Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report

(Announced)

Wylcwm Street Surgery, Powys Teaching Health Board

Inspection date: 23 February 2026
Publication date: 29 May 2026

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

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

In writing:

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

Or via

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

Digital ISBN 978-1-83745-621-5

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 Wylcwm Street Surgery, Powys Teaching Health Board on 23 February 2026.

Our team for the inspection comprised of two HIW healthcare inspectors, one clinical peer reviewer 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 13 questionnaires were completed by patients or their carers and 11 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 the practice provided person-centred care and made efforts to ensure patients were treated with dignity, respect, and fairness. Patients were supported through a wide range of health promotion activities, including access to written information, digital resources, and self-referral pathways to a variety of support services. The practice also demonstrated awareness of local population needs by providing relevant health information and ensuring patients without digital access could receive information through alternative channels. Staff were observed to communicate with patients in a respectful and confidential manner, and systems were in place to protect privacy during consultations and examinations.

The practice had arrangements to support timely access to care, including a call queuing and ring-back system and trained care navigators who directed patients to the most appropriate services. In addition, the practice was contracted by the Health Board to provide a limited minor injury support service for the local population, reflecting the rural location of the practice and the significant distance to the nearest emergency department. Clear processes were also in place for urgent care and mental health support.

Communication with patients was delivered through multiple channels, including the practice website, social media, and information displayed within the practice. Translation services and bilingual materials were available to support patients with different language needs.

The premises were generally accessible and supportive of patient needs, with step-free access, a hearing loop, and facilities for patients with mobility difficulties. The practice also demonstrated efforts to support vulnerable groups, including neurodivergent patients and those unable to attend the surgery in person.

However, the rural location of the practice and limited nearby secondary care services were reported to create challenges for patients accessing some aspects of care.

This is what we recommend the service can improve:

- Seating in the waiting area was not well suited for patients with mobility difficulties
- Demonstrating how patient feedback informs improvements.

This is what the service did well:

- The practice demonstrated a strong commitment to health promotion
- The building was fully accessible
- Systems supported timely access to care.

Delivery of Safe and Effective Care

Overall summary:
The practice had systems in place to support the safe and effective delivery of care. Staff demonstrated awareness of emergency procedures, safeguarding processes, and patient safety alerts, and regular meetings were used to discuss incidents and share learning. Medicines management arrangements were generally appropriate, with safe storage of vaccines, regular checks of emergency equipment, and secure management of controlled drugs. Patient records reviewed during the inspection were of good quality, clear and contemporaneous, and systems were in place to manage referrals, test results and diagnostic investigations. The practice also demonstrated collaborative working to support vulnerable patients, including regular multidisciplinary discussions for frail adults.

However, several areas required improvement. The business continuity plan did not clearly address workforce sustainability risks associated with operating as a single-handed GP practice, and recommendations from a recent fire risk assessment had not yet been implemented. Some infection prevention and control arrangements required strengthening, including the development of a site-specific IPC policy and ensuring clinical sinks meet current best practice. Medicines management processes could be improved by introducing ambient temperature monitoring for medicines stored in treatment rooms and establishing formal clinical oversight arrangements for non-medical prescribers.

The most significant governance issue related to the management of incoming clinical correspondence. Although letters were scanned and made available within patient records, there was a substantial backlog of approximately 900 documents awaiting clinical coding. The absence of a formal coding protocol, limited coding capacity and lack of documented clinical oversight increased the risk that important clinical information may not be fully reflected in patient summaries. The practice had recognised this issue and were seeking support from the Health Board to address the backlog.

Finally, some challenges affecting efficiency of care were linked to external factors, including the practice's rural location and proximity to the English border, which can complicate referral pathways and access to secondary care services. Despite these constraints, the practice showed awareness of these issues and worked to maintain continuity of care for its patients.

This is what we recommend the service can improve:

- The practice must prioritise clearing the backlog of clinical correspondence awaiting coding
- There were no formal supervisory processes for non-medical prescribers, and structured oversight is required
- The practice should develop a site-specific infection prevention and control policy.

This is what the service did well:

- The practice had a range of risk management systems in place
- Patient records reviewed were of good quality, clear, contemporaneous and compliant with data protection requirements.

Quality of Management and Leadership

Overall summary:
The practice had governance structures in place to support the management of the service, including regular team meetings, designated leads for key areas of practice activity, and processes for sharing information and safety alerts with staff. Policies relating to complaints, whistleblowing, and information governance were in place, and systems were established to monitor complaints and share learning within the team.

Staff roles and responsibilities were generally well defined, and systems were in place to monitor professional registration and support staff induction. The practice also demonstrated a commitment to learning through clinical meetings and some quality improvement activity, such as prescribing and infection prevention audits.

However, staff survey responses highlighted concerns regarding GP staffing levels, workload pressures, and limited involvement in decision-making. Many staff reported not receiving an appraisal within the past year and felt training opportunities were insufficient or not appropriately tailored to their roles. Concerns were also raised about leadership, communication, and organisational culture, with some staff expressing limited confidence in incident reporting processes and follow-up actions.

Additional areas for improvement included strengthening recruitment procedures to ensure all appropriate pre-employment checks are clearly outlined, improving communication with patients about how their feedback informs service improvements, and ensuring all staff complete Duty of Candour training. While the practice had undertaken some quality improvement work, the development of a

more structured audit programme would help strengthen oversight and support ongoing service improvement.

This is what we recommend the service can improve:

- The practice should review staffing levels, workload distribution, and staff engagement to ensure staff feel supported and able to contribute to decision-making
- The recruitment policy should be strengthened to include clear requirements for all pre-employment checks.

This is what the service did well:

- The practice had governance structures in place
- Roles and responsibilities within the team were clearly defined.

3. What we found

Quality of Patient Experience

Patient feedback

Patient feedback to our survey was largely positive, with respondents reporting good access to appointments and high levels of satisfaction with opening hours and contact arrangements. Most patients felt they could obtain urgent and routine appointments when required, and those with ongoing conditions generally accessed regular support easily. The environment was described as accessible and clean, although some respondents felt the practice was not particularly child-friendly.

Patients reported that infection prevention and control measures, such as hand sanitiser availability and appropriate use of protective equipment during procedures, were in place. Most respondents felt their privacy and dignity were maintained during consultations. The majority felt listened to and treated with respect and were satisfied with the explanations and advice provided by clinicians.

A small number of concerns were raised about continuity of GP care and the workload of nurse practitioners. No significant concerns were reported in relation to discrimination or equality of access.

Person-centred

Health promotion

We found that the practice supported health promotion through a wide range of accessible and tailored approaches. During consultations, both GPs and nurses were reported to provide patients with appropriate health promotion materials, including printed leaflets, website links, personalised text messaging resources, and signposting to the practice website. Staff also told us that information could be provided in larger print or in alternative languages to meet individual communication needs.

Patients were able to self-refer to a broad selection of support services. These included physiotherapy, audiology, podiatry, mental health therapy via SilverCloud, weight management programmes, smoking cessation support, the Integrated Autism Service, domestic abuse and sexual violence support services, drug and alcohol misuse services, dementia support, and counselling for children and young people. Cancer support from The Bracken Trust was also available. These services were promoted through the practice's website, which hosted a comprehensive self-help hub.

Health promotion was also responsive to the needs of the local population. Inspectors noted positive examples of information relating to lambing and associated health risks, including toxoplasmosis and the specific risks posed to pregnant women. This demonstrated an understanding of local occupational and environmental factors and an effort to provide relevant, context-specific advice to patients.

The physical environment of the practice further supported health promotion activity. A large range of printed materials, including leaflets and posters, was available within the reception and waiting areas. A television screen displayed health promotion content, reinforcing key public health messages while patients awaited their appointments. In addition, the practice maintained a well-organised and informative website, ensuring that patients could access reliable health information remotely.

Patients had access to a variety of other healthcare professionals through the practice to support healthy lifestyles. For example, a physiotherapist could be booked via reception, and the mental health team, learning disability team and a diabetes specialist visited the practice to see specific patients.

The practice demonstrated a coordinated and inclusive approach to its winter vaccination programme. Eligible patients were invited through personalised booking links sent via an online messaging platform, supported by posters within the practice, information shared on social media channels, notices displayed at the local community hub, and direct promotion during consultations. These varied communication methods ensured that patients without digital access, including older individuals, were not disadvantaged and could receive information through alternative channels.

In terms of collaborative working to improve access, prevent disease and promote health, the practice described some limitations arising from the large geographical area covered by the Cluster, which reduced opportunities for joint initiatives and engagement with partner agencies. Additionally, the lack of nearby secondary care services was reported to have an adverse impact on both the practice and its patients, particularly in relation to travel and timely access to specialist input. To mitigate some of these challenges, the Cluster had introduced and piloted an online communications platform designed to improve access for patients.

The practice had processes in place to safeguard and support patients who did not attend appointments. Individuals who were not brought to appointments were managed in accordance with the practice's Was Not Brought policy, which was current and up to date at the time of inspection. There was also an established

system to monitor instances where patients did not attend hospital appointments. All digital letters relating to Did Not Attend notifications for children and vulnerable adults were reviewed by administrative staff, who highlighted the patient record and ensured follow-up by the relevant clinical team.

The practice manager also described measures to ensure that older people and those without digital access were not disadvantaged when accessing services offered by other agencies. Telephone calls were triaged by trained care navigators, who explored patients' needs and offered alternative solutions where appropriate, such as referral to community pharmacy services. The practice telephone message provided clear information about available options, helping patients to understand alternative routes of care.

Dignified and respectful care
We found clinical rooms provided suitable levels of privacy, with doors closed during consultations to prevent conversations from being overheard. The layout of the premises further supported confidentiality, as the waiting area was separate from the reception desk, reducing the likelihood that discussions between patients and reception staff could be heard by others. Privacy curtains were available in treatment rooms to maintain dignity during examinations and procedures.

During the inspection, staff were observed to be discreet and sensitive when speaking to patients and when discussing patient information with colleagues. No conversations were overheard during the visit, and patients were seen in a timely manner. Telephones were answered away from the main reception area to help maintain confidentiality.

The practice offered both male and female chaperones, with trained administrative staff providing chaperone support where requested or clinically indicated. The availability of the chaperone service was clearly advertised within the practice, ensuring that patients were aware of their right to request this support. An up-to-date Chaperone Policy was in place to guide staff practice. Clinicians recorded verbal consent for intimate examinations in the patient's medical record and documented whether a chaperone had been offered or requested.

Timely

Timely care
We found that the practice had a range of systems in place to support timely access to care. Patients were informed of the different appointment options and ways to seek advice from a doctor or healthcare professional through the recorded telephone message and the practice website. Staff told us the practice sought

feedback on the appointment system through participation in the All-Wales Patient Survey, as required under the access standards. Paper copies of the survey were available within the practice to ensure the views of older people and those without digital access were gathered effectively.

The practice operated a call queuing system and offered a ring-back service, helping to manage demand more effectively and reduce waiting times on the line. Reception staff were available to answer calls throughout opening hours. An up-to-date Practice Access Policy was in place to underpin these arrangements and provided clarity regarding appointment systems and prioritisation.

Reception staff, acting as care navigators, had received care navigation training and followed a clear pathway to direct patients to the most appropriate service or professional. There were established opportunities for non-clinical care navigators to seek guidance from clinical staff if they were uncertain about the best course of action for a patient.

Patients mainly accessed appointments by telephoning the practice or attending reception in person. Staff told us that patients who required or requested a same-day appointment were either seen or triaged by the duty doctor and offered a face-to-face appointment where this was clinically appropriate. The GP partner confirmed that the practice accommodated patient choice in how services were accessed, offering face-to-face consultations, telephone appointments, or home visits where appropriate.

Patients were able to provide updates on their condition in person, by telephone, by letter, or via text messaging. Staff were trained to identify symptoms requiring urgent escalation, such as chest pain, and to direct patients to emergency services where necessary. Clinicians provided safety netting advice, for example advising patients with asthma to seek further review if symptoms deteriorated, and arrangements were in place for patients to be reassessed promptly should their condition worsen.

Clear processes were established for patients requiring urgent mental health support or who were in crisis. Patients, including both children and adults, were advised to contact NHS 111 and select option 2 for urgent mental health assistance. Clinicians could also make referrals directly by telephoning the Single Point of Access and submitting a referral by email, with patients seen the same day where clinically appropriate. For routine secondary mental health referrals, children were referred to Child and Adolescent Mental Health Services (CAMHS) and adults to the Community Mental Health Team (CMHT), ensuring defined pathways into specialist care.

Equitable

Communication and language

The practice demonstrated a multi-channel approach to communication to ensure that patients were informed about the services available to them. Information was shared through the practice website, a social media page, a community noticeboard, and posters displayed within the waiting area. In addition, the practice utilised an online communication platform to promote specific public health campaigns, such as sepsis awareness, thereby supporting targeted and timely dissemination of important clinical information. This varied approach enabled the practice to reach patients through both digital and non-digital means.

A comprehensive and up-to-date Patient Consent Policy was in place, providing a clear framework to guide staff in obtaining and recording consent appropriately.

In relation to the Active Offer for the Welsh language, the practice manager advised that there were very few Welsh speakers within the practice's catchment area and that there were currently no fluent Welsh speakers among staff. However, staff had access to Welsh language training provided by the local Health Board, demonstrating an awareness of their responsibilities in this area. Bilingual signage, posters, and reading materials were available within the surgery building, helping to create an inclusive environment and signalling that Welsh language needs would be respected and supported where required.

The practice also had access to translation services to support patients whose first language was not English or Welsh. This ensured that language barriers did not prevent patients from understanding information about their care or from communicating effectively with healthcare professionals.

The practice recorded telephone calls to support quality assurance and patient safety. Callers were informed of this as part of the recorded telephone message, ensuring transparency and maintaining trust.

Rights and equality

We found that the practice had arrangements in place to support patients' rights and promote equality. The service operated from a purpose-built building that provided good physical accessibility for patients. All patient areas were located on the ground floor. The premises included a wheelchair-accessible toilet equipped with grab handles and an emergency alarm. The waiting area was observed to be spacious, clean, and well-furnished, with ample seating available. However, the chairs in the waiting room were not specifically designed to support individuals who have trouble standing from a seated position, such as those with reduced mobility, which may limit comfort for some patients.

The practice should review the seating provided in the waiting area to ensure it meets the needs of people with mobility difficulties, including the provision of chairs that are easier to rise from.

A hearing loop was available to support people with hearing impairments. The practice had an Equality, Diversity and Inclusion (EDI) policy in place. Staff training records seen during the inspection showed that those staff had completed EDI training.

The practice engaged with a Patient Participation Group (PPG) that met quarterly. Staff reported that this group included representatives from Llais, the local council, the league of friends, patient representatives, Powys Association of Voluntary Organisations (PAVO). This engagement helped the practice ensure it was providing appropriate support and inclusion for patients.

Although staff told us there were currently no transgender patients registered at the practice, they reported that transgender patients would be treated sensitively and that preferred names and pronouns would be used.

The practice also demonstrated sensitivity to the needs of neurodivergent patients. An empty consulting room was used to create a quieter and less stimulating environment for patients who may feel overwhelmed by busy or noisy spaces.

For patients who were unable to attend the surgery in person, home visits were available upon request. This ensured that individuals with mobility issues or other barriers to travel were not disadvantaged and could continue to receive appropriate medical care.

Delivery of Safe and Effective Care

Safe

Risk management

The practice had an up-to-date Business Continuity Plan (BCP) in place, which set out arrangements to maintain service delivery in the event of disruption. The plan adequately addressed how the practice would respond to a significant health

emergency and outlined appropriate escalation and contingency measures. However, it was not clear whether the BCP fully considered the potential risks associated with the current business partnership arrangements, particularly given that the practice was operating with a single-handed GP at the time of inspection.

The practice should consider further strengthening the business continuity plan to ensure that partnership and workforce sustainability risks are clearly identified and mitigated.

There was a dedicated member of staff responsible for receiving patient safety alerts, with a suitable deputy available in their absence. Staff told us that significant events, including patient safety incidents, were reviewed and discussed at clinical meetings. Minutes were shared where appropriate, and relevant staff attended these discussions.

Staff demonstrated awareness of emergency procedures and were able to describe the location of emergency drugs and equipment. Clear signage was displayed on the door of the room where oxygen and the defibrillator were stored, supporting prompt access in an emergency.

Waste management procedures were in place, including the appropriate use of sharps containers, clinical waste bins, and recycling facilities. Outside the premises, recycling and yellow clinical waste bins were positioned against a wall directly beneath the building's eaves. These bins were metal, secured in a locked position, and had been assessed within the fire risk assessment as presenting a low level of risk. In addition, many filled and sealed confidential waste bags were observed awaiting collection within the building.

The practice should ensure:

- **They continue to monitor the external storage arrangements for clinical and recycling waste, ensuring that although the metal, locked bins have been assessed as low risk, any changes in environmental, security or fire-safety risk are identified and mitigated promptly**

- **Confidential waste collections occur at appropriate intervals to prevent accumulation and that storage arrangements remain compliant with good information-governance practice, including secure handling and timely removal of confidential material.**

A fire risk assessment had been completed within the last year. However, the recommendations identified within the assessment had not yet been implemented at the time of inspection.

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

There was also an up-to-date risk assessment in place relating to home visits, demonstrating consideration of staff safety and lone working arrangements.

Infection, prevention and control (IPC) and decontamination
At the time of inspection, there were no outstanding estates requests. A cleaning contract was in place, supported by documented cleaning schedules which were completed as required.

The practice had a designated Infection Prevention and Control (IPC) lead. Staff demonstrated an understanding of their respective roles and responsibilities in maintaining IPC standards, and training records confirmed that staff completed annual IPC training at a level appropriate to their role.

Although the practice operated in line with a generic Health Board IPC policy, there was no evidence of a site-specific IPC policy tailored to the risks, layout and operational procedures of the practice.

The practice should develop a site-specific infection prevention and control (IPC) policy that reflects the risks, layout and operational procedures of the practice.

The premises had suitable facilities to allow for segregation of patients with an actual or suspected infectious presentation if required, helping reduce the risk of healthcare-associated infections.

Clinical areas were equipped with wipeable examination couches and chairs to facilitate effective cleaning between patients, and foot-operated waste bins were in use, reducing hand contact and supporting good hand hygiene practice. However, handwashing sinks within clinical rooms were fitted with plugs. While the taps were elbow-operated, the presence of plugs meant the sinks were not fully compliant with current IPC standards.

The practice should review all clinical handwashing sinks and remove any plugs to ensure they function as dedicated hand hygiene sinks.

Clear guidance was available to staff regarding the procedure to follow in the event of a needlestick or sharps injury, with printed instructions displayed in the treatment room. In addition, the practice maintained a complete Hepatitis B immunisation register for staff, providing assurance that appropriate occupational health measures were in place to protect staff and support safe clinical practice.

Medicines management
An up-to-date Prescribing Policy was in place to guide safe and effective prescribing practice. The Electronic Prescription Service (EPS) was in use, supporting efficient transmission of prescriptions to community pharmacies and reducing the risk of transcription errors. A pharmacy technician was responsible for undertaking medication reviews.

Vaccines were stored appropriately within dedicated vaccine refrigerators that had undergone annual maintenance checks. An up-to-date cold chain policy was in place to guide the safe storage and handling of refrigerated medicines. Staff were able to describe the actions required in the event of a breach in the cold chain, and evidence of daily temperature monitoring was provided, demonstrating adherence to policy requirements.

There was a named individual responsible for undertaking routine drug checks, and records were maintained to evidence that these checks were completed. Medicines stored within treatment rooms were reviewed and found to be within their expiry dates. However, ambient room temperature monitoring was not being undertaken to ensure that medicines stored outside of refrigerators were maintained within recommended temperature parameters.

The practice should carry out and record ambient room temperature checks to ensure drugs are stored under appropriate conditions.

Emergency medicines and equipment were available, with a named person responsible for conducting regular checks of emergency drugs and equipment, including the automated external defibrillator (AED). An AED was present, fully charged, and stocked with pads suitable for both adults and children. Staff had completed appropriate training in managing medical emergencies and cardiopulmonary resuscitation, supporting readiness to respond effectively in urgent situations.

The emergency trolley contained an extensive range of equipment. While consideration could be given to aligning the contents more closely with current Resuscitation Council UK guidance, the practice's rural location, significant distance from the nearest emergency department, and reported pressures on the Wales Ambulance Service NHS Trust, which may result in extended ambulance response times, were factors influencing local decision-making regarding emergency preparedness.

The practice employed two non-medical prescribers. While these practitioners contribute to service capacity and patient access, there were no formal processes

in place to provide structured oversight of their competencies or to review the quality of their prescribing and clinical assessments.

The practice should introduce a formal review and supervision process for non-medical prescribers. This could include a programme of periodic audit, assessed against agreed and pre-determined quality measures.

A sample of Patient Group Directions (PGDs) was reviewed. These were appropriately completed and signed, providing legal authority for specified registered healthcare professionals to supply and administer medicines to defined patient groups. Controlled drugs were stored securely, and records maintained for controlled drugs were consistent with stock balances.

Safeguarding of children and adults
Staff were aware of the procedures to follow in the event of a safeguarding concern and were able to describe the internal reporting processes. Up-to-date safeguarding policies were in place, providing clear guidance for staff, and a named safeguarding lead had been appointed to provide oversight and leadership in this area.

There was a system to identify children on the child protection register within the clinical record system. We saw evidence that children at risk and looked-after children were appropriately coded.

The practice held a weekly virtual ward round during which frail and vulnerable adults were discussed. These meetings were attended by the GP, district nurses, occupational therapists, and physiotherapists, enabling shared oversight of risk and coordinated care planning.

Training records reviewed during the inspection confirmed that staff had completed safeguarding training. However, it was noted that the practice manager had completed safeguarding training at level one only.

The practice should ensure that the practice manager completes safeguarding training to level two as a minimum, in line with the responsibilities of their role.

Management of medical devices and equipment
Single-use equipment was utilised wherever possible, thereby reducing the risk of cross infection and supporting compliance with infection prevention and control standards.

A named individual had been designated with responsibility for ensuring that medical devices and equipment remained safe and suitable for use. Routine checks were undertaken and appropriately documented.

The practice had established contracts for the routine servicing and maintenance of medical devices, and evidence was seen of service calibration and Portable Appliance Testing (PAT).

Effective

Effective care

There was a system in place to circulate new and updated information to relevant members of staff, ensuring that changes in guidance or policy were shared appropriately across the team. Staff reported that new National Institute for Health and Care Excellence (NICE) guidelines were discussed at clinical meetings.

Referrals, both routine and urgent, were processed using the Welsh Clinical Communications Gateway (WCCG), which facilitated a standardised and efficient approach to onward referral. In addition, the practice had a well-established system for the management of test results. Results were reviewed, actioned, and followed up appropriately, with arrangements in place to organise repeat testing where clinically indicated.

Clear processes were also in place for ordering diagnostic tests and communicating results to patients. The practice recognised the needs of older patients and those without digital access, ensuring that results could be relayed via telephone or letter where appropriate, rather than relying solely on digital messaging.

Senior staff described the system in place to ensure that information received through incoming correspondence was reviewed and incorporated into patients' medical records. Incoming post was opened by administrative staff, scanned, and uploaded electronically to the relevant patient record. The content of each letter was then reviewed and directed to the appropriate clinician or pharmacy technician. Where medication changes were identified, the correspondence was forwarded to the practice pharmacist to undertake medicines reconciliation. If blood tests were required, the letter was directed to the nursing team to arrange this. Where GP input was necessary, the correspondence was allocated to a GP for action, and dedicated administrative appointment slots were in place to enable this work to be completed. This process ensured that scanned correspondence was visible within the patient record at an early stage and that immediate clinical actions, such as medication adjustments or investigation requests, could be progressed without delay.

The final stage of the process involved clinical coding of new problems and relevant information. It was at this stage that a significant backlog had developed. At the time of review, approximately 900 documents were awaiting coding, with the oldest dating back to late 2025. Although the letters had been scanned and were accessible within patient records, they had not all been coded to ensure that key diagnoses and information were incorporated into the patient summary. The practice manager confirmed that there was no formal clinical coding protocol in place and that only one member of staff was able to code to the required level. There was no recorded evidence of clinical oversight of the coding process. The practice had recognised the scale of the backlog and had requested support from the Health Board to assist in addressing this, with a further meeting planned to progress the matter.

While the processes described for scanning and initial allocation of correspondence were safe in principle, they relied heavily on the administrative staff member correctly identifying and signposting each document to the appropriate clinician. It was not clear whether this individual had received specific training or competency assessment for this role, which carries potential risk if important clinical information is not triaged accurately or in a timely manner. Although urgent actions such as medication changes and required investigations were reportedly managed appropriately, the absence of a robust coding protocol, limited coding capacity, and lack of formal oversight increased the risk that significant clinical information may not be fully integrated into the patient's coded summary.

The practice must:

- **prioritise clearing the backlog of clinical correspondence awaiting coding and ensure that future coding is completed in a timely and consistent manner**
- **develop a more robust, site-specific process for managing incoming clinical correspondence, including the introduction of a clear clinical coding protocol and appropriate clinical oversight**
- **ensure that administrative staff responsible for directing incoming documents have the appropriate training and competency, and that clinical staff provide support and oversight to strengthen the safety and reliability of the process**
- **expand coding capacity by providing additional training to suitable administrative staff, supported by competency assessment and ongoing supervision**
- **consider utilising clinical staff, such as GPs and nurses, to assist with reviewing, coding or quality-assuring clinical information where appropriate, to support the reduction of the backlog and to improve the resilience of the process.**

Patient records

A sample of ten patient records was reviewed as part of the inspection. The records examined were of good quality and demonstrated that clinical entries were clear, contemporaneous, and sufficiently detailed. There was appropriate documentation of clinical findings, assessment, and the rationale underpinning decisions made in relation to patient care.

Records were up to date, complete, and written in a manner that was understandable to other clinicians. Appropriate clinical coding was evident, enabling accurate identification of diagnoses and long-term conditions. Chronic disease management was well documented, with structured reviews and monitoring recorded clearly within the clinical system. Medicines management was also appropriately reflected within the records reviewed, with prescribing decisions and medication reviews documented in a structured and traceable manner.

Evidence was seen that patients were offered a chaperone where appropriate, and this was recorded within the clinical notes.

Patient records were stored securely in accordance with the requirements of the General Data Protection Regulation.

Efficient

Efficient

The practice described several factors that influence the efficiency of care pathways for its patient population. Its geographical location, near the border with English healthcare services, can present challenges in coordinating care across differing administrative and commissioning arrangements. Variations in referral pathways, service eligibility criteria, and communication systems between Welsh and English providers may create additional complexity when arranging onward care and treatment.

The remote and rural setting of the practice also impacts the efficient movement of patients through care pathways. Transport was identified as a particular challenge, both in terms of patient access to secondary care services and the availability of public or community transport options.

Despite these external constraints, the practice demonstrated awareness of the challenges faced by its population and sought to navigate cross-border systems and transport limitations to facilitate continuity of care. The efficiency of care delivery was therefore influenced not only by internal processes, but also by wider geographical and system-level factors beyond the direct control of the practice.

Quality of Management and Leadership

Staff feedback

Eleven staff members responded to the survey, and the findings indicate a workforce committed to delivering good patient care despite significant operational challenges. While most respondents were satisfied with the quality of care they provide and reported positive practices in relation to dignity, safeguarding, and patient involvement, there were widespread concerns regarding staffing levels, workload pressures, and limited involvement in decision-making.

The practice should review staffing levels, workload distribution, and opportunities for staff engagement to ensure that operational pressures are appropriately managed and that staff feel supported in delivering safe and effective care.

Many staff reported not having received an appraisal in the past year, and many felt training opportunities were insufficient or not appropriately tailored to their roles.

The service should ensure that:

- **all staff receive an annual appraisal or development review**
- **they review how training is planned and delivered so that staff have access to learning opportunities that are sufficient, role-appropriate and support their ongoing development.**

Responses highlighted concerns about leadership, communication, and organisational culture, including limited confidence in incident reporting processes and follow-up actions. Staff wellbeing responses were mixed, with low awareness of occupational health support and limited confidence that positive action is taken to support staff health. Environmental concerns, including the condition of the building and equipment, were also raised in free-text comments.

The practice should:

- **strengthen its leadership, communication and organisational culture by reviewing how staff concerns, incidents and improvement suggestions are captured, responded to and fed back**
- **take steps to raise staff awareness of available wellbeing and occupational health support**
- **review and address the environmental concerns reported by staff, including issues related to the condition of the building and equipment.**

Staff comments included:

“We aim to give our patients the best care and support possible. Ensuring we give our patients the best service is our main concern.”

“There are insufficient GP hours, too much work is directed to the ACP and Nurse practitioner.”

“Since being here there has been very little training other than Bluestream online modules”

“Leadership to act upon and follow up issues that arise in practice meetings”

“On the whole we are a strong supportive team who I believe try our hardest for our patients and we have a good rapport with each other.”

Leadership

Governance and leadership
Staff and managers spoken with during the inspection were clear about their individual roles, responsibilities, and reporting lines. Practice leaders told us that they aim to be visible and approachable to the wider practice team and described operating an open-door approach that allows staff to raise queries or concerns when needed.

There were defined structures in place for communication and oversight. Clinical information was shared and discussed at regular clinical meetings, and minutes from these meetings were reviewed during the inspection. The practice held a range of scheduled meetings to support governance and team communication. All meetings were formally minuted, providing a record of discussions, decisions, and actions. We were told staff were able to contribute to meeting agendas and raise matters for discussion through these forums.

Processes were in place to ensure that information, including updates to policies or procedures, was shared with all staff. Changes were circulated via email and stored on a shared electronic drive, enabling staff to access the most current versions of policies and guidance.

The practice had systems in place to receive and implement safety alerts, such as those issued by the Medicines and Healthcare products Regulatory Agency or the Welsh Government. A designated member of staff was responsible for receiving and disseminating safety notices, with a deputy identified to undertake this role in the absence of the practice manager.

There were designated leads for specific areas including clinical oversight, safeguarding, minor injuries, nursing, infection prevention and control, and complaints. These leads were available to provide advice and support to the wider team.

Arrangements were also in place to support staff wellbeing. Information about wellbeing services, including a poster for the Canopi Wales service, was displayed in the staff coffee room. Staff were also able to access the local Health Board's Employee Assistance Programme, providing additional support if required.

Workforce

Skilled and enabled workforce

Practice leaders told us that responsibilities for management, administration, accountability, and reporting structures within the team were clearly defined and understood by staff. Job descriptions were in place and there was evidence that responsibilities for different clinical staff members were outlined within internal documents, including spreadsheets detailing specific roles and duties.

The practice had an induction programme available for new staff, which provided a framework to support staff when joining the organisation. There were also systems in place to ensure that healthcare professionals maintained appropriate professional registration. Evidence was seen that staff registration with relevant regulatory bodies was monitored, and Disclosure and Barring Service checks had been carried out where required. Training records reviewed during the inspection showed that staff had completed training updates and maintained qualification records relevant to their roles.

Recruitment processes were described as undertaken in line with the practice's recruitment policy. However, the policy itself was relatively basic and did not include clear reference to several key pre-employment checks, such as verification of identity, Disclosure and Barring Service checks at the appropriate level, verification of employment history, confirmation of relevant qualifications, or evidence of registration with professional regulatory bodies where applicable.

The practice should strengthen its recruitment policy to include all key pre-employment checks.

Practice leaders told us that workforce capacity was currently stretched. There were plans to use new funding to expand the administrative team to support operational demands. The practice also reported that it was seeking to recruit a

permanent GP, ideally a new partner, to improve clinical capacity and sustainability of the service.

Culture

People engagement, feedback and learning
An up-to-date complaints policy was in place, and information about the NHS "Putting Things Right" process was clearly displayed in the reception area through accessible patient information leaflets.

The practice monitored the number and type of complaints and concerns received, and a named member of staff had responsibility for managing this process. Complaints and concerns were discussed at staff meetings, with learning points shared with the wider team.

Patient feedback was also gathered through an annual patient survey. While practice leaders reported that feedback from this survey was used to inform service improvements, there was no formal system in place at the time of the inspection to communicate outcomes or actions back to patients.

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

The practice had up-to-date policies in place for both whistleblowing and the Duty of Candour, providing a framework to support openness, transparency, and the raising of concerns within the organisation. However, training records reviewed during the inspection did not demonstrate that staff had completed Duty of Candour training.

The practice must ensure staff complete Duty of Candour training.

Information

Information governance and digital technology
An up-to-date information governance policy was in place, covering all information processed by the practice and providing guidance to staff on the secure handling, storage, and sharing of patient and organisational data. A designated Data Protection Officer had been appointed to oversee compliance with data protection requirements and to provide advice on information governance matters.

Procedures relating to the management of patient data were clearly documented, providing staff with guidance on maintaining confidentiality and protecting sensitive information. Information about how the practice processes and manages patient data was also made publicly available through the practice website.

Learning, improvement and research

Quality improvement activities
The practice demonstrated a commitment to learning and improvement through established governance processes. Clinical meetings were held regularly, during which complaints and concerns relating to clinical matters were discussed.

Practice leaders told us that engagement in quality improvement and service development activities could be challenging at times due to workforce pressures. Despite these constraints, the practice reported that it participated in training opportunities and cluster initiatives where possible.

Evidence was seen that the practice had undertaken some quality improvement activity, including audits related to infection prevention and control and prescribing. While some internal practice audits were undertaken, we recommend that this is consolidated into a forward-looking year ahead schedule of audits, which are recorded, shared and followed up, as required.

The practice should consider creating an annual audit schedule, with a process in place to record, share and follow up, as required.

4. Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

The improvement plans should:

- Clearly state how the findings identified will be addressed
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

Appendix A – Summary of concerns resolved during the inspection

The table below summarises the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns Identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns were identified on this inspection			

Appendix B - Immediate improvement plan

Service: Wylcwm Street Surgery

Date of inspection: 23 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.	No immediate assurance issues were identified on this inspection.					
2.						

Appendix C - Improvement plan

Service: Wylcwm Street Surgery

Date of inspection: 23 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.	The chairs in the waiting room were not specifically designed to support individuals who have trouble standing from a seated position.	The practice should review the seating provided in the waiting area to ensure it meets the needs of people with mobility difficulties, including the provision of chairs that are easier to rise from.	Health and Care Quality Standards (2023) – Person-centred Care, Safe, Equitable.	Review waiting area seating to ensure it meets the needs of patients with mobility difficulties, including providing chairs that are easier to rise from.	Practice Manager	Completed
2.	It was not clear whether the BCP fully considered the potential risks associated with the current business partnership arrangements,	The practice should consider further strengthening the plan to ensure that partnership and workforce sustainability risks are clearly identified and mitigated.	Health and Care Quality Standards (2023) – Safe, Leadership, Effective, Workforce.	BCP updated to include single-handed GP Risk.	Practice Manager	Completed

	particularly given that the practice was operating with a single-handed GP at the time of inspection.					
3.	Recycling and yellow clinical waste bins were positioned against a wall directly beneath the building's eaves, which may present environmental or security considerations. In addition, many filled and sealed confidential waste bags were observed awaiting collection within the building.	The practice should ensure that: • They continue to monitor the external storage arrangements for clinical and recycling waste, ensuring that although the metal, locked bins have been assessed as low risk, any changes in environmental, security or fire-safety risk are identified and mitigated promptly • Confidential waste collections occur at appropriate intervals to prevent accumulation and that storage arrangements remain compliant with good information-governance	Health and Care Quality Standards (2023) – Safe, Leadership, Efficient, Effective, Information, Workforce.	Continue to regularly monitor external clinical and recycling waste storage, reviewing for any changes in environmental, security, or fire safety risks and taking prompt action where required. Ensure confidential waste is collected at appropriate intervals to prevent build-up, with all storage and handling remaining secure and compliant with information governance standards.	Practice Team	Ongoing

		practice, including secure handling and timely removal of confidential material.				
4.	The practice had undertaken a fire risk assessment in February 2026 and had received the report shortly prior to the inspection. As a result, the recommendations identified within the assessment had not yet been implemented at the time of inspection.	The practice should implement the outstanding recommendations from the fire risk assessment without delay and review the contents of the overall risk assessment.	Health and Care Quality Standards (2023) – Safe, Leadership, Effective, Learning, Improvement & Research, Workforce.	Recommendations from FRA actioned. Review and update the overall risk assessment to ensure it remains accurate and comprehensive.	Health and Safety Lead	End of April 2026
5.	The practice operated in line with a generic Health Board IPC policy, there was no evidence of a site-specific IPC policy tailored to the risks, layout and operational procedures of the practice.	The practice should develop a site-specific infection prevention and control (IPC) policy that reflects the risks, layout and operational procedures of the practice.	Health and Care Quality Standards (2023) – Safe, Effective, Leadership, Information	Develop and implement a site-specific Infection Prevention and Control (IPC) policy tailored to the practice's risks, layout, and operational procedures.	IC Lead	Completed

				Review and update the IPC policy regularly to ensure it remains current and effective.		
6.	Handwashing sinks within clinical rooms were fitted with plugs. While the taps were elbow-operated, the presence of plugs meant the sinks were not fully compliant with current IPC best practice.	The practice should review all clinical handwashing sinks and remove any plugs to ensure they function as dedicated hand hygiene sinks.	Health and Care Quality Standards (2023) – Safe, Effective, Leadership, Workforce.	Remove all Plugs	IC Lead	Completed
7.	Room temperature monitoring was not being undertaken to ensure that medicines stored outside of refrigerators were maintained within recommended temperature parameters.	The practice should carry out and record ambient room temperature checks to ensure drugs are stored under appropriate conditions.	Health and Care Quality Standards (2023) – Safe, Effective, Leadership, Workforce.	Room monitoring Policy created with ambient temperature checks being taken daily to ensure compliance in line with guidance.	IC Lead	Completed

8.	The practice employed two non-medical prescribers; there were no formal processes in place to provide structured oversight of their competencies or to review the quality of their prescribing and clinical assessments.	The practice should introduce a formal review and supervision process for non-medical prescribers. This could include a programme of periodic audit, assessed against agreed and pre-determined quality measures.	Health and Care Quality Standards (2023) – Safe, Effective, Leadership, Workforce, Learning, Improvement & Research.	6 Monthly formal review process for non-medical prescribers. With audits against agreed quality measures to monitor prescribing practice and support ongoing improvement	Clinical Lead	Ongoing
9.	It was noted that the practice manager had completed safeguarding training at level one only.	The practice should ensure that the practice manager completes safeguarding training to level two as a minimum, in line with the responsibilities of their role.	Health and Care Quality Standards (2023) – Safe, Leadership, Workforce, Effective, Learning, Improvement & Research.	Practice manager to complete level 2 Safeguarding	Practice Manager	Level 3 Safeguarding Completed
10.	Senior staff described the system in place to ensure that information received through incoming correspondence was	The practice should: • prioritise clearing the backlog of clinical correspondence awaiting coding and ensure that future coding is completed	Health and Care Quality Standards (2023) – Timely, Safe, Effective,	Prioritise clearing the backlog of clinical correspondence and ensure timely, consistent coding going forward.	Coding Team and PTHB	Back log to be reduced by half – May 2026 and

	reviewed and incorporated into patients' medical records. The final stage of the process involved clinical coding of new problems and relevant information. It was at this stage that a significant backlog had developed.	in a timely and consistent manner • develop a more robust, site-specific process for managing incoming clinical correspondence, including the introduction of a clear clinical coding protocol and appropriate clinical oversight • ensure that administrative staff responsible for directing incoming documents have the appropriate training and competency, and that clinical staff provide support and oversight to strengthen the safety and reliability of the process • expand coding capacity by providing additional training to suitable administrative staff, supported by competency assessment and ongoing supervision	Information, Leadership, Workforce, Learning, Improvement & Research, Efficient.	Expand coding capacity through additional training and competency assessment of suitable staff. Utilise clinical staff, where appropriate, to support reviewing, coding, and quality assurance to reduce backlog and improve process resilience.		completed July 2026

		• consider utilising clinical staff, such as GPs and nurses, to assist with reviewing, coding or quality-assuring clinical information where appropriate, to support the reduction of the backlog and to improve the resilience of the process.				
11.	There were widespread concerns regarding staffing levels, workload pressures, and limited involvement in decision-making.	The practice should review staffing levels, workload distribution, and opportunities for staff engagement to ensure that operational pressures are appropriately managed and that staff feel supported in delivering safe and effective care.	Health and Care Quality Standards (2023) – Workforce, Leadership, Culture, Safe, Effective	The practice will undertake a comprehensive workforce review with Royal College General Practitioners support focusing on safe and sustainable staffing levels based on patient demand, appointment activity and administrative workload, ensuring these are consistently met through effective rota planning and	Partner & Practice leadership	Ongoing

				monitoring. Workload reviews to identify pressures and support redistribution of tasks, reduce backlogs and strengthened workforce planning. Structured staff engagement processes, including regular practice meetings and feedback to ensure staff views are actively sought. Staff wellbeing will be assessed through workload pressures, promotion of support services and encouragement of healthy working patterns. Progress reviewed regularly to ensure continuous improvement and that staff feel supported to		

				deliver safe and effective care.		
12.	Many staff reported not having received an appraisal in the past year, and many felt training opportunities were insufficient or not appropriately tailored to their roles.	The service should ensure that: • all staff receive an annual appraisal or development review • they review how training is planned and delivered so that staff have access to learning opportunities that are sufficient, role-appropriate and support their ongoing development.	Health and Care Quality Standards (2023) – Workforce, Leadership, Safe, Effective, Learning, Improvement & Research.	Ensure all staff receive an annual appraisal or development review. Review and improve training planning and delivery to ensure it is sufficient, role-appropriate, and supports ongoing staff development	Leadership Team	Ongoing
13.	Responses highlighted concerns about leadership, communication, and organisational culture, including limited confidence in incident reporting processes and follow-up actions. Staff wellbeing responses were mixed, with low	The practice should: • strengthen its leadership, communication and organisational culture by reviewing how staff concerns, incidents and improvement suggestions are captured, responded to and fed back • take steps to raise staff awareness of available	Health and Care Quality Standards (2023) – Leadership, Culture, Workforce, Safe, Learning, Improvement & Research, Information, Effective.	Structured staff engagement processes, including regular practice meetings and feedback to ensure staff views and concerns are actively sought and communicated with structured plans in place. Increase staff	Partner and Practice Manager	Quarterly Reviewed

	awareness of occupational health support and limited confidence that positive action is taken to support staff health. Environmental concerns, including the condition of the building and equipment, were also raised in free-text comments.	wellbeing and occupational health support • review and address the environmental concerns reported by staff, including issues related to the condition of the building and equipment.		awareness of health and wellbeing support. Practice to hold team building. e.g. SDI Event.		
14.	The recruitment policy was relatively basic and did not include clear reference to several key pre-employment checks.	The practice should strengthen its recruitment policy to include all key pre-employment checks.	Health and Care Quality Standards (2023) – Workforce, Safe, Leadership, Effective.	Review and update recruitment policy to include all key pre-employment checks and evidenced.	Practice Manager	Completed
15.	Although feedback was used to inform improvements, there was no formal system in place at the time of the inspection to	The practice should implement a formal system to provide feedback to patients on how their views have informed service improvements.	Health and Care Quality Standards (2023) – Person-centred, Leadership, Effective,	Patient poster for patient feedback. "You said we did"	Practice Manager	Ongoing

	communicate outcomes or actions back to patients.		Information, Learning, Improvement & Research.			
16.	Training records reviewed during the inspection did not demonstrate that staff had completed Duty of Candour training.	The practice must ensure staff complete Duty of Candour training.	Health and Care Quality Standards (2023) – Safe, Leadership, Workforce, Effective, Culture,	All Staff to complete Duty of Candour Training	All Staff	Completed within E Learning module "being open"
17.	While some internal practice audits were undertaken, we recommend that this is consolidated into a forward-looking year ahead schedule of audits, which are recorded, shared and followed up, as required.	The practice should consider creating an annual audit schedule, with a process in place to record, share and follow up, as required.	Health and Care Quality Standards (2023) – Learning, Improvement & Research, Leadership, Information, Effective, Safe.	Annual audit schedule created with follow ups	Practice Manager	Completed

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): Gary May

Job role: Practice Manager

Date: 23 April 2026