Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report (Announced)

Park Surgery, Aneurin Bevan University Health board

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

Our Purpose

We check the safety and quality of healthcare across Wales.

Our Vision

A future where healthcare in Wales is safe, effective, and high-quality for everyone.

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 Priorities

Putting People First - We will focus on the biggest risks facing people and communities as they access healthcare services now and in the future.

Learning and Working Together - We will collaborate with partners to share learning and drive lasting improvements.

Investing in Our People - We will ensure our people feel supported, valued, and empowered.

Taking Action That Matters - We will take action to improve the quality and safety of healthcare for the future of Wales.



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1. What we did

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

Healthcare Inspectorate Wales (HIW) completed an announced inspection of Park Surgery, Aneurin Bevan University Health Board on 18 June 2026.

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

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

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

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

2. Summary of inspection

Quality of Patient Experience

Overall summary:

Overall, the inspection findings relating to the quality of patient experience were positive. Patient feedback, while based on a limited number of questionnaire responses, was largely favourable, with almost all respondents rating the service as good or very good.

The practice demonstrated a strong commitment to person-centred care through health promotion activities and multidisciplinary working. Staff interactions with patients were observed to be polite, helpful and friendly. The practice environment was accessible for patients of varying needs. However, there was scope for the practice to work with the health board and co-located services to further develop community access and to ensure that once inside the health centre building patients could easily find the service they were planning to attend.

This is what we recommend the service can improve:

- Ensure patients are made aware that the side room next to reception is available for private conversations and reinstate self-check-in to reduce the need for potentially sensitive discussions at reception.

This is what the service did well:

- Operated an effective care navigation and clinical triage system to ensure patients received care according to clinical need
- Made use of a range of means to support communication with patients. These included digital flags within patient records to indicate patient's preferred language, name and pronoun, provision of a hearing loop, access to multilingual staff and formal translation services.

Delivery of Safe and Effective Care

Overall summary:

Appropriate fire equipment and action plans were in place. Electrical items had been portable appliance tested (PAT) and medical devices calibrated to ensure their on-going safety. Staff were able to request emergency assistance from their individual areas and were confident that a response would be gained from within the practice team or other services on site. Appropriate safeguarding policies and the designation of a safeguarding lead within the practice ensured staff were aware of the process to follow for reporting any safeguarding concerns. Patient records reviewed demonstrated good quality clinical assessments and appropriate decision making and actioning of treatment plans, including the completion of onward referrals for further investigations.

This is what we recommend the service can improve:

- Review and update infection prevention and control policies and procedures to implement all expected requirements
- Strengthen clinical fridge management and check emergency drugs and equipment on a weekly basis
- Introduce formal internal quality assurance mechanisms for data entry in patient records.

This is what the service did well:

- Maintained a visibly clean and uncluttered clinical environment and had completed an IPC audit and actioned recommendations
- Ensured all staff involved in prescribing and medication reviews were appropriately trained and supervised
- Patients approaching the end of life were assigned a named GP to oversee their care.

Quality of Management and Leadership

Overall summary:

At the time of inspection practice staff hoped that they would be entering a period of stability following four changes of practice manager within five years and a relocation of premises. Leaders were visible and decisive and staff we spoke with were clear about their roles, responsibilities and lines of reporting. Messaging systems and informal discussions enabled clear communication.

A change in practice management had resulted in some data loss from staff personnel files. Information available indicated that job descriptions, contracts and annual appraisals had previously been provided. Disclosure and Barring Service (DBS) checks and the staff Hepatitis B register were being regathered. A suitable induction programme was in place to ensure any new employees and locums working at the practice were oriented to the environment and relevant procedures.

A systematic audit plan was in place but still required full implementation. Recent Chronic Kidney Disease and Cardiovascular Disease quality improvement projects had been completed. The Quality Assurance and Improvement Framework and enhanced service audits were completed in line with contractual requirements.

This is what we recommend the service can improve:

- Ensure annual appraisals are completed and regular, formal meetings and communication are reintroduced to further support development and performance
- Confirm that core training includes all expected requirements in line with roles
- Ensure Listening to People (2026) complaint handling processes are fully embedded

This is what the service did well:

- Leaders had implemented a recovery plan following management changes and data loss to help restore organisational stability.

3. What we found

Quality of Patient Experience

Patient feedback

As the HIW patient questionnaire received a low number of responses, findings should be interpreted with care and may not be considered representative of the wider practice patient population. However, we note that overall, all but one patients who responded to the HIW patient questionnaire rated the service as either 'good' or 'very good'.

Person-Centred

Health promotion

We saw that health promotion information was displayed within the practice waiting area, in their patient information leaflet and on their website. Information was up to date and covered a range of topics including common illnesses, screening campaigns and local support services.

The practice provided a range of services to patients, including an Alternative Treatment Scheme and seasonal vaccination programmes. Practice services were delivered by General Practitioners (GPs), physician associates, nurses and paramedics. There were also plans to expand the multidisciplinary team to further support the delivery of timely and prudent health care. Cluster pharmacists and psychological health practitioners regularly worked from the practice which practice staff felt was positive for patient care.

Co-location within the building with other primary and community teams including district nurses and health visitors, and third sector partners on a sessional basis, also maintained close professional links and enabled effective signposting for timely and joined up care for the local community. We were told that the building had intentionally been designed to adjoin existing community facilities and support access to health services. However, professionals we spoke with felt there was scope for the practice, in collaboration with the health board and co-located services, to develop this access further and to ensure that once inside the health centre building patients could easily find the service they were planning to attend.

Dignified and respectful care

We observed polite, helpful and friendly interactions between staff and patients.

Reception staff were located behind a glass partition to prevent their interactions with patients at reception or on the phone from being overheard. However, three respondents to the HIW patient questionnaire strongly disagreed that they could talk to reception staff without being overheard. One patient commented:

'Privacy should be provided at the reception, I felt embarrassed to be asked about

sensitive issues at the reception while other patients are listening'.

At the time of inspection a side room was available for private conversations but a self-check-in screen to reduce the need for detailed check in conversations to occur at reception was out of use .

The practice should ensure that patients are aware that the side room next to the reception area is available for private conversations and arrange for the self-check-in option to be reinstated.

All consultation rooms had lockable doors and window coverings. Suitable arrangements were in place for patients to be offered a chaperone for intimate examinations. We discussed placing posters informing patients of their right to be accompanied during examinations within clinical rooms in addition to where these were already displayed at reception and on the clinical room doors.

Timely

Timely care

Care navigation and an appointment triage system aimed to enable timely patient access to appropriate care based on clinical need.

Care navigation was underpinned by robust resources. Links to information regarding services patients were signposted to would be sent via text for ease of access. Care navigators were also aware of symptoms requiring an emergency response and would signpost patients accordingly. GP support was readily available to provide a clinical opinion regarding appropriate pathways if care navigators were unsure.

Patients requesting an urgent appointment at the practice were encouraged to telephone at 8am. Clinical triage would then determine whether a same day or routine appointment would best meet the patient's needs and the patient would be contacted back for an appointment to be offered accordingly.

Pre-bookable appointments were available for patients to book digitally, in person or by phone. The practice had started sending links for patients to self-book clinic appointments, such as for vaccinations, and were told that this had increased the uptake of health initiatives and appointment attendances.

However, patients who responded to the HIW questionnaire provided mixed opinions regarding whether they could access either urgent or routine appointments when needed.

Equitable

Communicating and language

Staff confirmed they would accommodate any known language or communication need. A hearing loop was available for patients experiencing hearing loss and a form could be completed for patients to provide consent for the involvement of family members, carers or advocates to assist discussions regarding their care. Staff at the practice spoke a range of languages between them which we were told could assist communication with patients whose first language was not English. A formal Language Line service was also available and a portable screen-based system to improve access to translators, including for British Sign Language, was on order. Digital flags within patient records would be used to indicate patient's preferred language, name and pronoun to support personalised communication and care.

We were told that the number of Welsh speakers within the local area or registered with the practice was very low. Despite this two members of staff had taken up the offer of Welsh language training. A Welsh language policy was in place and leaflets received from health care and third sector organisations would be displayed in Welsh and English where available. We discussed the practice displaying the 'Iaith Gwaith' sign to further enhance their implementation of the Welsh Language Active Offer.

The patient records we reviewed evidenced that clinical information provided to patients was appropriate to their communication needs. The majority of respondents to the HIW patient questionnaire agreed that during appointments the clinician explained things well to them, that they felt listened to, and that they were treated with dignity and respect.

Patients were provided with information about the practice through the practice website, written information, texts and by staff when attending for appointments.

Rights and equality

We found all areas of the practice to be accessible for people of various needs. This included the provision of seating for children. Access to the building was through an automated door. All thresholds were level, flooring secure and walkways wide enough to accommodate wheelchairs or other walking aids. The practice was situated on the first floor via stairs or a lift. A Personal Emergency Evacuation Policy was in place to ensure patients with additional needs would be supported in the case of a fire or other emergency requiring them to evacuate the building.

Home visits could be arranged to ensure patients unable to leave their home to attend appointments still had access to the care they required.

All patients who completed a questionnaire and attended the practice for their appointment said that the building is easily accessible, and that there were enough seats in the waiting area.

Up-to-date equality and diversity policies were in place. A learning disability and autism policy promoted staff awareness of the standard offer for an annual health check for patients identified as living with a learning disability. The violence and aggression policy provided guidance on the proportionate use of digital flags within patient records to highlight known risks but also ensure these were also removed when concerns were no longer present.
We saw evidence that some training regarding the principles of equality, diversity and inclusion were had been undertaken within the team. The lead practice nurse had also undertaken additional training to become a menopause champion to provide information and support to patients experiencing menopause.

Delivery of Safe and Effective Care

Safe

Risk management

The premises were purpose built and fit for purpose. Appropriate fire equipment and action plans were in place. Electrical items had been PAT tested to ensure their on-going safety and effectiveness. Staff were able to request emergency assistance from their individual areas and were confident that a response would be gained from within the practice team or other services on site. A suitable home visit risk assessment was in place to support the safety of practitioners completing clinical visits within the community.

We saw an up-to-date business continuity plan. This covered contact details of key personnel and services to enable appropriate action to be taken in the event of disruption to service delivery although it could be strengthened with respect to partnership risk.

We saw that a suitable system for receiving and disseminating patient safety alerts to relevant team members was in place.

Infection prevention and control (IPC) and decontamination

The interior of the practice was visibly clean and free of clutter. Cleaning of clinical areas was suitably recorded and data sheets for cleaning products were available. However, we saw that mops were stored head down in buckets and the blue mop heads for use in general areas needed replacing with new ones which were already available.

The practice should ensure that all mops are suitably stored and maintained.

An IPC policy was available to staff. However, the guidance this included on decontamination required expanding. No waste management policy was available during the inspection. The blood borne virus and needlestick policies required updating with a flow chart and details of who staff should contact should a needlestick injury or other transmission hazard occur and this information should also be displayed within

clinical areas.

The practice should ensure that:

- **All policies and procedures relevant to Infection Prevention and Control include all required details**
- **A needlestick flow chart is displayed within relevant clinical areas.**

We saw that a recent IPC audit had been completed and recommendations actioned. However, no clinical waste audit was available. Clinical waste was secured while awaiting collection.

The practice should ensure that a clinical waste audit is completed.

All respondents to the HIW patient questionnaire thought the practice was 'very clean'. All patient and staff responses also indicated that handwashing and other IPC measures were implemented within the practice. Hand washing instructions were placed above all hand wash basins in clinical areas and toilets. However, we saw that there was no hand sanitiser available for patient use on arrival or elsewhere within the practice which one patient also noted.

The practice should ensure that hand sanitising facilities are available to both staff and patients within the practice environment.

During our inspection the health board works and estates team were contacted regarding a build-up of bird excrement outside the entrance to the building and this issue was resolved. We suggested the practice confirm the process for the routine monitoring and maintenance of the outside of the building as they told us they were unsure regarding this.

Medicines management

There were processes in place for the ordering and disposal of vaccinations and other medication.

Temperature monitoring of the clinical fridge and room where medications were kept was completed. However, fridge management could be improved:

- Temperatures were only checked and recorded once daily
- No paper temperature records were kept. Displaying these on or near the fridge would provide a visual indicator for staff to check temperatures should this not be completed as expected
- A data logger would provide additional assurance regarding the maintenance of fridge temperatures out of practice hours, although it was acknowledged that an out of hours practice response to any temperature breach was restricted by building opening times
- The fridge was not overstocked. However, items stored at the top and bottom of the fridge needed to be moved to allow more air flow around the fridge from the

fan

- Staff were aware of the cold chain policy and actions to take in the event of a temperature breach. However, displaying a cold chain flow chart on the fridge would more fully support staff in the event of an incident
- No backup fridge was available for use in the event of clinical fridge failure.

The practice should review the robustness and sufficiency of their processes in relation to refrigerated vaccinations and medications.

We found that all drugs held on the practice premises were in date. However, not all equipment was in a suitable condition. We found a large number of out of date scalpel blades, dressings, blood bottles and butterfly needles during our inspection. We raised these issues with senior staff and the actions taken to resolve our concerns are provided in Appendix A.

Ambu bags within the emergency equipment were found unwrapped and visibly covered in build-up of dust. Monthly documented checks confirmed that the presence and expiry dates of emergency drugs was completed. However, these checks also needed to include all emergency equipment and be completed weekly in line with Resuscitation Council UK guidelines. Notices were displayed throughout the practice to inform staff where the emergency equipment and defibrillator was located. However, we suggested the location of emergency equipment and drugs be reconsidered to ensure that items are kept in an area central to the practice but not within a clinical room which may be locked during consultations, and in a staff only area or within tamper evident storage. We saw one oxygen cylinder and were told there was also a second within a different room to ensure adequate oxygen was available for patient use if required. However, training specific to the oxygen cylinders used at the practice was required following Patient Safety Notice 041.

The practice should strengthen their processes with respect to ensuring that suitable emergency drugs and equipment remain available and ready for use through:

- **Completing and recorded checks on a weekly basis**
- **Ensuring that all items, including equipment, are checked for condition and expiry dates and any unsuitable items are removed and replaced as soon as possible**
- **Reconsidering appropriate storage and location of emergency items to ensure these remain accessible but secure**
- **Ensure relevant staff have completed training on oxygen cylinder use.**

Practice staff were aware of the yellow card scheme for the reporting of adverse drug reactions and told us they had good links with relevant health board teams for medicines management. Appropriate training, supervision and audits were available to

ensure all staff involved in the review and prescribing of medications were working safely and within their scope of practice. However, we found two Patient Group Directions for vaccinations were out of date and needed to be replaced by the latest versions to ensure full legal compliance with respect to the supply and administration of specified medicines to a pre-defined patient group by healthcare professionals other than general practitioners.

The practice should ensure that all Patient Group Directions used at the practice are the most up-to-date versions.

We saw that processes to strengthen the security of prepared prescriptions had been implemented following an incident. Blank prescription pads and forms were securely stored and a record kept of when they were taken out of storage for use by practitioners. However, we recommended updating this process so that prescription papers were tracked from their entry to the practice and signed out when taken for use.

The practice should consider their processes for tracking prescription forms and pads from initial entry to the practice through to use to further increase prescription security.

Safeguarding of children and adults

Appropriate safeguarding policies and the designation of a safeguarding lead within the practice ensured staff were aware of the process to follow for reporting any safeguarding concerns. Communication pathways also kept the practice aware of patients how frequently patients were presenting to, or not attending, appointments with other services and enabled a joined up multiagency approach to supporting patients identified as at risk. Formal, minuted safeguarding meetings had recently restarted, and we discussed the practice continuing with these on a regular basis for ongoing patient safety.

We reviewed the documentation of safeguarding within five electronic patient records and found that in all cases digital flags and coding were appropriately used to highlight safeguarding concerns and when these had been resolved. The practice also aimed to link records of other family members where a child was on the safeguarding register.

Management of medical devices and equipment

We saw that medical devices at the practice were clean and in good working order. Processes were in place to ensure devices remained safe and suitable for use. There was evidence of calibration through a relevant contractor.

Effective

Effective care

We found auditable processes were in place to support timely referrals and correspondence within the practice and externally with other healthcare providers including secondary care and mental health services.

We were told that the practice knew its patients well and communication assisted continuity of care and safety netting for patients with changing health conditions. Patients approaching the end of life were assigned a named GP to support continuity of care alongside community nurses, which is noteworthy practice.

Patient records

We reviewed a sample of 10 electronic patient records within the secure IT system and found them to demonstrate good quality clinical assessments and appropriate decision making and actioning of treatment plans, including the completion of onward referrals for further investigations. Patient signed consent and evidence of the offer and use of a chaperone when relevant was also seen. However, one patient record was seen in which not all significant diagnoses had been included on the list of summary problems. The records of another patient did not include an adverse drug reaction within the relevant section to ensure clinician awareness. Delegated administrative staff had been trained to complete summaries and coding. However, no formal system of data entry quality assurance was in place.

The practice should consider these findings and formal mechanisms to provide data entry quality assurance on an on-going basis.

Quality of Management and Leadership

Staff Feedback

All staff we spoke with appeared committed to patient care. All respondents indicated they believed patients were able to access practice services in a timely way and that measures were in place to protect patient confidentiality, privacy and dignity.

Responses regarding staff support were more mixed. Of the four respondents, not all indicated that their job was not detrimental to their health or were aware of how to access well-being support if they needed this. However, most respondents felt able to meet conflicting demands on their time at work, that they were involved in decisions regarding changes affecting their work and that the practice learnt from incidents.

One member of staff commented:

"a good place to work and we work as a team"

Prior to our inspection the practice had experienced four changes of practice manager within five years and a premises relocation within the last 18 months. Staff told us they hoped that they would be entering a period of stability. We suggest the practice continues to engage with staff and seek feedback as it enters a period of stability.

Leadership

Governance and leadership

A recovery plan had been implemented following data loss associated with the change of management and a new practice manager was being supported to settle into their role by other practice leaders, an experienced team and a consultant practice manager. Leaders were visible and decisive and staff we spoke with were clear about their roles, responsibilities and lines of reporting. Messaging systems and informal discussions enabled clear communication. Staff hoped that formal meetings would be reintroduced in the near future to provide opportunity for more in depth update and reflective discussions. Maintaining minutes or a register would also be helpful to confirm staff have received key information.

All policies and procedures to support the effective running of the practice had been created within the last five weeks. However, some policies required a version number and personalising to the practice to ensure that templated documents were relevant and useful to the needs of the practice and that staff would access only the most up-to-date versions.

The practice should ensure that policies are sufficiently personalised and display clear version control.

Workforce

Skilled and enabled workforce

We reviewed the personnel information and training records which had not been lost to the practice.

Personnel information indicated that job descriptions, contracts and annual appraisals had previously been provided. However, appraisals were now due to be arranged and many of the job descriptions and contracts were old or had been updated multiple times and so required reissuing to ensure clarity for staff and that roles were aligned with the skill mix required at the practice.

The practice should ensure that:

- **All job descriptions and contracts are reviewed and reissued to ensure staff and practice needs and expectations are aligned**
- **Appraisals continue to be booked and completed on an annual basis going forward to ensure staff remain supported to fulfil and develop their role.**

We saw evidence of professional registration for clinical staff working at the practice. Due to Disclosure and Barring Service checks having been lost an application had recently been made for new checks for all clinical staff. Hepatitis B antibody evidence was also in the process of being collated. The recruitment policy indicated that any new offers of employment would be conditional on appropriate background checks and told that processes were in place to ensure registration and DBS checks would be refreshed for all clinical staff on a regular basis.

A suitable induction programme was in place to ensure any new employees and locums working at the practice were oriented to the environment and operational procedures. Proficiency to complete higher risk activities were also expected to be demonstrated through training and competency assessments and new starters would also undergo a period of probation to ensure they consolidated the skills and behaviours they required for their role within a defined timescale. Robust clinical supervision arrangements and a range of HR policies underpinned staff capability and performance. A supportive management approach, access to health board occupational health and an annual staff flu vaccination programme supported staff well-being.

Training records indicated that clinical practitioners had undergone a range of relevant clinical training and a matrix provided an overview of core training across the team. We were told that all staff completed resuscitation training and that some of the clinicians were also cascade trainers. However, records we saw of resuscitation training did not indicate this included anaphylaxis training. In addition, we saw that only some staff had completed safeguarding training to the required level for their role and that Duty of Candour training was not included in the core training programme.

The practice should confirm its core training requirements include appropriate anaphylaxis, safeguarding and Duty of Candour training and that training courses completed are fully compliant with expectations.

Culture

People engagement, feedback and learning

Patients were able to provide feedback in person or through the annual national patient experience survey and could raise formal complaints with the practice manager. Practice staff told us they preferred to resolve any concerns patients had at the time they were raised if possible. Listening to People: the NHS Wales concerns, complaints and redress framework (2026) leaflets were available to patients on the practice premises. However, we saw that the practice specific complaints policy displayed on the practice website needed updating to align with Listening to People and provide the current practice manager details as the named person for complaints handling. Our review of complaints handling records also indicated that the Listening to People process required embedding. We were told that complaints were discussed for learning within the practice team and themes formally reviewed on an annual basis. Displaying 'You said, we did' information would also raise the profile of practice feedback mechanisms and changes implemented in response to feedback received.

The practice should:

- **Review and update the practice complaints policy to ensure this provides current information to patients regarding making complaints and the complaints handling process**
- **Ensure processes aligned with Listening to People (2026) are embedded**
- **Consider mechanisms for providing patients with information regarding practice learning in response to feedback received. This could be via a 'You said, we did' board within the practice, a notice on the website, or other means.**

Information

Information governance and digital technology

We saw that a suitable data protection officer had been appointed and that a range of data protection and information governance policies were in place to protect confidential information. The practice privacy policy was available to patients to inform them of how data was processed, used and stored, and the right to access their individual patient record.

Learning, improvement and research

Quality improvement activities

We saw that there was a systematic audit plan in place but that this still required full implementation. Recent Chronic Kidney Disease and Cardiovascular Disease quality improvement projects had been completed. The Quality Assurance and Improvement Framework and enhanced service audits were completed in line with contractual requirements.

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
A large number of out of date scalpel blades, dressings, blood bottles and butterfly needles were found during our inspection.	Potential for healthcare acquired infection to occur through the use of expired items.	Concern discussed with senior staff.	Items removed from clinical areas and stocks. Agreed the practice would review what items are routinely used and how many to ensure appropriate reordering.

Appendix B – Immediate improvement plan

Service: **Park Surgery**

Date of inspection: **18 June 2026**

The table below includes any immediate non-compliance concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Findings	No immediate assurances were found on this inspection.

Appendix C – Improvement plan

Service: **Park Surgery**

Date of inspection: **18 June 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.	Three respondents to the HIW patient questionnaire strongly disagreed that they could talk to reception staff without being overheard.	The practice should ensure that patients are aware that the side room next to the reception area is available for private conversations and arrange for the self-check-in option to be reinstated.	Health and Care Standards (2023) – Person-centred	The practice will promote the availability of the private consultation room through clear signage at reception and staff reminders to patients when discussing confidential matters. The self-check-in system will be reinstated to reduce the need for patients to verbally provide personal information at the reception desk. Reception staff have received a reminder of their responsibility to offer a private space	Practice Manager	Completed following inspection, with ongoing monitoring thereafter

				where confidentiality may be compromised. Compliance and patient feedback will be monitored through the practice patient survey and complaints process.		
2.	Mops were stored head down in buckets and the blue mop heads for use in general areas needed replacing.	The practice should ensure that all mops are suitably stored and maintained.	Health and Care Standards (2023) – Safe	The practice has reviewed its cleaning equipment storage arrangements. All mops will be stored correctly to allow them to dry effectively and reduce the risk of contamination. Worn blue mop heads have been replaced and a system implemented to routinely inspect cleaning equipment and replace items when required. Cleaner has been reminded of the correct storage and maintenance requirements for	Practice Manager & Office Manager	Completed following inspection, with ongoing monitoring thereafter

				cleaning equipment, and compliance will be monitored through regular infection prevention and control checks.		
3.	A waste management policy was not available and other policies and procedures relevant to IPC required updating to ensure all relevant details were contained.	All policies and procedures relevant to Infection Prevention and Control to be in place and include all required details: • Waste management policy to be in place and available to staff • Guidance on decontamination within the IPC policy to be expanded • Blood borne virus and needlestick policies to include details of who staff should contact should a needlestick injury or other	Health and Care Standards (2023) – Safe	The practice has undertaken a review of its Infection Prevention and Control (IPC) policies and procedures. A Waste Management Policy has been developed and made available to staff. The IPC policy is being updated to include expanded guidance on decontamination processes, and the Blood Borne Virus and Needlestick Injury policies are being revised to provide clear guidance on reporting arrangements, escalation procedures and appropriate contacts following an exposure incident. A	Practice Manager	Review and update of all IPC policies to be completed by 31 October 2026, with ongoing review and monitoring thereafter.

		transmission hazard occur • Flow chart to be included within the needlestick policy and displayed in relevant clinical areas.		needlestick injury flowchart will be incorporated into the policy and displayed in relevant clinical areas to support staff awareness and prompt action. A policy review schedule has been implemented to ensure IPC documentation remains current and compliant with relevant guidance.		
4.	No clinical waste audit available.	Clinical waste audit to be completed.	Health and Care Standards (2023) – Safe	The practice has reviewed its arrangements for the management of clinical waste and has implemented a clinical waste audit process to assess compliance with waste segregation, storage and disposal requirements. Findings from the audit will be reviewed through the practice governance process, with any	Practice Manager	Clinical waste audit to be completed by 31 October 2026, with ongoing audit and monitoring thereafter.

				actions identified implemented and monitored to support ongoing compliance and continuous improvement.		
5.	No hand sanitiser available for patient use on arrival or elsewhere within the practice.	Hand sanitising facilities are available to both staff and patients within the practice environment.	Health and Care Standards (2023) – Safe	Pump-action hand sanitiser bottles have been made more visible at the reception area and other appropriate locations throughout the practice to support effective infection prevention and control. Regular checks have been incorporated into the cleaning schedule to ensure supplies remain stocked and readily available for staff and patients.	Practice Manager	Completed immediately, with ongoing weekly monitoring
6.	The management of the clinical fridge could be improved.	The practice should review the robustness and sufficiency of their	Health and Care Standards (2023) – Safe	The practice has reviewed its procedures for the storage and monitoring	Practice Manager & Lead Nurse	Procedure review and staff briefing completed by 30

		processes in relation to refrigerated medications.		of refrigerated medicines. Clinical fridge temperature monitoring processes have been strengthened to ensure temperatures are recorded consistently and reviewed promptly. Staff responsible for vaccine and medication management have been reminded of the practice's cold chain requirements, including the escalation process for temperature excursions. Regular audits of temperature records and fridge contents will be undertaken to ensure ongoing compliance and the safe storage of medicines.		September 2026, with ongoing monthly audit and monitoring.

7.	Emergency drugs and equipment were only being checked monthly which is not in line with Resuscitation Council UK guidelines. Ambu bags needed replacing. Oxygen cylinder specific training was required. We also recommend the practice reconsider the location and storage of emergency drugs and equipment.	The practice should strengthen their processes with respect to ensuring that suitable emergency drugs and equipment remain available and ready for use.	Health and Care Standards (2023) – Safe	The practice has reviewed and strengthened its arrangements for the management of emergency drugs and equipment. Emergency drugs and equipment are now checked weekly, with records maintained to demonstrate compliance. Ambu bags have been replaced and staff have completed oxygen cylinder training. Following the inspection, the practice clarified that oxygen cylinders were already available in both Room 9 and Room 10 and this information has been fed back to HIW. The location and storage of emergency drugs and equipment have been reviewed to ensure they are readily	Practice Manager / Lead Practice Nurse	Completed following inspection. Ongoing weekly checks and regular audit monitoring in place.

				accessible in an emergency. Regular audits will be undertaken to ensure equipment remains in date, fully stocked and ready for use.		
8.	Two Patient Group Directions (PGDs) for vaccinations were out of date.	All PGDs used at the practice to be the most up-to-date versions.	Health and Care Standards (2023) – Safe	The practice reviewed all Patient Group Directions (PGDs) immediately following the inspection. The two out-of-date PGDs were replaced with the current authorised versions, and checks were undertaken to confirm that all PGDs in use across the practice were valid and up to date. A process has been implemented to routinely review PGD expiry dates and update documentation as required to ensure ongoing compliance.	Lead Practice Nurse / Practice Manager	Actioned immediately following inspection, with ongoing monitoring and review of PGD expiry dates.
9.	Prescription pads and forms could be more	The practice should consider their processes	Health and Care Standards (2023) – Safe	The practice has reviewed and	Practice Manager	Actioned following

	robustly tracked from entry to the practice to use for increased prescription security.	for tracking prescription forms and pads from initial entry to the practice.		strengthened its procedures for the management and tracking of prescription forms and pads. A centralised log has been implemented to record the receipt, storage, allocation and use of prescription stationery, providing a clear audit trail from entry into the practice through to use. Prescription pads and forms are stored securely, with regular checks undertaken to ensure stock is accounted for and any discrepancies are identified and investigated promptly.		inspection, with ongoing monitoring and regular audit of prescription stationery records
10.	Patient records reviewed were generally considered of good quality. Summarising and coding were	The practice should consider these findings and formal mechanisms to provide data entry quality assurance on an	Health and Care Standards (2023) – Safe	The practice has reviewed the findings from the records audit and discussed the identified omissions with relevant staff to	Practice Manager / Clinical Lead	Actioned following inspection, with ongoing regular audits and quality

	appropriately delegated. However, two omissions in data entry were found and no formal system of data entry quality assurance was in place.	on-going basis.		reinforce the importance of accurate and complete data entry. A formal quality assurance process has been introduced, including regular spot checks and audits of summarising, coding and data entry to monitor accuracy and identify learning opportunities. Findings will be reviewed through our governance processes to support continuous improvement and maintain high standards of record keeping.		assurance monitoring.
11.	Some policies required a version number and personalising to the practice to ensure that templated documents were relevant and useful	Policies to be sufficiently personalised and display clear version control.	Health and Care Standards (2023) – Safe	The practice has reviewed its policy folder and updated policies to ensure they are appropriately personalised to reflect local processes and	Practice Manager	Review commenced following inspection and due for completion by 30 September

	to the needs of the practice and that staff would access only the most up-to-date versions.			practice arrangements. Clear version dates and have been added to relevant documents to ensure staff can easily identify the most current version. A document review schedule has also been implemented to support the ongoing maintenance and review of policies and procedures.		2026, with ongoing policy review and version control monitoring thereafter.
12.	Appraisals were due to be arranged and many of the staff job descriptions and contracts were old or had been updated multiple times and so required reissuing.	The practice should ensure that: • All job descriptions and contracts are reviewed and reissued to ensure staff and practice needs and expectations are aligned • Appraisals continue to be booked and	Health and Care Standards (2023) – Effective	Following a period of staffing changes and organisational challenges, the practice has commenced a review of all staff employment documentation. Job descriptions and contracts will be reviewed, updated where required and reissued to ensure they accurately reflect current roles, responsibilities and	Practice Manager	Review of contracts and job descriptions to be completed by 31 December 2026. Staff appraisals to be completed and maintained through an ongoing annual appraisal programme

		completed on an annual basis going forward to ensure staff remain supported to fulfil and develop their role.		practice expectations. A programme of staff appraisals has also been implemented, with appraisals being scheduled and completed to support staff development, wellbeing and performance. An annual appraisal cycle and document review process will be maintained going forward.		
13.	Records of core training did not indicate that resuscitation training included anaphylaxis. Only some staff had completed safeguarding training to the required level for their role. Duty of Candour training was not included in the core training programme.	The practice should confirm its core training requirements include appropriate anaphylaxis, safeguarding and Duty of Candour training and that training courses completed are fully compliant with expectations.	Health and Care Standards (2023) – Safe	Following a period of staffing changes and organisational challenges, the practice has undertaken a review of its training records and core training requirements. At the time of inspection, some supporting evidence was not readily available to demonstrate compliance with all training requirements.	Practice Manager	Training matrix review completed following inspection, with any outstanding training to be completed by 31 December 2026 and ongoing compliance monitoring thereafter.

				The practice has since reviewed its training matrix to ensure that mandatory training aligns with current regulatory and professional requirements. Resuscitation training records have been reviewed to confirm inclusion of anaphylaxis management, safeguarding training requirements have been identified according to staff roles and responsibilities, and Duty of Candour training has been incorporated into the core training programme. A training compliance monitoring process has been implemented to ensure all staff complete and maintain the required level of training, and that accurate, accessible		

				training records are retained and available for review.		
14.	The practice complaints policy required some updates and Listening to People (2026) needed fully embedding. There was also no 'You said, we did' information available to patients.	• Practice complaints policy to be reviewed and updated to ensure this provides current information to patients regarding making complaints and the complaints handling process • Processes aligned with Listening to People (2026) to be embedded • Mechanisms for providing patients with information regarding practice learning in response to feedback received to be considered.	Health and Care Standards (2023) – Effective	The practice has reviewed its complaints policy to ensure it reflects current guidance and provides patients with clear information regarding how to raise concerns and the complaints handling process. As Listening to People (2026) had only recently come into force prior to the inspection, the practice has reviewed its existing processes and is embedding the requirements of the new regulations into its complaints and patient feedback procedures. A 'You Said, We Did' approach has been introduced to demonstrate how patient feedback is used to inform service	Practice Manager	Updated complaints policy and implementation of 'You Said, We Did' communications by 30 September 2026, with ongoing embedding, monitoring and review thereafter.

				improvements and learning. Patient feedback, complaints and lessons learned will continue to be reviewed through the practice governance process to support continuous improvement.		

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

Service representative:

Name (print): Rachel Hazell

Job role: Practice Manager **Date: 17th August 2026**