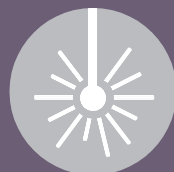
arolygiaeth gofal iechyd cymru
healthcare inspectorate wales

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report (Announced)

Town Gate Practice, Aneurin Bevan University Health Board

Inspection date: 12 March 2026
Publication date: 12 June 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 978-1-83745-628-4

© Crown copyright 2026

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:

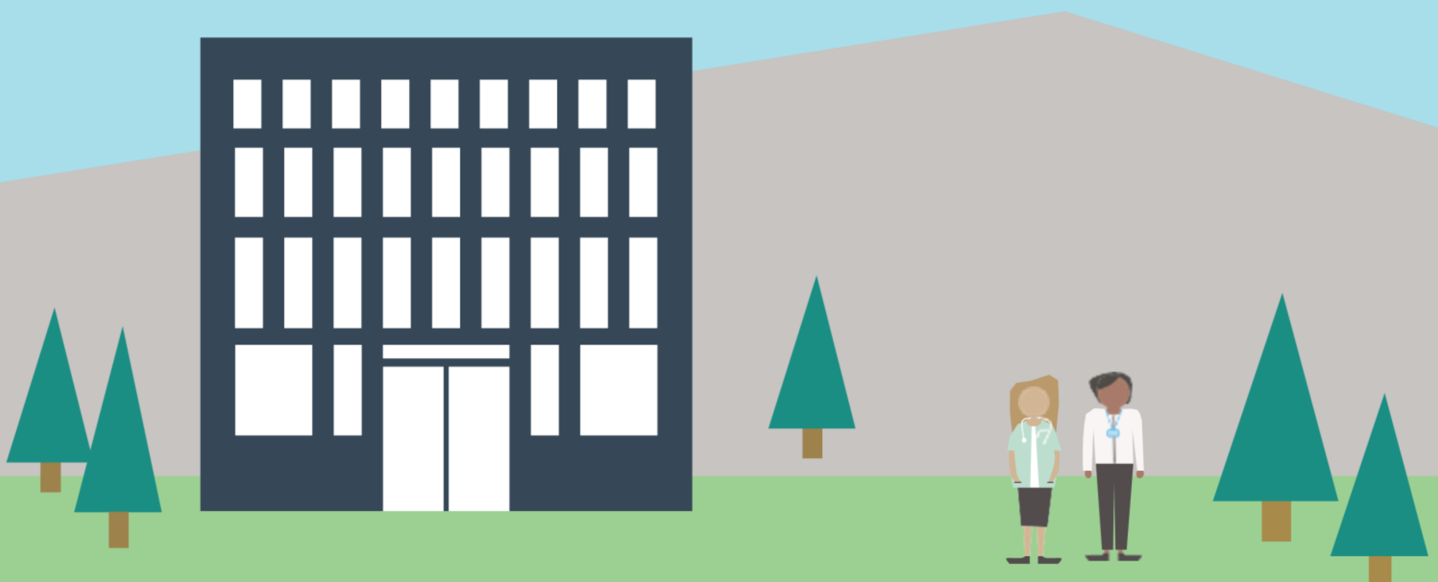
- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and 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 5

2. Summary of inspection 6

3. What we found 8

- Quality of Patient Experience 8
- Delivery of Safe and Effective Care 12
- Quality of Management and Leadership 19

4. Next steps 24

Appendix A – Summary of concerns resolved during the inspection 25

Appendix B – Immediate improvement plan 26

Appendix C – Improvement plan 27

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 Town Gate Practice, Aneurin Bevan University Health Board on 12 March 2026.

Our team for the inspection comprised of one HIW healthcare inspector, two clinical peer reviewers and a practice manager reviewer.

During the inspection we invited patients and staff to complete a questionnaire to tell us their views on working for the service. A total of 14 questionnaires were completed by staff. Feedback and some of the comments we received appear throughout the report. Unfortunately no patient questionnaires were completed, but we reviewed patient feedback collected by the practice as part of the inspection.

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:
Staff were observed welcoming patients to the practice in a professional and friendly manner and suitable measures were in place to ensure patient privacy and confidentiality. Equality, diversity and inclusion was promoted through a suitable policy and the internal practice environment was accessible to patients of varying needs. The practice demonstrated a commitment to health promotion and the appointment system supported the delivery of timely urgent patient care. Recent improvements had been implemented in relation to the active Welsh language offer. Patient feedback received by the practice was positive and highlighted professionalism, good communication and compassionate care.

This is what we recommend the service can improve:

- Streamline resources to better support reception staff in their care navigation role
- Review and update the practice website, patient information leaflet and access policy.

This is what the service did well:

- Provided flexible appointment options, including home visits where appropriate
- Supported Welsh language use and also made other reasonable communication adjustments to support people with sensory needs or who did not understand or speak Welsh or English
- Evidenced good teamwork and clinical oversight, particularly for urgent needs.

Delivery of Safe and Effective Care

Overall summary:
Information sharing supported the safe and effective care of patients. In general, Infection Control and Prevention measures were suitable. Most equipment used at the practice was single use and all medical devices at the practice were clean and had been calibrated within the last 12 months. Prescription and medicines management policies ensured the timely and appropriate processing of repeat prescription requests. However, we identified several aspects of documentation, training coverage and environmental controls that required strengthening.

This is what we recommend the service can improve:

- Ensure business continuity arrangements are fully communicated to all relevant staff
- Introduce room temperature monitoring in areas where non-refrigerated medications are stored
- Ensure patient records comprehensively document the offer and use of a chaperone, link medications to medical conditions and provides reasoning for decisions to discontinue medications.

This is what the service did well:

- The practice was clean, tidy and free of clutter
- Appropriate signage informed staff and patients of fire escape routes and hazards such as medical gases and water unsuitable for drinking
- Robust safeguarding procedures were in place.

Quality of Management and Leadership

Overall summary:
We found that the practice was well led, with clear governance arrangements supporting the delivery of safe, effective and sustainable care. A positive culture was evident, with staff reporting high levels of job satisfaction and confidence in the quality of care provided. The practice demonstrated a willingness to learn from feedback. However, we identified that recruitment and induction processes and oversight of learning from complaints could be strengthened and that creation of an overarching audit programme would be beneficial to ensure audits were relevant and timely.

This is what we recommend the service can improve:

- Improve monitoring of complaints handling and understanding of themes to ensure practice learning and development which can be highlighted to patients
- Implement more consistent pre-employment checks and staff induction
- Ensure all staff are aware of occupational health or other employee well-being schemes available to support them in the workplace.

This is what the service did well:

- Leadership was visible and approachable, and staff understood their roles, responsibilities and lines of accountability.
- Effective systems supported information governance and quality improvement activity.

3. What we found

Quality of Patient Experience

Person-centred

Health promotion
We saw a range of information raising awareness of health condition symptoms, self-help and sources of health promotion and lifestyle support was available for patients and their carers. Information available included vaccination programme promotion, burns prevention in the home, smoking and alcohol services, talking therapies, pregnancy and domestic abuse support, common ailments that could be managed in the community and access to emergency healthcare. Patients could view information on the practice website or posters within the premises or take information leaflets away.

The practice aimed to take supportive and empowering approach to patients. A 'place based care' coordinator had recently started to work from the practice to support continuity of care for people aged 75 years and over who had recently been discharged from hospital.

Dignified and respectful care
We observed all staff welcoming patients to the practice in a professional and friendly manner. Clinical rooms were fitted with suitable window coverings and privacy curtains and we observed that doors were kept closed during consultations.

Two main telephone lines to reception were available for patients to contact the practice. The practice had recently recruited more administrative staff to ensure the practice would improve their abandoned call rate respond to patient phone calls more effectively.

The options for patients to check-in for appointments at one of two separated check-in desks or via a self-check-in screen aimed to preserve patient confidentiality at reception. A separate room for more in-depth discussions between reception staff and patients was also available should patients require this.

An appropriate chaperone policy was in place and promoted through posters in reception and clinical rooms. Patients were able to request a chaperone at any time including when phoning for appointments. Most staff had undertaken training

and two further individuals had training booked to ensure they understood the chaperone role and responsibilities. A quick reference guide had been devised to support staff in easily identifying when a chaperone would be required, and how to record and code the offer and patient decision. This was to be appended formally to the chaperone policy.

Timely

Timely care
We found that the practice generally had the capacity to respond to urgent patient needs through the provision of appointments or signposting if more suitable.

Patients were able to contact digitally or by phone and were able to request face-to-face or telephone appointments according to preferences. If a physical examination may be indicated practice staff would encourage patients to attend in person appointment to ensure an appropriate assessment of need could be offered. Home visits were provided by Advanced Nurse Practitioners or GPs as patients required.

Advance appointments were also available to book. We were told that patients may need to wait up to six weeks for a routine appointment but that these could be expedited if clinically indicated. Clinical records indicated that patients with long-term conditions that could flare up or advance were provided with robust safety netting advice.

We reviewed the practice access policy and found that this was in draft form and needed completing to ensure it was specific to the practice and services it offered.

The practice should ensure that a practice specific access policy is confirmed and implemented.

The practice telephone message was compliant with access standards and patients were made aware that all calls were recorded.

Reception staff were trained in care navigation to assist them in signposting patients to emergency services, primary mental health services, the Common Ailments Scheme and other community services. A resource folder containing information regarding symptoms of medical conditions and available services was also available to reception staff. However, this required reformatting to ensure that information was readily available for effective and timely signposting.

The practice should streamline the information provided to the reception team regarding symptoms of medical conditions and available services to better support the care navigation role.

We were told that clinical staff provided support if reception were unsure regarding a patient's health care need and that good teamwork and communication ensured a patient first approach.

Patients identified as requiring urgent secondary mental health assessment were referred directly by phone to the appropriate service by a GP. Patients would also be signposted to 111 press 2 or other sources of support to maintain safety should there be a wait for specialist mental health assessment. Whilst there was no mental health provision directly provided by the practice, clinical staff were knowledgeable about national and local mental health services. A recent practice-based staff training session had also been provided to enhance awareness of the 111 press 2 service. The practice should explore mental health awareness training more broadly for staff to complement its existing learning and development offer.

The practice should consider staff completing mental health awareness training to assist them in identifying and responding to patients presenting with mental health concerns.

Letters coming into the practice from mental health services could be delayed on occasion. Any communication received would be reviewed and actioned by GPs as appropriate.

Equitable

Communication and language

A patient information leaflet was available to new patients and online. Updates regarding the practice and the services it provided were also shared with patients through the practice website, in discussions with patients in person or over the phone and written information sent to patients homes when considered necessary. We were told that the practice website was to be developed further. We noted that some information on the website and patient information leaflet was outdated and required refreshing to ensure it was accurate.

The practice should review the patient information leaflet and practice website to ensure information is accurate and up to date.

'Iaith Gwaith' badges were worn by practice staff able to use Welsh in communication and signs also provided an active Welsh language offer to patients.

Some key information about the practice, the complaints process and some health promotion materials were also available in both Welsh and English.

We were told a language line was available to support consultations with patients unable to understand and speak English or Welsh. This service was not available at reception. However, we were informed this had not been problematic for the local population attending the practice and with the use of the self-check-in-screen which was available in a variety of languages.

We found evidence that barriers to communicating with patients were addressed through reasonable adjustments. For example, patients with dementia may be provided with verbal and written communication and, with consent, have involvement in their healthcare from a relative or carer. A hearing loop was available to patients requiring this.

Patient records we reviewed indicated that patients were provided with information both verbally within consultations and via follow-up text message when appropriate. Text messages were also used to remind patients to contact the practice for follow-up tests and we were told messages could be scheduled in advance to ensure these messages were promptly delivered.

Rights and equality

We saw evidence that staff had undertaken relevant Equality, Diversity and Inclusion (EDI) training and that a suitable EDI policy was in place. The practice consent policy made reference to the Mental Capacity Act (2005) to ensure that the practice had a process in place to deliver care in line with principles of the Act.

Flooring and thresholds were level throughout the practice to enable access for people of varying physical needs. Reception and self-check-in desks were suitable for people to engage with standing up or seated in a wheelchair. An accessible toilet with baby change facility was available. However, this was poorly signposted. The practice was located alongside another practice within a hospital building owned and managed by the health board. Automatic doors allowed patients to easily enter the building. However, the internal doors to the practice and to access two treatment rooms were heavy which would be difficult for some people to operate independently.

The practice should work with the health board to ensure that all practice facilities are as accessible as possible.

Delivery of Safe and Effective Care

Safe

Risk management
We saw the practice was clean, tidy and free of clutter. Appropriate signage informed staff and patients of fire escape routes and hazards such as medical gases and water unsuitable for drinking. A Health and Safety Executive poster was displayed in a staff area to raise awareness of employer and employee responsibilities within the team. Some fire doors were noted to be open. This was escalated to the practice for doors to be closed and the practice team to be reminded regarding the implementation of fire precautions. Further information on the issues we identified, and the actions taken by the service, are provided in Appendix A.

The premises were owned by the health board and we were told that this limited the practice's control over their environment and how quickly maintenance concerns could be resolved. On-going issues with plumbing had meant that the staff toilets had been out of use for some time, and we also noted that the water pressure was inconsistent and hand washing water temperature was low.

The practice should work with the health board to ensure that the practice environment is suitably maintained. This must include timely remedial action regarding water temperatures to mitigate any IPC and legionella risks.

A comprehensive Business Continuity Plan (BCP) was in place to support staff should major disruption to service provision occur. This was stored centrally within the practice premises and shared computer drive. However, the BCP had not been actively circulated to staff to raise their awareness and maximise accessibility.

The practice should ensure that the BCP is circulated to all relevant staff to ensure they are aware of the processes to follow should major disruption to service provision occur.

Processes were in place to ensure that any patients whose medical condition deteriorated while attending the practice would be suitably monitored while awaiting emergency transport. A home visit policy was also available to enable suitable risk assessment and mitigation plans to be implemented for patient and staff safety. Team members remaining at the practice would contact clinicians if they did not return from a visit as expected. However, there was no clear process for safe reporting from visits when clinicians were not planning to return back to the practice premises before the end of the working day.

The practice should ensure there is a suitable safe reporting process in place following completion of all visits.

We were told that an alert system in place via the computer enabled staff to rapidly summon assistance if an emergency situation arose. Teamwork and access to clinical expertise and appropriate resources ensured all team members felt supported. Incidents that occurred within the practice were analysed in clinical meetings using a learning framework process to support reflection and identify any further action required. Practice managers had responsibility for receiving patient safety alerts and incident notifications from the health board and distributing these to relevant members of the team.

Infection, prevention and control (IPC) and decontamination

We saw that an IPC policy was available and that staff were aware of their roles and responsibilities with respect to IPC. A practice IPC lead was in place and IPC updates were also provided from the health board. Any information received regarding IPC would be circulated to relevant team members. Staff had also completed appropriate IPC training.

A waste management policy was in place and monthly practice waste management audits completed. The arrangements for the removal of waste from site was managed by the health board who received all confirmatory documentation and completed the annual waste management audit.

An end-of-day protocol prompted practitioners of their responsibilities in leaving a tidy workspace and cleaning services were provided by the health board on a daily basis or on demand if required. However, no cleaning schedules or logs were available. There was also no documented evidence of legionella control measures to ensure water safety.

The practice should work with the health board to ensure that waste management, cleaning records and legionella control records are available.

We observed that suitable hand hygiene facilities were available throughout the practice. Signs encouraged both staff and patients to engage in hand hygiene and informed of thorough cleansing techniques. We noted staff undertaking hand hygiene practices throughout the day.

Consultation rooms away from the main waiting and treatment areas could be used for patients attending the practice with suspected transmissible illnesses to prevent the spread of infections. All flooring, couches and chairs were wipeable, signs and posters were laminated to allow for cleaning and disposable privacy curtains within clinical rooms were visibly clean and dated. However, further

detail regarding when curtains should be replaced was required within the IPC policy to ensure this was clear for staff to implement.

The practice should ensure their IPC policies provide clear guidance on the frequency of replacement of disposable privacy curtains.

Two practice treatment rooms were also housed in an area adjoining an in-patient ward. We were told that the fire door arrangement separating these areas had recently been altered resulting in in-patient and practice areas no longer being fully separated. This should be reviewed with the health board in terms of Infection Prevention and Control, ward security and patient safety.

The practice should work with the health board to consider how Infection Prevention and Control and security can be fully preserved between the practice and in-patient areas.

Suitable blood-borne virus and needlestick policies were in place. Needlestick flow charts and posters were displayed in all clinical areas and staff were aware of the processes and where to contact for occupational health support if needed. Systems were in place to ensure that relevant staff were offered appropriate vaccinations to maintain and promote their own and patients' health. A register of clinical staff Hepatitis B vaccination and antibody levels was also seen.

Medicines management

Suitable processes were in place for the safe prescribing of medication. Patients could request repeat prescriptions via the NHS app or a manual form submitted to the practice. Teamwork underpinned by prescription and medicines management policies ensured that the practice processed repeat prescription requests in an appropriate and timely way. Any prescription training or updates were identified through staff appraisals and subsequently arranged. The practice was planning to implement the Electronic Prescription Service in July 2026 which was anticipated would further ensure ease of timely patient access to repeat prescriptions.

An appropriate policy regarding the storage, use and audit of prescription pads was available and implemented. Authorised prescriptions collected from the practice to be taken to a pharmacy to supply the prescribed medications were signed for.

We reviewed the drugs and equipment kept on the practice premises. Suitable arrangements were in place for the procurement and disposal of drugs and equipment. However, we found some out of date blood bottles, nasal cannulas, dressings for use with intravenous cannulation and medical gloves. This was escalated to the practice for items to be taken out of clinical areas on the day of

the inspection. Further information on the issues we identified, and the actions taken by the service, are provided in Appendix A.

No controlled drugs were kept on the practice premises.

Staff were aware of where drugs and equipment used to manage medical emergencies were kept. Signs displayed in corridors and clinical rooms also informed patients. We saw that all required items were kept within a suitable and secure location and that comprehensive checks were completed and recorded on a weekly basis in line with Resuscitation Council UK guidelines. Oxygen cylinders were safely stored and labelled to indicate when they were partially full but still suitable for use. All but one member staff who had recently been recruited had completed emergency resuscitation and defibrillator training. However, no specific training to underpin the safe use of oxygen cylinders had been undertaken in line with Patient Safety Notice 041.

The practice should ensure that all staff have undertaken training regarding:

- **Emergency resuscitation and been offered training regarding the use of a defibrillator in line with practice policy**
- **Use of oxygen cylinders where appropriate to their role.**

Non-emergency drugs and equipment were checked on a monthly basis and suitable checklists maintained. We saw that vaccination fridges were appropriately stocked, cleaned and calibrated. Temperatures were checked and recorded twice each working day. We discussed also introducing data loggers to confirm that items had been stored at a suitable temperature outside of practice operating hours. Ambient room temperature was not recorded in areas of the practice where medications which did not need refrigeration were stored.

The practice should ensure that room temperatures are monitored in areas where non-refrigerated medications are stored.

A suitable cold chain policy was available to guide staff should a breach occur. A dedicated immunisation team was also available through pharmacy services should additional advice be required. However, there was no quick-access flow chart summarising procedures for staff to refer to if needed.

The practice should ensure a cold chain flow chart is appended to the cold chain policy and displayed near vaccination fridges to better support staff should a cold chain breach occur.

The yellow card scheme was used for the reporting of any adverse reactions to medications experienced by patients. Signs in English and Welsh informed patients

of this to encourage reporting. Clinical staff had clear delegation of duties for reporting incidents.

Safeguarding of children and adults

We considered the safeguarding procedures in place at the practice. We found that a safeguarding lead was in place and that protected time was available to them to review safeguarding records to support practice involvement with these patients. Staff had undertaken relevant training and were aware of how to raise concerns and seek support via the safeguarding lead. The practice safeguarding policy was aligned with Wales Safeguarding Procedures and provided staff with relevant contact details and flow charts to support timely action. Clinicians had also downloaded the Wales Safeguarding Procedures app to their phone to refer to on community visits.

Patient records we reviewed indicated clear recording and coding of all safeguarding concerns, including Looked After Children (LAC), children placed and removed from the child protection register, family contacts. A list of patients with on-going safeguarding concerns and LAC was maintained and reviewed in multidisciplinary safeguarding meetings.

Management of medical devices and equipment

We found that medical devices at the practice were clean and had been calibrated within the last 12 months. Clinicians were responsible for checking any devices they used. Formal regular, documented, in-house checks and arrangements for servicing and maintenance also ensured that faulty or broken devices would be quickly noticed and addressed.

All equipment was single use, ensuring equipment was sterile for use with patients for safety.

Effective

Effective care

Information sharing supported the safe and effective care of patients and we saw evidence of auditable processes for receiving and responding to information.

Clinical information would be directed to an appropriate GP to review and then task actions to administrative support. Administrators were proactive in checking that referrals followed the pathways required by different organisations.

Appropriate opportunities were provided to patients to discuss test results and follow-up care with clinicians. However, from a review of patient records we did

find two instances where the completion of follow-up actions had not been clearly documented.

The practice should ensure the clear documentation of all aspects of clinical care, including actions taken in response to receipt of information from other services.

We found that suitable Did Not Attend and Was Not Brought procedures were in place to follow up with patients who had missed appointments at the practice or secondary care services.

Patient Group Directives were fully authorised and clinicians told us they would also look at best practice guidance during consultations to underpin patient care. Should a clinician not be sure about the implementation of guidance or need other assistance with assessment or decision making they would contact a suitable colleague for advice.

Staff would be made aware of new best practice or other information received into the practice through emails forwarded by the practice manager. Receptionists would meet together as a group to ensure they remained informed of any changes relevant to their role. Some staff indicated they would also like the historical practice newsletter format to be reinstated as this had highlighted key for ease of access.

Patient records

We examined a sample of ten electronic patient records which were kept within the secure IT system. Records and note summaries were generally considered to be of good quality and appropriately READ coded.

Patient records presented very clear information regarding the patient's presenting problem, examination findings, prescribing and follow-up plans. Notes also evidenced that robust recall systems were in place to support patients with chronic disease management. Verbal consent for examination was consistently recorded. However, the recording of the offer and use of a chaperone for intimate examinations was missing on occasion. Medications prescribed to patients were also not routinely linked to a medical condition and the reasoning for discontinuation of a medication was not always provided.

The practice should ensure that patient records provide comprehensive evidence of all aspects of care in line with professional standards, including:

- **The offer and use of a chaperone for intimate examinations**
- **Linkage between medications and medical conditions**
- **Reasoning for the discontinuation of medications.**

Non-clinical staff who completed notes summarising had undertaken suitable training and a process of GP quality reviews of notes summaries was in place.

Paper records stored securely off site could be requested when required. Records that were in use within the practice were suitably protected from unauthorised access.

Quality of Management and Leadership

Staff feedback

All respondents to the HIW staff questionnaire told us that they agreed that patient care was the practice's top priority and that they would be happy with the standard of care provided by the practice for themselves, friends and family. All would also recommend the practice as a good place to work and in general felt they had the resources, training, time and systems they needed for their roles. Most staff had had an appraisal within the last 12 months.

The practice development plan had identified potential improvements to be made to staff areas and equipment to better support staff well-being. This aligns with one staff questionnaire comment:

> *"Some furniture very old & office could do with a refresh"*.

Leadership

Governance and leadership
We found processes in place to support the governance and accountability of sustainable, safe and effective care. A recent practice development plan had been created to address areas of limited assurance within the practice Clinical Governance Self-Assessment Tool (CGPSAT) and actions and improvements had begun to be implemented. Clear progress goals had been set and a collaborative approach to quality assessment, improvement and reporting was apparent. Leaders told us they recognised value in protecting time for practice development activities and that they considered recent new recruitment and our inspection as a positive opportunity.

Clinical leadership was clear and partners and practice managers were visible. One practice manager who had been appointed two months prior to the inspection recognised limitations in their working knowledge of the practice and local processes and valued the strength they had in well-established colleagues around them.

Staff we spoke to were clear about their roles, lines of reporting and accountability within the practice and that they could approach leaders with any queries, concerns or ideas they had. Practice policies were accessible and staff were notified of any changes affecting their work via messages, meetings or formal update processes as required. Most policies we examined had been recently reviewed. All remained in date and displayed comprehensive version control. We

discussed practice management making use of a matrix or other system to ensure policies continued to be reviewed regularly at timely intervals.

Workforce

Skilled and enabled workforce

We observed good working relationships at the practice and discussions indicated a well-supported team who aimed to deliver quality patient care. Working patterns enabled an appropriate staff skill mix for the delivery of services suitable for the local population. Informal and formal meeting opportunities and considerations of individual staff members' needs ensured effective support within the team.

Staff told us they were able to work within their scope of practice and that appropriate opportunities were provided to support role development as the practice required. Clinical staff engaged in regular supervision. GPs undertook an annual appraisal with an external reviewer and fed learning and development needs identified back to practice management for support with actioning. The internal annual appraisal process for other staff monitored training, performance and development needs. New practice management had started meeting with staff to ensure all had a recent appraisal.

A comprehensive recruitment policy was in place. New members of staff were supported through induction, side-by-side working and regular reviews. However, these induction processes were not formally articulated within a policy or procedure.

The practice should ensure there is clear guidance for staff induction to ensure new starters are provided with an overview of the practice and specific information linked with their individual role.

We reviewed five staff files and found that appropriate Disclosure and Barring checks were in place. Professional registration and insurance arrangements were in place for all clinical staff. Suitable health declaration and screening and identity checks had been completed for most staff during the recruitment process and most had been issued with a job description and terms and conditions of employment. However, reference checks and evidence of employment history and employment gaps were only found within two staff files.

The practice should ensure that:

- **comprehensive pre-employment checks are completed for all staff recruited to the practice**
- **all staff are issued with a job description to work to.**

Staff feedback regarding training opportunities at the practice was positive. Completion of training was overseen via the use of a matrix. This was in the process of being updated to ensure accuracy and that staff were enabled to undertake any training they still required. In addition to core safety training, practice-based training and external courses were also available to staff as required.

Return to work interviews supported staff to return the workplace following episodes of sickness absence and we were told that reasonable adjustments and counselling services were available to staff if these were required. However, while some staff reported they knew how to access occupational health support if they needed it, others did not.

The practice should ensure that all staff are made aware of occupational health or other employee well-being schemes available to support them in the workplace.

Culture

People engagement, feedback and learning

We reviewed the complaints policy and mechanisms for collecting patient feedback. Signs in Welsh and English informed patients of mechanisms to raise concerns or complaints. Patients could speak directly to staff, complete an online feedback form or place written suggestions into a suggestion box within the practice waiting area. The practice local complaints policy clearly indicated practice leads accountable for complaints and responsible for complaints handling and complemented Putting Things Right procedures.

We examined records of complaint handling which indicated that communication with complainants provided feedback from investigations and provided an appropriate apology. Staff told us they were made aware of complaints and investigation findings on an individual basis or within team meetings as appropriate. However, we did not find clear evidence that all Putting Things Right response timescales were met or that themes from concerns or complaints were collated to aid practice learning. Information was also not available to patients to inform them of areas of concern raised and actions the practice had taken to implement appropriate improvements.

The practice should ensure that:

- **Comprehensive records of complaints received and responses clearly indicate response times aligned with current NHS complaints handling guidance and themes for practice learning**

- **Feedback is made available to patients regarding concerns and complaint themes and actions the practice has taken to implement appropriate improvements.**

Practice management made an effort to share positive feedback received to the practice with relevant team members and aimed to improve patient satisfaction scores collected through the national patient survey each year. We saw positive recent patient feedback had been received by the practice and circulated to staff within the last three months. Reception team communication, clinical staff compassion and all staff professionalism had all been praised.

A range of policies and procedures were available within the staff handbook to support staff in raising concerns in the workplace if required.

Information

Information governance and digital technology
We were told that digitalisation was being driven forward within the practice and wider cluster. The practice had implemented templates to ensure robust coding within the electronic records system, enabling data to be more easily pulled for reviews of clinical practice with particular patient groups or universal health management provision to the local population.

Patients were made aware of data handling procedures via the practice website. A suitable Information Governance policy was in place and a Data Protection Officer had been identified through the health board. The practice met their contractual Information Governance requirements through completion of an annual submission.

Learning, improvement and research

Quality improvement activities
We found that an evidence based approach to practice development planning. For example, 20 patients who had responded to the last practice survey had indicated they would have valued the opportunity to communicate in Welsh within the practice so improved signage and staff awareness had been implemented to better promote the active Welsh language offer.

We saw evidence of a number of recently completed, on-going and planned quality improvement projects including multidisciplinary working to support patients living with frailty, identification of carers to be able to more proactively support them, clinical practice with respect to specific conditions, continuity of care. We were told that the practice pharmacists would lead on condition specific quality improvement projects and collaborate with other members of the practice team to

share responsibilities and learning. Other quality improvement activities were planned and completed through cluster arrangements.

Monthly multidisciplinary clinical meetings provided a forum for staff to share information and findings from quality improvement activities they were involved with. External speakers could also be invited to provide updates on local services and develop working relationships with other services. All staff who attended clinical meetings were able to input into the agenda to ensure it was meaningful.

No research activity took place at the practice. Audits were completed. However, there was no overarching programme prioritising audits or informing how regularly audits should be undertaken.

The practice should produce an overarching plan for audit activity to ensure audits are relevant and timely.

Whole-systems approach

Partnership working and development
We were told that cluster arrangements worked well and that the practice could input and develop from this contact with other practices. Co-location with other services including district nurses, x-ray and another GP practice, also assisted communication that enhanced the patient experience.

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
Some fire doors noted to be open.	Fire doors will not be effective in containing fire or smoke, therefore not creating time for evacuation from the area or reducing fire damage to the building.	Discussed with practice management.	Doors closed and the practice management to remind staff regarding the implementation of fire precautions.
Some out of date blood bottles, nasal cannulas, dressings for use with intravenous cannulation and medical gloves found.	Out of date items may not be sterile or in suitable condition for use placing patients at risk of infection or other complications.	Discussed with relevant staff.	Items removed and other stock in place confirmed to be suitable for use.

Appendix B - Immediate improvement plan

Service: Town Gate Practice

Date of inspection: 12 March 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 assurances were found on this inspection					

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: Town Gate Practice

Date of inspection: 12 March 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.	Access policy in draft and generic only.	Practice specific access policy to be confirmed and implemented.	Health and Care Standards (2023) - Effective	**PDP Status: ALIGNED** **Specific:** Implement the completed practice-specific Patient Access Policy v1.0 (signed off 19/03/2026) covering all modes of access, care navigation, appointment scheduling, and the Accessible Information Standard. **Measurable:** Policy published on the practice website; shared with all staff; confirmed on training matrix/acknowledgement log. **Achievable:** Policy already completed by the Practice Manager. Publication and staff briefing are straightforward operational steps. **Relevant:** Supports GMS Access Commitment obligations and PDP Strategic Objective 1.2 (Improve access	Practice Manager	Completed 19 March 2026

				and patient experience). Aligns with CGPSAT Ch6 (Timely, L2). **Time-bound:** Immediate — policy completed 19/03/2026. Staff briefed and website to be reviewed for alignment by 30 June 2026. ***PDP Alignment:*** *PDP Objective 1.2 and CGPSAT Ch6 already cover access improvement. GMS Access Commitment Reflective Report (April 2026) confirms website and patient communications are under active review. No PDP amendment required beyond confirming completion.*		
2.	Information available to support reception staff in care navigation required reformatting to ensure that information was readily available for appropriate and timely signposting.	Information to be streamlined to better support reception staff in their care navigation role.	Health and Care Standards (2023) – Effective	**PDP Status: UPDATE REQUIRED** **Specific:** Review and reformat the reception care navigation resource folder into a concise, tabbed quick-reference guide covering key services, symptom indicators, referral pathways (including 111 press 2, Common Ailments Scheme, PMHSS), and escalation contacts. Validate content with clinical leads before issue. **Measurable:** New quick-reference guide produced, signed off by Clinical Lead, distributed to all reception staff, and positively reviewed at the next reception team meeting. **Achievable:** Led by the Reception Manager with	Practice Manager / Reception Manager	30 June 2026

				clinical input. Achievable within current staffing given the resource already exists and requires reformatting rather than creation from scratch. **Relevant:** Directly addresses the HIW finding. Supports PDP Objective 1.2 (Improve access and patient experience) and the care navigation standard under CGPSAT Ch6 (Timely). **Time-bound:** Draft by 30 May 2026; validated and issued to reception team by 30 June 2026. ***PDP Alignment:*** *PDP Objective 1.2 and CGPSAT Ch6 reference care navigation training and the Reception Manager role but do not include this specific action. PDP should be updated to add 'Streamline care navigation quick-reference resource' under Objective 1.2 with a target of Q2 2026.*		
3.	Staff had not undertaken formal mental health awareness training to assist them in identifying and responding to patients presenting with	Formal mental health awareness training to be considered for completion by all relevant staff.	Health and Care Standards (2023) - Safe	**PDP Status: ALIGNED** **Specific:** An appropriate accredited mental health awareness training programme was identified within current supplier services. **Measurable:** 100% of staff have completed training. Training matrix updated. Completion confirmed at next staff meeting.	Practice Manager	Completed 27 March 2026

	mental health concerns.			**Achievable:** A range of accredited programmes are available (e.g. Mental Health First Aid England; NHS Wales equivalents, current service provider (Bright)). Scheduling was incorporated into existing CPD and mandatory training cycles. **Relevant:** Addresses HIW finding and reinforces the existing 111 press 2 awareness session. Supports PDP Objective 2.1 (Build and retain a sustainable MDT workforce) and CGPSAT Ch2 (Workforce). **Time-bound:** Programme identified and staff trained. ***PDP Alignment:*** *PDP Objective 1.2 and CGPSAT Ch6 already cover access improvement. No PDP amendment required beyond confirming completion.*		
4.	The practice patient information leaflet and website both required updating.	The practice patient information leaflet and website to be reviewed to ensure information is accurate and up to date.	Health and Care Standards (2023) - Effective	**PDP Status: ALIGNED** **Specific:** Conduct a full review of all content on the practice website and patient information leaflet. Update outdated information including services, staff, contact details, complaints process, Welsh language provision, and health promotion materials. Publish updated versions and establish a scheduled review cycle. **Measurable:** Website and leaflet fully updated and published. Review cycle	Practice Manager / Partners	30 July 2026

				documented (minimum annually or on any service change). Confirmed at Partners meeting. **Achievable:** Led by the Practice Manager with Partner sign-off. Content updates are within existing operational capacity. **Relevant:** Directly addresses HIW finding. Supports PDP Objective 1.2 (Improve access and patient experience), PDP Section 7.2 (Patient Communication Strategy), and CGPSAT Ch10 (Person-Centred, L2 Limited Assurance). **Time-bound:** Review commenced immediately; website and leaflet updated and published by 30 July 2026. ***PDP Alignment:*** *PDP Section 1.2 states 'To develop website and increase digital communication updates.' The GMS Access Commitment Reflective Report (April 2026) confirms website review is in progress. No PDP amendment required; action should be confirmed as on track at the next Partners review.*		
5.	Business Continuity Plan (BCP) in place but not circulated to relevant staff to promote ease of	BCP to be circulated to all relevant staff.	Health and Care Standards (2023) - Effective	**Specific:** Circulate the BCP to all relevant staff via email and ensure it is saved in an accessible location on the shared drive. Confirm awareness via a standing agenda item at the next all-staff or team meeting. Review	Practice Manager	30 May 2026

	access and awareness of processes to follow should major service disruption occur.			off-site accessibility as part of the BCP's annual review. **Measurable:** Distribution confirmed via email read receipts. BCP location confirmed accessible on shared drive. Recorded in governance log. **Achievable:** BCP already exists. Circulation is a straightforward step within normal management communications. **Relevant:** Ensures staff are prepared for major service disruption. Supports PDP Objective 1.3 (Strengthen clinical governance and safety). **Time-bound:** BCP circulated and staff awareness confirmed by 30 May 2026.		
6.	No safe reporting process in place for visits clinicians are not expecting to return to the practice from within the working day.	Suitable safe reporting process to be in place for all visits.	Health and Care Standards (2023) - Safe	**Specific:** Develop and implement a safe lone-working and visit reporting protocol covering expected return/check-in time, nominated contact, escalation process if clinician does not report in. Brief all visiting clinicians and relevant administrative staff. **Measurable:** Protocol documented, approved by Clinical Lead, appended to Lone Working Policy, and briefed to all relevant staff. Confirmed on governance log. **Achievable:** A straightforward policy addition. A nominated	Practice Manager / Clinical Lead	30 June 2026

				contact and check-in process can be implemented within current staffing arrangements. **Relevant:** Addresses a patient and staff safety risk identified by HIW. Supports PDP Objective 1.3 (Strengthen clinical governance and safety). **Time-bound:** Protocol drafted by 31 May 2026; implemented and staff briefed by 30 June 2026. ***PDP Alignment:*** *This action is not currently in the PDP. PDP should be updated to add 'Implement safe visit reporting protocol' as a specific safety action under Objective 1.3, with a target of Q2 2026.*		
7.	Infection Prevention and Control policies did not provide specific guidance for the frequency of replacement of disposable privacy curtains.	IPC policies to provide clear guidance on the maintenance and replacement of disposable privacy curtains.	Health and Care Standards (2023) - Safe	**Specific:** Amend the IPC policy to include the manufacturer-recommended frequency for replacement of disposable privacy curtains. Ensure curtains are dated on fitting. Add curtain replacement to the IPC audit. **Measurable:** IPC policy updated. Curtains at both sites dated. Replacement included in next IPC audit. Confirmed by IPC Lead. **Achievable:** A targeted policy amendment led by the IPC Lead. No additional resource required. **Relevant:** Reduces infection risk and ensures compliance with national IPC standards.	IPC Lead / Practice Manager	30 June 2026

				Supports PDP Objective 1.3 (Strengthen clinical governance and safety). **Time-bound:** IPC policy amended IPC audit updated dated by 30 June 2026.		
8.	One member staff found not to have undertaken resuscitation and defibrillator training.	All staff to have undertaken training regarding emergency resuscitation and have been offered training in the use of a defibrillator in line with practice policy.	Health and Care Standards (2023) - Safe	**PDP Status: ALIGNED** **Specific:** Schedule and confirm completion of online resuscitation training for the identified nonclinical member of staff and enrol them in the scheduled practice wide practical resuscitation and defibrillation training. All other staff are up to date with their training as evidenced in the training matrix. **Measurable:** 100% training compliance confirmed on training matrix. No outstanding training identified at next matrix review. **Achievable:** Training can be scheduled immediately through existing CPD arrangements. **Relevant:** Addresses a direct patient safety risk. Supports PDP Objective 1.3 and CGPSAT Ch2 (Workforce). Training compliance (% mandatory training compliance) is already a PDP KPI. **Time-bound:** Identified staff member trained by 7 May 2026; full matrix compliance confirmed by 30 June 2026.	Practice Manager	07 May 2026

				PDP Alignment: *PDP Objective 1.3 and the training matrix KPI already cover mandatory training compliance. No PDP amendment required; progress should be confirmed at the next Partners review.*		
9.	No staff had undertaken training to underpin the safe use of oxygen cylinders.	All appropriate staff to complete training regarding safe use of oxygen cylinders.	Health and Care Standards (2023) - Safe	**Specific:** Staff for whom oxygen cylinder training is appropriate identified. Source training in line with NHS Patient Safety Notice 041. Schedule and complete training. Record completion in the training matrix and incorporate into the mandatory training renewal cycle. **Measurable:** All identified staff trained and recorded on training matrix. Renewal date set in line with PSN 041 requirements. **Achievable:** Training is available and incorporated into existing CPD scheduling. **Relevant:** Directly addresses a patient and staff safety risk and a specific HIW requirement. Supports PDP Objective 1.3 and CGPSAT Ch2 (Workforce). **Time-bound:** Staff identified and training scheduled for completion by 8 May 2026.	Practice Manager / Clinical Lead	08 May 2026
10.	No room temperature monitoring of areas	Room temperatures to be monitored in areas where	Health and Care Standards (2023) - Safe	**Specific:** Introduce daily room temperature monitoring and recording in all areas where non-refrigerated medications are stored. Procure suitable	Practice Manager / Medicines Lead	18 May 2026

	where medications were kept.	non-refrigerated medications are stored.		thermometers or data loggers. Create a recording log, assign daily responsibility, define acceptable temperature range, and specify the escalation process for exceedances. Reflect requirements in the medicines management policy. **Measurable:** Thermometers/loggers in place; recording log in active daily use; medicines management policy updated. Confirmed at next medicines management review. **Achievable:** Low-cost, low-complexity implementation using standard clinical thermometers or loggers. **Relevant:** Mitigates medicines safety risk and supports compliance with medicines management standards. **Time-bound:** Equipment procured and recording commenced by 30 May 2026; policy updated by the same date.		
11.	No cold chain flow chart available to support staff should a cold chain breach occur.	Cold chain flow chart to be appended to the cold chain policy and displayed near vaccination fridges.	Health and Care Standards (2023) - Safe	**Specific:** Develop a clear, laminated cold chain breach flow chart summarising: detection, immediate actions, contacts (including dedicated immunisation team/pharmacy), documentation requirements, and patient notification process. Append to cold chain policy and display near vaccination fridges at both	Practice Manager / IPC Lead / Medicines Lead	18 May 2026

				Chepstow and Sedbury sites. Brief relevant staff. **Measurable:** Flow chart produced, appended to cold chain policy, and displayed at both sites. Staff briefed and briefing recorded. **Achievable:** Can be developed using existing national cold chain guidance. Straightforward design and print task. **Relevant:** Directly addresses a medicines safety risk. **Time-bound:** Flow chart produced and displayed by 30 May 2026.		
12.	Documentation found to not always clearly indicate: • completion of clinical follow-up actions • offer and use of a chaperone for intimate examinations • linkage between medications and medical conditions	Documentation of all aspects of clinical care to be clear and in line with professional standards.	Health and Care Standards (2023) - Safe	**PDP Status: PARTIALLY ALIGNED** **Specific:** Raise findings with all clinical staff at the next clinical meeting. Issue a written clinical reminder and guidance note covering chaperone offer and recording, medication–condition linkage, discontinuation reasoning, and follow-up action documentation. Review and update relevant EMIS templates to prompt required coding. Conduct a re-audit of a sample of patient records (10 records) within 3 months to confirm improvement. **Measurable:** Clinical reminder issued and attendance at briefing recorded. EMIS templates reviewed and updated where necessary. Re-	Clinical Lead / Practice Manager	Q2 2026 (initial); re-audit Q4 2026

	• reasoning for the discontinuation of medications.			audit completed with findings reported to clinical meeting. Re-audit and report to clinical meeting by 30 September 2026. ***PDP Alignment:*** *PDP Objectives 1.1 and 1.3 and CGPSAT Ch7 cover clinical governance and EMIS template development, but do not include a specific documentation standards action. PDP should be updated to add 'Clinical records standards review and re-audit' under Objective 1.3, with initial actions by Q2 2026 and re-audit by Q4 2026.*		
13.	No formal induction process in place.	Clear guidance for staff induction to be created and implemented to ensure new staff are provided with an overview of the practice and specific information linked with their individual role.	Health and Care Standards (2023) - Effective	**PDP Status: ALIGNED** **Specific:** Develop and implement a formal staff induction policy and programme comprising. Formalise the existing side-by-side working and review schedule. Induction records to be held on the individual's staff file. **Measurable:** Induction policy and checklists produced and approved. All new starters from date of implementation receive a completed induction checklist on their file. **Achievable:** Led by the Practice Manager, drawing on existing induction arrangements and the recruitment policy. Achievable within current management capacity.	Practice Manager	30 June 2026

				Relevant: Addresses a direct HIW finding. Supports PDP Objective 2.1 (Build and retain a sustainable MDT workforce) and CGPSAT Ch2 (Workforce, L3). **Time-bound:** Policy and checklists drafted by 31 May 2026; approved and implemented by 30 June 2026. ***PDP Alignment:*** *PDP Objective 2.1 and 2.3; No PDP amendment required beyond confirming completion.*		
14.	Pre-employment checks not consistently completed within the recruitment process.	• Comprehensive pre-employment checks to be completed for all staff recruited to the practice • All staff to have a job description to work to.	Health and Care Standards (2023) - Safe	**Specific:** Audit all existing staff files and identify any gaps in pre-employment checks (references, employment history/gap evidence, identity, health declaration, DBS). Address any gaps identified. Implement a pre-employment checklist within the recruitment policy to ensure all checks are evidenced before employment commences. Confirm all staff have a current signed job description on file. **Measurable:** All staff files audited and gaps remediated. Pre-employment checklist embedded in recruitment process. 100% of staff have a current job description confirmed on file. **Achievable:** Led by the Practice Manager. The audit of existing files and gap remediation can be completed	Practice Manager	30 July 2026

				incrementally alongside routine HR activity. **Relevant:** Addresses a patient safety and governance risk. Supports PDP Objective 2.1 (Build and retain a sustainable MDT workforce) and CGPSAT Ch2 (Workforce, L3). **Time-bound:** File audit complete by 31 May 2026; all gaps remediated and checklist embedded by 30 July 2026.		
15.	Not all staff aware of how to access occupational health if required.	All staff to be made aware of occupational health or other employee well-being schemes available to support them in the workplace.	Health and Care Standards (2023) - Person centred	**PDP Status: ALIGNED** **Specific:** Communicate full details of all available occupational health and employee wellbeing schemes to all staff via team meeting, email, and staff newsletter. Include occupational health information in the staff induction checklist (see item 13). Confirm awareness in annual appraisals going forward. Ensure the Practice Manager is familiar with ABUHB occupational health referral pathways. **Measurable:** Communication issued and recorded. Occupational health section added to induction checklist. Awareness confirmed for all staff at next appraisal cycle. **Achievable:** Low-effort communication task. Information is available from ABUHB. Achievable within current management capacity.	Practice Manager	30 June 2026

				Relevant: Supports staff wellbeing and retention. Supports PDP Objective 2.1 (Build and retain a sustainable MDT workforce) and CGPSAT Ch2 (Staff Health and Wellbeing, L3). **Time-bound:** Communication issued to all staff by 30 June 2026; embedded in induction checklist from the same date. ***PDP Alignment:*** *PDP Objective 2.1 includes staff wellbeing and CGPSAT Ch2 covers staff health and wellbeing. No PDP amendment required beyond confirming completion.*		
16.	Comprehensive records of complaint investigations with timescales and themes collated not available.	• Comprehensive records of complaints received and responses to clearly indicate response times and themes for practice learning • Feedback to be made available to patients regarding concerns and complaint themes and actions the practice has taken to	Health and Care Standards (2023) - Safe	**Specific:** Implement a master complaints log record: date received, nature/theme, assigned lead, acknowledgement date, response date, Listening to People met (Y/N), outcome, and learning identified. Conduct quarterly thematic review and share themes and actions at team meetings. Produce a patient-facing summary (e.g. via practice website or waiting room display) of complaint themes raised and improvements made. Review complaints policy to confirm PTR timescales are explicitly referenced. **Measurable:** Complaints log in active use with all required fields completed for every complaint. Quarterly thematic	Practice Manager / Partners	30 June 2026

		implement appropriate improvements.		Patient-facing summary published and updated at least annually. **Achievable:** Log can be implemented immediately using a simple spreadsheet or practice management system. Patient-facing summary can be incorporated into website update (see item 4). **Relevant:** Directly addresses HIW finding. Supports regulatory compliance with Listening to People (NHS Wales). **Time-bound:** Complaints log implemented by 30 June 2026 including thematic review and patient-facing.		
17.	No overarching audit programme.	Audit plan to be created to ensure audits are relevant and timely.	Health and Care Standards (2023) – Effective	**PDP Status: ALIGNED** **Specific:** Develop an annual audit programme covering: mandatory/contractual audits, clinical audits linked to QIF priorities (Continuity of Care, CKD, CVD/Hypertension, Diabetes), medicines management audits (waste management, prescription pads, temperature monitoring), IPC audits, and any re-audits triggered by inspection findings. Assign a lead and timescale for each audit. Present to clinical meeting for agreement. Review and update the programme at least annually. **Measurable:** Audit programme document	Clinical Lead / Practice Manager	30 July 2026

				produced, agreed at clinical meeting, and minuted. All scheduled audits have an assigned lead and target date. Programme reviewed at next annual cycle. **Achievable:** Led jointly by the Clinical Lead and Practice Manager. **Relevant:** Addresses a specific HIW finding. Supports PDP Objective 1.1 (Achieve and sustain QIF targets) and CGPSAT Ch7 (Effective, L2 Limited Assurance). **Time-bound:** Audit programme drafted by 30 July 2026. ***PDP Alignment:*** *PDP Objective 1.1 includes audit completion as a KPI and PDP*		
18.	Some aspects of the environment did not promote accessibility, health and safety or IPC as far as they could: • Heavy access doors • Accessible toilets poorly signposted	The practice should work with the health board to ensure that the practice environment is suitably maintained for accessibility, health and safety and IPC.	Health and Care Standards (2023) - Safe / Person centred.	**Specific:** Formally escalate all identified environmental issues to ABUHB Estates in writing, clearly referencing the HIW inspection findings, with a request for a timescale for resolution. Issues to be escalated: (1) heavy internal access doors — request assessment and automatic opener/adjustment; (2) accessible toilet signage — request improved signage (3) plumbing/water temperature and pressure — urgent remediation required (legionella/IPC risk); (4) request access to waste removal, cleaning schedules, and legionella control records	Practice Manager / Senior Partner	Initial escalation: 30 June 2026 Resolution: dependent on ABUHB Estates

• Issues with water / plumbing • No documentary evidence of waste removal, cleaning or legionella control measures available • Practice areas not fully separated from an in-patient area which could pose an IPC, security and safety risk.			held by ABUHB; (5) IPC/security separation between practice and in-patient areas — request formal review. Maintain a written log of all escalations, responses, and agreed timescales. Report progress at Partners meetings. **Measurable:** Written escalation sent to ABUHB Estates with all five issues itemised. Written response received from ABUHB with confirmed timescales. Progress log maintained and reviewed monthly at Partners meeting. All items closed or with documented ABUHB commitment. **Achievable:** The practice has limited direct control over the health board estate. However, a formal written escalation with reference to the HIW report provides a strong basis for action. Senior Partner to support escalation where needed. **Relevant:** Addresses multiple patient and staff safety risks identified by HIW. **Time-bound:** Formal written escalation to ABUHB Estates by 30 June 2026. Progress reported at Partners meeting monthly until all items are resolved or have confirmed ABUHB timescales.		

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): Kaylyn Hudson

Job role: Practice Manager

Date: 07 May 2026