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Healthcare Inspectorate Wales

General Practice Inspection Report (Announced)

Llangennech Surgery, Hywel Dda University Health Board

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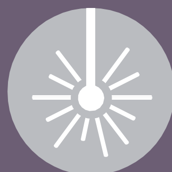

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

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:

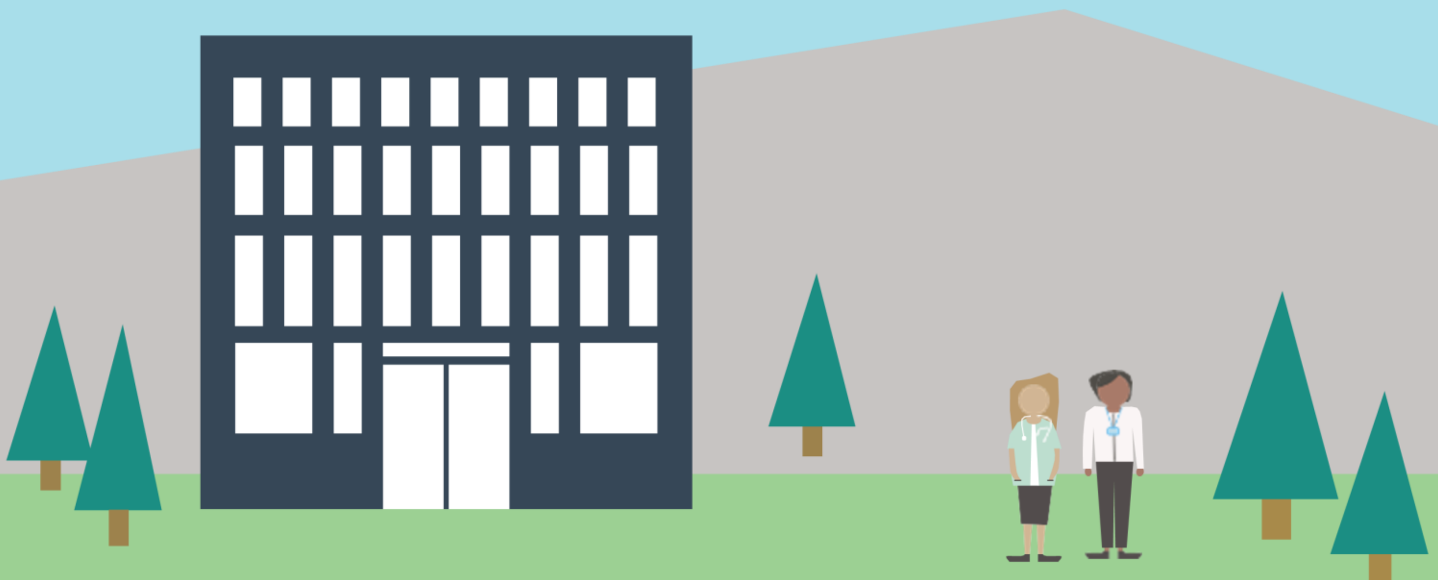
- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and 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.



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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 Llangennech Surgery, Hywel Dda University Health Board on 11 February 2026.

Our team for the inspection comprised of two HIW healthcare inspectors, two clinical peer reviewers and a practice manager peer 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 17 questionnaires were completed by patients or their carers and 4 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:

We found that patients received care in a clean, welcoming and accessible environment. Staff were observed interacting with patients in a kind, professional and considerate manner. Measures were in place to support privacy and dignity during appointments, including closed consultation room doors and the use of privacy curtains, and a clearly signposted private room near reception for confidential discussions. Patient feedback reflected these strengths, with many respondents commenting positively on staff courtesy, respectful treatment and overall cleanliness of the premises.

A range of bilingual health-promotion materials were available in the waiting area, including information on common conditions, screening programmes and local and national support services. A dedicated carers' information board was also present in the waiting area. Patients were able to access additional cluster-based services, including physiotherapy and community pharmacy support for minor illness. The practice website provided useful self-help resources, supporting people to manage aspects of their own health. However, information about some services – including urgent mental health support via NHS 111 press 2 – was not available online.

Communication arrangements supported patients with a range of needs. Information could be provided in different formats, interpreter services had been used when required, and staff contacted older or digitally excluded patients by telephone to ensure important updates were received. Patient feedback suggested that communication was often clear and informative, although some respondents reported not always feeling fully listened to or consistently involved in decisions about their care.

Patients were able to request appointments in person or by telephone, and we were told that urgent cases were triaged by a GP, with children requiring urgent care seen the same day. However, information about appointment types was not consistently visible within the waiting area or online, and care-navigation materials used by reception staff were not consolidated into a single, clear pathway. Patient feedback reflected mixed experiences in accessing timely care, with some patients reporting prompt support while others described difficulty obtaining same day or face-to-face appointments.

The practice made reasonable adjustments for patients who required additional support, including access to interpreters, a hearing loop at reception, and the recording of preferred names in patient records. The building was accessible, with level entry points, appropriate toilet facilities and sufficient seating to support patients with mobility needs.

This is what we recommend the service can improve:

- Improve key operational policies that directly affect patient experience – including Was Not Brought, Care Navigation and Workflow – by ensuring they are clear and accessible
- Ensure patients have clearer information about available services and appointment types by updating waiting room information and online resources

This is what the service did well:

- Provided a clearly signposted private room near reception, enabling patients to discuss sensitive matters confidentiality
- Offered a designated room equipped with a blood pressure machine, allowing patients to check their readings independently in a comfortable and private environment
- Maintained an accessible building with level entry points, appropriate toilet facilities and sufficient seating to support patients with mobility needs.

Delivery of Safe and Effective Care

Overall summary:

The practice was clean, well maintained and generally organised to support safe care. Clinical and non-clinical areas were tidy, free from clutter, and supported by visible cleaning schedules. However, we identified several environmental risks, including unmarked steps and exposed external drains, which presented potential trip hazards for patients, visitors and staff.

A designated Infection Prevention and Control (IPC) lead was in place, and staff had completed relevant IPC training. Whilst appropriate facilities and equipment supported good hygiene practice, IPC-related policies, including those covering waste management and blood-borne viruses, existed in duplicate and requires consolidation into single, comprehensive documents.

Emergency systems were in place, but several issues needed attention, including missing baby-sized Guedel airways, expired adrenaline, and emergency drugs located in a treatment room that may not always be accessible during clinical

activity. These issues were raised during the inspection and missing or expired equipment was replaced immediately. Emergency equipment such as oxygen cylinders and the AED were in working order, and staff had completed recent resuscitation and AED training. Processes for receiving patient-safety alerts were established, with arrangements in place to ensure continuity when key staff were absent.

Medicines and vaccines were managed safely. Prescription pads were secured with an audit log, and repeat prescribing processes were overseen by the GP and practice pharmacist. Vaccines were stored in dedicated fridges, checked twice daily, and supported by an up-to-date cold-chain policy. There was no audit trail for Controlled Drug prescriptions collected by patients or carers, limiting the ability to fully monitor controlled medication.

Safeguarding arrangements were in place, and staff demonstrated awareness of referral pathways and local contacts. However, safeguarding governance required strengthening. The practice manager had also not completed level two safeguarding training at the time of inspection, though this was resolved immediately.

Patient records were generally legible and contemporaneous but varied in detail. Several records contained limited information about assessments, symptoms or safety-netting advice. Medications were not always linked to corresponding conditions, and documentation of consent and chaperone use during intimate examinations was inconsistent. There was no workflow policy outlining how incoming correspondence should be processed, and no formal process for monitoring the quality or consistency of clinical or administrative entries.

Immediate assurances:

- We required immediate assurance regarding Legionella control as water temperatures at clinical hand-wash basins were below recommended levels for effective infection prevention and Legionella management. This was addressed through our Immediate Assurance process, and more details can be found in **Appendix B**.

This is what we recommend the service can improve:

- Address environmental safety risks, including clearly marking steps and covering or replacing exposed external drains to reduce trip and fall hazards
- Strengthen emergency preparedness by ensuring emergency drugs and equipment are stored in an accessible and central location, that all required items are present and in date, and that checks are completed weekly
- Strengthen safeguarding governance, including formally minuted multidisciplinary safeguarding and palliative-care meetings.

This is what the service did well:

- Maintained clean, well-presented premises with tidy clinical areas, visible cleaning schedules, and staff who demonstrated understanding of their IPC responsibilities
- Managed medicines and vaccines safely, including secure storage of prescription pads, twice daily fridge temperature checks, and an up-to-date cold chain policy.

Quality of Management and Leadership

Overall summary:

Leadership and governance arrangements were visible at the practice, with clear roles, responsibilities and reporting lines in place. The practice manager operated an open-door approach and used email to cascade operational updates, including policy changes and safety notices. Monthly team meetings occurred, although these were not minuted. The lead GP engaged with the cluster and fed back requirements to the practice manager regarding local projects and initiatives.

Workforce processes showed strengths as well as areas for development. Recruitment and induction policies were in place and pre-employment checks (including references, qualifications, DBS and professional registration) were described. Formal appraisals had recently been re-introduced, showing the practice's intention to strengthen governance. However, occupational health screening was not being used during recruitment and there was no formal system of clinical supervision.

Staff had completed mandatory training, though we did not see evidence of additional continued professional development in key clinical areas. The practice relied on regular locums to maintain service delivery and appeared to induct them locally.

Arrangements for concerns, complaints and feedback were in place, supported by a complaints policy aligned with NHS Wales Putting Things Right. Complaints were filed but not logged for trend analysis, and learning from complaints or feedback was not reliably evidenced as team meetings were not minuted. A patient feedback box was available in reception, and the practice recognised the benefit of developing a clear mechanism to show patients how their feedback informs improvements.

Some activities to support quality improvement were evident. Prescribing audits had been undertaken and the practice had explored opportunities to streamline processes, including outsourcing scanning. However, quality improvements were

informal and there was no structured practice-wide audit programme. Clinical discussions and incident learning occurred on an ad-hoc basis without minutes, limiting the ability to demonstrate a consistent cycle of audit, action and follow-up.

Information governance processes were robust, with an up-to-date policy, secure management of paper and electronic records, the use of a Data Protection Officer service, and a clear privacy policy. Activity data was shared with patients, and arrangements were in place to submit data to external bodes as needed.

Partnership working was positive. The practice participated in cluster activities and maintained links with community partners (for example, health visitors, district nursing and palliative care teams), supporting coordinated care and alignment with Hywel Dda pathways.

This is what we recommend the service can improve:

- Strengthen governance arrangements by ensuring monthly team and clinical meetings are minuted, with learning and actions shared with staff who cannot attend
- Improve workforce processes by ensuring complete recruitment evidence for all staff and introducing occupational health screening at recruitment
- Enhance learning from concerns by maintaining a complaints log to support trend analysis and establishing a clear method of demonstrating actions taken in response to patient feedback.

This is what the service did well:

- Visible leadership and accountability, with engagement in cluster activities and local networks
- Sound information governance arrangements
- Positive partnership working, with established links to community teams (health visitors, district nurses and palliative care).

3. What we found

Quality of Patient Experience

Patient feedback

HIW issued a questionnaire to obtain patient views on the care at Llangennech Surgery. In total, we received 17 responses from patients at this setting. Some questions were skipped by some respondents, meaning not all questions had 17 responses. All respondents agreed that their comments could be published anonymously within this report.

Overall, feedback was mixed. Many respondents reported positive experiences of staff courtesy, the cleanliness of the building, and the accessibility of premises. Most patients said they could contact the practice when needed, were satisfied with its opening hours, and knew how to access out-of-hours services.

Responses highlighted concerns about appointment access and communication. Patients described difficulties securing same day or in-person appointments, limited appointment choice, and variation in interactions. Feedback also indicated that many patients were not aware of how to provide feedback or raise a concern, and carers reported limited signposting to support.

Despite these concerns, almost half of respondents rated their overall experience as very good, with others describing caring and professional interactions with staff.

Patient comments included:

> *" Staff are always pleasant and accommodating... very happy with care given"*

> *"Can never see a doctor, told to go to a prescribing pharmacy"*

> *"Members of my family have left the practice due to its poor customer service, access to GP, and lack of health support"*

> *"I felt cared for and listened to"*

> *"The practice is under pressure but overall I feel that we receive a fair service"*

” Never feel listened to… very degrading and disheartening”

“The surgery is outdated... I would change surgery if I knew how”

“Very professional service all round”

Person-centred

Health promotion
The practice demonstrated a commitment to promoting healthy lifestyles through a range of accessible information and services. Health promotion materials were displayed throughout the practice, with leaflets available in both English and Welsh. These included information on common conditions, national screening programmes and details of local and national support services. We found the information to be current, relevant and of good quality.

We were informed that clinicians provide tailored lifestyle advice during consultations, supported by relevant printed materials. Patients without digital access were able to receive physical copies of information leaflets to support understanding. Patient feedback indicated that while most respondents saw health information on display, only half recalled being offered healthy lifestyle advice during their appointment.

A dedicated ‘Carers’ Information’ board was present in the reception area, signposting support available for individuals in unpaid caring roles.

The practice benefitted from weekly on-site input from a cluster physiotherapist, with patients accessing this service via GP referral. The cluster also operated a minor illness service across four local pharmacies. Patients could either self-refer or be signposted by care navigators, and information about this service was displayed in the waiting area.

The practice website featured a comprehensive self-help hub, enabling patients to manage aspects of their own health independently. However, information about additional services – such as mental health support, including national services such as NHS 111 press 2 – was not available online. The practice should also remove reference to ‘Primecare’ on its front page.

The practice should update its website to ensure all additional services are signposted adequately for patients, particularly in relation to NHS 111 Press 2 services.

The practice had recently completed their winter vaccination programme. Appointments were offered in order of clinical priority, and older patients were contacted directly by telephone. Where patients did not respond with their decision regarding the vaccination offer, staff took a proactive approach by making repeated attempts to reach them by telephone, text message or letter.

We were told that the practice had a low 'Did Not Attend' rate. Staff contacted patients who were late for appointments to establish whether they planned to attend. For children who were not brought to appointments, staff stated that this was escalated to health visitors. We noted two existing 'Was Not Brought' policies; however, only one contained a clear flowchart and procedural detail.

The practice should review and combine the two 'Was Not Brought' policies, to create a single, clear, accessible document.

The practice provided a designated room equipped with a blood pressure machine, which patients could use independently. Readings were printed and could be reviewed by the appropriate healthcare professional. We found the room to be comfortable, private and accessible to all patients.

Dignified and respectful care

We found that the practice was committed to delivering dignified and respectful care. Throughout the inspection, staff were observed interacting with patients in a kind, professional and considerate manner. Notably, a dedicated room adjacent to reception was clearly signposted for 'private conversations' and offered patients an appropriate space for discussing sensitive matters in confidence. Of those that responded to the HIW questionnaire, less than half of respondents agreed that they could talk to reception staff without being overheard.

Observations during the inspection confirmed that clinical rooms supported privacy and dignity. Doors were closed during consultations, and disposable privacy curtains were in place to maintain patient dignity during physical examinations. All respondents to the HIW questionnaire agreed that measures were taken to protect their privacy.

Chaperone notices were displayed in both English and Welsh across the practice; however, we found they were not particularly prominent and could be easily overlooked by patients. All respondents to the HIW questionnaire agreed that they were offered a chaperone where applicable. Staff told us they had completed chaperone training, and a comprehensive chaperoning policy was in place.

The practice should ensure chaperone notices are more visible to support patient awareness of the service.

Timely

Timely care

We found that the practice had several processes in place to support patients in accessing care in a timely and appropriate manner. Patients could request appointments by telephone, or by attending the surgery in person. Staff told us that they explained the different appointment options available; however, this information was not available on the practice website or displayed within the waiting area.

The practice should update its website and display information in the waiting area to ensure that patients are fully informed of the appointment options available to them to manage expectations.

Reception staff had completed care navigation training and used a range of documents to support signposting. However, these documents were not consolidated into a single, clear pathway.

The practice must develop a written Care Navigation Policy and Pathway to ensure processes are clearly defined and easily accessible to staff.

On the day of inspection, we found that patients were generally able to access care in a timely manner. Where appropriate, patients were offered same day appointments or booked into future slots. Patients who requested urgent care were triaged by a GP and given a face-to-face appointment if clinically required. We were told that children requiring urgent assessment were always seen on the same day.

However, patient feedback highlighted mixed experiences with access. Whilst most respondents (15/17) were satisfied with opening hours and said they could contact the practice when needed, fewer than half reported being able to secure a same day urgent appointment. Several patients described difficulties obtaining in-person appointments and noted that limited appointment choice sometimes affected the timeliness of their care. Feedback included:

> *"Today yes, managed to get an appointment but 2 weeks ago no, was told only phone appointments were available"*

> *"Only seem to want to do phone appointments"*

We were told that patients who contacted the practice requiring urgent mental health support or experiencing crisis were followed up immediately by a GP and where appropriate, referred to the local crisis team. Staff reported that patients

had good access to secondary mental health services. Additional support was available through Mind and local NHS-funded counselling services, and these services were used regularly by the practice. We did not see evidence that staff had completed mental health awareness training.

Equitable

Communication and language

We found that the practice had an up-to-date website, and we were told that written patient information leaflets were available in reception and given to individuals when registering with the practice. Staff told us that information could be made available in Easy Read or large print on request, supporting patients with additional communication needs. Patients were kept informed of changes to practice arrangements through telephone calls and notices displayed on waiting area boards.

Staff told us that they contacted older patients and those without digital access by telephone to ensure they received important information. We were told that interpreter services had been used previously to support patients with hearing impairments. A comprehensive consent policy was in place.

Staff were able to describe the process used to manage incoming mail and ensure information was reviewed and recorded in patients' notes promptly. However, there was no formal workflow policy in place to outline these processes, including arrangements for managing out-of-hours correspondence received via the Welsh Clinical Communications Gateway (WCCG).

The practice must implement a workflow policy covering all tasks related to incoming correspondence, including WCCG letters and out-of-hours information.

The practice allocated daily home-visit slots, and housebound patients were clearly flagged on their clinical records, enabling staff to identify them easily.

We found that information received from secondary care was managed appropriately. Records reviewed showed that information was clearly coded in patients' notes, supporting continuity of care.

Staff understood the importance of communicating with patients in their preferred language. Whilst language preference was not recorded in any of the records that we reviewed, staff confirmed that language preference was now recorded for newly registered patients.

Staff were not aware of the Welsh Government's Active Offer, and no Welsh-speaking staff were employed at the practice. We were told that translation services would be utilised if patients required care in Welsh or in another language.

The practice must ensure that 2019 Welsh language duties on primary care providers is reviewed and embedded, including progress towards the 'Active Offer'.

Patient feedback indicated generally positive communication, with most respondents (12/17) reporting that clinicians explained things well, and felt they had enough time to discuss their concerns (13/17). A portion of respondents (6/17) told us that they did not feel fully listened to or involved in decisions about their care (7/17). One respondent highlighted that their British Sign Language needs were not proactively met by the practice, unless a relative attended with them.

Rights and equality

We found that the practice took steps to promote equality and uphold patients' rights. Staff told us that equality and diversity were supported through regular learning, and we saw certificates confirming completion of relevant training courses. This was supported by an Equality and Diversity policy.

The practice was accessible to patients with mobility needs. A disabled ramp was present at both the front and side entrances, and the building was situated on a single level with an accessible car park at the rear of the practice. The toilet facilities were suitable for patients with mobility needs, with handrails, a foot-pedal bin and an emergency cord available. All respondents to our questionnaire agreed that the building was accessible, and that the waiting area had enough seats.

On the day of inspection, we saw that reasonable adjustments were made for patients where required. A hearing loop was available at reception, we were told that interpreters were proactively utilised when needed, and a private room was available for patients who required a quieter or more confidential space. Staff told us that preferred names and pronouns were recorded in patient notes, supporting the rights and dignity of transgender patients.

Of those who answered our questionnaire, 10 patients reported that they could access the right healthcare at the right time, and six disagreed with this statement. Most respondents (15/17) confirmed that they had not faced discrimination when accessing the service.

Delivery of Safe and Effective Care

Safe

Risk management

We found that the practice was clean, clutter-free and in a good state of repair. During a tour of the premises, we noted several steps that were not clearly signposted and identified several external drains around the building that were missing covers. These presented potential trip and fall hazards for patients, visitors and staff.

The practice must ensure appropriate signage or hazard tape is used to alert staff and patients to potential hazards, and must replace or cover exposed drains to reduce the risk of accidents.

The practice had an up-to-date Business Continuity Plan (BCP), available in both paper and digital formats. This included contingencies for health emergencies such as pandemics. However, the plan did not sufficiently address business partnership risks associated with operating as a single-handed GP partner practice. The plan did also not consider risks relating to long-term locum GPs who work regularly at the practice.

The practice should update the Business Continuity Plan to include business partnership risks and the reliance on long-term locum clinicians.

We were told that the lead GP regularly attends collaborative cluster meetings, with the practice manager attending on occasion. The practice manager also participated in weekly Practice Manager meetings, which provided an opportunity to share ideas and discuss operational matters. The practice manager felt that the cluster provided supportive peer engagement across practices.

Processes were in place for receiving patient safety alerts. These were received by the practice manager and forwarded to the lead GP. When the practice manager was on leave, alerts were re-directed to the generic enquiries mailbox to ensure continuity.

We found that the practice relied heavily on locum GP and nurses to maintain service delivery. This was mitigated by the consistent use of regular locums who were familiar with the practice. There appeared to be a good induction process in place for new starters and locum staff, supported by a recently implemented policy.

Staff told us that EMIS was available on all computers, which had an embedded call alert system that could be used in the event of an emergency. Staff were aware of the location of emergency drugs, which were stored in the treatment room. However, we advised the practice to relocate emergency drugs and equipment to a central, accessible location to reduce the risk of delays during emergencies. Current storage arrangements could hinder immediate access if intimate examinations were taking place in the treatment room, or if the treatment room doors were locked.

The practice should risk-assess and consider relocating emergency drugs and equipment to a central, easily accessible location.

Infection, prevention and control (IPC) and decontamination

We found that the practice generally had appropriate arrangements in place for infection prevention and control. There were no outstanding estate requests, and the premises appeared clean, tidy, and well maintained. Staff told us that cleaning was undertaken daily by an external contractor, and we saw cleaning schedules displayed for all areas of the practice. Of all that answered the question, all respondents rated the practice as clean.

An appointed IPC lead was in place. On review, we saw four separate policies relating to IPC processes and arrangements. The practice is advised to consider consolidating this into one accessible document.

We saw evidence that staff had completed IPC training appropriate to their roles. Staff told us they were able to segregate patients if necessary to reduce the risk of healthcare-associated infections. Soap, hand gel and paper towels were available in all treatment rooms. Clinical facilities included elbow-operated taps, foot-operated bins and wipeable flooring and surfaces. Examination couches and chairs were wipeable. We saw evidence of hand hygiene audits being undertaken.

Appropriate waste management procedures were in place, and a monthly waste audit was seen. However, the practice had two waste management policies, and are advised to consolidate this into one accessible document.

Similarly, we found two policies relating to blood-borne viruses, and the practice is advised to do the same in this regard.

Hepatitis B immunisation records were maintained for all relevant staff, and annual flu vaccinations were offered.

Sharp containers in treatment rooms were securely fixed and not over filled. We reviewed two policies relating to needlestick and sharps injuries. One contained a clear flowchart, while another referenced occupational health but there were no contact details for this service. The practice is advised to consolidate this into a single, up-to-date document.

During the inspection, we found that water at clinical hand basins was lukewarm. One basin reached only 34°C after two minutes of running time, which is below the recommended levels for effective hand hygiene and Legionella control. We were not assured that effective systems were in place to manage hot water temperatures in line with Legionella control requirements. **This was addressed through our Immediate Assurance process, and further details can be found in Appendix B.**

Medicines management

We found that the practice had appropriate arrangements in place for the safe management of medicines. We saw that prescription pads were kept in the locked storeroom, with an audit log.

The practice did not have an audit trail for when Controlled Drug prescriptions were collected from the practice by patients or carers. This limited the practice's ability to monitor and account for these prescriptions.

The practice should establish a robust audit trail for Controlled Drug prescriptions issued and signed awaiting collection and once collected.

We were told that patients could request repeat prescriptions through the NHS app, or via the repeat prescription form. Provisions were made for housebound patients, who were able to request repeat prescriptions over the phone. There were adequate controls in place when re-authorising certain prescriptions, with all re-authorisations tasked to the GP with a note about blood tests.

Medication reviews were undertaken by the GP and practice pharmacist. Repeat prescription requests were managed by dedicated staff who were experienced in this role. We were told that checks were taken to prevent overuse, and any issues would be escalated to the GP before issuing. Staff told us that they would be encouraged to seek further learning and development, if the need arose.

We found that vaccines were kept in dedicated clinical refrigerators, which were checked twice daily. We were told that vaccines are directly placed in the fridge upon delivery. The refrigerators were locked, not over stocked, and all vaccines seen were in date. A comprehensive up-to-date Cold Chain Policy was seen. For

improved temperature monitoring, we advise the practice to implement data loggers.

There was appropriate signage around the practice detailing where staff could find the emergency drugs and equipment. A named person was responsible for checking emergency drugs and equipment, and staff were aware of this role. However, we noted that these checks were undertaken monthly.

The practice must ensure that checks on emergency drugs and equipment are completed on a weekly basis.

On review of emergency equipment, we noted a few issues that were resolved on the day. Guedel airways for babies were missing, and two ampoules of adrenaline were expired. This was raised with the practice manager and resolved immediately. **More details can be found in Appendix A.**

Two oxygen cylinders were available and ready to use. A defibrillator was located in reception, and it was charged and ready to use. Both adult and paediatric pads were available and in date. It was located on the wall in reception, and there was appropriate signage around the surgery to highlight this. All staff had completed recent resuscitation training, including use of the defibrillator.

Otherwise, we found all medicines were in date and stored securely in the practice. The room temperature was recorded to ensure that ambient stock did not exceed recommended storage temperatures. Expired drugs and sharps were disposed of in sharps boxes taken to pharmacy, and new stock would be ordered. Adverse effects to drugs were reported via the 'Yellow Card' System.

Safeguarding of children and adults

We found that the practice had an appropriate safeguarding policy in place, which included guidance for vulnerable adults and children. The policy identified the Safeguarding Lead at the practice and provided local contact information for staff to use when making a referral. Staff were aware of who to contact in the event of a safeguarding concern.

We saw evidence that staff had completed safeguarding training appropriate to their roles. However, the practice manager had not completed level two safeguarding training at the time of inspection. This was addressed and resolved on the day. **More details can be found in Appendix A.**

We identified that there was a system in place to flag vulnerable persons. However, there were limitations in the timely identification of relevant records and in the use of the application of relevant Read codes during the inspection.

We were told that the Safeguarding Lead met with safeguarding and palliative care teams on an individual basis, rather than through a scheduled, formal meeting structure.

The practice must implement formal safeguarding and palliative care meetings with multidisciplinary teams, and these meetings should be formally minuted.

Management of medical devices and equipment

We found that all medical devices and equipment appeared to be in good condition, stored appropriately, clean and fit for purpose. We observed that the practice used single use equipment wherever possible. A named person was responsible for checking medical devices and equipment to ensure they remained safe and suitable for use. We saw evidence that these checks were being completed and recorded.

We saw contracts in place for the servicing and maintenance of medical devices and equipment, with recent PAT testing undertaken on all devices. Staff confirmed that equipment requiring emergency repair or replacement would be dealt with by the practice manager.

Effective

Effective care

We found that the practice had systems in place to keep up to date with best practice and national guidance. Medical staff received updates from the National Institute for Health and Care Excellence (NICE), and the practice manager attended regular Practice Manager meetings, as well as a social media forum, where best practice could be shared. We were told that new information would be circulated to relevant staff members through staff meetings.

Incidents were reported to the practice manager, who documented these through the DATIX system where required.

Referrals were managed through the Welsh Clinical Communication Gateway (WCCG) with urgent referrals completed by clinicians at the time of consultation. Locum GPs were made aware of referral processes during their induction. Staff told us that the practice had adapted to recent changes in death certificate legislation, and processes were working well; however, these changes had resulted in longer waiting times for bereaved families.

Reception staff demonstrated awareness of life-threatening emergencies and confirmed they would advise patients to ring 999 or seek urgent GP advice where

appropriate. While non-clinical staff did not receive any formal medical training in recognising patient deterioration, reception staff felt able to identify when a patient's condition appeared serious or changed suddenly.

The practice had an established system for managing patient tests and results. Staff explained that patients were informed of normal results, and those requiring follow-up were advised to arrange an appointment. GPs reviewed all incoming test results and, where action was needed, tasked administrative staff to relay this to patients.

Patient records

The practice used EMIS as their clinical records system, having recently migrated from Vision. We saw that paper records were stored securely within the administration office.

We reviewed a sample of ten patient records and found that overall, records were legible, generally contemporaneous, and contained summaries of past medical history, long-term conditions and repeat medication. Chronic disease information was overall well documented, and most entries included relevant clinical findings.

However, we identified considerable variation in the quality and detail of record keeping. Several records contained very brief consultation notes, with limited information about patient symptoms, assessment or safety-netting advice.

While some clinicians routinely documented examination findings and management plans, others provided minimal narrative detail, limiting the clarity of the clinical reasoning.

The practice must ensure that patient records contain sufficient detail to support safe, effective continuity of care, including clear documentation of clinical assessment, advice provided, and management plans.

We noted that documentation relating to consent and chaperones was inconsistent across the practice team. In records where intimate examinations were carried out, the offer or use of a chaperone was not recorded. Consent for examinations was documented in some cases but absent in others.

The practice must ensure consent and the offer or use of a chaperone is clearly documented in the patient record, particularly for intimate examinations.

Read codes were used for chronic conditions and some acute problems; however, coding was not applied consistently for new presentations. In some cases, medications prescribed were not linked to the corresponding clinical condition.

The practice should strengthen its use of Read codes for new problems, risk factors and strengthen medication linkage to the corresponding clinical condition.

Although most entries were made on the day of consultation, we identified one occasion where notes were entered two days later. Staff told us this related to the practice's triage system.

We reviewed how information from secondary care was managed and found that administrative staff coded incoming correspondence and forwarded tasks to GPs where action was required. However, there was no formal process for reviewing the quality of entries or ensuring consistency in summarising records.

The practice should introduce a process for reviewing the quality and consistency of record keeping, including entries made by non-clinical staff.

Quality of Management and Leadership

Staff feedback

In total, we received 4 responses from staff at this setting. Some questions were skipped by some respondents, meaning not all questions had 4 responses. Due to the low response rate, it is not possible to fully include this feedback.

Overall, staff reported positive working relationships and felt able to raise concerns. Feedback highlighted potential areas strengthening in relation to the sufficiency of staffing levels, the completion of annual appraisals, and awareness of wellbeing or occupational health resources.

All staff agreed that patient care, privacy and confidentiality were prioritised by the practice. Of those who responded, all agreed that they felt satisfied with the quality of care and support they give to patients.

Leadership

Governance and leadership

We found that staff and managers were clear about their roles, responsibilities and reporting lines, and understood the importance of working within their scope of practice. The practice manager was visible and approachable, operating an open-door policy and telling us that staff could seek support at any time.

Team meetings were held monthly, however, these were not minuted. Staff who were unable to attend meetings were updated by email.

The practice should ensure that minutes are recorded for monthly team meetings and shared with staff who are unable to attend.

We identified several policies that were duplicated and of variable quality. These included policies relating to IPC, Waste Management, Blood-Borne Viruses and Needlestick and Sharps injuries.

The practice must ensure that policies and procedures are robust, comprehensive and are relevant to the practice.

The lead GP maintained accountability for service standards and key decision making.

Workforce

Skilled and enabled workforce

We found that the practice had processes in place to support safe recruitment and workforce governance. An up-to-date recruitment policy and induction policy were available; however, for long-standing members of staff, some aspects of the recruitment process, such as historic reference checks, were not available.

The practice must ensure full adherence to the recruitment policy and induction policy for all new staff.

Vacancies were advertised through Indeed, and pre-employment checks included verification of employment history, references, qualifications and Disclosure and Barring Service (DBS) checks. The practice manager confirmed that professional registration was checked directly via the relevant regulatory body's website, and we were told that formal appraisals had recently been introduced to ensure ongoing suitability for roles. However, an individual workplace / health screening had not been utilised in recruitment processes.

The practice should introduce a workplace / health screening form as part of the recruitment process to identify any reasonable adjustments and ensure any health-related risks are appropriately assessed.

Staff were trained to the required mandatory levels and were appropriately qualified for their roles. However, we did not see evidence of additional Continuing Professional Development (CPD) undertaken by clinical staff in areas such as diabetes, asthma, COPD or travel health.

There was no formal system of clinical supervision in place. Staff told us they would be invited to attend a support meeting following an incident, but there was no regular or structured clinical supervision framework.

Responsibilities for management and reporting were understood by staff, and contracts of employment and job descriptions were in place.

We were told there was no access to formal wellbeing programmes for staff. Designated leads were in place for specific areas of practice and were available to provide advice when required.

Culture

People engagement, feedback and learning
A feedback box was available in the reception area to support the collection of patient views. However, there was no feedback loop to demonstrate how suggestions were considered or acted upon.

The practice should introduce a system to inform patients of changes made as a result of feedback.

The practice had an up-to-date complaints policy aligned with NHS Wales Putting Things Right, and patient advocacy information, including contact details for Llais, was available. Whilst a complaints leaflet was in use, we noted it did not set out timelines in accordance with the Putting Things Right procedure.

The practice must update its complaints leaflet to ensure that timelines are aligned with NHS Wales Putting Things Right.

Complaints were stored in a dedicated folder, however there was no complaints log in place. As a result, the practice was unable to easily track concerns, review themes or demonstrate that complaints had been consistently managed in accordance with the policy.

The practice should implement a complaints log and undertake an annual review of complaints to support trend analysis and drive improvement.

A named member of staff was responsible for managing complaints and concerns, with arrangements in place for cover during periods of absence. We were told that learning from complaints, concerns and feedback may be discussed at team meetings, however, these meetings were not minuted and therefore learning and actions could not be evidenced or shared across the team.

The practice must ensure that discussions and learning from complaints are recorded in meeting minutes and shared with relevant staff.

An up-to-date Whistleblowing policy was in place. We were told that that staff at all levels are encouraged to speak up with new ideas or raise concerns, and the practice manager’s open-door approach supported this.

We reviewed the Duty of Candour policy. Whilst the practice had not yet had an incident that met the threshold for Duty of Candour reporting, staff described the process that would be followed should it be triggered. We saw evidence that only one member of staff had completed Duty of Candour training.

The practice must ensure that all staff complete Duty of Candour training.

Information

Information governance and digital technology
We found that the practice had an up-to-date information governance policy in place. Paper records were stored securely, and electronic records were appropriately protected in line with GDPR requirements. The practice made use of a Data Protection Officer service provided by the health board, and a clear privacy policy was available which described the process for handling data.

GP activity data was published monthly and made available to patients both in the waiting room and on the practice website.

Learning, improvement and research

Quality improvement activities
We found that the practice engaged in some activities to support quality improvement, however, arrangements were informal and not part of a structured programme. A named GP provided clinical oversight and held responsibility for the overall management of the Quality Assurance and Improvement Framework (QAIF). The lead GP attended cluster meetings and fed back requirements to the practice manager regarding cluster projects and initiatives.

The practice appeared to be open to quality improvement and had explored service developments such as outsourcing scanning to streamline processes. Prescribing audits had been undertaken, although we did not see evidence of a wider, structured programme of clinical or internal audits to monitor quality across the practice.

The practice should develop and implement a structured programme of clinical and internal audits to support ongoing quality improvement.

Learning from internal reviews and incidents was shared during ad-hoc clinical discussions, and clinical information was shared between doctors and nurses. However, these meetings were not minuted and there was no formal process to ensure learning was recorded and disseminated.

The practice must formalise clinical meetings to support the sharing of good practice, learning from incidents, and discussion of audits, and ensure these meetings are minuted.

Whole-systems approach

Partnership working and development

We found that the practice engaged with wider system partners and contributed to the collaborative working within the local network. Staff told us that the practice followed Hywel Dda University Health Board pathways to ensure consistency and alignment with wider system processes.

The practice participated in cluster activities and worked closely with neighbouring GP practices and local practice managers. We were told that GPs had regular face-to-face contact with system partners including health visitors, district nurses and the palliative care team.

We were told that the practice was involved in GP collaborative meetings and had recently received an assurance visit from the health board. The practice manager attended weekly practice manager meetings and active in her peer network.

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
Guedel airways for babies were missing from the emergency equipment kit.	The absence of appropriately sized airways for babies could delay effective airway management during a paediatric emergency, increasing the risk of inadequate ventilation or airway obstruction.	We escalated this to the practice manager.	Replacement Guedel airways were ordered immediately during the inspection for next day delivery.
Two expired ampoules of adrenaline were found in the emergency drug kit.	Expired adrenaline may be less effective or unusable during an anaphylactic emergency, potentially delaying	We escalated this to the practice manager.	The expired adrenaline was disposed of during the inspection, and in-date adrenaline was immediately located and placed in the emergency kit.

	life-saving treatment and increasing the risk of serious harm.		
The practice manager had not completed level two safeguarding training at the time of inspection.	Failure to complete the appropriate level of safeguarding training could delay appropriate recognition and escalation of safeguarding concerns.	We escalated this to the practice manager.	Immediately following inspection, we received evidence that safeguarding training had been completed to the appropriate level.

Appendix B - Immediate improvement plan

Service: Llangennech Surgery

Date of inspection: 11 February 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.

	Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	During the inspection, water at clinical hand basins felt lukewarm, with one basin reaching only 34°C after two minutes of running time, which is below the recommended levels.	The practice must ensure that the temperature of hot water in clinical handwash basins meets nationally recommended standards.	Health & Safety Executive (2024): HSG274 Welsh Health Technical Memorandum 04-01 (2016): Part B	Immediate testing of all clinical handwash basins undertaken. Thermostatic mixing valves (TMVs) arranged to be checked and will be adjusted where required. Plumber contracted to inspect hot water system and ensure compliance with Legionella control guidance. Weekly water temperature	Dr Rafique (Registered Manager & Responsible Person for Legionella) Practice Manager (Monitoring & Compliance)	Immediate action taken.

				monitoring log implemented. Staff reminded of procedure for reporting lukewarm water. Records updated in Legionella Book kept at reception and reviewed weekly.		
2.	Whilst the practice had proactively arranged for a legionella risk assessment to be completed on 25 February 2026, we did not see evidence of any previous risk assessments or audits.	The practice must ensure that the legionella risk assessment is periodically reviewed (at least 2 yearly).	Health & Safety Executive (2024): HSG274 Welsh Health Technical Memorandum 04-01 (2016): Part B	External Legionella risk assessment booked 25 February 2026. Risk assessment to be completed by accredited contractor. We aim to do regular risk assessment at least 2 yearly.	Dr Rafique (Responsible Person) Practice Manager (Monitoring & Audit)	External risk assessment booked. Future reviews scheduled: every 2 years (next due 2028)

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

Service representative:

Name (print):

Job role:

Date:

Appendix C - Improvement plan

Service: Llangennech Surgery

Date of inspection: 11 February 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.	Information about additional services - such as mental health support, including national services such as NHS 111 press 2 - was not available online.	The practice should update its website to ensure all additional services are signposted adequately for patients, particularly in relation to NHS 111 Press 2 services.	Health and Care Quality Standards (2023) - Information, Timely	The practice has reviewed and is updating its website to ensure all available services, including mental health and national services, are clearly signposted. Information on NHS Wales "Help Us Help You" and other appropriate services has been added. Information is also displayed within the	Practice Manager (Julie Howells)	10.04.2026

				waiting area to support patient awareness.		
2.	We noted two existing 'Was Not Brought' policies; however, only one contained a clear flowchart and procedural detail.	The practice should review and combine the two 'Was Not Brought' policies, to create a single, clear, accessible document.	Health and Care Quality Standards (2023) - Safe, Effective	The practice has reviewed and updated all relevant policies to ensure they are clear, accessible and include procedural detail. A workflow policy and care navigation pathway, including flowcharts, have been implemented and are available to all staff. Staff have been informed and training provided where required. We will create a single, clear, accessible document.	Practice Manager (Julie Howells) and GP Lead (Dr Rafique)	Completed 31.03.2026
3.	We found that chaperone notices were not particularly prominent and could be easily overlooked by patients.	The practice should ensure chaperone notices are more visible to support patient awareness of the service.	Health and Care Quality Standards (2023) - Person-centred, Information	The practice has reviewed and updated its chaperone notices to ensure they are clear, visible and accessible to patients.	Practice Manager (Julie Howells)	Completed 31.03.2026

				New bilingual (Welsh-first) posters have been displayed in the waiting area, reception and clinical rooms to improve awareness.		
4.	Information about appointment options was not available on the practice website or displayed within the waiting area.	The practice should update its website and display information in the waiting area to ensure that patients are fully informed of the appointment options available to them to manage expectations.	Health and Care Quality Standards (2023) - Information, Timely	The practice will update its website and in-practice information to clearly outline appointment options available to patients. Information is displayed in the waiting area and on the practice website to ensure patients are fully informed and able to access services appropriately.	Practice Manager (Julie Howells)	31.03.2026
5.	Signposting documents for care navigation were not consolidated into a single, clear pathway.	The practice must develop a Written Care Navigation Policy and Pathway to ensure processes are clearly defined and easily accessible to staff.	Health and Care Quality Standards (2023) - Safe, Effective, Information	The practice has developed and implemented a written Care Navigation Policy and clear pathway,	Practice Manager (Julie Howells) and GP Lead (Dr Rafique)	31.03.2026

				including a flowchart, to ensure processes are clearly defined and accessible to all staff. Staff have been informed and training provided.		
6.	There was no formal workflow policy in place.	The practice must implement a workflow policy covering all tasks related to incoming correspondence, including WCCG letters and out-of-hours information.	Health and Care Quality Standards (2023) - Safe, Effective, Information	The practice has implemented a formal workflow policy covering all incoming correspondence, including WCCG letters and out-of-hours information. A clear workflow pathway has been developed and shared with staff to ensure safe and timely processing of all information.	Practice Manager (Julie Howells) and GP Lead (Dr Rafique)	31.03.2026
7.	Language preference was not recorded in medical notes reviewed, and staff were not aware of the	The practice must ensure that 2019 Welsh language duties on primary care providers is reviewed and embedded, including	Health and Care Quality Standards (2023) - Safe, Information, Equitable	The practice has reviewed its processes to ensure compliance with the Welsh Language (Wales)	Practice Manager (Julie Howells)	Ongoing

	Welsh Government's Active Offer.	progress towards the 'Active Offer'.	NHS (Welsh Language in Primary Care Services) (Miscellaneous Amendments) (Wales) Regulations 2019	Measure 2011. Language preference is recorded within the clinical system where appropriate for new patients and patients already registered we will try to update.		
8.	We identified potential trip and fall hazards for patients, visitors and staff that did not have appropriate signage (steps, exposed drains).	The practice must ensure appropriate signage or hazard tape is used to alert staff and patients to potential hazards, and must replace or cover exposed drains to reduce the risk of accidents.	Health and Care Quality Standards (2023) - Safe Health and Safety Regulations: Safety Signs and Signals 1996 The Workplace (Health, Safety and Welfare) Regulations 1992	The practice has completed a risk assessment of identified hazards. and patients, and measures have been implemented to reduce risks, including addressing exposed drains and yellow paint has been painted to alert staff and patients to the step that was pointed out to us on the visit Ongoing monitoring is in place to ensure safety.	Practice Manager (Julie Howells)	31.03.2026

9.	The Business Continuity Plan did not address risks associated with operating as a single-handed GP partner practice, as well as the risks relating to long-term locum usage.	The practice should update the Business Continuity Plan to include business partnership risks and the reliance on long-term locum clinicians.	Health and Care Quality Standards (2023) - Safe, Leadership, Workforce	The practice has reviewed and will be updating its Business Continuity Plan to include all identified risks, including partnership risks. The plan is accessible to staff and will be reviewed regularly to ensure it remains current and effective.	Lead GP Dr Zahid Rafique	10.04.2026
10.	Emergency drugs and equipment were stored in a treatment room.	The practice should risk-assess and consider relocating emergency drugs and equipment to a central, easily accessible location.	Health and Care Quality Standards (2023) - Safe, Effective, Timely	The practice has reviewed the storage of emergency drugs and equipment. A risk assessment will be completed, and emergency equipment will be stored in a safe and accessible location. Staff will be informed of the location and processes.	Practice Manager (Julie Howells)	10.04.2026

11.	The practice did not have an audit trail for collection of Controlled Drug prescriptions by patients or carers.	The practice should establish a robust audit trail for Controlled Drug prescriptions issued and signed awaiting collection and once collected.	Health and Care Quality Standards (2023) - Safe, Information	The practice has implemented a clear audit trail for Controlled Drugs prescriptions, including monitoring of prescriptions issued and awaiting collection. Processes are in place to ensure safe handling and accountability.	Practice Manager (Julie Howells) GP Lead (Dr Zahid Rafique)	31.3.2026
12.	Emergency drugs and equipment checks were being undertaken monthly.	The practice must ensure that checks on emergency drugs and equipment are completed on a weekly basis.	Health and Care Quality Standards (2023) - Safe, Effective, Timely	The practice has implemented a weekly checking system for emergency drugs and equipment. A checklist has been introduced, and records are maintained to ensure compliance and patient safety.	Practice Manager (Julie Howells)	31.3.2026
13.	The Safeguarding Lead met with safeguarding and palliative care	The practice must implement formal safeguarding and palliative care meetings with	Health and Care Quality Standards (2023) - Safe,	If there is a need for these meetings and if we can get MDT team to attend.	GP Lead (Dr Rafique)	Ongoing

	teams on an individual basis.	multidisciplinary teams, and these meetings should be formally minuted.	Effective, Leadership, Learning			
14.	On review of medical notes, we found that some clinicians routinely documented examination findings and management plans, but others provided minimal narrative detail, limiting the clarity of the clinical reasoning.	The practice must ensure that patient records contain sufficient detail to support safe, effective continuity of care, including clear documentation of clinical assessment, advice provided, and management plans.	Health and Care Quality Standards (2023) - Safe, Effective, Information	The practice has reinforced standards for clinical record keeping to ensure all patient records contain sufficient detail, including clear documentation of clinical assessment, advice given and management plans. This has been communicated to all clinicians and will be monitored.	GP Lead Dr Zahid Rafique	31.03.2026
15.	The offer of a chaperone and consent was inconsistently documented in the medical notes.	The practice must ensure consent and the offer or use of a chaperone is clearly documented in the patient record, particularly for intimate examinations.	Health and Care Quality Standards (2023) - Safe, Information, Effective	The practice has reinforced the requirement to document consent and the offer or use of a chaperone within the patient record, particularly for	Practice Manager (Julie Howells) and GP Lead (Dr Rafique)	31.03.2026

				intimate examinations. Staff have been reminded and compliance will be monitored.		
16.	Read coding was not consistently applied in the medical notes, medications prescribed were not linked to the corresponding clinical condition.	The practice should strengthen its use of Read codes for new problems and risk factors and strengthen medication linkage to the corresponding clinical condition.	Health and Care Quality Standards (2023) - Safe, Information, Effective	The practice has strengthened the use of Read coding within clinical records to ensure consistency and accuracy. Clinicians and administrative staff have been reminded of the importance of coding diagnoses, medications appropriately. This will be monitored regularly.	Practice Manager (Julie Howells) and GP Lead (Dr Rafique)	31.03.2026
17.	There was no formal process for reviewing the quality of entries or ensuring consistency in summarising records.	The practice should introduce a process for reviewing the quality and consistency of record keeping, including entries made by non-clinical staff.	Health and Care Quality Standards (2023) - Safe, Information, Learning	The practice has implemented a process for reviewing the quality and consistency of record keeping, including	Practice Manager (Julie Howells)	31.03.2026

				entries made by non-clinical staff		
18.	Team meetings were not minuted.	The practice should ensure that minutes are recorded for monthly team meetings and shared with staff who are unable to attend.	Health and Care Quality Standards (2023) – Information, Learning, Workforce, Leadership	The practice holds regular team meetings. Minutes of meetings are recorded, shared with all staff, and stored securely. Staff who are unable to attend are provided with copies of the minutes to ensure they are kept informed.	Practice Manager (Julie Howells)	31.03.2026
19.	We identified several policies that were duplicated and of variable quality. These included policies relating to IPC, Waste Management, Blood-Borne Viruses and Needlestick and Sharps injuries.	The practice must ensure that policies and procedures are robust, comprehensive and are relevant to the practice.	Health and Care Quality Standards (2023) – Safe, Effective, Information, Leadership	The practice has up-to-date policies in place covering IPC, waste management, blood and body fluids, needlestick injury, and sharps handling. These are reviewed yearly by the Practice Manager and communicated to staff. Staff are informed of updates	Practice Manager (Julie Howells)	31.03.2026

				and have access to all policies. We will amend the duplicated polices		
20.	Some aspects of the recruitment process were not available for long-standing members of staff.	The practice must ensure full adherence to the recruitment policy and induction policy for all new staff.	Health and Care Quality Standards (2023) – Safe, Workforce, Leadership	The practice has a recruitment policy and an induction process in place for all new staff. New staff receive an induction which includes mandatory training, policies, and procedures relevant to their role.	Practice Manager (Julie Howells)	31.03.2026
21.	Workplace / health screening wasn't part of the recruitment process.	The practice should introduce a workplace / health screening form as part of the recruitment process to identify any reasonable adjustments and ensure any health-related risks are appropriately assessed.	Health and Care Quality Standards (2023) – Workforce, Safe, Leadership	The practice will introduce a workplace health screening form as part of the recruitment process to identify any health needs or risks and ensure staff are fit for their role.	Practice Manager (Julie Howells)	31.03.2026

22.	There was no feedback loop to demonstrate how suggestions were considered or acted upon.	The practice should introduce a system to inform patients of changes made because of feedback.	Health and Care Quality Standards (2023) - Person-centred, Information, Leadership	The practice will introduce a formal system to record, review and respond to patient feedback. Feedback will be discussed in practice meetings and actions taken will be documented. A feedback log will be maintained to demonstrate improvements made.	Practice Manager (Julie Howells)	31.03.2026
23.	The complaints leaflet did not set out timelines in line with NHS Wales Putting Things Right.	The practice must update its complaints leaflet to ensure that timelines are aligned with NHS Wales Putting Things Right.	Health and Care Quality Standards (2023) - Information, Effective, Leadership	The practice will ensure all complaints are managed in line with Putting Things Right guidance. A complaints policy is in place and will be reviewed regularly. Staff are aware of the complaints procedure and timescales.	Practice Manager (Julie Howells)	31.03.2026

24.	The practice did not have a complaints log in place.	The practice should implement a complaints log and undertake an annual review of complaints to support trend analysis and drive improvement.	Health and Care Quality Standards (2023) - Information, Efficient, Learning, Leadership	The practice will implement a complaints log to record all complaints, actions taken and outcomes. The log will be reviewed regularly to identify trends and support service improvement.	Practice Manager (Julie Howells)	31.03.2026
25.	Meeting minutes were not recorded so we could not see evidence that actions and learning from complaints were shared amongst the team.	The practice must ensure that discussions and learning from complaints are recorded in meeting minutes and shared with relevant staff.	Health and Care Quality Standards (2023) - Information, Leadership, Workforce, Learning	The practice will ensure that learning from complaints is discussed in team meetings and clearly documented in meeting minutes. Actions and improvements identified will be recorded and monitored.	Practice Manager (Julie Howells)	31.03.2026
26.	Only one member of staff had completed Duty of Candour training.	The practice must ensure that all staff complete Duty of Candour training.	Health and Care Quality Standards (2023) - Safe, Effective, Learning	The practice will ensure that all staff complete Duty of Candour training. A training log will be	Practice Manager (Julie Howells)	ongoing

				maintained and monitored to ensure compliance. Updates will be discussed in team meetings and recorded in minutes.		
27.	We did not see evidence of a wider, structured programme of clinical or internal audits to monitor quality across the practice.	The practice should develop and implement a structured programme of clinical and internal audits to support ongoing quality improvement.	Health and Care Quality Standards (2023) - Effective, Leadership, Information, Safe	The practice will develop and implement a structured programme of clinical and internal audits. Audits will be undertaken regularly to monitor performance, identify improvements and support ongoing quality improvement. Audit findings will be discussed in practice meetings.	Practice Manager (Julie Howells)	Ongoing
28.	Clinical discussions were held on an ad-hoc basis, with no structure or meeting minutes.	The practice must formalise clinical meetings to support the sharing of good practice, learning from incidents, and discussion of	Health and Care Quality Standards (2023) - Workforce, Leadership, Safe, Effective, Learning	The practice will formalise clinical meetings with a structured agenda to include significant events, incidents,	Practice Manager (Julie Howells)	31.03.2026

		audits, and ensure these meetings are minuted.		audits and learning. All meetings will be minuted and shared with relevant staff to ensure learning and continuous improvement.		

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): **Julie Howells**

Job role: **Practice Manager** **Date:**