Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report
(Announced)
Aberbeeg Medical Centre, Aneurin Bevan University Health Board

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

Our purpose

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

Our values

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

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

Our goal

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

Our priorities

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

Contents

1. What we did

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

Healthcare Inspectorate Wales (HIW) completed an announced inspection of Aberbeeg Medical Centre, Aneurin Bevan Health Board on 19 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 or their carers to complete a questionnaire to tell us about their experience of using the service. A total of six were completed. We also spoke to staff working at the service during our inspection. Feedback and some of the comments we received appear throughout the report.

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

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

2. Summary of inspection

Quality of Patient Experience

Overall summary:
We found the practice aimed to offer services in a person-centred and empowering manner to direct patients to appropriate and timely treatment options. A wide range of health education and promotion resources were available to raise patients awareness of specific medical symptoms and conditions and when emergency, primary care or other services may be most suitable. Staff were observed welcoming patients and communicating in a friendly and considerate manner. However, respondents to the HIW patient questionnaire indicated less satisfaction regarding being treated with dignity and respect, being listened to and being involved in decisions regarding their healthcare as much as they wanted to be. It was noted that the practice environment required some updates to improve privacy and the full implementation of initiatives advertised to specific patient groups.

This is what we recommend the service can improve:

- Evaluate the patient feedback received through the HIW patient questionnaire against its own feedback mechanisms and consider whether any improvements can be made
- Ensure information regarding the practice and other services is similarly displayed on the practice website and within the practice premises
- Embed the Welsh Active Offer.

This is what the service did well:

- The Accessible Information Standard was referenced on the practice website and implemented by the practice team flagging individual patients communication needs within their patient records
- Suitable consent and Equality, Diversity and Inclusion (EDI) policies in place to promote patient choice and equality for all. Some staff had undertaken EDI training and the staff we spoke with demonstrated compassion and commitment to supporting individual patient needs and preferences.

Delivery of Safe and Effective Care

Overall summary:
Areas that patients accessed were generally tidy. However, some issues with the storage of equipment and maintenance and cleanliness of the premises were noted. Hand hygiene facilities and other Infection Prevention and Control (IPC)

mechanisms were available to staff and patients throughout the practice premises. Staff we spoke to were clear on their roles and responsibilities regarding IPC.

Delegation of chronic disease management to nursing staff ensured continuity of support to patients with long term conditions. Multidisciplinary palliative care meetings and other regular communication with relevant agencies ensured continuity of care for patients approaching the end of life. However, formal governance structures required strengthening to ensure the suitable oversight of medicines management processes and support patient safety within the practice.

Immediate assurances:

- HIW was not assured regarding risk management procedures within the practice. Waste bins kept outside the practice building were not secured and the sharps waste bin was not lockable. No evidence was available of legionella control measures implemented by the health board. No register of staff Hepatitis B immunity was maintained.

This is what we recommend the service can improve:

- Frequency of emergency drugs and equipment checks to align with Resuscitation Council UK guidelines
- All clinical documentation to adhere to professional standards including General Medical Council guidelines

This is what the service did well:

- Worked effectively with cluster professionals including paramedics and psychological health practitioner services
- Promoted and completed annual immunisation programmes
- Prescription logs were comprehensive and patients and pharmacists would sign when collecting prescriptions which is considered noteworthy practice.

Quality of Management and Leadership

Overall summary:
New partnership and management structures implemented within the last three months provided clear and supportive management and leadership. Staff and leaders accepted shared responsibility for building working relationships.

Staff reported to be clear about their roles. However, a number of policies and procedures required updating to ensure these provided suitable instruction to staff regarding work procedures within the practice. Practice management had met informally with staff members at the beginning of the partnership arrangement and planned to schedule team and individual meetings to review performance and agree development plans. However, these had not yet been scheduled.

Patient feedback mechanisms also required developing to ensure these were clear, easily available, and used to ensure appropriate learning and quality improvement.

Immediate assurances:

- HIW was not assured that robust systems were in place to ensure safe recruitment practices and the on-going fitness and suitability of those employed by the practice, or to ensure staff received consistent, effective training relevant to their roles, including effective oversight of staff training and competence.

This is what we recommend the service can improve:

- Offer structured inductions to all new members of staff and ensure written induction information is up to date
- Schedule and implement regular structured clinical, operational and learning meetings
- Ensure all policies and procedures are up to date and available to staff and patients as required.

This is what the service did well:

- A speaking up policy and strong working relationships within the practice ensured open-door management and formal process were in place to support staff in sharing any ideas, suggestions or concerns they had
- Maintained staffing cover through rotas, consideration of skill mix, recruitment and close working with the Health Board
- Had begun to establish a small Patient Participation Group.

Details of the concerns for patient's safety and the immediate improvements and remedial action required are provided in Appendix B.

3. What we found

Quality of Patient Experience

Patient feedback

Due to the relatively low number of patient responses, it is not possible to provide a full analysis within this report. However, only some patients were positive regarding the service, with comments generally criticising communication and appointment mechanisms and implementation of Infection Prevention and Control measures.

Patient comments included:

> *"…some not all reception staff can be rude and challenging…"*
>
> *"I have lost confidence in the surgery's ability to prioritise my son's healthcare needs and am worried about future interactions."*
>
> *"It was once a nice doctors but if I could drive I would happily move."*

The practice should evaluate patient feedback received through the HIW patient questionnaire against its own feedback mechanisms and consider whether any improvements can be made.

Person-centred

Health promotion

We saw a wide range of health education and promotion information available to patients both on the practice premises and website. Health education resources provided patients with information regarding specific medical symptoms and conditions and when emergency or primary care services may be most suitable. Health promotion included information on smoking, drug and alcohol services, healthy eating, weight management services and staying well in work support. One notice board displayed some information for carers. However, this information was limited and required a refresh to ensure it would be easily noticed and seen by relevant people visiting the practice. Information regarding services provided from the practice premises was also well displayed through the practice website but not on the premises and no patient leaflet was available. Some health organisations information we saw was out-of-date.

The practice should ensure that carers, health promotion materials and information regarding health services available at the practice are:

- **Similarly displayed on the practice website and premises and contained within a practice leaflet available to patients**
- **Are in date**
- **Are displayed in an accessible way so that information can be easily noted.**

It was positive to note that cluster paramedic, pharmacy and psychological health practitioner services were based at the practice to support patients to access timely and convenient care and support options.

Posters promoting immunisation were on display and the practice had completed their annual flu vaccination programme. The practice had also applied to run a Covid vaccination clinic over coming weeks.

We were told that the patients who had missed vaccination appointments would be followed up by the practice nurse. GPs would contact patients they were clinically concerned about and had missed other practice appointments and patients who had missed urgent hospital appointments. Patients considered to be lower risk would be contacted by text message, phone or letter following missed appointments. However, this did not match the Did Not Attend and Was Not Brought policy.

The practice should ensure:

- **There is an appropriate Did Not Attend and Was Not Brought policy in place to guide staff on the procedures to follow-up with patients who have missed appointments**
- **Consistent implementation of the updated policy.**

Dignified and respectful care

We observed staff welcoming patients in a friendly and considerate manner. However, responses to the HIW questionnaire indicated less patient satisfaction regarding being treated with dignity and respect, being listened to and being involved in decisions regarding their healthcare as much as they wanted to be.

Consultation rooms were fitted with lockable doors that were kept closed during consultations. Most had privacy curtains. We were told that privacy curtain fittings had been removed from some rooms during redecoration and not replaced. One way glass was in place to ensure that patients could not be seen from outside during consultations. However, as no visible window coverings were in place this did not give the impression of privacy, especially where privacy curtains were missing.

The practice should ensure that privacy curtains are fitted around all couches within all clinical rooms and / or that the fitting of additional window coverings is considered to further reassure patients regarding privacy.

Reception staff were observed moving out of earshot of patients in the waiting area for discussions with other colleagues. However, we found that discussions with patients within the reception and waiting area and consultation rooms could be easily overheard compromising confidentiality.

The practice should explore ways in which confidentiality can be maintained in the reception area and adjacent consulting rooms.

Patients did have access to a self-check-in-screen which reduced the need for conversations with reception staff. We were also told that a spare consultation room would be used for any in-depth discussions between patients and staff. However, there signs displayed offering this facility to patients could easily be missed and we were told that the self-check-in-screen frequently did not update the reception staff system to inform them that the patient had arrived for their appointment.

The practice should:

- **Ensure that the offer of a separate room for in-depth conversations is advertised to patients**
- **Take steps to ensure the self-check-in-screen is working correctly.**

Chaperone notices were prominently displayed on consultation room doors. We were told that patients would be offered a chaperone for any intimate examinations and that patients were also able to request a chaperone if they felt this was needed. Any requests for a chaperone would be recorded on the appointment details to ensure suitable chaperone provision was planned.

We confirmed that male and female staff were available to act as chaperones and that chaperoned appointments would be arranged to suit patient needs. Some non-clinical staff told us they had undertaken chaperone training. However, there was no documentary evidence of this and the practice chaperone policy also indicated that only suitably trained health care professionals would undertake the chaperone role.

The practice should review their chaperone policy and implement in line with General Medical Council guidance.

Timely

Timely care

We saw a practice access policy providing information regarding how patients could make appointments. This information was available to patients on the practice website. The NHS app was also promoted on the practice website and the practice premises. However, we noted that full information regarding how patients should contact the practice for urgent and routine consultations and appointments with different practitioners was not displayed on the premises such that information provision was not equitable to patients unable to use the internet. Practice access information also did not provide details of the additional services that were available to patients through the practice and co-located cluster professionals.

The practice should ensure that:

- **The access policy provides full details of practice and co-located services**
- **Full access policy information is available to patients on the practice website and within the practice premises.**

Patients could make appointments via telephone or online. We saw that telephone answering figures reflected staffing levels, with a recent reduction in the number of calls coinciding with unplanned absence. We were told that this issue would resolve itself, as staffing levels would soon stabilise following additional recruitment and the return to work of staff.

We were told that patients could request either face-to-face or telephone appointments according to their preference. At the time of inspection appointment capacity was bolstered by additional funding provided by the health board to support the establishment of the new practice management arrangements and appointment schedules indicated there was a wait of around one week for a pre-bookable non-urgent appointment. However, respondents to the HIW patient questionnaire generally indicated dissatisfaction regarding access to urgent and non-urgent appointments and the offer of in-person or telephone consultations. We were told that patients with long-term conditions that could flare up or advance were made aware they could contact the practice to alert clinicians of a change in medical condition and seek additional support. However, although patients responding to our questionnaire indicated they could make contact with the practice, they found that eliciting the support they required could be difficult. Patient comments included:

> *"…hard to get a appointment. Not very working people friendly."*

"No appointments available made to call at 8 in the morning for a appointments then to be told there is none can't pre book unless its 3 weeks away."

A triage policy was available and clinicians would review home visit requests, requests for urgent appointments once all same day appointments had been allocated, and patients contacting the practice in mental health crisis. GPs would also request telephone appointments be converted to face-to-face if they felt this was more appropriate on receipt of their patient list.

Some members of non-clinical staff had undertaken care navigation training to enable them in signposting to the Common Ailments Scheme, dentist, optician or more emergency health services. Administrative staff confirmed that a GP was always contactable for support if they were unsure regarding signposting. However, there was no formal policy confirming the scope of delegated responsibility to non-clinical staff for the signposting of patients or standard pathways to follow.

The practice should ensure that suitable policy and pathways are available to confirm the scope of delegation and support any care navigation activity by non-clinical staff.

Appropriate processes were in place for GPs to refer patients experiencing mental health symptoms to secondary care services as required. GP support and other appropriate safety netting was offered to manage risk should there be a wait for specialist mental health assessment. Communication between the practice and mental health services supported continuity of care. Patients presenting with low risk mental health concerns could also be signposted or referred onto third sector services with the patient's consent.

All respondents to the HIW patient questionnaire indicated they were aware of how to contact out of hours services for medical advice or a consultation that could not wait until practice opening times.

Equitable

Communication and language

We found the Accessible Information Standard referenced on the practice website and implemented by the practice team. Patient communication needs were flagged within the patient records so that staff were aware of individual requirements. We observed staff checking with patients attending the practice that they felt fully informed regarding future appointments.

Patients could receive information from the practice via text, email or phone as required. Patients phoning into the practice were informed that calls were recorded. Recordings were maintained within a secure system.

Clinicians were able to access a language line. Double appointments would be booked to ensure sufficient time for communication when using the language line during consultations. Clinicians would also support administrators to communicate with patients via the language line if needed. However, we saw very limited evidence of the Welsh Active Offer within the practice.

The practice should ensure that the Welsh Active Offer is embedded for patients to access services in the Welsh language should they prefer.

Rights and equality
We saw suitable consent and Equality, Diversity and Inclusion (EDI) policies in place to promote patient choice and equality for all. Some staff had undertaken EDI training and the staff we spoke with demonstrated compassion and commitment to supporting individual patient needs and preferences.

We observed posters at the practice promoting supportive environments for LGBTQ+ people. However, there were no resources seen to evidence that a period dignity initiative advertised was being fully implemented.

The practice should review its posters and ensure that any initiatives offered at the practice are fully implemented.

All patient facilities were situated on the ground floor of the premises to ensure level access to all patient areas. A spacious toilet with grab rails and a baby change table was in place. However, we found that the practice environment required further consideration to ensure all facilities were as accessible to patients of varying needs as possible:

- All seating within the waiting area was sofa-style which did not promote independence for patients with mobility difficulties or provide much space for patients attending with mobility aids or in wheelchairs.
- There was no lower section of the reception desk which meant that patients attending in wheelchairs would need to use the self-check-in only or have difficulty seeing reception staff to speak with them
- Doctors used consultation rooms which were a long way from the reception. We were told that a wheelchair was available and could be used to push patients with mobility issues to consultation rooms if required but this was not advertised to patients to make them aware

- There was no pull cord in the toilet for patients to summon emergency assistance
- A hearing loop was available for communication with patients with cochlear implants or hearing aids though there was no signage regarding this on the premises.

The practice should ensure that:

- **The layout of the waiting area, including desk height and seat types, is reconsidered and any feasible alterations made**
- **Patients are informed of the availability of a wheelchair and a hearing loop for use if required while attending the practice**
- **A pull cord is installed in the toilet or that the toilet is not advertised as disabled access within practice information as a pull cord is required for this.**

Delivery of Safe and Effective Care

Safe

Risk management
We noted practice areas that patients accessed were generally tidy. However, the practice grounds were littered and external signage was unreadable. The toilet seat in the patient toilet was broken. Equipment was not always stored where it was most accessible to clinicians during consultations and staff only areas were cluttered. A carpet in staff only areas was also uneven and so could pose a trip hazard. Within the current lease arrangement the practice was responsible for both internal and external building maintenance with the health board supplying support for health and safety, for example, through completion of minor works and water check services.

The practice should:

- **Work with the health board to ensure timely completion of all works and estates requests. This includes replacing the broken toilet seat in the patient toilet and maintenance of staff only areas and the practice grounds**
- **Reconsider the storage of items, including items used regularly and emergency drugs and equipment, to ensure these are as accessible as possible when clinically required. Items should not be kept within areas which may be locked during patient consultations**
- **Ensure that oxygen cylinders are appropriately secured within their storage area**
- **Dispose of all disused items stored in staff areas, including expired cleaning chemicals, and ensure that nothing is stored within the boiler cupboard to promote fire safety.**

Suitable signage was seen informing patients and staff of safety measures in place within the practice premises. This included the location of emergency equipment and medical gases and fire escape routes.

We saw that a home visit policy and risk assessment were in place. However, these required updating to ensure accuracy regarding safety measures in place for clinicians working in the community to summon assistance in the case of an unsafe or emergency situation and include a safe reporting mechanism.

The practice should update their home visit policy and risk assessment to ensure these are comprehensive regarding mechanisms to support clinician safety when working in the community.

Staff working on the practice premises could summon emergency assistance through the computer system and wall-mounted alarms. However, the lone working policy stated all staff carried emergency alarms with them and so required updating.

The practice should update their lone working policy to indicate the use of resources available at the practice and ensure that staff are made aware.

A Business Continuity Plan (BCP) was in place and available to all members of the practice team to access as required. However, this did not contain any detail around the partnership risk.

The practice should update their BCP to ensure that it covers partnership risk.

The use of rotas and locums ensured appropriate GP staffing levels and absence cover. At the time of our inspection health board funding was also bolstering GP time to support the practice in transitioning away from health board management to a new partnership arrangement. We discussed practice planning to ensure continuity of service once this temporary arrangement ended. Monthly escalation levels and sustainability framework information was appropriately reported.

We found a suitable significant events process was in place to underpin the documentation and discussion of any patient safety incidents or other significant events for reflective learning and action planning. A suitable system was in place for the practice to receive patient safety alerts from external partners.

Infection, prevention and control (IPC) and decontamination
We saw hand hygiene facilities for staff and patients throughout the practice premises. A separate room was available for patients with suspected infectious diseases to wait in for their appointments. We observed staff undertaking effective hand hygiene practices throughout the day and staff we spoke to were clear on their roles and responsibilities regarding IPC.

Clinicians told us that they cleaned their rooms at the end of each working day and that a cleaner was employed to complete general cleaning duties. However, no contract was available to confirm cleaner responsibilities or information regarding contingency for cleaner absence to ensure cleaning processes would still be completed. Cleaning schedules also indicated that cleaning had been undertaken by one consistent person across clinical and general areas and lacked detail with respect to what facilities within each room would be cleaned or the frequency of routine or deep cleaning. All respondents thought the practice was ‘fairly clean’. We saw the standard of cleaning required some improvement throughout the

building to ensure the environment was visibly clean with no build-up of dust or other debris.

The practice should ensure that robust cleaning arrangements are in place and completed as scheduled.

We noted issues with aspects of waste management and the practice awareness of legionella control measures and staff Hepatitis B immunity. This meant that HIW was not fully assured regarding practice IPC risk management. Our concerns regarding these issues were dealt with under our immediate assurance process. More details can be found in **Appendix B**.

IPC, blood-borne virus and needlestick policies were in place and accessible to staff. However, needlestick flow charts were not displayed in all clinical areas.

The practice should display needlestick flow charts within all clinical areas as a quick access guide to appropriate action if required.

Handwashing in all but one clinical rooms seen were also not non-touch operated in line with current IPC standards.

The practice should explore updating any hand operated taps within clinical areas to elbow operated or non-touch models within a reasonable timeframe.

The IPC lead for the practice had received IPC training and updates via the health board in November 2025. Recent IPC and waste management audits had also been completed. However, we were told that learning from updates and audits had yet to be incorporated into practice. We also saw no evidence that staff other than the IPC lead had undertaken IPC training appropriate to their role.

The practice should ensure that:

- **All staff complete IPC relevant to their role and records of this are maintained**
- **Learning from training, audits and other IPC updates received is incorporated into practice.**

Medicines management

Clinical staff we spoke to were clear regarding their roles and responsibilities with respect to the prescribing and management of medicines. However, formal governance structures required strengthening to ensure the suitable oversight of medicines management processes and support patient safety.

Patients were able to request repeat prescriptions by handwritten or online forms. These requests were processes by prescription clerks if appropriate or forwarded to the practice or cluster pharmacist or a GP for reauthorisation or other action in relation to any queries. Medication reviews were conducted by pharmacists and GPs. However, we found that the governance of processes was not underpinned by robust policies or procedures. Prescribing policies required updating and no scope of practice for pharmacists or standard operating procedures for professionals involved in shared care or other prescribing activity had been established with the new practice partnership. There was also no evidence of prescription clerk training or recent appraisals which would identify any prescription training needs.

The practice should ensure that comprehensive governance structures underpinning medication prescribing and review processes are in place, including:

- **Up-to-date prescribing and repeat prescribing policies**
- **Scope of practice agreements for pharmacists working from the practice**
- **Clarity of shared care agreements and delegation to all relevant prescribers**
- **Evidenced completion of appraisals and identified training for all professionals involved in prescribing or the processing of repeat prescriptions.**

Prescription logs were comprehensive. Patients and pharmacists would sign when collecting prescriptions which is considered noteworthy practice.

Responsibility for checking all drug and equipment stocks had been appropriately delegated to a clinical member of the team. Arrangements were in place for the safe disposal of drugs and all drugs we saw, including those required for use within a medical emergency. Emergency drugs and equipment was in place in line with Resuscitation Council UK guidelines and all staff we spoke with were aware of where the emergency drugs and equipment were kept. However, although regular, documented, checks of emergency drugs and equipment were completed, this was done on a monthly basis which is not in line with current guidance.

The practice should ensure that documented checks of emergency drugs and equipment kept on the premises are completed on a weekly basis in-line with Resuscitation Council UK guidelines.

Medications requiring refrigeration were stored in dedicated clinical refrigerators. Refrigerators were suitably maintained and daily temperature checks were completed and documented. However, we saw that some medications were stored on the bottom shelves and touching the sides of the fridge which could impede the effective circulation of cold air such that the conditions ceased to be suitable for

the storage of refrigerated medications and medications became unsuitable for use.

The practice should ensure that items are not stored on the bottom shelves or in contact with the sides of medication fridges.

An in date cold chain policy and flow charts were in place to support staff to follow suitable processes should a cold chain breach occur.

Suitable processes were in place for the reporting of any adverse effects from medications via the yellow card scheme and incidents involving the use of oxygen cylinders via the cylinder provider.

Safeguarding of children and adults
The practice had a nominated safeguarding lead who all staff we spoke to were aware of. A safeguarding policy and Was Not Brought and Did Not Attend policy were in place. However, we found that there were discrepancies between these policies regarding the actions staff should take in the event that a patient did not attend an appointment or a child or other vulnerable person was not brought as planned. The safeguarding policy did not contain any contact numbers for local agencies relevant to safeguarding or signpost staff to contact the police should a person be considered at immediate risk of harm. This meant that processes were not in line with the Wales Safeguarding Procedures as referenced and that staff would need to look through a large directory of contact information to find the details of agencies to report concerns to if they required. The safeguarding policy also required a safeguarding deputy and mental capacity act lead to be nominated within the practice but these individuals had not been identified.

The practice should review their safeguarding policies in line with national standards, including Royal College of GP Safeguarding Standards (2024) and Wales Safeguarding Procedures.

Suitable processes were in place for GPs to review hospital attendance records received by the practice and ensure appropriate follow-up with any patients noted as frequently attending emergency departments.

We were told that muti-agency safeguarding meetings and communication took place on a regular basis to discuss any patients professionals identified were at risk or living with known safeguarding concerns.

Systems were in place to ensure that children on the child protection register and relevant contacts could easily be identified via digital flags within the clinical

record. Children at risk, Looked After Children and other vulnerable patients records were also appropriately READ coded.

Management of medical devices and equipment
Suitable processes were in place for the maintenance, repair and replacement of medical devices as required. Regular visual inspections were completed and documented within the practice and a contract was in place for formal annual calibration and servicing. All devices were used according to their intended purpose and stored appropriately. Single use equipment was used whenever possible. However, we found some blood bottles that had expired and others very close to their expiry date, indicating that these had not been recently checked. 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.

Effective

Effective care
We saw that communication supported the delivery of safe and effective care.

The practice answerphone, website and care navigation ensured that patients contacting with an emergency health need were signposted away from primary care if appropriate. Cluster services, including a psychological health practitioner, paramedics and pharmacists also offered alternatives to GP appointments although we were informed that the capacity of these services and patient acceptance of appointments with other practitioners were barriers to their effective use.

Delegation of chronic disease management to nursing staff ensured continuity of support to patients with long term conditions. Multidisciplinary palliative care meetings and other regular communication with relevant agencies ensured continuity of care for patients approaching the end of life. Mortality reviews were completed where there was concern identified around the cause of death or the care received.

Referrals from the practice to other services were managed appropriately through the use of the Welsh Clinical Communications Gateway. GPs generally completed their own referrals or instructed administrative staff when appropriate. Administrative support was routinely provided to locums providing clinical cover. However, we were told that the practice currently did not have a process in place undertake analysis of referral rates to identify whether these were comparable to other practices in the local area. The practice may wish to consider working with other cluster practices to enable better understanding of their referral rates and consider potential reasons for any differences found.

There were processes in place for receiving, recording and actioning information received into the practice.

Clinical letters and documents were scanned onto patient notes and directed to the most appropriate professional to complete any required action. The use of electronic messages for task allocation provided an audit trail to ensure safe and effective care. Administrative or clinical staff would contact patients to discuss test results and any further follow-up actions as appropriate. However, anecdotes provided within responses to our patient questionnaire indicated that when patients were invited to book appointments to receive and discuss results this process was not always easy to navigate. We also found that there was no process in place to confirm patients had received or actioned messages regarding booking appointments for follow-up blood or other diagnostics tests that did not require practitioner referral.

The practice should put a process in place that:

- **Ensures the timely provision of test results and follow-up care for patients**
- **Provides confirmation that patients have received and actioned any information advising them to book an appointment to support continuity of care with respect to the investigation and management of health conditions.**

Updates to clinical guidelines were received by practice management and distributed as appropriate.

Patient records

We reviewed a sample of five electronic patient records kept within a secure computer system. Records were found to be of generally consistent quality in terms of being contemporaneous and clear. However, the depth of detail provided varied across practitioners. We discussed that recent turnover of practitioners and change in practice partnership arrangements provided an opportunity for re-establishing record keeping practices in line with professional guidance. Two areas for particular improvement were the documentation of the offer and use of a chaperone when appropriate and record keeping of treatment planning discussions with patients.

The practice should ensure that all clinical documentation adheres to professional standards including General Medical Council guidelines.

We found that in general clinical READ codes were used effectively and consistently. However, the practice did not use templates to assist in ensuring data quality and retrieval from notes generated in diabetes and asthma clinics.

Efficient

Efficient

We found that the practice aimed to offer services in a person-centred and empowering manner to direct patients to appropriate and timely treatment options. We discussed bolstering delegation and implementing clear workflows within the practice as opportunities for the further development of care navigation and clinical roles and ensuring the efficient use of available resources.

Quality of Management and Leadership

Leadership

Governance and leadership
We found a clear and supportive management and leadership structure in place. Staff we spoke with were clear about their roles and responsibilities. A new practice management structure had been implemented three months prior to our inspection. Team members we spoke with were positive about this new arrangement, describing leaders as visible and approachable and it was clear that building working relationships was considered a priority to all.

A practice development plan was in place. However, we found this lacked detail and suggested that a more detailed plan defining key milestones and delegating responsibilities within the practice team would better support the development of clear working practices, governance and accountability structures.

Any policy or procedure updates, safety alerts or other information would be cascaded via the Practice Manager. Team members we spoke with reported this had been helpful in establishing ways of working within the new partnership arrangement. Team members also took ownership for keeping a central telephone directory updated when new services were made available or contact details were found to have changed.

A wide range of policies and procedures were available to staff. However, several of these needed updating to ensure they were clear and accurate. All staff were clear regarding when and how they would gain clinical advice to support patient care. However, some additional policies and procedures, including for the Control of Substances Hazardous to Health (COSHH) and care navigation pathways, would further support all team members in the delivery of safe patient care.

The practice should review all policies and procedures identified as requiring updates within this report and develop a COSHH policy and care navigation pathways.

Workforce

Skilled and enabled workforce
Staff we spoke with across a range of roles appeared committed to providing a quality service to patients. Work was allocated in line with role expectations and a rota system ensured suitable clinical cover and support was available each working day. We were told there was no formal workforce plan in place. However, skill mix

was regularly considered by practice leadership and additional staff had recently been appointed to reduce the pressure on administration and reduce waiting times for appointments. Locum GPs would be used when required and a locum pack was available to provide introductory information to the practice. However, we found that this required updating to ensure it accurately reflected practice staffing structure, services and meetings. No formal induction policy or checklist was in place for other newly appointed team members although staff were able to describe how new employees would be supported by management and provided time to shadow colleagues to learn from them.

The practice should ensure temporary and newly appointed team members are supported by structured induction materials:

- **An induction checklist to confirm job description, contract details and provide a comprehensive overview information of practice structures and processes**
- **An up-to-date locum pack for locum GPs.**

We reviewed a sample of five staff records and found that these did not assure us that robust processes underpinned suitable recruitment, maintenance of professional obligations or continuous professional development across the workforce. Our concerns regarding these issues were dealt with under our immediate assurance process. More details can be found in **Appendix B**.

During the inspection we found evidence of supervision and appraisal mechanisms in place for nursing staff. Practice management told us they had met informally with all staff members for introduction at the beginning of the partnership arrangement and that they planned to meet with non-clinical staff on an individual basis to review performance and agree development plans. However, these had not yet been scheduled.

The practice must ensure that all members of staff receive regular support and oversight and an annual appraisal to discuss performance, set objectives and identify any training needs.

We were informed that contracted mental health support schemes would soon be made available to staff to access should these were required. However, arrangements for ensuring staff support with support for other workplace adjustments, such as related to display screen equipment set up, were less clear, though potentially informally accessed via strong links with the health board.

The practice should confirm arrangements for occupational health or other employee well-being and assistance schemes available to the workforce.

Culture

People engagement, feedback and learning
We saw that the annual patient survey was promoted to patients in electronic and paper formats. Staff told us that should patients require assistance with completion feedback forms or surveys regarding the practice this would be arranged from within the administration team. Data collected by the health board had been made available to the new partnership arrangement. However, no analysis of results had yet been completed. There was also no on-going channel for feedback, such as a suggestion box, provided to patients. Complaints procedures were available to view on the website. However, these lacked clarity, were not also available within the practice premises, and were not clearly evidenced as implemented by complaints records we saw. The majority of patients responding to our questionnaire indicated that they were not aware of how to provide feedback.

The practice should ensure that robust mechanisms are in place for collecting patient feedback, concerns and complaints and analysing, actioning and sharing themes to demonstrate learning and provide assurance. This should include:

- **Implementing patient feedback and suggestion mechanisms both on the practice premises and website**
- **Ensuring patients are fully informed of complaints procedures both on the practice premises and website**
- **Complaints procedures clear and in-line with current NHS concerns and complaints processes: Listening to People from 1 April 2026 Listening to People - The NHS Wales Complaints, Incidents and Redress Process: People's Guidance**
- **Complaints and feedback fully analysed and resulting in learning and positive action**
- **Themes from feedback, concerns and complaints and how these have been addressed through learning and action are provided, for example, through 'You said, we did' boards for patients and staff meetings for the practice team.**

A speaking up policy and strong working relationships within the practice ensured open-door management and formal process were in place to support staff in sharing any ideas, suggestions or concerns they had.

Information

Information governance and digital technology
We found suitable arrangements in place for the protection and use of patient information compliant with Information Governance and General Data Protection Regulations (GDPR). A privacy notice was available to patients. However, this was only displayed on the practice website and not also on the practice premises.

The practice privacy notice should be available to patients when attending the practice.

Learning, improvement and research

We were told that staff meeting had occurred to provide a basis for team working within the newly established partnership arrangement. Clinical, partnership and educational meetings had not yet been scheduled to ensure on-going clinical and operational support.

The practice should ensure that there are scheduled, structured meeting opportunities for clinical, operational and learning discussions.

We found evidence of condition specific quality improvement projects and prescribing audits. The practice also reported monthly operational workload and access data and Quality Assurance and Improvement Framework data as required.

All staff we spoke with during the inspection were receptive to our views, findings and recommendations and showed commitment to addressing areas of improvement. Action must also be taken following the completion of the inspection process to sustain improvements made within all practices managed by the partnership.

Whole-systems approach

Partnership working and development
Established health board pathways were used to underpin referrals to and communication with secondary care. We also found that a strong relationship with the health board provided support to the partnership while the new management structure was embedded.

One senior partner and the practice manager were designated to attend cluster meetings where primary care providers and other speakers would come together to collaborate to develop and implement quality improvement projects. Cluster

initiatives included social prescribing that could be accessed by patient self-referral, cluster paramedics who supported patients requiring home based medical treatment and cluster pharmacists to bolster prescribing and medication provision within primary care centres. We were told that the cluster hoped to expand the psychological health practitioner talking therapies service to strengthen the mental health support available to patients.

A Patient Participation Group had begun to be established by the practice manager and although only a small number of patients were involved at the time of inspection the formation of the group was considered noteworthy practice.

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
Blood bottles found to have expired or to be very near to their expiry date indicating that these items had not been recently checked.	Potentially contaminated or otherwise denatured blood bottles could be used which could result in false test results affecting patient safety.	Relevant clinicians informed.	Expired items removed. Expiry dates of all others to be checked to ensure they remain suitable for use and replaced as required.

Appendix B – Immediate improvement plan

Immediate improvement plan

Service: Aberbeeg Medical Centre

Date of inspection: 19 March 2026

Findings
HIW was not assured that robust systems were in place to ensure staff received consistent, effective training relevant to their roles, including effective oversight of staff training and competence. Our review of a sample of five staff training records and discussions with staff from clinical and non-clinical professional groups highlighted the following issues:

- Only one of five staff training records evidenced in-date training across a range of patient safety topics. Evidence of any training regarding key safety topics including Safeguarding, Infection Prevention and Control, Basic Life Support, Information Governance, Equality, Diversity and Inclusion, Health and Safety at work was missing from three of the five staff records reviewed. One record indicated that Basic Life Support and Fire Safety training had been historically undertaken but not renewed
- There was no evidence that staff who would be required to use oxygen cylinders within routine or emergency care had undertaken training regarding the safe use of oxygen cylinders or that vaccinators had undergone the required immunisation and vaccination training or updates.

In addition, HIW was not assured that robust systems were in place to ensure safe recruitment practices and the on-going fitness and suitability of those employed by the practice. Our review of a sample of five staff employment records and discussions with staff from clinical and non-clinical professional groups highlighted the following issues:

- Four out of five staff records reviewed contained appropriate Disclosure and Barring service checks. However, no other evidence of qualifications, experience or good character was available. There was no evidence that identity checks were completed during the recruitment process and the registration pin number was only readily available within one of the two clinical staff files reviewed and clinicians were difficult to track on professional registers due to inconsistent use of names
- We found that job descriptions and contracts were provided within administrative staff records but not clinical
- In addition, there was no evidence of a scope of practice agreement in place for the practice pharmacist.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
1.	The practice must take immediate action to strengthen recruitment and staff training governance arrangements. This includes: • Implementing robust systems to determine training needs, and to monitor, record, and assure on-going compliance with staff training, including refresher training • Ensuring all clinical staff are in receipt of an enhanced DBS check, and to risk assess and have a clear policy and rationale in place for when DBS checks are renewed and when they are required for non-clinical staff, based on their roles and responsibilities • Ensuring staff recruitment records are complete, accurate, and readily available for review.	Health and Care Quality Standards (2023) - Safe	Conduct a full audit of all staff training records to identify gaps across: • Safeguarding (Adults & Children) • Infection Prevention & Control • Basic Life Support (BLS) • Fire Safety • Information Governance • Equality, Diversity & Inclusion • Health & Safety at Work • Any staff with expired or missing training will be enrolled on online or face to face sessions. • Safe use of oxygen cylinders for all clinical staff who may handle oxygen in routine or emergency care. • Immunisation and Vaccination training for all vaccinators, including: • Annual updates • Competency assessment sign off a. Implementation of a Central Training Matrix • Create a digital training matrix covering all staff, listing: o Required training per role o Completion dates	Practice Manager	• Training matrix, recruitment checklist implemented within 4 weeks. DBS Policy already done.

			o Expiry/refresh dates o Evidence links b. Designation of Training Lead • Assign a named individual responsible for: o Oversight of training compliance o Monthly monitoring o Reporting to the practice manager/partners • Add “Training & Recruitment Compliance” as a monthly governance agenda item. • Designate leads for: • Training compliance • HR and recruitment • Clinical governance Implement a standardised recruitment checklist for all staff, ensuring: • Verification of identity • Evidence of relevant qualifications and experience • Verification of professional registration and PIN numbers for all regulated staff • Evidence of good character		

			• Enhanced DBS checks will be confirmed for all clinical staff. • A risk-based DBS policy will be implemented, clearly outlining: • DBS requirements for non-clinical staff • Renewal timeframes • Risk assessment and rationale where DBS checks are not required or renewal is deferred. • All recruitment records will be centrally stored, complete, accurate and readily accessible for inspection. Job descriptions and contracts will be reviewed and updated to ensure they are in place for all staff groups, including clinical roles. • A written scope of practice agreement will be developed, agreed, and signed for the Practice Pharmacist, with annual review.		

Findings

HIW was not assured regarding risk management procedures within the practice. Our inspection highlighted the following issues:

- No Hepatitis B register. Evidence of immunity was available for one doctor, but no other evidence of vaccination or immunity was available for other clinical staff
- Waste bins kept outside the practice building were not secured and the sharps waste bin was not lockable. This meant that members of the public could access clinical and sharps waste which would pose an infection prevention and control, health and safety, and environmental risk
- No evidence of legionella control measures implemented by the health board. This meant that the practice was not aware regarding the safety of water within the practice, particularly to the staff shower which was not used on a regular basis.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
1.	The practice must implement a Hepatitis B log, ensuring relevant risk assessments are in place for non-responders or where evidence of immunity is unavailable / refused.	Health and Care Quality Standards (2023) - Safe	A Hepatitis B vaccine and immunity register will be implemented for all clinical staff. Evidence of vaccinations or immunity will be obtained and recorded. The register will be reviewed and updated regularly as part of annual staff checks.	Practice Manager	Within 2 weeks
2.	The practice must ensure that waste bins are secured and locked at all times.	Health and Care Quality Standards (2023) - Safe	Contact has been made to Health Board and Works and Estates to make arrangements to secure waste bins and to obtain copies of the regular water checks carried out at the practice.	Practice Manager	Within 4 weeks
3.	The practice, in conjunction with the health board, must sure that periodic legionella risk assessments are completed, with regular water temperature checks and flushing completed.	Health and Care Quality Standards (2023) - Safe			

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): Angela Jarrett

Job role: Practice Manager

Date: 02.04.2026

Appendix C - Improvement plan

Service: Aberbeeg Medical Centre

Date of inspection: 19 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.	Generally negative comments elicited from the HIW patient questionnaire.	The practice should evaluate the patient feedback received through the HIW patient questionnaire against its own feedback mechanisms and consider whether any improvements can be made.	Health and Care Standards (2023) – Person centred			
2.	Information regarding services available at the practice not clearly displayed on the practice website and premises.	Similar information to be available across the practice website and premises and contained within a practice leaflet which is made available to patients.	Health and Care Standards (2023) – Equitable			

3.	Information displayed regarding wider health services outdated.	All information displayed to be kept up to date.	Health and Care Standards (2023) – Effective			
4.	Information regarding health promotion and carers support schemes not displayed in an easily accessible way.	All information to be displayed in an accessible way to ensure it can be easily noted by target audiences.	Health and Care Standards (2023) – Effective			
5.	Practices regarding Did Not Attend and Was Not Brought not consistent with policy.	• Appropriate Did Not Attend and Was Not Brought policy to be in place to guide staff on the procedures to follow-up with patients who have missed appointments • Policy to be consistently implemented.	Health and Care Standards (2023) – Safe			

6.	Not all consultation rooms fitted with privacy curtains.	Privacy curtains to be fitted around all couches within all consultation rooms and / or the fitting of additional window covering to be considered to further reassure patients regarding privacy.	Health and Care Standards (2023) – Safe / Person centred			
7.	Conversations with patients could easily be overheard through the walls of adjacent consultation rooms and within the reception and waiting area.	• Ways in which confidentiality can be maintained within the waiting area and adjacent consultation rooms to be explored • Patients to be made aware of the offer of a separate room away from reception for patients to have in-depth conversations.	Health and Care Standards (2023) – Person centred			

8.	Self-check-in-screen reported to be inconsistent in informing reception of a patient's arrival.	• Self-check-in-screen to be checked and maintained to ensure reliability.	Health and Care Standards (2023) – Effective / Efficient			
9.	Chaperone policy not fully implemented as intended.	Chaperone policy to be reviewed and implemented in line with General Medical Council guidance.	Health and Care Standards (2023) – Safe			
10.	Practice access policy didn't inform patients fully of the practitioners or services available at the practice and was only available online.	• Access policy to provide full details of practice and co-located services • Full access policy information to be available to patients both on the practice website and within the practice premises.	Health and Care Standards (2023) – Effective Health and Care Standards (2023) – Equitable			

11.	Very limited evidence that the Welsh Active Offer was made to patients.	The Welsh Active Offer to be embedded for patients to access services in the Welsh language should they prefer.	Health and Care Standards (2023) – Person centred			
12.	Period dignity initiative signage seen but no resources to evidence its implementation.	The practice should review its posters and ensure that any initiatives offered at the practice are fully implemented.	Health and Care Standards (2023) – Effective / Person centred			

13.	Several aspects of the practice environment presented accessibility barriers to patients.	• The layout of the waiting area, including desk height and seat types, to be reconsidered and any feasible alterations made • Patients to be informed of the availability of a wheelchair and a hearing loop for use if required while attending the practice • Pull cord to be installed in the toilet or patients to be informed that the toilet not fully disabled accessible.	Health and Care Standards (2023) – Person centred			

14.	Several issues regarding the storage of equipment es found.	• Practice to reconsider the storage of items, including items used regularly and emergency drugs and equipment, so these are as accessible as possible when clinically required • Oxygen cylinders to be appropriately secured within their storage area • All disused items stored in staff areas to be disposed of, including expired cleaning chemicals. No items to be stored within the boiler cupboard to promote fire safety.	Health and Care Standards (2023) – Safe			

15.	Premises maintenance issues observed.	• The practice should work with the health board to ensure timely completion of all works and estates requests including replacement of the broken toilet seat in the patient toilet • Cleanliness and maintenance of the practice grounds and signage to be improved.	Health and Care Standards (2023) – Safe			
16.	The standard of cleaning required some improvement throughout the building to ensure the environment was visibly clean with no build-up of dust or other debris.	Robust cleaning arrangements to be in place and completed as scheduled.	Health and Care Standards (2023) – Safe			

17.	Needlestick flow charts not displayed within all clinical areas.	Needlestick flow charts to be displayed within all clinical areas as a quick access guide to appropriate action if required.	Health and Care Standards (2023) – Safe			
18.	Hand operated taps in all but one clinical areas.	The practice should explore updating any hand operated taps within clinical areas to elbow operated or non-touch models within a reasonable timeframe.	Health and Care Standards (2023) – Safe			
19.	• Learning from IPC training, updates and audits not implemented in practice. • Only the IPC lead had documentary evidence of any IPC training.	• All staff complete IPC relevant to their role • A record of staff IPC training is maintained • Learning from training, audits and other IPC updates received is incorporated into practice.	Health and Care Standards (2023) – Safe			

20.	Governance structure underpinning medication prescribing and review processes not robust as: • Policies were out-of-date • No scope of practice was in place for pharmacists • There was a lack of clarity over shared care arrangements and delegation to all relevant prescribers • There was no evidence of recent staff training in relation to prescribing or repeat prescription processes.	• Prescribing and repeat prescribing policies to be updated • Scope of practice agreements for pharmacists working from the practice to be in place • Clear Shared Care Agreements and Standard Operating Procedures to delegate responsibilities to relevant prescribers to be in place • Evidenced completion of relevant training for all professionals involved in prescribing or the processing of repeat	Health and Care Standards (2023) – Safe			

		prescriptions required.				
21.	Documented checks of emergency drugs and equipment kept on the premises only completed on a monthly basis.	Documented checks of emergency drugs and equipment kept on the premises to be completed on a weekly basis in-line with Resuscitation Council UK guidelines.	Health and Care Standards (2023) – Safe			
22.	Refrigerated medications observed to be on the bottom shelves and in contact with the sides of fridges.	Medications not to be stored on the bottom shelves or in contact with the sides of medication fridges.	Health and Care Standards (2023) – Safe			

23.	Processes in place to receive results and follow up care reported by patients to be difficult and does not provide confirmation that patients have received and actioned any information sent advising them to book an appointment for further investigation or management of health conditions.	• Process for receiving test results and follow-up care to be made easier for patients • Process to be implemented to ensure confirmation that patients have received and actioned any information sent advising to book an appointment.	Health and Care Standards (2023) – Safe			
24.	Clinical records found to be of varying depth and required improvement in the documentation of the offer and use of a chaperone and treatment planning discussions with patients.	All clinical documentation to adhere to relevant professional standards including General Medical Council guidelines.	Health and Care Standards (2023) – Safe			

25.	Not all staff had been offered one-to-one support or appraisals to discuss performance, set objectives and identify any training needs.	All members of staff receive regular support and oversight and an annual appraisal to discuss performance, set objectives and identify any training needs.	Health and Care Standards (2023) – Safe			
26.	Unclear arrangements for occupational health or other employee well-being and assistance schemes.	Arrangements for occupational health or other employee well-being and assistance schemes available to the workforce to be confirmed.	Health and Care Standards (2023) – Person centred			

27.	Limited arrangements for the practice to collect patient feedback, concerns and complaints and analyse, action and share learning regarding information received.	• On-going patient feedback and suggestion mechanisms to be available both on the practice premises and website • Patients to be fully informed of complaints procedures both on the practice premises and website and provided feedback on themes, learning and action taken by the practice • Themes, learning and action also to be shared with practice staff.	Health and Care Standards (2023) – Person centred			

28.	Only one meeting had taken place in the three months since the new partnership arrangement had been in place. No further clinical, operational or learning meetings scheduled.	Structured meeting opportunities for clinical, operational and learning discussions to be scheduled.	Health and Care Standards (2023) – Safe			

29.	A number of policies and procedures required updating to ensure these provided suitable instruction to staff regarding work procedures within the practice.	• Complaints procedures to be clear and in-line with current NHS concerns and complaints processes: Listening to People from 1 April 2026 • Home visit policy and risk assessment to be updated to ensure these are comprehensive regarding mechanisms to support clinician safety when working in the community • Lone working policy to be updated indicate the use of resources available at the practice	Health and Care Standards (2023) – Effective			

		• BCP to cover partnership risk • Safeguarding, Was Not Brought and Did Not Attend policies and procedures need reviewing to ensure they are consistent and in line with national guidance including Royal College of GP Safeguarding Standards (2024) and Wales Safeguarding Procedures. • Locum pack to ensure this accurately reflected practice staffing, structures and meetings				

30.	Some additional policies and procedures needed.	• COSHH policy • Care navigation policy and pathways • Induction checklist to confirm job description, contract details and provide a comprehensive overview information of practice structures and processes	Health and Care Standards (2023) – Safe			

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:**