Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report

(Announced)

Clase Surgery, Swansea Bay University Health Board

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

Our purpose

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

Our values

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

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

Our goal

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

Our priorities

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

Contents

1. What we did

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

Healthcare Inspectorate Wales (HIW) completed an announced inspection of Clase Surgery, Swansea Bay University Health Board on 19 January 2026.

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. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of 16 questionnaires were completed by patients or their carers and four were completed by staff. Feedback and some of the comments we received appear throughout the report.

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

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

2. Summary of inspection

Quality of Patient Experience

Overall summary:
The practice demonstrated a commitment to delivering person-centred care, particularly through digital health promotion and flexible access arrangements. Patients were supported with personalised information during consultations, and a comprehensive range of self-referral services was promoted via the practice website. Seasonal vaccination programmes were well managed and promoted through multiple channels. However, opportunities to enhance patient engagement for those without digital access were missed, with limited health information available in the waiting area.

Respect for patient dignity was evident in private consultation practices and the availability of a quiet room, though issues with overheard conversations and the lack of visible chaperone information required attention. Timely care was supported by a clear appointment system. However, the access and care navigation policies lacked detail on additional services and staff responsibilities. Vulnerable and digitally excluded patients were supported through appropriate appointment arrangements and triage processes.

Communication and language support included accessible formats and translation tools. However, internal communication processes carried clinical risk due to a reliance on verbal messaging and unclear delegation for handling patient information. Staff without clinical training were involved in managing correspondence and updating medication records, raising safety concerns. The absence of a Patient Consent Policy and limited Welsh language provision were also noted, with a need to promote the Welsh Government's 'Active Offer' more fully.

In terms of equity and inclusion, the practice offered step-free access, quiet areas for anxious patients, and was sensitive in its approach to transgender care.

Immediate assurances:

- The accessible toilet was found to be cluttered and lacked an emergency pull cord and suitable locking mechanism, compromising its suitability for disabled users
- Issues around the provision and documentation of chaperones during intimate examinations were identified, with no visible signage and no record of chaperone offers in patient notes.

This is what we recommend the service can improve:

- Improve internal communication processes by using secure clinical system messaging and ensuring administrative staff do not undertake clinical tasks, including adding or amending medication records
- Strengthen policies and procedures by updating the access and care navigation policies, clarifying delegation within the workflow policy, and developing a Patient Consent Policy
- Address issues affecting privacy, including ensuring conversations in consultation rooms cannot be overheard.

This is what the service did well:

- Provided a wide range of self-referral and support services accessible through a comprehensive digital self-help hub
- Delivered well-organised seasonal vaccination campaigns, using varied communication methods to reach patients with and without digital access.

Delivery of Safe and Effective Care

Overall summary:
The practice had some systems in place to support safe and effective care, including an up-to-date Business Continuity Plan, regular medication reviews, and processes for managing repeat prescriptions and test results. Equipment was maintained in good condition and emergency drugs were in date. The practice also engaged with clinical guidance and cluster initiatives to support continuous learning.

However, the inspection identified several safety concerns requiring urgent attention. Risk management systems were not always robust, with limited documentation of significant events, absence of emergency call buttons in key areas, and inappropriate use of storage spaces presenting safety risks. Infection prevention and control (IPC) measures were inadequate in several areas, including expired clinical items, lack of staff training, no IPC audits, and unsuitable hand hygiene facilities.

Medicines management was compromised by poor stock control, unsecured prescription pads, and the absence of systems to monitor non-refrigerated medicine storage conditions. Safeguarding systems required strengthening, particularly the development of an adult safeguarding policy, improved documentation, and regular multi-agency meetings. Staff training records were incomplete for key areas such as safeguarding and medical emergencies.

The quality of patient records was inconsistent, with some lacking essential clinical details, coding, and documentation of patient information or chaperone offers.

The absence of a mortality review process also limited opportunities for reflective learning.

Immediate assurances:

- Emergency medical equipment and oxygen were stored in separate rooms, which could delay access in an emergency
- No infection prevention and control (IPC) audit was available; additionally, critical IPC policies were missing and staff had not received mandatory IPC training
- Inappropriate use of the electrical cupboard
- There was limited evidence of mandatory training records and no system in place to ensure ongoing staff suitability for their role.

This is what we recommend the service can improve:

- Improve medicines management and clinical safety by securing prescription stationery, monitoring medicine storage (including non-refrigerated drugs), removing expired stock, and ensuring only qualified staff make clinical entries or decisions
- Reinforce safeguarding arrangements by developing an adult safeguarding policy, updating children's safeguarding procedures, and reinstating regular safeguarding and palliative care meetings.

This is what the service did well:

- Engaged with national and local clinical guidance using National Institute for Health and Care Excellence (NICE) guidelines, health board updates, and cluster meetings.

Quality of Management and Leadership

Overall summary:
Staff feedback indicated a strong personal commitment to patient care, with respondents reporting that patients were treated with dignity and respect and supported through appropriate communication methods.

There were some foundations for effective leadership. The practice held quarterly team meetings and had designated leads for safeguarding, complaints and clinical oversight. Staff reported that GPs were accessible for advice. The practice was also engaged in cluster and health board activity, contributing to wider partnership working.

Governance systems lacked oversight in several areas, including the absence of documented clinical meeting minutes, out-of-date or incomplete policies, and a

lack of systems to track mandatory training, appraisals, and ongoing staff suitability.

Workforce processes were found to be underdeveloped, with no job descriptions for clinical staff, poor compliance with recruitment procedures, and gaps in Disclosure and Barring Service (DBS) checks. Additionally, there was no formal clinical supervision framework in place, and at times, nursing staff were working without on-site prescribing support.

The practice's complaints process was not fully aligned with NHS Wales guidance, and there was limited evidence that complaints were analysed or used to support organisational learning. Patient engagement was limited, with no structured system in place to share survey results or demonstrate action taken in response to feedback.

Information governance arrangements were generally appropriate, supported by a Data Protection Officer and data quality monitored with cluster support. However, medical records stored upstairs were not consistently secured, posing a risk to confidentiality.

This is what we recommend the service can improve:

- Improve internal governance and accountability by recording clinical meetings, routinely analysing complaints, and sharing learning to support continuous improvement and transparency
- Update all policies to reflect current Welsh healthcare legislation and guidance, including safeguarding, whistleblowing, and complaints, and ensure regular policy reviews are undertaken and documented
- Address gaps in information governance by ensuring all patient records are always securely stored and inaccessible to unauthorised individuals.

This is what the service did well:

- Enabled flexible and resilient service delivery by multi-skilling administrative staff, supporting continuity during staff absence
- Maintained positive engagement with wider health and care partners through regular participation in cluster and health board meetings.

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 supported health promotion through a range of digital and personalised approaches. During consultations, both GPs and nurses provided relevant leaflets and signposted patients to the practice website. This ensured that information was tailored and easy to access.

The practice facilitated self-referral to a wide range of services, including physiotherapy, podiatry, mental health therapy via SilverCloud, and weight management programmes. In addition, patients could access support for smoking cessation, domestic abuse, sexual violence, drug and alcohol misuse, dementia, and autism spectrum conditions through the Integrated Autism Service. These services were prominently featured within the practice's website, which hosted a comprehensive self-help hub designed to promote self-management and engagement with appropriate care pathways.

While digital health promotion was embedded within the practice, the physical environment offered limited material. There was no information in the waiting area about how to access services. Enhancing this space with a broader range of health education and service displays would complement existing strategies and support patient engagement, particularly for those without digital access.

The practice should enhance the waiting area by providing a wider range of health education materials and clear information on how to access available services.

The practice demonstrated preparedness in managing seasonal health needs, notably through its winter vaccination and immunisation campaigns. These were promoted through multiple communication channels, including posters, SMS messages, and telephone calls for patients without digital access. Additional clinics for shingles and respiratory syncytial virus (RSV) vaccinations were also held.

Dignified and respectful care
The practice demonstrated a commitment to providing dignified and respectful care through several measures intended to protect patient privacy and support sensitive interactions. A private room was made available for patients wishing to

discuss personal matters with staff, which offered an appropriate setting for confidential conversations. Observations during the inspection confirmed that doors were kept closed throughout consultations, and privacy curtains were in place within examination rooms to maintain patient dignity during physical examinations.

However, despite these provisions, concerns were noted in relation to auditory privacy. While seated in the waiting area, we were able to clearly overhear a consultation taking place in the nurse's room, even though the door was closed. This raises issues around confidentiality and may deter patients from openly discussing personal health concerns.

The practice should take steps to improve auditory privacy in consultation rooms.

Although the practice had an up-to-date Chaperone policy, there were no visible signs in consulting or waiting rooms informing patients of their right to request a chaperone. The absence of such signage was raised through our immediate assurance process, as detailed in Appendix B.

Timely

Timely care

Information about the appointment system was readily accessible via the practice's website and through direct communication when patients contacted the surgery. The practice had an up-to-date access policy that detailed how appointments could be arranged. However, while the policy outlined the core appointment procedures, it did not include reference to additional services available to patients, such as physiotherapy, mental health support, or other self-referral options.

The practice should update its access policy to include information about additional services.

Although a care navigation policy was in place, it lacked clarity in terms of practical application. In practice, staff tended to refer patients to nurses or GPs for further guidance rather than actively signposting to other appropriate services. The existing policy and pathways did not clearly outline the steps staff should follow or the services they could confidently direct patients to, such as those for common ailments, physiotherapy, or mental health support.

The practice should revise its care navigation policy and pathways to consolidate and clarify the full range of signposting options available and

ensure consistency in how patients are directed to the most appropriate healthcare or support professional. Staff should be trained on the updated policy and encouraged to apply it in practice to ensure patients receive timely and appropriate guidance.

The practice had made arrangements to accommodate the needs of older people, those with communication difficulties, and patients who were digitally excluded. These groups were able to access appropriate appointment types, including face-to-face consultations or telephone appointments as needed.

Clinical triage was conducted by doctors, with decisions made regarding the most appropriate mode of consultation. For housebound patients, home visits were typically carried out by the cluster paramedic.

Support for patients in mental health crisis was also embedded within the practice's systems. Patients in immediate need could be triaged by the on-call doctor or directed to NHS 111 option 2 for urgent mental health support. In addition to crisis care, the practice promoted access to a range of alternative support options, including counselling and third sector mental health services, through its website.

Equitable

Communication and language
Information about the services offered by the practice was made available through the website, which allowed for on-demand translation into different languages. For patients requiring alternative formats, staff could provide printed materials, including Easy Read versions or documents in larger print for those with visual impairments. A hearing loop was available in the surgery to assist patients with hearing difficulties.

We were told that important updates or changes to the service were shared with patients via the website or by placing notices at the practice entrance. For older patients and those without digital access, communication was facilitated through SMS messages or letters.

We were not provided with a Patient Consent Policy; this is a key document that underpins the practice's approach to obtaining and recording consent for treatment or information sharing.

The practice should develop and implement a Patient Consent Policy to ensure patients are informed and consent is obtained appropriately for all relevant procedures and processes.

We were told there were no 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.

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

Rights and equality
We were told efforts were made to accommodate individuals who may be more vulnerable in busy environments, with quiet areas made available for patients who experience anxiety.

The practice was wheelchair accessible, with step-free access throughout and all patient areas located on the ground floor. An accessible toilet was available and equipped with grab handles; however, it was found to be cluttered with a disused shower door, a mop and bucket, and other items, which compromised its usability.

The practice should remove all unnecessary items from the accessible toilet to ensure it is fully usable for patients.

Additionally, the toilet lacked an emergency pull cord, and the design of the door handle and lock made it difficult to open or close easily. These concerns, which have implications for both safety and dignity, were addressed through our immediate assurance process, as outlined in Appendix B.

We were told that transgender patients would be treated with sensitivity. It was confirmed that their preferred names and pronouns would always be used

Delivery of Safe and Effective Care

Safe

Risk management
An up-to-date Business Continuity Plan (BCP) was in place, which appropriately addressed how the practice would respond to significant health emergencies and the impact of long-term GP sickness. However, the plan did not include reference to partnership risk.

The practice must update the business continuity plan to include a reference to partnership risk.

A dedicated member of staff was responsible for receiving and disseminating patient safety alerts, though no formal arrangement was in place for cover during their absence.

The practice should nominate a deputy to receive patient safety alerts when the responsible staff member is absent.

We were told that significant events, including patient safety incidents, were discussed in meetings, and there was an understanding that these events would be reviewed to determine any necessary changes. However, the minutes of meetings examined during the inspection did not include any reference to such discussions, raising concerns about the consistency and transparency of this process. While a policy on managing significant events was in place, it lacked detail, and the associated log referenced in the policy was not available for review.

The practice should:

- **ensure that discussions of significant events, including patient safety incidents, are consistently documented in meeting minutes**
- **revise its significant events policy to make it comprehensive and ensure a log of all events is maintained and reviewed regularly.**

The physical environment presented additional risks. An emergency call button was installed in the doctor's consulting room, but there were no similar alarms available in the reception or nurse's consulting rooms. This could result in delays in emergency responses in those areas.

The practice should install emergency call buttons or another system for summoning assistance in reception and the nurse's consulting room to improve response in an emergency.

Emergency medical equipment and oxygen were stored in separate rooms, which could hinder timely access in urgent situations. This issue was addressed through the concerns resolved during inspection process, as detailed in Appendix A.

Further concerns were noted regarding the condition and layout of the practice. Clinical rooms were cluttered, with insufficient storage contributing to disorganisation. The general fabric of the building appeared tired, with visible areas requiring redecoration and repainting.

The practice should:

- **declutter all rooms and review storage arrangements to maintain a safe and efficient working environment**
- **develop a plan for redecoration and maintenance to address areas of the building that appear tired.**

During the inspection, an electrical cupboard was found to be used as a storage area for items including cleaning cloths, mops and cleaning products. The cloths and chemicals 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. These concerns were addressed through our immediate assurance process, as outlined in Appendix B.

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.

Infection, prevention and control (IPC) and decontamination

The inspection identified several gaps in the practice's infection prevention and control (IPC) systems, which require urgent attention to ensure patient and staff safety. Although an IPC policy was in place, it was undated and did not appear to be actively implemented. While the policy named an IPC lead, staff interviewed during the inspection were unclear about who held this role.

Furthermore, no IPC audit was available for review during the inspection, a matter addressed through the immediate assurance process and detailed in Appendix B. There were no policies available covering key areas such as blood borne virus exposure or needlestick injuries. Although staff were aware of their responsibilities in relation to general cleaning, there was no evidence of formal IPC training for any staff members, and no cleaning schedules were seen in the clinical rooms.

The practice should:

- **confirm and communicate the appointed IPC lead to all staff. The IPC policy should be dated and reviewed regularly**
- **develop policies for managing blood-borne viruses and needlestick injuries**
- **ensure all staff receive IPC training appropriate to their role**
- **implement and display cleaning schedules in all clinical rooms.**

The practice did have a Waste Disposal Management Policy, but it was not consistently followed. A sharps bin in the doctor's consulting room was dated 2023, which significantly exceeded the recommended three-month changeover period as set out in the policy. No periodic clinical waste audits were provided to demonstrate that waste management practices were being monitored or reviewed.

The practice should ensure sharps bins are replaced in line with policy and conduct periodic clinical waste audits to monitor compliance.

The practice was also unable to provide a hepatitis B vaccination register for its clinical staff. While test results for two members of staff were seen, there was no evidence of a system in place to monitor immunisation status across the clinical team.

The practice should maintain a hepatitis B vaccination register for all clinical staff.

Facilities to support effective infection control were inadequate in several areas. The hand wash basin in the doctor's consulting room incorporated an overflow, had taps that were not lever operated, and retained a plug, all of which fall short of current infection prevention standards.

The practice must review and update hand wash facilities within a reasonable timeframe and where feasible to ensure compliance with current infection prevention standards.

Additionally, the nurse's treatment room and the patient toilet lacked hot water, a matter addressed through the immediate assurance process and detailed in Appendix B.

Medicines management

The practice had a structured process in place for managing repeat prescriptions, and there was evidence that doctors undertook regular medication reviews to ensure the continued appropriateness of prescribed treatments.

Prescription pads were stored in the administrative office rather than in a locked cupboard. There was no log in place to record the use of manual prescriptions or the movement of boxes of loose prescription forms.

The practice should secure all prescription stock and implement a logging system to track its use and distribution.

Vaccines were stored correctly within refrigerators, which were subject to daily temperature monitoring and annual maintenance checks to ensure they remained fit for purpose. However, one vaccine found during the inspection had expired in December 2025. Moreover, there was no cold chain policy available for review, and no documented system or checklist for the regular checking of all drug stock, including expiry dates.

Storage conditions for medicines that do not require refrigeration were not routinely monitored. As a result, the practice could not demonstrate that non-refrigerated drugs were being stored within the manufacturer's recommended temperature range.

The practice should:

- **review stock control processes to ensure expired vaccines are identified and removed promptly**
- **develop a cold chain policy and implement a system for monitoring and recording checks on all medicines, including those not requiring refrigeration**
- **monitor and record storage temperatures for drugs that do not require refrigeration to ensure compliance with recommended conditions.**

Emergency medicines were found to be in date but there was no evidence of weekly checks being conducted or recorded for either the emergency drug stock or associated equipment. The primary care equipment standards outlined by the Resuscitation Council UK guidance currently states that these checks should be done weekly. An automated external defibrillator (AED) was present on site.

The practice must ensure all emergency drugs and equipment are checked and documented on a weekly basis.

No controlled drugs were stored at the practice.

Safeguarding of children and adults

The practice had appointed a safeguarding lead, and staff interviewed during the inspection were aware of who held this responsibility. However, while a safeguarding policy for children was in place, it required further development to

ensure compliance with national guidance. Specifically, the policy did not make explicit reference to the Wales Safeguarding Procedures and lacked contact details for the relevant local authority safeguarding teams. No adult safeguarding policy was available for review, representing a significant gap in the practice's safeguarding framework.

The practice should:

- **develop and implement an adult safeguarding policy**
- **update its safeguarding children policy to include explicit reference to the Wales Safeguarding Procedures and local authority contact details.**

At the time of inspection, the practice reported that there were no vulnerable adult or child patients on their safeguarding register. While this may reflect the current caseload, it remains essential that robust systems are in place for identifying, monitoring, and responding to safeguarding concerns, regardless of whether any patients are currently listed. No evidence was found of safeguarding meetings being held, which limits the opportunity for multidisciplinary discussion and coordinated care planning.

The practice must reinstate regular safeguarding meetings to maintain oversight and coordination for vulnerable patients.

Safeguarding training is a mandatory requirement, yet no records were provided during the inspection to confirm staff compliance. This issue has been addressed through the immediate assurance process and is further detailed in Appendix B.

Management of medical devices and equipment

The practice had systems in place to support the effective management of medical devices and equipment. Wherever possible, single-use equipment was utilised, helping to reduce the risk of cross-contamination and support infection control standards. A named individual held responsibility for overseeing the safety and suitability of equipment in use, and a servicing contract was in place to ensure that all medical devices received regular maintenance in accordance with manufacturer guidelines.

The equipment observed during the inspection appeared to be in good condition, and the practice had an established process for addressing emergency repairs or replacing equipment where necessary.

Expired medical items were found in use in both clinical rooms at the time of inspection. These included items such as dressings and equipment that had exceeded their recommended usage date but had not been removed from clinical stock. The presence of expired items poses a potential risk to both patient and

staff safety, as expired materials may no longer be effective or meet the standards required for safe clinical 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.

Effective

Effective care

We identified several areas where internal communication practices presented a risk to patient safety. Staff were observed to rely heavily on verbal communication rather than using the clinical system or secure NHS mail, raising concerns about the reliability and traceability of internal messaging. This approach carried a risk of important messages being forgotten or lost.

The practice should make full use of their clinical system's messaging functions, including task features, to manage internal communications securely and ensure that clinical messages are acted upon appropriately.

Furthermore, while the practice had a workflow policy in place, it did not adequately reflect the procedures for handling internal documentation, nor did it define the responsibilities of staff for reviewing and processing incoming correspondence.

Currently, administrative staff were reviewing incoming mail, including communications from out-of-hours services, and determining which items required the attention of a GP. While only those letters deemed to involve a new diagnosis were sent to a clinician, this delegated decision-making process posed a clinical risk. Of particular concern was the practice of administrative staff entering new medication into patient records. This task carries a high risk of error, such as selecting an incorrect medication or dosage, and should be restricted to clinical staff to safeguard patient safety.

The practice should:

- **Revise its workflow policy to clearly define delegation of responsibility for reviewing and distributing all incoming correspondence**
- **Ensure administrative staff do not make clinical decisions about which letters are seen by a GP**
- **Ensure that only qualified clinical staff update patient medication records. Administrative staff must not add or amend medication details.**

In relation to patient follow-up, the practice had a system in place whereby doctors reviewed test results and provided action recommendations. Administrative staff then contacted patients to book follow-up appointments. However, there was no formal system to ensure that patients attended follow up appointments once invited.

The practice should introduce a robust follow-up process to confirm that patients attend appointments for further investigations or tests.

The practice reported keeping up to date with best practice through guidance issued by the health board, the use of NICE guidelines, participation in cluster meetings, and shared learning following staff training sessions.

Incidents were reported through the Datix system, which supports a culture of learning and safety. Referrals to specialist services were made using the Welsh Clinical Communications Gateway (WCCG), ensuring consistent and traceable clinical handovers.

However, the practice's capacity to respond effectively to medical emergencies was limited by gaps in staff training and awareness. While receptionists were able to advise patients to dial 999 if they called the practice in an emergency, there was limited evidence that non-clinical staff could recognise other urgent or life-threatening conditions, such as acute asthma or hypoglycaemia, should these present during patient contact. This mandatory training issue has been addressed through the immediate assurance process and is further detailed in Appendix B.

There was no evidence to indicate that palliative care meetings were taking place, which reduces opportunities for multidisciplinary discussion and coordinated planning of care.

The service should ensure that regular palliative care meetings are established and documented, enabling multidisciplinary teams to discuss patient needs and support consistent, coordinated care planning.

The practice did not appear to have a system for reviewing deaths that occurred either in the community or in hospital where there had been a primary care involvement. The absence of such a process limits opportunities for reflective practice and quality improvement and may result in missed learning from adverse outcomes or variations in care.

The practice should develop and implement a process for reviewing deaths in the community and hospital where there is a primary care element.

Patient records
We reviewed six electronic patient records which revealed variable standards in documentation, highlighting inconsistencies in clinical record-keeping. While some records demonstrated high-quality note-keeping, others lacked critical clinical information, undermining continuity of care and potentially compromising patient safety.

Two records did not include documentation of examination findings or clinical assessments. These records also lacked the use of appropriate clinical coding (READ codes) and contained no clear evidence that Patient Information Leaflets (PILs) had been provided to patients or carers. Furthermore, in one of these records there was no documentation of a chaperone being offered, despite the nature of some consultations potentially warranting it.

A third record, while clear and legible, also lacked READ coding and failed to document a chaperone offer during an intimate examination. Another record showed no indication that the patient had been informed about when to seek further medical attention should their condition deteriorate. Although this record had been READ coded, there was no evidence that the patient had been given adequate information about their condition, investigations, or management options, which is essential for informed decision-making and patient empowerment.

In contrast, the two remaining records reflected good practice, they included detailed clinical observations, appropriate use of READ coding, clear documentation of treatment plans. They also confirmed that the patients were given sufficient information about their condition and treatment options.

The practice should ensure that all patient records are complete, accurate, and consistently coded. Records should include examination findings, clinical details, and evidence of information provided to patients.

The issues surrounding the provision of a chaparone were raised through our immediate assurance process, as detailed in Appendix B.

Quality of Management and Leadership

Staff feedback

The staff survey received responses from four staff members, all of whom are based at the GP surgery. Due to the low number of responses, it has not been possible to include analysis within this report.

Leadership

Governance and leadership

Quarterly team meetings were held in person and open to all staff, providing a platform for shared discussion and collective input into practice operations.

There were designated leads for key areas such as safeguarding and complaints, and these individuals were accessible to colleagues for advice and guidance within their areas of responsibility. In addition, a clinical lead was in post and responsible for overseeing clinical standards and activity within the practice.

Doctors were reported to meet weekly to share clinical information, yet these meetings were not formally minuted and no agendas or records were available to demonstrate what had been discussed or how information was shared with the wider team. The absence of documented clinical meetings limits the ability to evidence decision-making, learning, and the dissemination of best practice.

The practice should ensure that these meetings are formally recorded, with clear agendas and minutes, to support transparency and accountability.

Workforce

Skilled and enabled workforce

The practice had taken some proactive steps to support workforce flexibility and resilience, particularly through the multi-skilling of administrative staff. This approach enabled greater adaptability during periods of planned or unplanned absence, helping to ensure continuity of service.

The practice manager told us that annual appraisals had only recently restarted. Regular appraisals are an important way to support development, maintain skills and assure competency.

The practice should ensure that annual appraisals are carried out consistently for all staff.

While basic job descriptions were available for administrative staff, there were no job descriptions on file for clinical staff or the practice manager. Maintaining up-to-date job descriptions is important to clarify expectations, define accountability, and support effective supervision.

The practice's recruitment policy referenced the Care Quality Commission (CQC), which is not relevant in the Welsh healthcare context.

The practice should review their policies and update them to reflect Welsh standards and guidance.

Furthermore, a review of recruitment records showed limited compliance with the practice's own recruitment procedures. No evidence was provided of recent Disclosure and Barring Service (DBS) checks or of a systematic approach to verifying ongoing staff suitability for employment in a healthcare setting. Similarly, there were no training records to confirm completion of mandatory training requirements. These gaps indicate a lack of oversight in critical areas of workforce governance and present potential risks to both patient safety and regulatory compliance. These issues have been addressed under the immediate assurance process outlined in Appendix B.

While there was no formal or structured clinical supervision in place for nursing staff, GPs were described as accessible and supportive in providing advice. In terms of on-site clinical cover, it was noted that a GP or prescriber was not always present, which at times left a nurse working without immediate access to prescribing support.

The practice should:

- **consider implementing a clinical supervision framework for nurses**
- **consider the development of non-medical prescribing among nursing staff to increase clinical capacity.**

Culture

People engagement, feedback and learning

The practice had a complaints policy in place, and the responsibility for managing complaints was clearly assigned to either the practice manager or the senior partner. However, the complaints procedure made available to patients did not reference the NHS Wales Putting Things Right process, which outlines statutory requirements for managing concerns in the Welsh healthcare context. While a Putting Things Right poster was displayed in the waiting area, the absence of explicit reference within the written policy limits its alignment with national standards.

The practice should update its complaints policy to explicitly reference the NHS Wales Putting Things Right process.

Complaints and concerns were being recorded, but the practice did not maintain a centralised complaints register. There was no evidence provided of how complaints were systematically analysed to identify emerging themes or trends, nor did the minutes of meetings reviewed during the inspection show any reference to complaint discussions or the sharing of learning arising from them.

The practice should:

- **routinely monitor and record complaints and concerns using a register to support future analysis and learning**
- **ensure that complaints are discussed in meetings and that learning from concerns is shared with the whole team to support continuous improvement.**

Patient engagement was limited in terms of formal feedback mechanisms. Although the practice took part in an annual survey conducted by the cluster, there was no evidence that the results of this survey were shared with patients or used to inform service development.

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

The practice had both a whistleblowing policy and a Duty of Candour policy; however, neither document included a review date.

The practice should review and update its whistleblowing and Duty of Candour policies to ensure they include a clear review date. The practice should also ensure regular policy reviews are carried out and documented.

Information

Information governance and digital technology

The practice had a Data Protection Officer (DPO) in place, supporting compliance with information governance requirements and the broader responsibilities under data protection legislation. The practice demonstrated an understanding of the importance of data quality in supporting safe and effective care. Audits were carried out in collaboration with the cluster to ensure that data accuracy and consistency were maintained. In addition, GP activity performance measures were

actively reported and monitored, providing assurance that service delivery was being evaluated against established benchmarks.

There were effective arrangements in place for the submission of data and notifications to external bodies, in line with shared agreements established through the cluster.

However, concerns were raised during the inspection regarding the physical security of medical records stored upstairs within the practice. Staff reported that these records were not consistently locked away when staff were not present in that area, posing a risk to the confidentiality and integrity of personal health information.

The practice must address this issue to ensure that all patient records are always stored securely, in line with information governance standards and to protect against unauthorised access.

Whole-systems approach

Partnership working and development
The practice demonstrated a commitment to partnership working and system-wide collaboration, engaging constructively with wider health and care networks to support integrated service delivery. In making clinical and operational decisions, the practice considered the broader implications for the health system by adhering to health board care pathways.

Engagement with external stakeholders was evident through participation in both health board and cluster meetings. These forums provided opportunities for the practice to contribute to strategic discussions, share local insights, and remain informed of developments across primary and community care. The practice also built collaborative relationships with external partners, including the involvement of guest speakers and representatives from outside organisations.

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
Emergency equipment and oxygen were stored in separate consultation rooms.	This created a risk that essential equipment may not be immediately accessible in an emergency.	Raised with the practice manager	The practice moved all emergency equipment and oxygen together to a single, accessible location in reception.

Appendix B – Immediate improvement plan

Service: Clase Surgery

Date of inspection: 19 January 2026

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.

Findings
We were not assured that effective systems were in place to ensure the appropriate offer, documentation, and recording of consent in relation to the chaperone service. There were significant concerns regarding how the availability of a chaperone was communicated to patients. Patients were not consistently made aware that a chaperone could be provided. In addition, staff did not consistently record in the clinical record whether a chaperone had been offered, whether the offer was accepted or declined, or the name of the chaperone present.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
1.	The practice must take immediate action to ensure that the chaperone service is safe, effective, and consistently applied. This includes: • Ensuring the availability of a chaperone is clearly advertised and routinely communicated to patients • Implementing robust systems to ensure a	Health & Care Quality Standards (2023) – Safe, Person-centred, Effective, Timely.	• Posters advertising the availability of a chaperone have been displayed in all consulting rooms and the waiting area on 20/01/2026. • Information regarding the chaperone service has been added to the practice website and practice leaflet on 22/01/2026. • All clinical and non-clinical staff have completed the required chaperone training. • Clinicians are required to record chaperone information within the consultation record, including:	Practice Manager (overall oversight); Lead GP – Dr Bohra (clinical compliance)	1 month (for the audit). from 09/02/2026 – 09/03/2026

	chaperone is consistently offered for all relevant examinations • Ensuring the offer, acceptance or decline, and the name of the chaperone present are clearly and accurately documented in the clinical record • Providing assurance that staff are aware of, and adhere to, the practice chaperone policy and consent requirements.		○ Whether a chaperone was offered (Yes/No) ○ Whether the offer was accepted or declined ○ The full name and role of the chaperone present, where applicable. • Clinicians have been instructed that chaperone details must be clearly documented within the consultation notes at the time of the examination. • Consultation records involving intimate examinations are subject to routine audit to confirm that chaperone discussions and outcomes are consistently and clearly documented. • A mandatory practice meeting was held on 02 February 2026 covering chaperone policy, consent requirements, and documentation expectations. • Minimum of 20 randomly selected relevant consultations will be undertaken quarterly. • Audit outcomes will be reviewed at practice meetings and action taken where non-compliance is identified.		

Findings

We were not assured that the accessible toilet within the practice was safe and fully equipped to meet the needs of patients with disabilities. During the inspection, we found that the accessible toilet did not have an emergency pull cord fitted, which is a key safety feature to enable patients to summon assistance if required. In addition, the door handles and locking mechanism were not suitable for individuals with limited motor movement, creating potential barriers to safe and independent use.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
2.	The practice must take immediate action to ensure the accessible toilet is safe, usable and meets the needs of patients with disabilities. This includes: • Installing an emergency pull cord within the accessible toilet to enable patients to summon assistance when required • Replacing or adapting door handles and the locking mechanism so they are suitable for use by people with limited motor movement • Ensuring facilities are regularly reviewed to confirm ongoing compliance with accessibility and safety requirements.	Health & Care Quality Standards (2023) – Safe, Person-centred, Equitable.	• The old bins were taken away from the staff and patients' toilets on 20/01/2026. • PHS sanitary waste disposal units have been installed in the accessible (disabled) toilet and staff toilet to ensure safe, hygienic disposal of sanitary waste in line with infection prevention and dignity requirements. • The accessible toilet has been risk-assessed, and temporary signage has been added advising patients to seek staff assistance if required on 23/01/2026. • A patient assistance bell will be installed within the accessible (disabled) toilet to enable patients to alert staff should they require assistance. • The bell will be positioned at an appropriate height and location to ensure it is easily reachable for patients with mobility or physical impairments. • An emergency pull cord will be ordered as soon as possible and will	Practice Manager (coordination); Practice Nurse – Christina (clinical assurance)	• Patient assistance bell installation: by 09/03/2026. • Emergency pull cord installation: by 09/03/2026. • Replacement of door handles and locking mechanisms: by 09/03/2026.

			be installed within the accessible toilet in line with accessibility and safety requirements. Door handles and locking mechanisms will be replaced with disability-compliant fittings suitable for individuals with limited motor movement, and following the practice manager's request, Jonathan from LHB visited the surgery on 06/02/2026, inspected the toilets, and confirmed he will provide the building contractor's contact details so the repairs can be arranged as soon as possible.		

Findings

We were not assured that effective systems were in place to ensure emergency equipment was clearly signposted, routinely checked, and safely maintained. During the inspection, the room used to store emergency equipment and the oxygen cylinder did not have appropriate signage, which could delay staff access and response in the event of a medical emergency. In addition, some emergency equipment items were found to be expired, indicating gaps in routine safety checks and governance arrangements.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
3.	The practice must take immediate action to strengthen emergency preparedness and governance arrangements. This includes: • Ensuring the location of emergency equipment and oxygen cylinders is clearly signposted to enable prompt access in an emergency	Health & Care Quality Standards (2023) – Safe, Timely, Effective, Efficient, Patient-centred.	• Emergency equipment, emergency drugs, and oxygen were relocated to a clearly labelled and signposted area at reception on 26 January 2026, ensuring rapid access in the event of an emergency. • All expired emergency equipment was identified, removed, and replaced immediately on 26 January 2026. • A formal emergency equipment checking system has been implemented.	Practice Manager (overall oversight); Practice Nurse – Christina Cavallucci (clinical compliance); Health Care Support Worker – Sharon Hall (support compliance)	• Monthly review of emergency equipment checklists in place by 09 March 2026 • Additional oxygen cylinder ordered and installed by 09 March 2026

	• Implementing and maintaining a system of regular, documented checks of all emergency equipment to ensure it is present, in date, and fit for use • Removing and replacing expired equipment without delay.		• The Practice Nurse, Christina Cavellucci, carries out regular spot checks and introduced a documented emergency equipment checklist on 28 February 2026. • The checklist records the presence of equipment, expiry dates, the date of each check, and the nurse's signature, providing a clear audit trail and assurance of ongoing compliance. • Nursing staff are responsible for recording and signing off expiry dates and equipment availability in line with the agreed schedule. • The Practice Manager undertakes a monthly review of all completed emergency equipment checklists to ensure continued oversight. • Any issues identified are escalated immediately and recorded within the governance logs, with prompt action taken. • An additional oxygen cylinder has been ordered and will be securely installed to further strengthen emergency preparedness.		

Findings
We were not assured that the practice had appropriate measures in place to prevent fire hazards and protect the safety of staff and patients. During our inspection, we found flammable items such as tissue paper, cleaning cloths and cleaning chemicals stored inside the electrical cupboard. This is a significant fire hazard and poses a risk to staff, patients and the building.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
4.	The practice must take immediate action to reduce fire risk and ensure safe storage arrangements. This includes: • Removing all flammable materials from the electrical cupboard without delay • Ensuring the electrical cupboard is kept clear and used only for the intended purpose • Ensuring that cleaning products and other flammable items are stored in compliance with fire safety regulations. This includes using appropriate cupboards or containers. • Providing assurance that fire safety risks are routinely identified, assessed, and managed, including through a robust fire risk assessment.	Health & Care Quality Standards (2023) – Safe, Efficient, Effective, Person-centred.	• All flammable materials were removed from the downstairs electrical cupboard on the next day of inspection on 20/01/2026. • Items previously stored in the downstairs electrical cupboard were relocated to the upstairs designated storage cupboard on 20/01/2026, ensuring electrical areas are kept free from combustible materials. • Clear signage has been installed on the electrical cupboard on 20/01/2026 to prevent inappropriate storage going forward. • The Practice Manager engaged with ADC Fire Systems Ltd on 09/02/2026 to complete a formal fire risk assessment, and a quotation has been received (Reference: 17207ARev1). • The fire risk assessment process is currently in progress and will be completed as a priority, with all recommended actions implemented immediately upon approval. • All fire extinguishers have been checked and replaced where required to ensure full compliance with current fire safety regulations.	Practice Manager (overall oversight); Data Clerk – Sonia Fish (support compliance)	• Fire risk assessment and associated actions progressing from February 2026 and to be completed as a priority

			• Fire safety and storage checks are now embedded within monthly health and safety walkabouts, with findings documented and escalated through governance processes where required. • Ongoing monitoring ensures electrical cupboards remain free from inappropriate storage. • Staff members who still need to complete their mandatory fire safety training have been informed to complete it via the Learning@Wales platform. • Training compliance is monitored via the staff training records.		

Findings
We were not assured that robust systems were in place to ensure safe recruitment practices and effective oversight of staff training and competence. During the inspection, complete staff training records and recruitment documentation were not available for review. We reviewed a sample of five staff records and found no Disclosure and Barring Service (DBS) checks dated within the last three years. This limited assurance that appropriate pre-employment and ongoing fitness to work checks had been completed.

In addition, we were not assured that mandatory training compliance was effectively managed or monitored. While evidence of some mandatory training was provided for one staff member, we were unable to confirm that all staff had completed required mandatory training, including safeguarding training.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
5.	The practice must take immediate action to strengthen recruitment and staff training	Health & Care Quality Standards (2023) – Safe,	• The practice uses the CareCheck system to record, monitor, and evidence DBS status for all staff. • CareCheck provides oversight of:	Practice Manager (overall oversight); Lead GP – Dr Bohra	Fully implemented, awaiting the DBS certificates.

	governance arrangements. This includes: • Ensuring staff recruitment records are complete, accurate, and readily available for review • Ensuring all clinical staff are in receipt of an enhanced DBS check, and to risk assess and have a clear policy and rationale in place for when DBS checks are renewed and when they are required for non-clinical staff, based on their roles and responsibilities • Implementing robust systems to monitor, record, and assure compliance with mandatory training, including refresher training.	Effective, Efficient, Person-centred.	○ DBS level required for each role ○ DBS issue and expiry/review dates ○ Alerts for DBS renewal requirements • A full review of DBS status for all staff has been undertaken using the CareCheck system on 04/02/2026. • Staff identified as not having a DBS check completed or renewed within the last three years have been formally invited to apply for an updated DBS check without delay on 04/02/2026. • DBS status is reviewed as part of routine governance and recruitment oversight. • Staff DBS certificates and training certificates are maintained in separate files, with a centralised master file containing all staff information, including DBS and training status, for easy review and audit purposes. • Staff members who have not yet obtained their DBS have begun the application process by using the invitation link sent to them via email, and they are now awaiting the arrival of their DBS certificates. • Monthly review of DBS status and training compliance is undertaken by the Practice Manager, with any	(clinical compliance)	

			gaps escalated and addressed promptly. • Staff recruitment records are maintained in a single master file on 29/01/2026, ensuring they are accurate and readily available.		

Findings
We were not assured that robust procedures were in place to ensure that infection prevention and control (IPC) was consistently maintained at the surgery. An IPC audit had not been completed, which limited assurance that IPC risks were being routinely identified, monitored, and managed. In addition, observations of the environment identified areas requiring immediate improvement. This included fabric privacy curtains where no records were available to evidence the date of replacement, and tears in the seat covering in the waiting area, meaning surfaces could not be effectively cleaned or decontaminated.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
6.	The practice must take immediate action to ensure effective and sustainable infection prevention and control arrangements are in place. This includes: • Completing and documenting a comprehensive IPC audit to identify, monitor, and manage infection risks and ensure this is conducted on at least an annual basis	Health & Care Quality Standards (2023) – Safe, Effective, Timely, Person-centred.	• IPC risks escalated to the IPC lead (Christina Cavallucci) on the day of inspection. • Waiting for the building contractor for the quotation. • Fabric curtains in clinical areas have been washed immediately and reinstated to maintain hygiene standards on 20/01/2026. • Privacy screen in the doctor's room has been removed on 20/01/2026. • A comprehensive IPC audit plan has been discussed with the practice nurse and will be implemented. • Torn seating in the waiting area will be replaced with medical-grade, wipeable vinyl seating.	Practice Nurse – Christina Cavallucci (IPC Lead); Senior Receptionist – Jayne Durk (environmental compliance)	A comprehensive IPC audit plan by the 20th of February 2026. Torn seating and Fabric curtains: by the 25th of February 2026.

	• Ensuring fabric privacy curtains are replaced or cleaned in line with IPC guidance, with clear records maintained to evidence replacement schedules • Repairing or replacing damaged seating in the waiting area so that surfaces are intact, cleanable and fit for purpose.		• Fabric curtains will be replaced with disposable antimicrobial curtains, each with a "date-fitted" tag. • Quarterly IPC spot checks established to ensure ongoing compliance.		

Findings
We were not assured that effective systems were in place to maintain infection prevention and control (IPC) standards, as there was no hot water supply to the patient toilet or the nurse's treatment room at the time of inspection. The absence of hot water meant that staff and patients were unable to wash their hands effectively, presenting a significant IPC risk.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
7.	The practice must take immediate action to ensure effective infection prevention and control arrangements are in place. This includes: • Restoring a reliable hot water supply to the	Health & Care Quality Standards (2023) – Safe, Effective, Timely, Person-centred.	• On the day of inspection, 19/01/2026, the hot water heating system was confirmed to be activated and functioning. • It was identified that a short delay occurs before hot water reaches outlets due to the pipe run; this was managed by ensuring taps were run for a sufficient time to allow hot water to flow.	Practice Manager (overall oversight); All staff on duty (operational compliance)	Contractor review – 16th of February 2026. A weekly facilities checklist – 13th of February 2026.

	patient toilet and the nurse's treatment room • Verify hot water availability in all areas • Implementing arrangements to monitor and maintain essential facilities, including escalation processes where failures are identified • Ensuring IPC risks relating to facilities are promptly identified, recorded, and addressed.		• All staff on duty were instructed to check that the water heating system was switched on at the start of each shift and to confirm the availability of hot water at clinical handwash sinks. • A contractor will be engaged promptly to review the system and confirm appropriate operation. • Daily hot water availability checks were logged until assurance was obtained that the hot water supply was consistently available. • A weekly facilities checklist will be implemented to provide ongoing monitoring and early identification of any future issues.		

Findings

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
8.	It is disappointing to note that a number of similar findings were identified during our 2019 inspection report of the main practice, Greenhill Medical Centre.		A review was undertaken by the Practice Manager to understand why similar issues identified during previous inspections were repeated. This review identified that earlier improvements relied too heavily on informal processes and individual staff awareness, with limited routine auditing, documentation, and follow-up. As a result,	Practice Manager (overall oversight); Lead GP – Dr Bohra (clinical compliance)	Implemented from February 2026 and ongoing

	The practice manager must ensure that findings are not systemic across other practices and take all necessary action to ensure that improvement is sustained.		issues were not always identified early or consistently monitored over time. To address this, the practice has strengthened its governance arrangements and implemented a cross-site governance approach across both Clase Surgery and Greenhill Medical Centre. Governance arrangements now operate across both sites using the same policies, procedures, audit tools, and review processes. Any issue identified at one site is checked across the other site to ensure it is not systemic. This ensures learning from inspections and incidents is shared and applied consistently across the service. A programme of regular internal audits will be implemented, covering: • Infection Prevention and Control (IPC) • Fire safety and environmental risks • Emergency equipment and preparedness • Accessibility and reasonable adjustments • Safer recruitment, DBS checks, and mandatory training compliance Audit findings from both sites are reviewed by the Practice Manager at governance meetings. Actions are clearly documented, allocated to a responsible person, and monitored until completed. Where non-compliance or risk is identified, clear escalation arrangements are in place to ensure timely action and senior oversight.		

			These strengthened governance arrangements provide assurance that risks are identified earlier, improvements are monitored effectively, and standards are consistently maintained across all practice locations.		

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): **Ranjana Bohra**

Job role: **Practice Manager**

Date: **09/02/2026**

Appendix C - Improvement plan

Service: Clase Surgery

Date of inspection: 19 January 2026

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 physical environment offered limited material. There was no information in the waiting area about how to access services.	The practice should enhance the waiting area by providing a wider range of health education materials and clear information on how to access available services.	Health and Care Quality Standards (2023) – Person-centred, Equitable, Effective, Timely.	The practice has enhanced the waiting area by providing a wider range of health-education leaflets and clear information on how to access available services on the website. The practice has also provided leaflets for all self-referral services mentioned on the website, and clear posters are displayed in the waiting area.	Senior Receptionist – Jayne Durk	30/04/2026

				This action is partially completed and will be fully updated by 30/04/2026.		
2.	While seated in the waiting area, we were able to clearly overhear a consultation taking place in the nurse's room, even though the door was closed.	The practice should take steps to improve auditory privacy in consultation rooms.	Health and Care Quality Standards (2023) – Person-centred, Safe, Effective, Equitable.	An audit of the room for sound leakage has been completed. Acoustic door seals will be installed, or the doors will be replaced with soundproof alternatives following quotations obtained from various companies. A white-noise machine will also be installed in the waiting area.	Practice Manager – Ranjana Bohra	31/05/2026
3.	The access policy outlined the core appointment procedures, it did not include reference to additional services available to patients,	The practice should update its access policy to include information about additional services	Health and Care Quality Standards (2023) – Person-centred, Effective, Equitable, Efficient.	The practice has noted this and will update the Access Policy to clearly outline the core appointment types.	Practice Manager - Ranjana Bohra	30/05/2026

	such as physiotherapy, mental health support, or other self-referral options.					
4.	A care navigation policy and pathway was in place, it lacked clarity in terms of practical application.	The practice should revise its care navigation policy and pathways to consolidate and clarify the full range of signposting options available and ensure consistency in how patients are directed to the most appropriate healthcare or support professional. Staff should be trained on the updated policy and encouraged to apply it in practice.	Health and Care Quality Standards (2023) – Person-centred, Effective, Efficient, Equitable.	Create a "Signposting Matrix" for reception; conduct staff training to ensure patients are directed to the right professional first time	Lead GP – DR Bohra	15/05/2026
5.	We were not provided with a Patient Consent Policy.	The practice should develop and implement a Patient Consent Policy to ensure patients are informed and consent is obtained appropriately for all relevant procedures and processes.	Health and Care Quality Standards (2023) – Person-centred, Safe, Effective, Equitable.	All clinical staff obtain consent from patients before any procedure takes place. Consent is either taken verbally and documented in the patient's notes, or a consent form is completed, scanned,	Lead GP - DR Bohra	30/06/2026

				and attached to the patient record.		
6.	We saw that some signs and posters were available in Welsh, however, most were available in English only.	The practice must ensure that the 'Active Offer' of Welsh language is promoted to patients.	Health and Care Quality Standards (2023) – Equitable, Person-centred, Effective.	Signs and posters in the waiting area will also be made available in the Welsh language.	Practice Manager – Ranjana Bohra	30/06/2026
7.	An accessible toilet was available and equipped with grab handles; however, it was found to be cluttered with a disused shower door, a mop and bucket, and other items, which compromised its usability.	The practice should remove all unnecessary items from the accessible toilet to ensure it is fully usable for patients.	Health and Care Quality Standards (2023) – Safe, Person-centred, Equitable, Effective.	The Practice Manager has contacted the builder to upgrade the disabled toilet with all required accessibility facilities for patients, and all non-essential items have been removed to ensure the toilet is fully usable. Action taken: the builder has provided a quotation, and the work will begin as soon as possible.	Practice Manager – Ranjana Bohra	30/06/2026
8.	The business continuity plan did not	The practice must update the business continuity plan to include a reference to	Health and Care Quality Standards (2023) – Safe,	Update Business Continuity Plan (BCP) to include specific	Senior Partner – DR Bohra.	31/03/2026

	include reference to partnership risk.	partnership risk.	Effective, Efficient, Timely, Person-centred.	mitigation strategies for partnership dissolution or long-term GP absence.		
9.	A dedicated member of staff was responsible for receiving and disseminating patient safety alerts, though no formal arrangement was in place for cover during their absence.	The practice should nominate a deputy to receive patient safety alerts when the responsible staff member is absent.	Health and Care Quality Standards (2023) – Safe, Timely, Effective, Efficient.	Senior Receptionists Jayne Durk and Anita David have been nominated as Deputy Safety Alert Leads.	Senior receptionist - Jayne and Anita David	31/03/2026
10.	We were told that significant events were discussed in meetings. However, the minutes of meetings examined during the inspection did not include any reference to such discussions. While a policy on managing significant events was in place, it lacked	The practice should: • ensure that discussions of significant events, including patient safety incidents, are consistently documented in meeting minutes • revise its significant events policy to make it comprehensive and ensure a log of all events is	Health and Care Quality Standards (2023) – Safe, Effective, Efficient, Person-centred, Timely.	The Significant Event Policy will be updated to include the creation of a central log, and all clinical meeting minutes will contain a dedicated "Significant Events" section. The practice has taken action to ensure that all SEAs are discussed during meetings, with	GP Partner – Dr Akter Hussain	30/06/2026

	detail, and the associated log referenced in the policy was not available for review.	maintained and reviewed regularly.		minutes recorded and follow-up actions documented and reviewed.		
11.	An emergency call button was installed in the doctor's consulting room, but there were no similar alarms available in the reception or nurse's consulting rooms.	The practice should install emergency call buttons or another system for summoning assistance in reception and the nurse's consulting room to improve response in an emergency.	Health and Care Quality Standards (2023) – Safe, Timely, Leadership.	Practice manager will make sure the emergency call button are available in all the rooms.	Practice Manager – Ranjana Bohra	31/05/2026
12.	Clinical rooms were cluttered, with insufficient storage contributing to disorganisation. The general fabric of the building appeared tired, with visible areas requiring redecoration and repainting.	The practice should: • declutter all rooms and review storage arrangements to maintain a safe and efficient working environment • develop a plan for redecoration and maintenance to address areas of the building that appear tired.	Health and Care Quality Standards (2023) – Safe, Effective, Leadership.	The Practice Manager has started decluttering the clinical rooms, and the general fabric of the building has been improved with the installation of new disposable curtains. Redecoration has also commenced in visibly worn areas.	Practice Manager - Ranjana Bohra	30/09/2026

13.	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.	Health and Care Quality Standards (2023) – Safe, Leadership.	The clinical waste bin has been moved to a secure, designated area as instructed by HIW.	Practice Manager - Ranjana Bohra	31/03/2026
14.	While the policy named an IPC lead, staff interviewed during the inspection were unclear about who held this role. There were no policies available covering key areas such as blood borne virus exposure or needlestick injuries. There was no evidence of formal IPC training for any staff members, and no cleaning schedules were seen in the clinical rooms.	The practice should: • confirm and communicate the appointed IPC lead to all staff. The IPC policy should be dated and reviewed regularly • develop policies for managing blood-borne viruses and needlestick injuries • ensure all staff receive IPC training appropriate to their role • implement and display cleaning schedules in all clinical rooms.	Health and Care Quality Standards (2023) – Safe, Workforce, Leadership.	The IPC Policy, Needle Policy, Blood-Borne Virus Policy, and Needlestick Injury Policy will be updated, and training will be provided to all relevant staff.	IPC Lead – Christina Cavallucci	26/07/2026

15.	A sharps bin in the doctor's consulting room was dated 2023. No waste audits were provided to demonstrate that waste management practices were being monitored or reviewed.	The practice should ensure sharps bins are replaced in line with policy and conduct periodic clinical waste audits to monitor compliance.	Health and Care Quality Standards (2023) – Safe, Effective, Leadership.	The Senior Nurse, Senior Receptionist, and Practice Manager will be responsible for managing clinical waste, sharps bins, and overall waste management. A quarterly audit will be conducted to monitor compliance.	IPC Lead - Christina Cavallucci	15/04/2026
16.	The practice was also unable to provide a hepatitis B vaccination register for its clinical staff.	The practice should maintain a hepatitis B vaccination register for all clinical staff.	Health and Care Quality Standards (2023) – Safe, Workforce, Leadership.	The Practice Manager will update the Hepatitis B vaccination register for clinical staff to ensure that all clinical staff are fully vaccinated before they start work.	Practice Manager – Ranjana Bohra	30/08/2026
17.	The hand wash basin in the doctor's consulting room did not meet current	The practice must review and update hand wash facilities within a reasonable timeframe and	Health and Care Quality Standards (2023) – Safe,	The Practice Manager will update the hand-washing facilities to meet current	Practice Manager - Ranjana Bohra	30/09/2026

	standards, which may compromise effective hand hygiene.	where feasible to ensure compliance with current infection prevention standards.	Effective.	infection-prevention standards and will contact the building contractor to replace the existing sink with a clinical sink featuring lever-operated taps and no overflow.		
18.	Prescription pads were stored in the administrative office rather than in a locked cupboard. There was no log in place to record the use of manual prescriptions or the movement of boxes of loose prescription forms.	The practice should secure all prescription stock and implement a logging system to track its use and distribution.	Health and Care Quality Standards (2023) – Safe, Information, Leadership.	The Practice Manager has moved all prescriptions into a locked cabinet and will implement a serial-number lock to track daily distribution. A logbook will also be introduced.	Practice Manager - Ranjana Bohra	30/06/2026
19.	One vaccine found during the inspection had expired in December 2025. Moreover, there was no cold chain policy	The practice should: • review stock control processes to ensure expired vaccines are identified and removed promptly	Health and Care Quality Standards (2023) – Safe, Effective, Leadership.	The Cold Chain Policy will be adopted and implemented. Practice nurses are checking the expiry dates of	Lead Nurse – Christina Cavallucci	30/07/2026

	available for review, and no documented system or checklist for the regular checking of all drug stock, including expiry dates. Storage conditions for medicines that do not require refrigeration were not routinely monitored.	• develop a cold chain policy and implement a system for monitoring and recording checks on all medicines, including those not requiring refrigeration • monitor and record storage temperatures for drugs that do not require refrigeration to ensure compliance with recommended conditions.		vaccines and drugs, carrying out stock checks, and monitoring room and fridge temperatures on a daily basis. The policy will be updated, and a meeting will be arranged for practice nurses, staff, and managers to ensure full compliance.		
20.	Emergency medicines were found to be in date but there was no evidence of weekly checks being conducted or recorded for either the emergency drug stock or associated equipment.	The practice must ensure all emergency drugs and equipment are checked and documented on a weekly basis.	Health and Care Quality Standards (2023) – Safe, Leadership.	A weekly emergency equipment and emergency drugs checklist will be implemented and signed by a clinician, with a monthly audit completed by the Practice Manager. Practice nurses are checking the emergency equipment and drugs on a weekly	Lead Nurse - Christina Cavallucci	30/07/2026

				basis, and these checks will be audited by the Practice Manager.		
21.	A safeguarding policy for children was in place. The policy did not make explicit reference to the Wales Safeguarding Procedures and lacked contact details for the relevant local authority safeguarding teams. No adult safeguarding policy was available for review.	The practice should: • develop and implement an adult safeguarding policy • update its safeguarding children policy to include explicit reference to the Wales Safeguarding Procedures and local authority contact details.	Health and Care Quality Standards (2023) – Safe, Leadership, Workforce.	Safeguarding policy and adult policy will be updated.	Safeguarding Lead – DR Bohra	30/09/2026
22.	No evidence was found of safeguarding meetings being held.	The practice must reinstate regular safeguarding meetings to maintain oversight and coordination for vulnerable patients.	Health and Care Quality Standards (2023) – Safe, Effective, Leadership.	Reinstate monthly internal safeguarding meetings and maintain formal minutes.	Safeguarding Lead - DR Bohra and GP Partners.	26/08/2026

23.	Expired medical items were found in use in both clinical rooms at the time of inspection. These included items such as dressings and equipment that had exceeded their recommended usage date but had not been removed from clinical stock.	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.	Health and Care Quality Standards (2023) – Safe, Leadership, Effective.	Immediate audit of all clinical cupboards to remove expired items; monthly stock checks assigned to HCSW.	IPC Lead - Christina Cavallucci and Lead health care support workers.	30/07/2026
24.	Staff were observed to rely heavily on verbal communication rather than using the clinical system or secure NHS mail, raising concerns about the reliability and traceability of internal messaging.	The practice should make full use of their clinical system's messaging functions, including task features, to manage internal communications securely and ensure that clinical messages are acted upon appropriately.	Health and Care Quality Standards (2023) – Safe, Effective, Efficient, Person-centred.	All staff are using the clinical system, including the task function, for all patient-related internal messaging.	Lead GP – DR Bohra and Practice manager.	30/07/2026
25.	The practice had a workflow policy in place, it did not adequately reflect the procedures for	The practice should: • Revise its workflow policy to clearly define delegation of responsibility for reviewing and	Health and Care Quality Standards (2023) – Safe, Effective,	The practice will hold a meeting to review its workflow policy and clearly define the delegation of	Senior Partner – DR Bohra	26/09/2026

	handling internal documentation, nor did it define the responsibilities of staff for reviewing and processing incoming correspondence. Currently, administrative staff were reviewing incoming mail and determining which items required the attention of a GP. Of particular concern was the practice of administrative staff entering new medication into patient records.	distributing all incoming correspondence • Ensure administrative staff do not make clinical decisions about which letters are seen by a GP • Ensure that only qualified clinical staff update patient medication records. Administrative staff must not add or amend medication details.	Efficient, Person-centred, Timely.	responsibilities for reviewing and distributing all incoming correspondence. The practice will ensure that administrative staff do not make clinical decisions and that any letters requiring clinical input are reviewed by a GP. The practice will also ensure that only qualified clinical staff update patient medication records, and administrative staff must not add or amend any medication details.		
26.	There was no formal system to ensure that patients attended follow up appointments once invited.	The practice should introduce a robust follow-up process to confirm that patients attend appointments for further investigations or tests.	Health and Care Quality Standards (2023) – Timely, Effective, Safe, Person-centred,	Create a "Safety Netting" tracker/report to identify patients who fail to book or attend	Lead GP - DR Bohra	31/05/2026

			Efficient.	requested follow-up investigations		
27.	There was no evidence to indicate that palliative care meetings were taking place, which reduces opportunities for multidisciplinary discussion and coordinated planning of care.	The service should ensure that regular palliative care meetings are established and documented, enabling multidisciplinary teams to discuss patient needs and support consistent, coordinated care planning.	Health and Care Quality Standards (2023) – Safe, Patient-centred, Effective, Leadership.	Re-establish monthly palliative care meetings with District Nurses and document care plans on the clinical system.	Lead GP - DR Bohra	01/05/2026
28.	The practice did not appear to have a system for reviewing deaths that occurred either in the community or in hospital where there had been a primary care involvement.	The practice should develop and implement a process for reviewing deaths in the community and hospital where there is a primary care element.	Health and Care Quality Standards (2023) – Safe, Leadership, Effective.	Implement a quarterly "Death Review" meeting to discuss community and hospital deaths for clinical learning.	Senior Partner - DR Bohra	30/06/2026
29.	We reviewed six electronic patient records which revealed variable standards in documentation,	The practice should ensure that all patient records are complete, accurate, and consistently coded. Records should include examination findings, clinical details,	Health and Care Quality Standards (2023) – Safe, Effective, Timely,	Clinical peer-review of 10 notes per clinician per month focusing on READ coding and examination details.	GP's and Clinicians	31/05/2026

	highlighting inconsistencies in clinical record-keeping.	and evidence of information provided to patients.	Information, Workforce.			
30.	Doctors were reported to meet weekly to share clinical information, yet these meetings were not formally minuted and no agendas or records were available to demonstrate what had been discussed or how information was shared with the wider team.	The practice should ensure that these meetings are formally recorded, with clear agendas and minutes, to support transparency and accountability.	Health and Care Quality Standards (2023) – Leadership, Information, Safe, Learning, Improvement & Research.	Formalize weekly clinical meetings with a set agenda (Safe Netting, Palliative, Significant Events) and signed-off minutes.	Lead GP - DR Bohra	15/04/2026
31.	The practice manager told us that annual appraisals had only recently restarted.	The practice should ensure that annual appraisals are carried out consistently for all staff.	Health and Care Quality Standards (2023) – Workforce, Leadership.	Develop an appraisal schedule to ensure 100% of staff receive a formal annual review by year-end.	Practice Manager - Ranjana Bohra	31/12/2026
32.	The practice's recruitment policy referenced the Care Quality Commission (CQC), which is not	The practice should review its policies and update them to reflect Welsh standards and guidance.	Health and Care Quality Standards (2023) – Leadership, Workforce.	Audit all policies; remove "CQC" references and replace with "HIW" and	Practice Manager - Ranjana Bohra	30/06/2026

	relevant in the Welsh healthcare context.			"NHS Wales" standards.		
33.	There was no formal or structured clinical supervision in place for nursing staff. It was noted that a GP or prescriber was not always present, which at times left a nurse working without immediate access to prescribing support.	The practice should: • consider implementing a clinical supervision framework for nurses • consider the development of non-medical prescribing among nursing staff to increase clinical capacity.	Health and Care Quality Standards (2023) – Safe, Workforce, Leadership.	Adopt a Clinical Supervision Framework for nurses; review rota to ensure a GP is always present at the site remotely or face to face.	Senior Partner - DR Bohra	31/05/2026
34.	The complaints procedure made available to patients did not reference the NHS Wales Putting Things Right process.	The practice should update its complaints policy to explicitly reference the NHS Wales Putting Things Right process.	Health and Care Quality Standards (2023) – Leadership, Person-centred, Information.	Update Complaints Policy and patient leaflets to explicitly follow the "Putting Things Right" statutory guidance.	Practice Manager – Ranjana Bohra	30/04/2026
35.	The practice did not maintain a centralised complaints register. There was no evidence provided of how complaints were systematically analysed to identify	The practice should: • routinely monitor and record complaints and concerns using a register to support future analysis and learning • ensure that complaints are discussed in	Health and Care Quality Standards (2023) – Leadership, Person-centred, Information.	An Excel sheet has been created for managing complaints, including the date, reason for the complaint, acknowledgment of the complaint, full	Practice Manager - Ranjana Bohra	15/04/2026

	emerging themes or trends, nor did the minutes of meetings reviewed during the inspection show any reference to complaint discussions or the sharing of learning arising from them.	meetings and that learning from concerns is shared with the whole team to support continuous improvement.		response within one month, learning outcomes, and confirmation that the complaint was discussed in the meeting. The Complaints Policy will also be updated according to health and care quality standard.		
36.	The practice took part in an annual survey conducted by the cluster; there was no evidence that the results of this survey were shared with patients or used to inform service development.	The practice should implement a suitable system to feedback to patients following their response to surveys.	Health and Care Quality Standards (2023) – Person-centred, Leadership, Information.	Display a "You Said, We Did" poster in the waiting area to summarize survey outcomes and practice actions.	Practice Manager - Ranjana Bohra	31/05/2026
37.	The practice had both a whistleblowing policy and a Duty of Candour policy; however, neither	The practice should review and update its whistleblowing and Duty of Candour policies to ensure they include a clear review	Health and Care Quality Standards (2023) – Leadership, Information.	Review both policies immediately; add "Next Review Date" to all policy headers for ongoing governance.	Practice Manager - Ranjana Bohra	30/07/2026

	document included a review date.	date. The practice should also ensure regular policy reviews are carried out and documented.				
38.	Concerns were raised during the inspection regarding the physical security of medical records stored upstairs within the practice. Staff reported that these records were not consistently locked away when staff were not present in that area.	The practice must address this issue to ensure that all patient records are always stored securely, in line with information governance standards and to protect against unauthorised access.	Health and Care Quality Standards (2023) – Information, Safe, Leadership.	Install a lockable door or keypad for the upstairs record storage; staff memo issued on the requirement to keep it locked.	Practice Manager - Ranjana Bohra	30/07/2026

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): **Ranjana Bohra**

Job role: **Practice Manager**

Date: **20/03/2026**