care delivery, supported by robust systems for managing safety alerts, significant incidents, and safeguarding concerns. Staff were knowledgeable about their responsibilities, and clear processes were in place for lone working, home visits and out of hours provision. Patient records were consistently well-maintained, with clear documentation and appropriate clinical oversight.

Administrative staff had received training in care navigation, enabling them to effectively direct patients to the right care pathway, and the practice's telephone system included clear emergency messaging for urgent needs.

Medicines and vaccines were generally stored and monitored safely, with appropriate cold chain procedures and regular emergency equipment checks. However, improvements are needed in the tracking of printed prescription forms and the labelling of vaccine fridge plugs to meet national safety standards.

Several environmental and procedural areas required attention to reduce potential risks. These included the inappropriate use of an electrical cupboard for storing flammable materials, the insecure placement of a clinical waste bin accessible to the public, and failure to use the correct bins for cytotoxic waste.

Recommendations from a fire risk assessment had not yet been implemented, and expired clinical items were found in some areas. Although cleaning processes were in place, the cleaning schedule was not readily accessible or signed by staff, and some aspects of the premises, including examination couches and storage arrangements, required refurbishment and reorganisation to meet infection prevention standards.

The practice had a safeguarding policy in place and staff were trained, although evidence of role-specific training was not immediately accessible. Oversight of training records should be strengthened to ensure compliance.

This is what we recommend the service can improve:
- Strengthening environmental and fire safety measures
- Improve medicines and equipment oversight
- Strengthening oversight infection prevention and control.

This is what the service did well:

- Robust incident and safety alert management
- High quality patient records and clinical oversight
- Comprehensive safeguarding procedures.

Quality of Management and Leadership

Overall summary:
The practice demonstrated visible and approachable leadership, with staff reporting a clear understanding of their roles and responsibilities. Governance arrangements were supported by regular meetings and designated leads for key areas such as safeguarding, prescribing, and infection control. However, some staff reported that meeting minutes were not consistently shared.

A commitment to quality improvement was evident through clinical audits, often led by GPs or trainees, and a focus on using patient feedback and complaints as opportunities for learning.

Staff wellbeing was supported through access to occupational health services and digital mental health resources. While recruitment processes were thorough, improvements are needed in workforce management. These include the development of a formal induction programme for new staff, regular appraisals, and annual DBS self-declarations. Additionally, some staff files lacked up-to-date job descriptions.

Inspectors identified concerns regarding nursing support and professional development. Nurses lacked protected time for training and administrative duties, and there was no clinical supervision framework in place. The absence of nurse prescribers and unsigned Patient Group Directions (PGDs) highlighted the need for strengthened nursing leadership and governance.

The practice had a complaints policy aligned with the Putting Things Right procedures, though visibility of this process within the reception area was limited. Patient feedback was gathered but not routinely shared back with patients to demonstrate how it informed service improvements.

Overall, while the practice demonstrated strong leadership principles and commitment to improvement, attention to workforce structures, governance documentation, and communication would strengthen its leadership framework further.

Immediate assurances:

- No system in place for managing and overseeing mandatory training compliance.

This is what we recommend the service can improve:

- Strengthening workforce governance and support
- Enhance nursing leadership and professional development
- Improve communication and feedback systems

This is what the service did well:

- Visible and supportive leadership
- Commitment to quality improvement and transparency
- Secure information governance.

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

Patient feedback

Patients who responded to the HIW questionnaire highlighted a generally positive impression of the practice environment, with high satisfaction levels regarding cleanliness, accessibility, and respectful treatment by clinical staff. Most respondents felt they were treated with dignity, listened to, and involved in decisions about their care. The practice's opening hours and the "Ask My GP" service were also positively received.

However, several areas for improvement emerged. Access to routine and same-day appointments was inconsistent, with some patients expressing frustration about difficulties booking in advance or at convenient times. The telephone system was a frequent source of dissatisfaction, particularly long wait times and difficulty getting through. Some of the patients responding to the questionnaire told us of their concerns about the predominance of telephone consultations, with many patients preferring in-person appointments.

Privacy at the reception desk was a significant issue for many respondents, and support for carers appeared limited, with few offered assessments or information about available resources. While many patients felt care was equitable, a minority reported experiences of discrimination, particularly in relation to age and disability. Additionally, many patients were unaware of how to provide feedback or raise complaints.

Overall, 87% of respondents rated their experience as good or very good, indicating a strong foundation for care, albeit with clear opportunities to enhance access, communication, and inclusivity.

Patient comments included:

> *"The Ask my GP service ensures that I am seen either the same day if necessary or receive a phone call if appropriate which is invaluable. I have no problems with this GP surgery, I have always received an excellent service."*

> *"Difficulty in getting telephone calls answered, long waits to get to speak to a receptionist"*

"The phone lines are always busy. The online request opening and closing times are very variable. Makes it difficult for a working person to obtain appointments."

"The GPs are always attentive and helpful. The support staff are always ready to help and provide first class customer service."

"…it is rarely that a face-to-face appointment is offered with a GP."

Person-centred

Health promotion
The practice demonstrated a commitment to health promotion through both clinical services and community engagement. The GP lead and practice manager attend cluster meetings, contributing to collaborative projects within the Llwchwr cluster aimed at improving population health outcomes. While direct liaison with other agencies is reported to be limited, the practice provided information about available services through the practice website and posters.

While digital health promotion was well embedded within the practice, the physical environment of the practice offered limited health promotion material in the waiting area.

The service should enhance this space with a broader variety of health promotional material to complement existing strategies and further support patient engagement during waiting times and for patient groups without digital access.

Patients were signposted to healthy lifestyle resources, and the practice offered access to a range of enhanced services including joint injection clinics, atrial fibrillation management, hypertension and chronic disease monitoring. Specialist services are available through the involvement of a paramedic, clinical and cluster pharmacists, a mental health link practitioner, and targeted clinics such as those for heart failure, diabetes prevention, chronic pain management, and mental health support, including self-help resources.

In addition to these resources, the practice provided an area in reception where patients could independently check their blood pressure, height, weight, and BMI.

A dedicated carers' information board was also in place to support individuals in unpaid caring roles.

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, website, text messages and via telephone calls.

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 were reported to have completed chaperone training. Chaperone information notices were displayed in the waiting area and within all clinical treatment rooms, indicating that this service was available.

Timely

Timely care
The practice had an up-to-date access policy in place, outlining the arrangements for patients to access care in a timely manner.

Patients were able to access a wide range of clinical services through multiple channels, including telephone, online via the 'Ask My GP' application, email, and in-person requests. Walk-in patients were triaged at the front desk to ensure appropriate and timely management. Reception staff supported care navigation by guiding patients to the most appropriate services.

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. Housebound patients could request a home visit by a GP.

A contingency process was in place for occasions when no appointments were available. This involved an on-call GP supported by a designated receptionist, ensuring patients with urgent needs were assessed and managed appropriately.

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

signposting were also available for patients needing mental health support, including counselling funded by the Llwchwr cluster.

Equitable

Communication and language
Information about the services offered by the practice was communicated to patients through a variety of formats, including the practice website and a patient information leaflet. The practice information leaflet was available in paper format and could be provided in larger print upon request; we suggested that it be uploaded to the website to improve accessibility for all patients.

We were told there were several fluent Welsh speaking staff at the practice. 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 proportionate to meet the language needs of the local population.

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

Information about available services and any updates were published on the practice's website, which could be translated into other languages, including Welsh. Staff told us they could access a translation service to help communicate with patients whose first language was not English or Welsh.

The practice ensured that paper forms were readily available to support individuals who may experience difficulties with digital access, including older patients. For those who were digitally excluded or less comfortable with online systems, the practice maintained communication by telephone, particularly for sharing test results or important information arising from clinical correspondence.

Rights and equality
The practice was in a purpose-built building that provided good accessibility for patients. All patient areas were situated on the ground floor, and a wheelchair ramp connected the car park to the main entrance.

The building included a wheelchair-accessible toilet on the ground floor, equipped with grab handles and an emergency alarm, alongside unisex toilet facilities. A lift was available for access to the first floor when required, and a wheelchair was provided for patient use on site. The patients' waiting area was spacious, clean, and well-furnished with ample seating.

The practice had an Equality, Diversity and Inclusion (EDI) policy in place. While training records relating to this policy were not available during the inspection, the practice demonstrated some practical steps to promote inclusion and fairness.

In addition, the practice showed sensitivity to neurodivergent patients by making use of a quieter corridor to create a more suitable environment for those who may be overwhelmed by busy or noisy settings.

Delivery of Safe and Effective Care

Safe

Risk management
The practice had an up-to-date business continuity plan in place; however, it required minor updates to reflect operational changes that had occurred since its last review.

The service should review and revise the business continuity plan to ensure it accurately reflects current arrangements and remains fit for purpose.

The systems and processes for managing patient safety alerts and significant incidents were robust. The practice manager held responsibility for ensuring that all relevant safety alerts were received and appropriately disseminated across the practice team. These alerts were routinely communicated during practice meetings, where they were discussed alongside significant event analyses (SEAs).

Incidents reported through the Datix system were directed to both the practice manager and the designated lead for complaints and concerns. This arrangement ensured that such matters were reviewed, addressed, and monitored effectively to support patient safety and service improvement.

Policies for home visits and lone working were in place and were supported by a clear system that required clinicians to check in and out when undertaking visits in the community.

The practice had waste management procedures, including the use of sharps containers, clinical waste bins, and recycling facilities. Outside the premises, a yellow clinical waste bin was positioned against a wall directly under the building's eaves.

The practice must ensure that the clinical waste bin is moved to a secure, designated area that is not accessible to the public and is positioned away from the building structure.

During the inspection, it was identified that the practice was not using the appropriate coloured clinical waste bins for the disposal of cytotoxic medications, such as Depo-Provera.

The practice must ensure that all cytotoxic and cytostatic medications are disposed of using the correct coloured clinical waste bins in accordance with national waste management regulations.

There was no clinical waste audit available for review during the inspection.

The practice should ensure that a clinical waste audit is carried out and that records are maintained and available for review.

A fire risk assessment had been carried out in 2022; however, the practice had not yet implemented the recommendations outlined in the report.

The practice should implement the outstanding recommendations from the fire risk assessment without delay and review the contents of the overall risk assessment.

During the inspection, an electrical cupboard was found to be used as a storage area for items including step ladders and paper hand towels. The hand towels were stored near the electrical circuit breakers, which presented a potential fire and safety hazard due to the inappropriate use of the space and the flammable nature of the materials stored.

The practice should ensure that electrical cupboards are used solely for their intended purpose and ensure that flammable items are stored safely and in appropriate locations, away from electrical components.

Infection, prevention and control (IPC) and decontamination
There were no outstanding estates requests at the time of the inspection. A cleaning contract was in place; however, the cleaning schedule was not readily available for cleaning staff to sign, which would have provided assurance that cleaning was being carried out in accordance with agreed standards.

The practice should ensure that the cleaning schedule is readily accessible to cleaning staff and includes a system for staff to sign upon completion of tasks.

Staff demonstrated a clear understanding of their roles and responsibilities in maintaining infection prevention and control standards, and the IPC lead was proactive in ensuring that staff remained informed of the latest guidance.

The Hepatitis B immunisation register for staff was complete, which supported safe practice and staff protection.

However, elements of the premises showed signs of wear and tear. Carpets were stained due to previous leaks, ripped examination couches, and cluttered areas with stock stored on open shelves rather than in drawers, covered containers, or cupboards were observed.

The practice should:

- **repair or replace the examination couches to address the tear in their surface and carry out a full review of all clinical furniture to identify any additional damage. Any items with compromised surfaces should be addressed to ensure they can be effectively cleaned.**
- **review and reorganise storage arrangements to ensure that stock is stored appropriately.**

Medicines management

During the inspection, it was identified that printed prescription stationery was not tracked, with blank forms found in consulting rooms and an administrative office. In contrast, handwritten prescription pads were observed to be stored appropriately and securely. However, the practice did not have a formal procedure in place for the oversight of printed prescription forms.

The practice must implement a formal procedure for tracking the movement of printed prescription forms and routine logging of serial numbers for all blank printed prescription stationery.

Vaccines were stored appropriately within dedicated vaccine fridges, which had appropriate annual maintenance and calibration. An up-to-date cold chain process document was in place to ensure safe storage of refrigerated medicines. There was a system in place for monitoring fridge temperatures. However, although the written policy stated that temperatures should be checked twice daily, this was only being carried out once a day at the time of the inspection.

The practice should ensure that fridge temperature checks are carried out in accordance with its written policy, with temperatures recorded twice daily.

During the inspection, a vaccine fridge located on the upper floor was found to be in use without a "Do Not Remove" label on its plug. This did not comply with the guidance set out in the Public Health Wales Advisory Document on Ordering, Storage and Handling of Vaccines, which specifies that all vaccine fridge plugs should be clearly marked to prevent accidental disconnection.

The practice should ensure that all vaccine fridge plugs are clearly labelled with a "Do Not Remove" sign in accordance with Public Health Wales guidance.

One of the vaccine fridges was out of use due to being broken and was no longer in operation.

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

Appropriate processes were in place for reporting adverse reactions to drugs, using the yellow card system, and for the disposal of expired medicines. The drugs we checked during the inspection were all in date. There was a named person responsible for the checking of drugs, and evidence was seen of regular weekly emergency trolley checks. However, we noted that the oxygen cylinder was stored horizontally, when it should have been stored upright. Staff corrected this during the inspection.

Safeguarding of children and adults
The practice had an up-to-date safeguarding policy which included the contact details for the local safeguarding team. Staff were aware of their responsibilities in relation to recognising and reporting safeguarding concerns, information sharing, and how to contact relevant agencies when needed. A system was in place to ensure that children on the child protection register could be identified through linked family records, supporting continuity and vigilance in safeguarding practices.

The safeguarding lead was reported to be trained to Level 4, and staff had access to the All-Wales Child Protection Procedures to guide their practice. There were comprehensive safeguarding procedures in place, including the appointment of a named lead with clearly delegated tasks and responsibilities.
Whilst we were assured that staff had received safeguarding training, evidence that the training was appropriate to their roles and responsibilities was not immediately accessible therefore, oversight of safeguarding training must be strengthened. This was addressed under our immediate assurance process in Appendix B.

The practice manager described a clear process for pre-employment checks for new staff, which included obtaining references and carrying out Disclosure and Barring Service (DBS) checks appropriate to the role. These measures helped to ensure that individuals employed by the practice were suitable to work with vulnerable groups.

Management of medical devices and equipment
The practice made use of single-use equipment wherever possible, reducing the risk of cross-contamination and supporting infection control measures. Medical devices in use appeared to be in good condition at the time of the inspection. The practice had established contracts for the routine servicing and maintenance of medical devices, and evidence was seen of service calibration and Portable Appliance Testing (PAT). However, it was noted that PAT testing was overdue at the time of the visit.

The service must ensure that all electrical equipment is tested within the required timeframes to maintain safety and compliance.

We were told that a process was in place for the emergency repair or replacement of equipment. Despite this, there was no designated person responsible for checking medical devices, and no physical record of equipment checks was available for review.

The practice should assign a designated individual to oversee the routine checking of medical devices and maintain a physical record of these checks.

During the inspection, expired items were found in clinical areas that had not been removed from use. These included face masks, stitch removers, and blood sugar monitoring strips. The presence of expired equipment poses a potential risk to patient and staff safety, as such items may no longer be effective or safe for use.

The practice should implement a system for regularly checking and removing expired items from clinical areas to ensure that only in-date and safe equipment is available for use.

It was noted that the room housing the Automated External Defibrillator (AED) and Oxygen cylinder did not have signage. Signage for emergency equipment had been placed on the appropriate room doors during the inspection. This is detailed in Appendix A.

Effective

Effective care
The practice telephone system included a clear message signposting callers with emergency conditions to dial 999, ensuring that patients in urgent need of care were directed appropriately. All administrative staff had completed Care Navigation training, equipping them with the skills to guide patients to the most suitable healthcare professional or service based on their needs.

An appropriate system was in place for reporting incidents, and there was evidence that shared learning from such events was discussed within team meetings, supporting a culture of continuous improvement and patient safety.

Patient records
Patient records reviewed during the inspection were of a consistently high standard. They were up to date, complete, and clearly documented, with information recorded in a manner that was both understandable and contemporaneous.

Clinical entries demonstrated a clear and concise approach, with management plans and follow-up arrangements clearly outlined. Where appropriate, safety-netting advice was also recorded to support patient care. All consultations were read-coded, ensuring effective data management and facilitating clinical audits. Repeat prescriptions were subject to regular review, and appropriate clinical monitoring was in place to ensure the safe and effective management of long-term conditions.

Quality of Management and Leadership

Leadership

Governance and leadership
Staff and managers demonstrated a clear understanding of their roles, responsibilities, and reporting lines, and were aware of the importance of working within their defined scope of practice. Leaders within the practice were described as visible and approachable, and an open-door policy was in place to support open communication and accessibility.

Structured governance arrangements were supported by regular meetings, including monthly practice meetings, clinical meetings held approximately every six weeks, and up to ten palliative care meetings each year. The deputy practice manager was usually responsible for disseminating information from these meetings. However, some staff reported that minutes were not always shared with those who were unable to attend, which may have limited wider staff engagement with discussions and decisions.

The practice should ensure that minutes of all relevant meetings are consistently shared with staff who are unable to attend.

The practice promoted shared responsibility for delivering improvement work, such as Quality Assurance and Improvement Framework (QAIF) and other local projects, with designated leads identified for each area of work. There were also named leads for specific operational and clinical areas, including complaints, safeguarding, infection prevention and control, prescribing, Speak Up Safely, and occupational health. These individuals were available to provide advice and guidance within their areas of responsibility, supporting safe and effective leadership across the practice.

Staff had access to wellbeing support, including GP occupational health services and digital mental health resources such as SilverCloud, helping to promote staff resilience and overall wellbeing. Wellbeing initiatives included the offer of flexible working arrangements, such as reduced hours, to accommodate staff needs. A new polo shirt uniform had also been introduced, which staff reported was more comfortable and practical.

Workforce

Skilled and enabled workforce

The practice had an up-to-date recruitment policy in place, which referenced regulatory guidance, including that of the Care Quality Commission (CQC).

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

For recently recruited staff, documentation was found to be in order, including proof of identity, Disclosure and Barring Service (DBS) checks at the appropriate level, a full employment history, written references from previous employers, and evidence of relevant qualifications. For healthcare professionals, verification of registration with the appropriate regulatory body was also in place. However, some staff files did not include up-to-date job descriptions, which are important for defining roles and responsibilities.

The practice should ensure that all staff files contain up-to-date job descriptions that clearly outline roles and responsibilities.

Leaders told us there was no formal induction programme or policy in place to support new staff.

The practice should develop and implement a formal induction policy or programme for all new staff.

The practice manager confirmed the practice had not yet implemented a process for obtaining annual DBS self-declarations or conducting regular appraisals.

The practice should introduce a system for completing annual DBS self-declarations and ensure that regular staff appraisals are conducted.

We reviewed the systems in place for managing and overseeing mandatory training compliance and were not assured that they were sufficiently robust to ensure all staff were competent to carry out their roles safely and effectively. During our visit, we were advised that the practice did not maintain a centralised record, such as a comprehensive training monitoring system, to systematically track whether staff had completed the necessary training and were up to date with refresher sessions. The absence of such a system raised concerns about the practice's ability to assure the ongoing safety of patients, staff, and visitors. This was addressed under our immediate assurance process in Appendix B.

Although nursing staff were experienced and contributed significantly to clinical care, we were concerned regarding their support and professional development. No protected time was allocated for additional responsibilities, training,

administrative duties, or regular nurse meetings. Notably, these concerns were identified through observation rather than direct expression by staff.

There were no nurse prescribers at the practice, and nurses were required to prepare prescriptions for GP authorisation. Whilst nurses can support prescription processes under delegation, they must not issue prescriptions independently unless they are qualified prescribers.

The practice should consider developing nurse prescribing capacity to strengthen safe and autonomous practice.

Additionally, there was no clinical supervision framework in place for the nursing team. The absence of regular supervision may limit opportunities for reflective practice, professional development, and support, particularly for nurses working in advanced or autonomous roles.

The practice should consider implementing a clinical supervision framework for nurses.

Furthermore, not all Patient Group Directions (PGDs) had been signed by the nurses expected to use them. Nurses must only administer or supply medications under a valid PGD that they have personally signed, in line with national guidance.

The practice must ensure all PGDs are correctly signed and in use only by authorised staff.

These gaps indicated a need for greater investment in nursing leadership, protected professional development time, and professional support to ensure the team was fully enabled to deliver care within their scope and according to current clinical governance standards.

Culture

People engagement, feedback and learning

The practice maintained a log to record the number and nature of complaints and concerns received, and we were told there were plans in place to introduce a system to monitor trends over time.

The service should implement this system to help identify recurring issues, improve responsiveness, and support continuous improvement.

A complaints policy was in place which aligned with the Putting Things Right procedures. While no specific Putting Things Right information was displayed in the

reception area at the time of inspection, a sign was visible advising patients to contact the practice manager with any feedback, concerns, or complaints.

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

The practice demonstrated that complaints and concerns were managed in accordance with the complaints policy. A named member of staff had responsibility for overseeing complaints handling, and processes were in place to support learning and improvement. Learning from complaints, concerns, and patient feedback was considered through a standing agenda item at practice meetings and shared with staff via email communication.

The practice gathered patient feedback through an annual survey and the Ask My GP application. Although feedback was used to inform improvements, a suitable system to feedback to patients was not in place at the time of the inspection. Such a system could help to demonstrate to patients how their feedback informs service development.

The practice should implement a formal system to provide feedback to patients on how their views have informed service improvements.

The practice had up-to-date policies in place for both whistleblowing (Speak Up Safely) and Duty of Candour. The Duty of Candour had been applied in line with the policy, providing assurance that the practice was committed to openness and transparency in the event of patient safety incidents.

Information

Information governance and digital technology

The practice had appointed a Data Protection Officer and had an up-to-date information governance policy in place. There was an appropriate system for the effective collation, sharing, and reporting of patient data, referrals, and information requests. Patient records were securely stored, providing assurance that confidentiality and data security were being maintained in accordance with relevant legislation.

The practice's procedures for managing patient data were clearly documented, and this information was also made publicly available on the practice website.

Learning, improvement and research

Quality improvement activities

The practice had engaged in a range of quality improvement activities, including audits linked to cluster projects and prescribing. Responsibility for individual audits was allocated according to the area under review, with lead GPs or the pharmacist taking the lead as appropriate. As a GP training practice, trainees were also actively involved in conducting audits, and their findings were presented and discussed during practice meetings, contributing to shared learning and service development.

The practice had processes in place for carrying out and recording significant event reviews. These were used constructively to identify learning points and to support ongoing improvements in clinical care and patient safety.

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
It was noted that the room housing the Automated External Defibrillator (AED) and Oxygen cylinder did not have clear signage.	The absence of AED and oxygen warning signage on the door to the room containing the portable oxygen cylinder and AED could compromise safety in emergency or high-risk situations. Oxygen is a highly flammable substance, and without appropriate signage, staff, contractors, or emergency responders may be unaware of the presence of oxygen and	Raised with the practice manager during the inspection.	The practice took immediate action during the inspection to display oxygen and AED warning signs on the door of the room containing the AED and oxygen cylinder, in line with safety regulations and best practice guidance.

	the AED, increasing the risk of fire or inappropriate use of equipment in those areas. Additionally, the lack of signage could delay appropriate responses during an emergency, particularly if staff were unfamiliar with the layout or unaware of the oxygen and AED storage locations. This could hinder timely access to life-saving equipment and affect the overall safety of the care environment.		

Appendix B – Immediate improvement plan

Service: Estuary Group Practice – Gowerton Medical Centre

Date of inspection: 14 October 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.	HIW is not assured that the systems in place for managing and overseeing mandatory training compliance are sufficiently robust to ensure all staff are competent to carry out their roles safely and effectively. During our visit, we were advised	The practice must: • Develop and implement a comprehensive training monitoring system that clearly identifies mandatory training requirements for each staff role and tracks completion and refresher dates. • Introduce a system for regular audit and review of	Health and Care Quality Standards – Safe; Effective; Workforce; Leadership; Information; Learning, Improvement & Research.	Estuary Group Practice is committed to providing a safe environment and high-quality care for all our patients. We fully understand and accept the seriousness of the concerns identified regarding mandatory training. We view	Estuary Group Practice Partners	Completed 17th Oct 2025

	that the practice does not maintain a centralised record, such as a comprehensive training monitoring system, to systematically monitor whether all staff have completed the necessary training and are up to date with refresher sessions. The absence of such a system raises concerns about the practice's ability to assure the ongoing safety of patients, staff, and visitors.	training compliance, including escalation procedures for overdue training. • Assign a designated training lead responsible for maintaining oversight of staff training records and ensuring alignment with national guidance and role-specific requirements. • Ensure senior leadership regularly reviews training compliance data and integrates findings into governance and risk management processes. • Establish a feedback mechanism for staff to identify training needs and suggest improvements to the training programme.		these findings with the utmost gravity and assure you that addressing these issues is our highest and most immediate priority. Therefore following the inspection feedback on 15th October 2025, we met as a partnership on 17th October 2025 and immediate action to mitigate these risks was initiated without delay. We have implemented a Mandatory Staff Training Policy. A copy is attached. This details training requirements including content and validity period for all staff groups at Estuary Group Practice. It designates lead	Dr R Spacie GP Partner	Completed 17th Oct 2025

				personnel for audit and review of compliance including process for non-compliance. It designates a training lead responsible for maintaining oversight of staff training records. It details responsibility (both administrative and at a partnership level) for regular review of compliance. Feedback routes are described. It will be reviewed within 3 months of inception to ensure it meets the needs of our organisation. A Mandatory Training Record System has been produced. This will be used to audit training compliance data, in line with the	Dr R Spacie GP Partner	Completed 17th Oct 2025

				Mandatory Training Policy. We will review the training of current staff against the Mandatory Staff Training Policy. Where training needs are identified this will be addressed as below. Identified training needs amongst staff will be dealt with using allocated time for staff members over the next 3 months. This will ensure that all have completed mandatory training. Overall oversight - Mandatory Training will be discussed at all Partnership meetings until the Mandatory Training Policy is	Practice Manager All staff. Facilitated by Operations Manager. Estuary Group Practice Partners	Within 4 weeks 3 months 12 months

				embedded as normal practice across the organisation.		

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): Dr R Spacie

Job role: GP Partner

Date: 17th October 2025

Appendix C - Improvement plan

Service: Estuary Group Practice - Gowerton Medical Centre

Date of inspection: 14 October 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.	While digital health promotion was well embedded within the practice, the physical environment of the practice offered limited health promotion material in the waiting area.	The service should enhance this space with a broader variety of health promotional material to complement existing strategies and further support patient engagement during waiting times and for patient groups without digital access.	Health & Care Quality Standards (2023) – Equitable, Person-Centred.	Will purchase tv screen displaying NHS health information and local services.	B Matthews PM	31.01.26
2.	As part of the Welsh Government's 'Active Offer' initiative, all practice information and signs should be	The practice must ensure that the 'Active Offer' of Welsh language is promoted to patients.	Health & Care Quality Standards (2023) – Equitable, Person-Centred, Leadership	Review current arrangements and update.	B Matthews PM	31.01.26

	bilingual. We saw that some signs and posters were available in Welsh, however, most were available in English only.					
3.	The practice had an up-to-date business continuity plan in place; however, it required minor updates to reflect operational changes that had occurred since its last review.	The service should review and revise the business continuity plan to ensure it accurately reflects current arrangements and remains fit for purpose.	Health & Care Quality Standards (2023) – Safe, Effective, Leadership.	PM to review.	B Matthews PM	31.01.26
4.	Outside the premises, a yellow clinical waste bin was positioned against a wall directly under the building's eaves. It was not securely stored away from publicly accessible areas.	The practice must ensure that the clinical waste bin is moved to a secure, designated area that is not accessible to the public and is positioned away from the building structure, to reduce the risk of fire and ensure compliance with health and safety regulations.	Health & Care Quality Standards (2023) – Safe, Effective, Leadership.	Practice to review suitable alternative area.	B Matthews PM	31.01.26

5.	During the inspection, it was identified that the practice was not using the appropriate coloured clinical waste bins for the disposal of cytotoxic medications, such as Depo-Provera.	The practice should ensure that all cytotoxic and cytostatic medications are disposed of using the correct coloured clinical waste bins in accordance with national waste management regulations, to promote safe handling and compliance with legal requirements.	Health & Care Quality Standards (2023) – Safe, Effective, Leadership, Workforce.	Clinical waste audit to be carried out.	Lead Nurse	31.01.26
6.	There was no clinical waste audit available for review during the inspection.	The practice should ensure that a clinical waste audit is carried out and that records are maintained and available for review.	Health & Care Quality Standards (2023) – Safe, Effective, Efficient, Information.	Pre-acceptance clinical waste audit to be carried out.	Lead Nurse	31.01.26
7.	A fire risk assessment had been carried out; however, the practice had not yet implemented the recommendations outlined in the report.	The practice should implement the outstanding recommendations from the fire risk assessment without delay and review the contents of the overall risk assessment, to ensure full compliance with fire safety regulations and to safeguard	Health & Care Quality Standards (2023) – Safe, Effective, Leadership.	Complete outstanding actions	Dr. G. Jones – Senior Partner	31.01.26

		the health and safety of patients, staff, and visitors.				
8.	An electrical cupboard was found to be used as a storage area for items including step ladders and paper hand towels. The hand towels were stored near the electrical circuit breakers.	The practice should ensure that electrical cupboards are used solely for their intended purpose and ensure that flammable items are stored safely and in appropriate locations, away from electrical components, to reduce the risk of fire and maintain health and safety standards.	Health & Care Quality Standards (2023) – Safe, Effective, Leadership.	Completed	B Matthews PM	Completed
9.	A cleaning contract was in place; however, the cleaning schedule was not readily available for cleaning staff to sign, which would have provided assurance that cleaning was being carried out in accordance with agreed standards.	The practice should ensure that the cleaning schedule is readily accessible to cleaning staff and includes a system for staff to sign upon completion of tasks, in order to provide assurance that cleaning is being carried out consistently and in line with agreed standards.	Health & Care Quality Standards (2023) – Safe, Effective, Leadership, Workforce.	Implemented.	B Matthews PM	08.12.25
10.	However, elements of the premises showed	The practice should:	Health & Care Quality Standards (2023) –	Review to be conducted.	Lead Nurse	31.01.26

	signs of wear and tear. Ripped examination couches, and cluttered areas with stock stored on open shelves rather than in drawers, covered containers, or cupboards were observed.	• repair or replace the examination couches to address the tear in their surface and carry out a full review of all clinical furniture to identify any additional damage. Any items with compromised surfaces should be addressed to ensure they can be effectively cleaned. • review and reorganise storage arrangements to ensure that stock is stored appropriately.	Safe, Effective, Person-centred, Leadership, Workforce.			
11.	The practice did not have a formal procedure in place for the oversight of printed prescription forms.	The practice must implement a formal procedure for tracking the movement of printed prescription forms and routine logging of serial numbers for all blank printed prescription stationery.	Health & Care Quality Standards (2023) – Safe, Information, Leadership.	Paper prescription log template obtained. Will review and adapt.	B Matthews PM	31.01.26
12.	There was a system in place for monitoring fridge temperatures.	The practice should ensure that fridge temperature checks are carried out in	Health & Care Quality Standards (2023) – Safe,	Implemented	Lead Nurse	Ongoing

	However, although the written policy stated that temperatures should be checked twice daily, this was only being carried out once a day at the time of the inspection.	accordance with its written policy, with temperatures recorded twice daily, to provide assurance that vaccines are stored safely and in line with cold chain requirements.	Effective, Leadership, Workforce.			
13.	During the inspection, a vaccine fridge located on the upper floor was found to be in use without a "Do Not Remove" label on its plug.	The practice should ensure that all vaccine fridge plugs are clearly labelled with a "Do Not Remove" sign in accordance with Public Health Wales guidance, to safeguard against accidental disconnection and protect the efficacy of stored vaccines.	Health & Care Quality Standards (2023) – Safe, Effective, Leadership, Information.	Implemented	Lead Nurse	08.12.25
14.	One of the vaccine fridges was out of use due to being broken and was no longer in operation.	A review of all clinical and non-clinical areas must be undertaken to remove faulty and unused equipment.	Health & Care Quality Standards (2023) – Safe, Effective, Leadership, Information.	Carried out 05.12.25	Lead Nurse	Completed
15.	It was noted that Portable Appliance Testing(PAT) was	The service must ensure that all electrical equipment is tested within	Health & Care Quality Standards (2023) – Risk,	Arranged for Jan 26.	B Matthews PM	31.01.26

	overdue at the time of the visit.	the required timeframes to maintain safety and compliance.	Safe.			
16.	There was no designated person responsible for checking medical devices, and no physical record of equipment checks was available for review.	The practice should assign a designated individual to oversee the routine checking of medical devices and maintain a physical record of these checks, to ensure equipment remains safe, functional, and fit for purpose at all times.	Health & Care Quality Standards (2023) – Safe, Effective, Leadership, Information.	Will introduce a system of regular checks and will record these.	Lead Nurse	31.12.25
17.	Expired items were found in clinical areas that had not been removed from use. These included face masks, stitch removers, and blood sugar monitoring strips. The presence of expired equipment poses a potential risk to patient and staff safety, as such items may no longer be	The practice should implement a system for regularly checking and removing expired items from clinical areas to ensure that only in-date and safe equipment is available for use, thereby protecting the safety of both patients and staff.	Health & Care Quality Standards (2023) – Safe, Effective, Leadership, Information.	Weekly checks implemented November 2025.	Lead Nurse	Ongoing

	effective or safe for use.					
18.	It was noted that the room housing the Automated External Defibrillator (AED) and Oxygen cylinder did not have clear signage. Signage for emergency equipment had been placed on the appropriate room doors during the inspection.	The practice must ensure that the recognised signs for AED and oxygen are added to the door in which they are located to improve visibility and access in an emergency.	Health & Care Quality Standards (2023) – Safe, Effective, Person-centred, Leadership, Workforce.	Will implement Dec 25.	Lead Nurse	15.12.25
19.	Some staff reported that minutes were not always shared with those who were unable to attend, which may have limited wider staff engagement with discussions and decisions.	The practice should ensure that minutes of all relevant meetings are consistently shared with staff who are unable to attend, to support effective communication, promote inclusive participation, and ensure all team members remain informed of key decisions and updates.	Health & Care Quality Standards (2023) – Effective, Leadership, Workforce.	Shared folder created for clinical meetings. Relevant extracts from practice meetings will be circulated by the PM to all staff.	B Matthews PM	08.12.25

20.	The practice had an up-to-date recruitment policy in place, which referenced regulatory guidance, including that of the Care Quality Commission (CQC).	The practice must review the policy to ensure all referenced services are appropriate for the Welsh healthcare context.	Health & Care Quality Standards (2023) – Leadership, Workforce, Safe.	Review current policy for relevance to NHS Wales.	B Matthews PM	31.12.25
21.	Some staff files did not include up-to-date job descriptions, which are important for defining roles and responsibilities.	The practice should ensure that all staff files contain up-to-date job descriptions that clearly outline roles and responsibilities, to support clarity of expectations, accountability, and effective workforce management.	Health & Care Quality Standards (2023) – Workforce, Leadership, Effective.	Review all staff files and job descriptions.	B Matthews PM	28.02.25
22.	There was no formal induction programme or policy in place to support new staff.	The practice should develop and implement a formal induction policy or programme to ensure that all new staff receive consistent, structured onboarding that supports their understanding of practice procedures, roles,	Health & Care Quality Standards (2023) – Workforce, Leadership, Safe, Effective.	Staff handbook was introduced for all admin staff in September 2025. This will be further enhanced.	B Matthews PM	31.01.26

		and responsibilities from the outset.				
23.	The practice had not yet implemented a process for obtaining annual DBS self-declarations or conducting regular appraisals.	The practice should introduce a system for completing annual DBS self-declarations and ensure that regular staff appraisals are conducted, to maintain ongoing suitability for roles, support professional development, and strengthen overall workforce governance.	Health & Care Quality Standards (2023) – Workforce, Leadership, Safe, Effective.	Will implement by 31.03.26.	B Matthews PM	31.03.26
24.	There were no nurse prescribers at the practice, and nurses were required to prepare prescriptions for GP authorisation. Whilst nurses can support prescription processes under delegation, they must not issue prescriptions independently unless they are qualified prescribers.	The practice should consider developing nurse prescribing capacity to strengthen safe and autonomous practice.	Health & Care Quality Standards (2023) – Safe, Effective, Workforce, Leadership.	The practice will review this for the MDT.	Dr. L. Walters	31.01.25

25.	There was no clinical supervision framework in place for the nursing team.	The practice should consider implementing a clinical supervision framework for nurses.	Health & Care Quality Standards (2023) – Workforce, Leadership, Safe, Effective.	Dr Lowri Walters will introduce this.	Dr L. Walters	28.02.26
26.	Not all Patient Group Directions (PGDs) had been signed by the nurses expected to use them.	The practice must ensure all PGDs are correctly signed and in use only by authorised staff.	Health & Care Quality Standards (2023) – Safe, Effective, Workforce, Leadership.	Lead Nurse to review.	Lead Nurse	31.12.25
27.	The practice maintained a log to record the number and nature of complaints and concerns received, and we were told there were plans in place to introduce a system to monitor trends over time.	The service should implement this system to help identify recurring issues, improve responsiveness, and support continuous improvement.	Health & Care Quality Standards (2023) – Person-centred, Safe, Effective.	Log implemented September 2025. Trends to be reviewed bi-annually.	B Matthews PM	30.04.26

28.	While no specific Putting Things Right information was displayed in the reception area at the time of inspection, a sign was visible advising patients to contact the practice manager with any feedback, concerns, or complaints.	The practice must ensure that the complaints and 'Putting Things Right' process is prominently displayed at the practice to support patient awareness.	Health & Care Quality Standards (2023) – Person-centred, Equitable, Information, Leadership.	Leaflets now available. This can be included in content for the tv screen in the waiting room to be purchased.	B Matthews PM	ongoing
29.	Although feedback was used to inform improvements, a suitable system to feedback to patients was not in place at the time of the inspection.	The practice should implement a formal system to provide feedback to patients on how their views have informed service improvements.	Health & Care Quality Standards (2023) – Person-centred, Equitable, Effective.	Feedback from the current patient survey will be made available on the website. A summary of changes made will also be made available in this way.	B Matthews PM	31.03.26

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): BARRY MATTHEWS

Job role: Practice Manager

Date: 08.12.25