

General Practice Inspection Report (Announced)

Amman Tawe Partnership - Gwaun
Cae Gurwen, Swansea Bay
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 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 Vision

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

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 Amman Tawe Partnership – Gwaun Cae Gurwen Practice, Swansea Bay University Health Board on 02 June 2026.

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

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of 531 questionnaires were completed by patients or their carers and 13 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:

Patient feedback from the Healthcare Inspectorate Wales (HIW) patient questionnaire responses indicated some negative experiences of the service, with concerns raised about timely access to care, appointment availability, continuity of care and communication. We received 531 questionnaire responses from patients and carers, with concerns raised about telephone and online access, appointment availability, continuity of care, involvement in decisions and the suitability of appointment types offered. Just over half (278/527) of respondents were satisfied with opening hours, most respondents reported difficulty contacting the practice when needed and accessing both urgent same-day and routine appointments. Patients with ongoing medical conditions also reported difficulty accessing regular support.

The practice operated in the context of wider pressures on GP services and had taken some steps to support access, including use of a triage-first model, care navigation processes and additional staff recruitment. While this helped the practice manage demand across its sites, many patients were dissatisfied with the appointment type offered and reported that they were not given a choice. Some patients also raised concerns about not being offered face-to-face appointments when they felt this was needed, including ongoing health concerns. Some respondents described feeling dismissed, not listened to, or not given enough time to explain their health needs. Some comments described poor individual experiences with clinicians. While some positive comments were made about nursing staff and individual clinicians, the overall patient experience survey results were poor, with most respondents rating the service as poor or very poor.

We found some positive arrangements to support patient dignity, privacy and communication. Clinical rooms provided appropriate privacy, telephone calls were answered away from the main reception area, and chaperone information was clearly advertised. The practice also used a range of methods to communicate with patients, including its website, social media, a surgery app and waiting room posters. Welsh language arrangements were in place, with bilingual signage, access to Welsh language training and staff wearing “Iaith Gwaith” badges. However, some patient feedback identified concerns about being overheard at reception, limited awareness of complaints processes, and inconsistent access to information for people who did not use digital services.

The practice provided health promotion information through consultations, its website, printed resources, text messages and displays in the waiting area. It also worked with

wider services and the cluster to support prevention and health promotion. However, some waiting room information was outdated, not specific to Wales, or linked to non-functioning QR codes. Information available in the waiting area did not fully reflect the more comprehensive information on the practice website, which may disadvantage patients without digital access.

Immediate assurances:

- The disabled toilet did not have an emergency pull cord fitted.

This is what we recommend the service can improve:

- Timely and equitable access to GP services
- Appointment choice and appropriate access to face-to-face and pre-bookable appointments
- Patient communication and involvement in care
- Visibility and accessibility of patient information.

This is what the service did well:

- Nurse-led care and support
- Protecting privacy and dignity during clinical care
- Supporting health promotion and wider community links.

Delivery of Safe and Effective Care

Overall summary:

Overall, we found that the practice had a number of established systems and processes to support safe and effective care, alongside several areas where further strengthening and consistency were required.

The practice maintained a clean and generally well-maintained environment, with staff demonstrating awareness of risk management, infection prevention and control, and safeguarding responsibilities. There were positive arrangements in place for business continuity planning, patient safety alerts, multidisciplinary safeguarding working and internal communication, which supported coordinated and effective care delivery. We also found that patient records were generally clear, up to date and appropriately coded. Effective referral-management arrangements were in place, including administrative follow-up within two weeks of an urgent suspected cancer referral to confirm that the patient had been offered an appointment. We identified this as noteworthy practice.

However, we identified several areas where safety governance needed to be strengthened. Some issues were addressed during the inspection or through our immediate assurance process, including concerns relating to vaccine fridge storage. We also found expired items in clinical areas, an unsecured oxygen cylinder, incomplete recording of medical device checks, and no ambient room temperature monitoring for medicines storage.

Infection prevention and control arrangements were supported by appropriate policies, an appointed lead and available hand hygiene products. However, some improvements were required.

Safeguarding arrangements were in place, and staff knew who the safeguarding lead was. Staff had completed safeguarding training appropriate to their roles, and we saw evidence of multi-agency working. However, safeguarding policies needed to be strengthened to include clearer referral routes, escalation processes, local contact details and coding guidance. The practice also needed to review child protection coding, as some adult patients remained coded as being on the child protection register after their circumstances had changed.

The practice had processes to support effective care, including arrangements for referrals, test results, secondary care correspondence, clinical meetings, locum induction and mortality review. Patient records were generally clear, up to date and contemporaneous, and chronic disease reviews were taking place for key long-term conditions. However, documentation varied, and in one remote consultation the record did not clearly explain why a face-to-face examination was not considered necessary or fully document the rationale for the investigation requested.

Immediate assurances:

- Some emergency equipment items and medications were expired
- Emergency equipment and medication were stored in a frequently used clinical nursing room.

This is what we recommend the service can improve:

- Medicines management and equipment checks
- Aspects of infection prevention and control
- Strengthen governance and oversight processes.

This is what the service did well:

- Positive approach to multidisciplinary working
- Sharing key information with staff
- Follow-up arrangements for urgent suspected cancer referrals.

Quality of Management and Leadership

Overall summary:

We found that the practice had generally effective leadership and governance arrangements in place. Staff described leaders as visible, approachable and supportive, and there were clear reporting lines and designated leads for key areas including safeguarding, infection prevention and control, complaints and nursing leadership. The practice held regular meetings, including clinical, management, teaching, palliative care and complaints meetings, which helped support communication, oversight and shared learning across the team.

Staff feedback was generally positive. Thirteen staff members responded to the HIW staff questionnaire, and all reported that they had received appropriate training and an appraisal or development review within the last 12 months. Staff were positive about access to equipment, supplies, ICT systems and the skill mix within the practice. They also reported positively on safeguarding, incident reporting and patient safety. However, when asked, some respondents noted potential areas for the practice to strengthen including staffing levels, involvement in decisions that affected their work, awareness of carer support, occupational health and wellbeing support.

The practice had appropriate recruitment, induction, appraisal, professional registration and indemnity arrangements in place. There was evidence that staff roles were aligned to their skills and scope of practice, and the practice supported staff development and upskilling. However, improvements were needed to ensure pre-employment health screening was consistently completed, and annual DBS self-declarations were considered.

The practice had positive systems for engagement, feedback and learning. A Patient Liaison Officer was in post, complaints and concerns were monitored, and the practice was working within the NHS “Listening to People” process. Complaints were reviewed at monthly meetings, learning was identified and shared, and a “You said, we did” section was available on the website. Staff told us they felt able to speak up, share ideas and raise concerns. However, Duty of Candour training was not consistently completed in the training records reviewed.

The practice had information governance arrangements in place, including an up-to-date policy and a data protection officer. GP activity data was reported monthly, and required data and notifications were submitted to external bodies. The practice also engaged in quality improvement through complaints learning, peer networks, cluster meetings and audit activity.

This is what we recommend the service can improve:

- Aspects of training completion and staff awareness
- Workforce governance checks, such as workforce pre-employment health screening
- Audit planning.

This is what the service did well:

- Visible and supportive leadership
- Structured communication and meeting arrangements
- Staff development and upskilling
- Positive and open culture

Details of the concerns for patients' safety and the immediate improvements and remedial action required are provided in [Appendix B](#).

3. What we found

Quality of Patient Experience

Patient feedback (from HIW questionnaire)

Healthcare Inspectorate Wales reviewed patient feedback collected through a patient questionnaire issued to assess experiences at Amman Tawe Partnership – Gwaun Cae Gurwen. In total, 531 responses were received, showing a predominantly negative patient experience, particularly in relation to access, appointment availability, continuity of care and patient involvement in decisions.

While just over half of respondents (278/527) were satisfied with the practice opening hours, 72% (378/525) disagreed that they could contact the practice when needed by telephone or online. Access to appointments was a significant concern, with 85% (449/529) disagreeing that they could obtain a same-day urgent GP appointment and 85% (449/529) disagreeing that they could access routine appointments when needed. Among patients with ongoing medical conditions, 79% (420/530) said they could not access regular support easily.

Responses about appointment type also showed dissatisfaction. 31% (162/530) of respondents said they were offered a choice of appointment type, and 72% (378/525) were not content with the appointment type offered. Patient responses to the survey confirmed that most appointments were delivered by telephone, accounting for 68% (361/531) of responses, compared with 31% (165/531) in person. Among respondents, telephone appointments were reported more often than in-person appointments, and many respondents were dissatisfied with the appointment type offered. Many respondents also reported poor experiences during appointments, with 64% (339/529) disagreeing that their appointment was on time and 60% (319/531) disagreeing that they were given enough time to explain their health needs.

Reported patient experience of care was also poor overall. Only 26% (131/526) agreed that the GP explained things well and answered questions, while 67% (351/526) disagreed. Similarly, 73% (383/527) disagreed that they felt listened to, and 67% (353/527) disagreed that they were involved in decisions about their healthcare as much as they wanted to be. Although 38% (201/527) agreed that they were treated with dignity and respect, 56% (295/527) disagreed. Healthy lifestyle advice was also not consistently reported, with 58% (305/528) disagreeing that this was offered.

The responses on privacy, dignity and carer support identified further concerns. Of those who answered the environment and privacy questions, 83% disagreed that they could speak to reception staff without being overheard. More positively, 70% agreed that measures were taken to protect privacy during care, such as using curtains, cover-ups or private rooms. Questionnaire responses indicated a need for the practice to

review how carers were identified, informed and supported. Of the 141 respondents who self-identified as carers, 4% reported that they had been offered support, including information about relevant organisations or networks. The questionnaire did not establish whether individual respondents were recorded on the practice carers register.

The environment-related findings were more positive; these questions were answered by 167 respondents. Most respondents who answered agreed that the building was accessible, there were enough seats, toilet and handwashing facilities met their needs, and health promotion information was displayed. Cleanliness was also rated positively by 88% of respondents as clean.

Feedback and complaint awareness amongst patients could be further highlighted. 9% (47/527) of respondents said the practice had previously asked them about their experience of the service, excluding this questionnaire, and 64% (337/529) said they would not know how to complain about poor service.

When asked about the overall service received from this practice, 85% (450/528) of respondents rated the service as poor, with 15% (78/528) rating it as good. Equality responses also raised concern, with 73% saying they did not feel they could access the right healthcare at the right time regardless of protected characteristics. While 64% (326/508) of respondents said they had not faced discrimination, a notable minority reported discrimination related to age, disability, sex, pregnancy and maternity, race, sexual orientation or other reasons.

The survey findings indicate significant dissatisfaction with access, communication, involvement in care, feedback opportunities and perceived equity of access, alongside more positive findings about the physical environment and cleanliness from the smaller group who answered those questions.

Patient comments included:

"You can never get a face to face appointment with a GP"

"Unable to get same day appt for my child"

"Couldn't get an appointment. Was told to go to the hospital or pharmacist."

"Doctor wasn't interested in my concerns"

"Quite often you will be pushed to a nurse instead of a GP"

"Appointments are very difficult to obtain"

"I have found it very difficult to get timely help and proper follow-up when I have ongoing health concerns. I often feel that I am left to keep chasing for answers, rather than being supported through the process."

"One of the doctors is very rude and offensive, not helpful at all, I left in tears, never thought things like that could happen in a surgery."

“Nurse led diabetic care is very good.”

“Nurses were outstanding when helping me. Communication was constant and clear, they were empathetic and professional at all times.”

The practice should undertake a structured review of the HIW questionnaire findings, triangulating the feedback with complaints, access and appointment data, its own patient surveys and other relevant service information. It should develop a proportionate action plan addressing areas where the combined evidence identifies an opportunity or need for improvement, with clear responsible leads, timescales and arrangements for reporting progress to patients and staff. This should include:

- reviewing options and opportunities to improve the overall timely access to GP services and its appointment system
- reviewing feedback in relation to use of telephone consultations and ensuring patients are offered face-to-face appointments where examination, communication needs, complexity or patient preference indicate this is appropriate
- reminding clinical staff of the importance of listening to patients, explaining decisions clearly, answering questions and involving patients in decisions about their care.
- ensuring that patients are made aware through signage that conversations can be held in private, if requested
- reviewing how carers are identified, how the carers register is promoted, and how carers are offered or signposted to assessments and information about local support organisations
- improving visibility of the complaints process by displaying clear information in the waiting area and online
- reviewing access arrangements to ensure equitable access for all patients, including those with long-term conditions and vulnerable groups.

Person-Centred

Health promotion

The practice promoted healthy lifestyles through a range of patient contact points, including routine consultations, new patient health checks and chronic disease reviews. Staff told us that patients were provided with tailored advice during consultations and were directed to condition-specific information where relevant. This

included sharing links to patient information leaflets and websites, printing information during consultations, and sending information by text message where appropriate.

The practice also used its website to provide health promotion information and signposting to wider sources of support. We found that the website contained comprehensive information about services available to patients, including support provided through external organisations. The practice worked with Swansea Bay University Health Board to support patients at risk of developing diabetes through access to pre-diabetes services.

Health promotion information was also displayed within the practice. This included posters in the waiting area and information shown on a television screen. The content displayed varied depending on seasonal campaigns and public health priorities. However, we found that some information displayed on the waiting room screen was not relevant to patients in Wales and some information was out of date. For example, bowel screening information displayed on the screen stated that the programme applied to people aged 60 to 75. This is not consistent with current Welsh guidance, which states that bowel screening is offered every two years to people aged 50 to 74 who are registered with a GP in Wales.

We also found that some information displayed on the screen linked to England-specific websites and included outdated COVID-19 information. The content observed on the waiting-room screen during the period reviewed by inspectors was in English only. The practice subsequently confirmed to us that some Welsh-language material formed part of the wider television reel.

The practice should:

- **Ensure that relevant patient information displayed on the waiting-room screen is current, applicable to Wales and made available bilingually with sufficient frequency and prominence**
- **Remove or update outdated COVID-19 information and links to England-specific resources where these are not applicable to patients in Wales.**

We reviewed the use of QR codes on posters displayed in the waiting room. QR codes on the Hywel Dda poster were functioning correctly and linked to the intended information. However, the QR codes on the large poster displayed next to reception mostly did not work. This limited the effectiveness of the poster as a health promotion resource and may prevent patients from accessing relevant information or support.

The practice had processes to support access for older people and patients without digital access. Patients could attend reception in person, contact the practice by telephone, and access information displayed in the waiting room. However, we found that the information available in the waiting room did not fully reflect the comprehensive information available on the practice website.

The practice should:

- **check all QR codes and links displayed on posters in the waiting room and update or replace any broken links to ensure they are functioning correctly**
- **ensure that patients have access to a reasonable range of relevant information in the waiting room, particularly those who are unable to access information through the practice website.**

The practice had arrangements in place to promote seasonal vaccination programmes. Staff told us there was a nominated lead for vaccinations. Eligible patients were contacted through a range of methods, including letters sent by the health board, text messages, push notifications through the surgery mobile application and follow-up letters to patients who had not responded. This was positive as it helped ensure that older people and patients without digital access were informed about vaccination opportunities.

The practice and wider cluster worked with a range of services and agencies to improve access, prevent disease and promote health. These included public health screening programmes, flu, COVID-19, RSV and shingles vaccination programmes, the Jac Lewis Foundation, social prescribing services, cluster pharmacy support, physiotherapy through Swansea Bay University Health Board, Mind mental health services and frailty support. The practice also funded and employed two frailty and palliative-care nurses to support older and housebound patients and local care homes. Staff told us that a spirometry machine had been purchased to bring spirometry testing back into the practice, supported by the practice respiratory nurse.

Staff told us there was a process in place for managing patients who did not attend appointments, and that the practice monitored instances where patients did not attend hospital appointments.

Dignified and respectful care

We found that the practice had suitable arrangements in place to support patients' dignity, privacy and confidentiality.

Clinical rooms provided appropriate levels of privacy for patients. Doors were kept closed during consultations, privacy curtains were available in examination rooms, and external windows had appropriate coverings. The clinical rooms were also located separately from the reception desk and waiting area, which helped to reduce the risk of conversations being overheard and supported patient confidentiality.

The practice had taken steps to maintain confidentiality of telephone calls at reception. Telephones were answered away from the main reception area, which helped prevent patients in the waiting area from overhearing confidential discussions. This

demonstrated a positive approach to protecting patient privacy.

The practice offered both male and female chaperones. Information about the chaperone service was clearly advertised to patients in an accessible manner. The practice also had an up-to-date chaperone policy available. Staff told us that chaperone training was completed in-house, and chaperone-related entries were included within the practice training matrix. However, the evidence reviewed did not provide consistent assurance that all relevant staff acting as chaperones had completed appropriate training.

The practice should ensure that all staff acting as chaperones receive appropriate training and that completion of this training is recorded, monitored and refreshed at suitable intervals.

We reviewed a selection of patient records and found that clinicians recorded verbal consent for intimate examinations. Records also documented whether a chaperone had been offered and whether this had been accepted or declined by the patient.

Timely

Timely care

The practice told us they had a range of processes in place to support patients to access care through an appropriate route and with an appropriate member of the team. Information about appointment options and available services was clearly set out on the practice website, and this provided useful guidance for patients about how to access care and advice. However, there was limited information available in the waiting area.

The practice gathered patient feedback through an annual patient survey, with the results published on its website. A total of 265 responses were received. Staff told us this was advertised through social media, the practice website and paper copies, which helped include patients who did not have digital access. We saw that the website included a complaints and concerns link and a “You said, we did” page.

The practice had routes through which patients could provide comments or feedback, including a general practice email address and a comment or appreciation form. However, these were not clearly promoted as a general feedback or suggestions mechanism in the waiting area. Inspectors did not see a dedicated feedback or suggestions box. We did not observe ‘You said, we did’ information during the period in which the waiting-room television display was reviewed. The practice subsequently confirmed that this information formed part of the wider television reel.

The practice should improve the visibility and accessibility of its existing feedback

arrangements by clearly promoting how patients can provide general feedback or suggestions, considering whether an additional accessible mechanism is needed in the waiting area, and ensuring that ‘You said, we did’ information is sufficiently prominent and regularly visible to patients.

Staff told us that measures had been taken to improve access, including the recruitment of additional staff and a desire to participate in an extended-hours service. Extended opening hours at local branch surgery had also been increased to support capacity across the partnership. Practice activity data across multiple months indicated a poor level of call answering, although at the time of the inspection there were no calls waiting. We noted that the number of abandoned calls was high; however, there was uncertainty about whether this data included patients selecting options to request a call back rather than waiting on the line.

The practice should review how telephone data is collected and interpreted to ensure it has an accurate understanding of telephone access and patient experience.

Reception staff and care navigators had clear pathways to support patients to access the right service. We saw the care navigation pathway, and the reception signposting and appointment allocation protocol was available. Staff told us that nationally recognised care navigation training was completed as part of induction. There were also opportunities for non-clinical staff to speak with clinical staff if they were unsure about the most appropriate option for a patient. Care navigators did not undertake clinical triage. Following the inspection, the practice provided evidence of a Clinical Buddy system, through which reception and care-navigation staff could obtain clinical advice to support appropriate signposting and routing. Where a patient required clinical input, they were added to a clinical list and GPs triaged their own lists.

Staff told us that vulnerable patients, including frail older people, children, adults at risk and patients with cognitive or communication difficulties, would be placed directly into an appointment where needed. A pop-up alert on the clinical system was used to identify vulnerable patients. Older people and patients without digital access were able to contact the practice by telephone or attend the surgery in person to arrange a suitable appointment.

The practice operated predominantly a “triage first” model. Staff told us there were usually two to three GPs working across three practice sites, depending on which sites were open on the day. This was reportedly increasing due to successful GP recruitment and was further supported by Advanced Nurse Practitioners and the wider multidisciplinary team. Pre-bookable appointments were available and patients could request a face-to-face review for pre-booked appointments. For urgent or same-day requests, calls were discussed with a GP or Advanced Nurse Practitioner, with capacity to convert to face-to-face appointments, when required. Staff told us that patient preference was considered alongside clinical need, although the evidence reviewed

suggested that most GP contacts were undertaken by telephone.

The practice had arrangements in place to support patients presenting with poor mental health or in mental health crisis. Patients could contact the practice by telephone or online, according to urgency and preference. Clinical staff told us the decision to see a patient face to face was based on clinical need. Where referral to secondary mental health services was required, staff told us the GP or clinician made the referral and arranged follow-up according to clinical concern. While patients were waiting for acceptance or treatment by secondary care services, staff told us they were signposted to other support services and advised contacting the practice if their condition changed or worsened. The practice also used a range of health board and third-sector mental health support services according to patient need and preference.

Equitable

Communicating and language

The practice used a range of methods to communicate information about the services it offered to patients. Information was provided through the practice website, social media platforms, the surgery mobile application and posters displayed in the waiting area. Important changes to the practice were communicated via website banners, social media updates, the surgery application and posters in the waiting room.

For patients who were older or did not have digital access, information about services and changes to the practice was primarily communicated through posters in the waiting area. Staff told us that letters were sent to housebound patients, and that palliative care and frailty nurses working in the community also shared relevant information with patients during their visits.

The practice had an up-to-date patient consent policy available. Telephone calls were recorded, and patients were informed of this through an automated message when calling the practice. Staff told us that call recordings were stored securely in the cloud with password protection to reduce the risk of unauthorised access.

The practice had arrangements in place to meet the needs of Welsh-speaking patients. Staff were aware of, and supported to deliver, the Active Offer. Staff understood the importance of communicating with patients in their preferred language within a healthcare setting. Welsh language training was available through the health board, and language requirements were considered as part of recruitment and workforce planning, including the option for interviews to be conducted in Welsh. We saw bilingual signs and posters available in the practice. We also saw staff wearing “Iaith Gwaith” badges to show patients, staff and visitors that they spoke Welsh.

Rights and equality

We found that the practice promoted equality and diversity through an up-to-date equality policy. Staff had access to relevant training resources, including the Equality, Diversity and Inclusion (EDI) “Treat Me Fairly” programme. The practice maintained a training matrix and many staff had completed equality and diversity training. However, the sample reviewed identified incomplete or out-of-date equality and diversity training for some staff. Autism-awareness training was not evidenced in the sampled records, and learning-disability training had not yet been incorporated consistently into the practice training programme.

The practice should review the rights and equality training required for each staff group, ensure that relevant equality and diversity, autism-awareness and learning-disability training is completed, and maintain accurate records for monitoring and renewal.

The practice had measures in place to support accessibility for patients. A wheelchair ramp was available at the rear of the building to provide access to a treatment room. The practice also had a nappy changing area, a disabled toilet, a hearing loop and access to translation services. However, we identified some areas where accessibility could be improved. The front entrance door was not automated, which may make access more difficult for patients using wheelchairs, patients with limited mobility, or patients attending with children in pushchairs. Reception staff had a direct line of sight towards the entrance, and the practice told us that staff provided assistance where required. However, some patients may still require staff support to enter the building. We also found that the double doors between the waiting room and consulting rooms were narrow when only one door was opened. Both doors needed to be opened to allow sufficient space for patients using wheelchairs, walking aids or crutches to pass through safely and comfortably.

The practice should review the physical accessibility of the premises to identify and address barriers to improve accessibility for all patients.

We found that the disabled toilet did not have an emergency call bell. This was addressed under our immediate assurance process, as described in [Appendix B](#).

Staff described examples of reasonable adjustments being made for patients who required them. Patients with a learning disability were offered double appointments to allow additional time. Staff also told us that neurodivergent patients could be offered appointments at quieter times, where this would better meet their needs.

The practice had arrangements in place to uphold the rights of transgender patients. Staff told us the practice had signed up to provide enhanced transgender services. Desired pronouns were documented on the clinical system, and staff described an approach based on dignity and respect.

Delivery of Safe and Effective Care

Safe

Risk management

The practice premises, including the clinical rooms, were clean, tidy and free from clutter. The building was generally in a good state of repair. However, some areas of paintwork appeared tired and required renewal. We also found a screw protruding through the tiles above the sink in the male toilet located near the waiting area.

The practice should:

- **aim to refresh tired paintwork within the premises where required**
- **remove or make safe the protruding screw above the sink in the male toilet near the waiting area.**

The practice had an up-to-date Business Continuity Plan in place, which was available to all staff. The plan adequately covered business partnership risks and included arrangements for responding to a significant health emergency.

The management team were aware of the sustainability framework and linked escalation levels. Staff told us that the practice manager completed related actions and received relevant email communications, with the senior management team also having access.

The practice had a dedicated member of staff responsible for receiving patient safety alerts. Several staff had access to the alerts system, which provided cover in the event of absence and reduced the risk of alerts being missed.

The practice had arrangements in place to review and discuss significant events, including patient safety incidents. The significant-event process recorded identified learning, actions and responsible persons. However, it did not include a documented later review confirming that actions had been completed and that identified improvements had been implemented and embedded.

The practice should strengthen its existing significant-event process by introducing a documented follow-up review to confirm that agreed actions have been completed and that identified improvements have been implemented and embedded.

The practice had an induction process in place for new and locum staff. There was also a mechanism for staff to obtain urgent help within the practice if required. Staff knew where to locate emergency drugs and equipment and how to access the area where these were stored. The practice also had an up-to-date risk assessment relating to home visits.

Infection prevention and control (IPC) and decontamination

The practice had an appointed infection prevention and control lead in place. Staff told us they understood their roles and responsibilities in upholding infection prevention and control standards. The practice also had a site-specific Infection Prevention and Control Policy, an up-to-date blood-borne virus policy and an up-to-date needlestick and sharps policy.

The practice had appropriate waste management procedures in place, including a waste management policy covering the safe disposal, transport and collection of healthcare waste.

We found that soap and hand gel were available, and clinical couches and equipment were wipeable. Disposable curtains were in use, were dated, and appeared clean. However, elbow-operated taps were not available in every clinical room. We also found plugs in handwashing sinks.

The practice must:

- **review and update hand wash facilities within a reasonable timeframe and where feasible to ensure compliance with current infection prevention standards**
- **remove any plugs to ensure they function as dedicated hand hygiene sinks.**

Cleaning schedules were available for all areas of the practice. However, we did not see signed checklists to confirm when cleaning had been completed.

The practice should introduce signed cleaning checklists to provide assurance that cleaning is completed consistently and in line with the schedule.

A completed infection prevention and control audit was not provided to or reviewed by the inspection team during the inspection. The practice subsequently supplied an audit dated and signed on 25 May 2026, confirming that an audit had been completed before the inspection.

Relevant clinical staff had received Hepatitis B immunisations. Needlestick posters were displayed in consulting and treatment rooms, providing limited guidance for staff in the event of a sharps injury.

The practice should update needlestick injury posters to include who staff should report incidents to and where staff should attend for urgent advice or treatment, including relevant telephone numbers and addresses, such as the local emergency department.

Medicines management

The practice had arrangements in place to support the safe management of medicines and prescribing. Prescription pads were stored securely. There was an audit trail in place for prescription pads, including records of when they were collected and by whom. However, the practice did not maintain a log for boxes of prescription stationery.

The practice should introduce a log for boxes of prescription stationery to provide a clear audit trail and strengthen prescription security.

The practice had an up-to-date prescribing policy and a process in place for managing repeat prescriptions. However, when reviewing more than 20 patient records, we were unable to find evidence of recent, formal medication reviews, despite many patients being prescribed multiple medications.

The practice should ensure that formal medication reviews are undertaken at appropriate intervals and clearly documented, particularly for patients taking multiple medicines or with complex health needs.

Staff told us, and records reviewed, indicated that the cold chain for vaccines and immunisations was maintained. The practice had one dedicated vaccine refrigerator, which was locked and subject to daily temperature monitoring and annual calibration. However, we found that a urine sample was being stored in the vaccine refrigerator on a middle shelf, and that the fridge was overstocked and disorganised, with vaccines and drugs stored on the bottom shelf. This was not in line with the practice's Medicines Storage and Cold Chain Policy. These issues were addressed during the inspection, as described in [Appendix A](#).

The practice should consider whether an additional fridge is required to support safe storage, particularly where overstocking may block the fridge fan and affect temperature control.

The practice had a process in place for checking drugs, and checks were recorded in a log. Most drugs we reviewed were in date. However, we did not see a room thermometer to monitor ambient storage temperatures.

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

The practice had a process in place for checking emergency drugs and equipment, including the automated external defibrillator (AED). However, we found that some emergency equipment items and medications had expired. This was addressed as part of our immediate assurance process, as described in [Appendix B](#).

We found two oxygen cylinders at the practice: a large freestanding oxygen cylinder and a BOC CD integrated valve oxygen cylinder. The large cylinder was not secured, which presented a risk of falling over. Staff had also not received training on the use of the

BOC CD integrated valve oxygen cylinder.

The practice should:

- **secure the large oxygen cylinder to prevent it from falling over**
- **ensure relevant staff complete appropriate online training on the use of the BOC CD integrated valve oxygen cylinder.**

A defibrillator was available and ready for use. However, we noted that emergency equipment and medications were stored in a frequently used clinical nursing room that was also used for intimate examinations. This arrangement may have delayed access to emergency equipment and compromised patient dignity. This issue was addressed as part of the immediate assurance process, as described in [Appendix B](#).

The practice did not hold controlled drugs on site.

Safeguarding of children and adults

The practice had a nominated safeguarding lead in place, and staff confirmed they were aware of who this person was. The practice had up-to-date safeguarding policies for adults and for children and young persons. However, the safeguarding policy for adults did not include sufficiently detailed processes to guide staff on when to refer, who to refer to, or how to seek appropriate advice. The policy for children and young persons also lacked essential contact information and should be updated to reflect local safeguarding pathways.

The practice must ensure that the safeguarding policies are revised to include clear referral processes, escalation routes, local safeguarding pathways and essential contact information.

We saw evidence that child protection cases were being clinically coded. However, we found multiple adult patients remained coded as being on the child protection register and had not been removed when their circumstances changed.

The practice should introduce a formal process to regularly review child protection coding, update records appropriately and apply a specific clinical code to indicate when a child protection marker has been removed.

Children at risk and looked after children were appropriately clinically coded. However, we found that the safeguarding policy did not include a relevant code for a family member.

The practice should update the policy to include relevant safeguarding coding guidance, including coding for family members where appropriate.

The practice had a process in place to monitor accident and emergency attendance

and repeated missed appointments, including instances where a person did not attend or was not brought to an appointment. However, the description of this process should be added to the new workflow policy recommended earlier in this report, to ensure staff have clear and consistent guidance about how these concerns are identified, escalated and acted upon.

We saw evidence of multi-agency and multi-professional working to support safeguarding. This included regular multidisciplinary team meetings, which provided opportunities to share information, discuss concerns and coordinate support for patients at risk.

We reviewed staff training records and saw evidence that staff had completed safeguarding training at a level appropriate to their role.

Management of medical devices and equipment

The practice had some processes in place to support the safe use and management of medical devices and equipment. Staff told us the practice used single-use equipment wherever possible and did not use reusable equipment.

The practice had contracts in place for the servicing and maintenance of medical devices and equipment. Records showed that servicing had most recently been completed in March 2026. Medical devices and equipment seen during the inspection appeared clean, in good condition and in working order. Staff told us that responsibility for checking medical devices and equipment was shared, with staff checking items as they were used. However, we did not see formal records documenting that these checks had been completed.

The practice should maintain a formal record of checks of medical devices and equipment.

During the inspection, expired items were found in clinical areas that had not been removed from use. These included blood collection bottles, needles and swabs. The presence of expired items poses a potential risk to patient and staff safety, as such items may no longer be effective or safe for use.

The practice should review and strengthen the system in place for regularly checking and removing expired items from clinical areas to ensure that only in-date and safe equipment is available for use.

Effective

Effective care

Internal communication processes were in place to support effective information sharing among staff. Non-clinical messages were communicated through email and the use of Microsoft Teams for chat functions. Clinical messages were communicated through the clinical system and remained visible until they had been seen by the relevant staff member.

The practice had processes in place to manage incoming correspondence. Letters received by the practice, whether in paper or electronic form, were scanned, coded and forwarded to clinical staff for review. However, we did not see a workflow policy which clearly set out how correspondence should be delegated, which staff were responsible for different types of letters, which letters needed to be reviewed by a doctor, and which letters could be filed without further clinical action.

The practice should develop a written workflow policy to support consistent and safe management of incoming correspondence.

There was a process in place for managing and acting on information received from secondary care, including actions following hospital discharge. Staff told us that doctors reviewed all test results and tasked administrative staff with follow-up actions and contacting patients where needed. However, we did not see a formal process to ensure that tests requiring repetition or re-booking were monitored to confirm that appointments had been made or that tests had been completed.

The practice should strengthen and document its existing test-results and follow-up process to ensure that tests requiring repetition or re-booking are tracked through to booking and completion, with proportionate escalation where patients do not respond or attend.

For patients receiving end of life care, the practice had a process in place for notification of death and used NHS mail to share this information.

The practice had processes in place to keep staff informed of best practice, national guidance and professional updates. Staff told us that new information was received by the practice and then shared with relevant staff by email or Microsoft Teams. Information could also be raised during the twice daily meetings or at a weekly meeting. The practice also used a staff notice board to share important information.

The practice had several routes for keeping up to date with wider primary care developments. Staff attended local practice manager group meetings and GP collaborative meetings, which sometimes included external speakers. The practice also had membership of the Institute of General Practice Management group and used

Primary Care IT and practice manager social media groups to share and access information. Staff told us they were also exploring the use of artificial intelligence tools.

The practice had a process in place for reporting incidents. Staff told us that when an incident was identified, a form was completed, and the incident was investigated and discussed at a monthly meeting. National Institute for Health and Care Excellence (NICE) guidance was discussed at a weekly meeting when required, supporting awareness of updated clinical standards.

Processes were in place for urgent referrals, routine referrals and urgent suspected cancer referrals. Staff told us that once urgent suspected cancer referrals were made, administrative staff checked within two weeks to confirm that patients had been offered an appointment. **We identified this as noteworthy practice.**

Referral activity was reviewed at management meetings, where monthly figures were compared. Where referral rates appeared higher or lower than expected, these were discussed with clinicians and, where appropriate, taken to clinical meetings to explore potential reasons.

Sessional and locum GPs were supported to understand referral processes through a national referral framework, information included in the locum induction pack and a structured induction, including a meeting with a member of the senior management team.

The practice had arrangements in place to review deaths in the community and in hospital where there was a primary care element. Care home deaths were discussed with the palliative care nurse at weekly meetings. Where concerns were identified, the significant event process was followed.

There was a clear process for ordering tests and relaying results to patients. Results were communicated face to face or by telephone, which supported access for older patients and those without digital access. The practice also had an established process to ensure that test results were followed up and communicated when the requesting clinician was not available.

The practice had arrangements in place to respond appropriately when patients contacted the practice in relation to emergency care rather than calling 999. A recorded telephone message advised patients to call 999 in the event of a medical emergency. Staff told us that callers were asked about symptoms such as chest pain, and where shortness of breath was identified, patients were advised to contact emergency services. A review of training records showed that staff had completed resuscitation training.

Patient records

We reviewed a sample of patient records and found that entries were generally clear, logical and possible to follow. The records were mostly contemporaneous, up to date and included appropriate clinical coding, particularly given the recent change in the clinical system. Overall, the quality of patient records was satisfactory, and the information recorded would generally allow a clinician unfamiliar with the practice to understand and safely use the records when providing care. However, the level of narrative detail varied. Some entries were concise and lacked context, for instance where a clinician unfamiliar with the patient may need to understand the reasoning behind clinical decisions.

We reviewed a patient record in which a GP requested an X-ray following a remote consultation without undertaking a face-to-face assessment. Based on the information available, the inspection team did not identify concerns regarding the clinical appropriateness of the decision to request the investigation. However, the team recognised that remote consultations may not be suitable for all clinical presentations and may present a risk that relevant clinical signs are not identified where a physical examination is not undertaken. The record did not clearly document why a face-to-face assessment was not considered necessary in this case. Under the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R), referrers are required to provide sufficient clinical information to support the justification of an exposure. Where diagnostic imaging is requested following a remote consultation, the clinical record should clearly document the assessment undertaken, the rationale for the referral and, where relevant, why a face-to-face examination was not considered necessary.

The practice should strengthen arrangements for documenting diagnostic imaging referrals arising from remote consultations. Clinical records should clearly demonstrate the assessment undertaken, the rationale for the referral, and why a face-to-face examination was not considered necessary. This will support continuity of care, provide assurance that patients are assessed using the most appropriate consultation method for their presentation, and ensure that referrals contain sufficient clinical information to support justification under IR(ME)R.

We found limited evidence in the records reviewed that patients' preferred language was documented.

The practice should ensure that patients' preferred language is recorded consistently to support effective communication and delivery of the Active Offer.

Chronic disease reviews appeared to be taking place for the most important long-term conditions. This included patients under shared care arrangements, such as those prescribed direct oral anticoagulants and patients with atrial fibrillation. Reviews were also evident for patients with conditions such as diabetes, respiratory conditions and dementia.

Where non-clinical staff were used to summarise information, staff had received training to recognise what needed to be added to the record and how information should be coded. However, the practice did not currently have a process in place to review the quality of case records and summaries.

The practice should introduce a regular audit of the summarising of records to provide assurance that entries are accurate, complete, appropriately coded and contain sufficient clinical context.

Quality of Management and Leadership

Staff Feedback (from HIW questionnaire)

Thirteen staff members responded to the HIW staff questionnaire. Overall, responses were positive and indicated that staff felt appropriately trained, supported and able to provide safe care. All respondents said they had received appropriate mandatory and role-specific training, and all confirmed they had received an appraisal, annual review or development review within the last 12 months. Staff were also positive about access to equipment, supplies, ICT systems and the skill mix within the practice.

Most respondents were positive about patient care, privacy and dignity. Eleven of the 13 respondents agreed or strongly agreed that patients could access services in a timely way, while all respondents agreed or strongly agreed that chaperones were offered when appropriate. Responses from staff also showed strong awareness of communication needs, health promotion and patient involvement in care. However, three respondents disagreed that there were enough staff to allow them to do their job properly, and three disagreed that they were involved in decisions about changes affecting their work.

The survey showed positive findings in relation to safeguarding, incident reporting and patient safety. All respondents knew who the safeguarding lead was, knew how to report safeguarding concerns and said they were up to date with safeguarding training. All respondents also agreed or strongly agreed that the practice encouraged staff to report errors, near misses and incidents, treated staff fairly, and took action to prevent recurrence. However, three respondents disagreed that they received feedback about changes made following incidents, suggesting the practice could strengthen how learning is shared.

Some areas of staff awareness could be improved. Responses about carer support were mixed, with several respondents unsure whether the practice maintained a carers register, had a carers champion, offered carers assessments or signposted carers to support. Three respondents were not aware of occupational health and wellbeing support, and three disagreed that they knew and understood the Duty of Candour or

their role in meeting the standards. Infection prevention and control responses were generally positive, although two respondents disagreed that there was an effective cleaning schedule.

The practice should:

- **improve staff awareness of carer support arrangements**
- **increase awareness of occupational health and wellbeing support**
- **review how infection prevention and control cleaning arrangements are communicated to staff.**

Leadership

Governance and leadership

Staff and managers told us they were clear about their roles, responsibilities and reporting lines, and understood the importance of working within their scope of practice. Designated leads were in place for specific areas of practice, including safeguarding, infection prevention and control, complaints and nursing leadership. This provided staff with identified points of contact for advice and support.

Leaders were visible and approachable to the wider practice team. Staff described an open-door approach, and senior team members used Microsoft Teams each day to inform staff which members of the leadership team were available.

The practice held regular meetings to support communication, oversight and shared learning. These included weekly management meetings, weekly senior staff meetings, monthly administrative meetings with management, twice daily clinical meetings, weekly Friday teaching sessions, monthly palliative care meetings and complaints meetings. Minutes were shared as appropriate and emailed to senior staff. We saw evidence of clinical meetings and dissemination of information to staff. Clinical information was shared through weekly meetings and daily escalation meetings, helping ensure that relevant clinical issues could be discussed in a timely way.

There was a process in place for sharing information with staff, including changes to policies and procedures. The practice manager and deputies had access to an email folder for safety notices, including those from bodies such as the Medicines and Healthcare products Regulatory Agency and Welsh Government, and these were forwarded to relevant staff as appropriate. The practice's policies and procedures were clearly named, readily accessible to staff and regularly reviewed and updated where necessary.

Clinical oversight was historically led by the senior partner, although staff told us all partners now shared responsibility for this. The practice manager had responsibility for

the Quality Improvement Framework. Staff also had access to wellbeing programmes.

The practice also had arrangements in place for the governance of cluster projects and initiatives. A cluster governance document was in place. Staff told us that projects were discussed, presented to the cluster and agreed before implementation. Projects were monitored through meetings held at least four times a year, and they were also discussed during fortnightly practice manager meetings.

Workforce

Skilled and enabled workforce

The practice had a recruitment process in place, including arrangements for completing pre-employment checks. The practice also had an up-to-date recruitment policy and an up-to-date induction policy and programme. We found that there was a system in place to check that healthcare professionals' registration with their regulatory body remained current, with annual checks undertaken.

The practice had processes to check that staff remained suitable to work for the service. We saw evidence of annual appraisals and Disclosure and Barring Service (DBS) checks. Staff told us the practice repeated DBS checks every three years.

The practice should consider introducing interim annual DBS self-declaration as part of the appraisal process, to provide ongoing assurance that staff remain suitable to work for the service.

While we saw evidence of vaccination and immunisation histories for clinical staff, we did not see evidence of pre-employment health screening.

The practice should ensure that pre-employment health screening is completed for all new staff, with appropriate risk assessments undertaken where health issues are identified.

The practice had a workforce plan in place to ensure there was appropriate capacity and skill mix of competent staff available when required. At the time of the inspection, staff told us that additional reception staff were being recruited and inducted to support overall capacity.

Annual immunisation and vaccination update training had been completed by all vaccinators.

There was evidence that staff roles were aligned with their qualifications, current skills, knowledge and experience. Nurse clinics were allocated according to individual scope of practice and competence, including diabetes, respiratory and treatment room duties.

The practice supported staff development and upskilling in line with roles and responsibilities. Examples included a practice nurse who had trained as an advanced nurse practitioner and become a partner, two practice nurses who had upskilled to minor illness nurse roles, one nurse undertaking coils and implants training and planning to complete independent prescribing, and a frailty nurse due to complete an enhanced examination course.

There was evidence of appropriate clinical supervision. Staff gave the example of twice daily clinical support meetings, which provided opportunities for staff to seek advice, discuss clinical issues and receive support.

Culture

People engagement, feedback and learning

The practice had arrangements in place to support patients, relatives and carers to provide feedback about the service. A Patient Liaison Officer was employed and was the named member of staff responsible for handling complaints and concerns. We saw that the practice maintained a spreadsheet to monitor complaints and concerns. This included both formal and informal complaints, with matters referred to the Patient Liaison Officer and relevant members of the practice management or clinical team as appropriate. The spreadsheet tracked progress and resolution, including relevant dates, which helped demonstrate oversight of complaints handling.

The practice was working within the new NHS “Listening to People” process. We saw that the previous “Putting Things Right” process was retained on file for 2025/26, with the current “Listening to People” process and patient complaints information placed at the front of the complaints file for 2026/27. The practice had an up-to-date complaints policy which aligned with the NHS Listening to People procedures. Information about the procedure was displayed in the patient waiting area.

There was evidence that the practice welcomed and acted on patient feedback. A “You said, we did” section was available on the practice website. Despite low awareness amongst HIW survey respondents, the practice also completed an annual patient survey. Compliments were logged, recorded and shared with staff.

The practice had a process for considering and implementing learning from complaints, concerns and feedback. Learning from complaints was identified in response letters sent to complainants. Complaints were also discussed at monthly meetings, where themes were reviewed and learning was considered. Where learning was relevant to wider staff groups, this was shared with the team.

Staff told us they felt able to speak up and share ideas. All staff we spoke with described the practice as open and friendly, with an open-door approach from senior

staff. Staff were encouraged to raise concerns with management, and relevant procedures were available on the shared drive and discussed through regular team meetings. The practice had an up-to-date whistleblowing policy in place.

The practice had an up-to-date Duty of Candour policy available. However, only one of the five staff training records we reviewed showed that Duty of Candour training had been completed.

The practice should ensure all staff complete Duty of Candour training appropriate to their role.

Information

Information governance and digital technology

The practice had arrangements in place to support information governance and the safe handling of patient data. An up-to-date information governance policy was available, covering information processed by the practice. The practice also had a data protection officer in place, providing a clear point of responsibility for data protection matters.

The practice appeared to have processes in place for handling data appropriately. A privacy notice was available on the practice website. However, this was not displayed in the waiting room at the time of the inspection. This meant that patients who did not use digital services, or who were not aware of the website, may not have had easy access to information about how their personal data was used. This was addressed as part of the concerns resolved during the inspection process, as described in [Appendix A](#).

The practice had arrangements in place to monitor performance information. GP activity data was reported monthly, which supported oversight of service activity and helped the practice monitor demand and access. The practice also had effective arrangements to ensure that data and notifications were submitted to external bodies as required.

Learning, improvement and research

Quality improvement activities

The practice had arrangements in place to use concerns and complaints as opportunities for learning and improvement. Complaints were discussed at monthly meetings, where lessons learned and any emerging themes were considered. The senior management team was responsible for identifying themes and bringing relevant

matters to weekly meetings where further discussion or action was required. This helped support a structured approach to learning from patient feedback and concerns.

The practice engaged in improvement activity through regular contact with external peers and wider primary care networks. Practice managers met regularly with their peers, and GP cluster meetings provided opportunities for speakers to discuss innovation and new ways of delivering care. The practice had also recently introduced a new human resources service to support practice management, which demonstrated a willingness to strengthen internal systems and improve organisational support.

The practice undertook some audit activity to monitor quality and performance. This included audit relating to staffing levels and workload. Prescribing audits were completed by the pharmacist, and occasional audits were undertaken by GPs. However, we did not see evidence of a systematic annual audit programme covering clinical and internal audit activity across the practice.

The practice should consider developing an annual audit schedule, with a clear process for recording audit findings, sharing learning and following up actions where required.

The practice engaged in learning from internal and external reviews, including mortality reviews, incidents and complaints. Learning was discussed during monthly meetings and then shared with relevant teams. Staff told us that learning was shared across the practice through meetings, with minutes made available to staff.

Whole-systems approach

Partnership working and development

The practice demonstrated an awareness of its role within the wider health and care system and took steps to ensure patients were directed to appropriate services. Staff described signposting patients to other services where this was suitable and making referrals to secondary care according to clinical need and in line with health board pathways.

The practice engaged with a range of system partners. Staff told us the practice received funding from two health boards and was subject to review arrangements from both organisations. This required the practice to work across different health board processes and maintain awareness of the expectations and pathways relevant to each. The practice also participated in collaborative meetings and practice manager meetings, which supported communication, shared learning and discussion of operational issues across the system. Staff also described good working relationships with local pharmacies. The practice participated in GP collaborative arrangements, where patient needs and wider service challenges were discussed.

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
We found that a urine sample was being stored in the vaccine refrigerator on a middle shelf, and that the fridge was overstocked and disorganised, with vaccines and drugs stored on the bottom shelf.	The storage of a urine sample in the vaccine fridge, along with overstocking and poor organisation, presented a risk to patient safety. This created a risk of cross-contamination, which could compromise the integrity and effectiveness of vaccines and medicines. Overstocking also increased the risk that appropriate temperatures were not maintained, potentially affecting the cold chain and reducing vaccine potency.	Raised with a responsible clinician.	The urine sample was removed from the vaccine fridge. The contents of the fridge were reorganised to ensure adequate spacing between items.
A privacy notice was available on the practice website. However, this was not displayed in the waiting room at the time of the inspection.	Patients who did not use digital services, or who were not aware of the website, may not have had easy access to information about how their personal data was used	Raised with the practice manager.	A privacy notice was posted in the waiting area.

Appendix B – Immediate improvement plan

Service: Amman Tawe Partnership – Gwaun Cae Gurwen

Date of inspection: 02 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	We were not assured that effective systems were in place to ensure emergency equipment was safely maintained. We found that some emergency equipment items and medications were expired, which indicates deficiencies in routine safety checks and governance arrangements.		
	We also found that emergency equipment and medication were stored in a frequently used clinical nursing room. This room is used for intimate examinations. This arrangement may delay access to emergency equipment in an emergency and potentially compromise patient dignity for individuals using the room at the time.		
Improvement needed		Standard / Regulation	
1.	The service must take immediate action to: - ensure all emergency equipment and medications are checked and logged on a weekly basis, are within expiry, and are safe for use - risk assess the location of the emergency equipment to ensure it is always readily accessible without impacting patient dignity or delaying emergency response.	Health & Care Quality Standards (2023) – Safe, Timely, Person-centred. Resuscitation Council UK – Quality Standards: Primary care equipment and drug lists.	
Service Action:		Responsible officer	Timescale

Following the inspection, the practice has reviewed and strengthened its emergency drugs and equipment checking process. The previous audit template recorded expiry dates and weekly signatures only. A revised 'Emergency Drug and Equipment Weekly Audit Tool' has now been implemented to provide greater assurance, accountability and transparency. The new audit tool includes additional fields to record: ➤ Quantity of stock checked. ➤ Expiry dates. ➤ Actions taken where issues are identified. ➤ Weekly completion and sign-off. To improve oversight, the audit tool has been redesigned to cover a two-week period at a time. A dedicated emergency drugs and equipment audit folder has been established within the treatment room. This folder contains: ➤ The revised audit documentation ➤ A copy of the practice policy relating to emergency drugs and equipment checks. The Senior Nurse has been assigned responsibility for overseeing the process and will scan completed audit sheets monthly into a secure electronic folder to provide an auditable record and enable future review and monitoring. All clinical staff have been informed of the revised process via email. The communication outlined the new documentation requirements, weekly checking responsibilities and the expectation that any discrepancies, shortages or out-of-date items are documented and acted upon immediately. The practice is satisfied that this revised process provides assurance that emergency drugs and equipment are checked weekly, remain within expiry, are maintained in a safe condition and are available for use when required.	Practice Manager	Completed
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A formal risk assessment has been undertaken to review the location and accessibility of the Defibrillator and to ensure compliance with the requirement that emergency equipment can be accessed promptly in the event of a medical emergency. The assessment considered accessibility, response times, patient dignity, confidentiality and security. Following this review, it was determined that a clinical room and reception area was not the most appropriate location, as access could be delayed by the requirement to pass through a key-code secured door. As a result, a decision has been made to relocate the emergency equipment to the main hallway, which provides improved accessibility for all staff during an emergency while minimising any potential impact on patient dignity and reducing the risk of delayed response. To facilitate the relocation, a dedicated defibrillator wall bracket has been ordered and is due for delivery during the week commencing 8 June 2026. Installation has been scheduled for completion by 12th of June 2026. Until installation is complete, staff have been reminded of the current location of the emergency equipment and the planned relocation. The practice is satisfied that the interim arrangements maintain safe access to emergency equipment whilst the permanent solution is implemented.	Practice Manager	1 week
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Findings	We were not assured that the accessible toilet within the practice was safe and fully equipped to meet the needs of patients with disabilities. During the inspection, we found that it did not have an emergency pull cord fitted, which is a key safety feature to enable patients to summon assistance if required.		
	Improvement needed	Standard / Regulation	
2.	The practice must ensure that the accessible toilet is safe and suitably equipped for patients with disabilities by installing an emergency pull cord without delay. Regular checks should also be implemented to ensure that this safety feature remains in place and functional.	Health and Care Quality Standards (2023) – Safe, Person-centred. Welsh Health Building Notice: 36	
	Service Action:	Responsible officer	Timescale
	The practice acted immediately following the inspection to address this issue. An emergency assistance pull cord suitable for use within the accessible toilet has been ordered, with confirmed delivery scheduled for 8th of June 2026. Installation has been prioritised and will be completed no later than 12th of June 2026. The installation of the pull cord will ensure that patients requiring assistance are able to summon help in an emergency, thereby improving patient safety and supporting the needs of patients with disabilities. In addition, the practice has incorporated the emergency pull cord into its routine premises checks. Regular inspections will be undertaken to ensure that the pull cord remains present, accessible, undamaged and fully functional. Any defects identified will be reported and addressed immediately through the practice's maintenance procedures. The practice is satisfied that these actions will ensure the accessible toilet is safe, appropriately equipped and maintained in accordance with patient safety requirements.	Practice Manager	Completed 19 th June 2026

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): Cerys Preston

Job role: Managing Partner

Date: 05/06/2026

Appendix C – Improvement plan

Service: Amman Tawe Partnership – Gwaun Cae Gurwen

Date of inspection: 02 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	A total of 531 responses to the HIW patient survey were received showing a predominantly negative patient experience, particularly in relation to access, appointment availability, continuity of care and involvement in decisions.	The practice should undertake a structured review of the HIW questionnaire findings, triangulating the feedback with complaints, access and appointment data, its own patient surveys and other relevant service information. It should develop a proportionate action plan addressing areas where the	Health & Care Quality Standards (2023) – Timely, Person-centred, Effective, Equitable, Leadership, Information, Learning, improvement & Research.	The Practice has reviewed the HIW patient survey findings and the areas identified for improvement. A number of relevant arrangements were already established at the time of inspection; these will continue, with the following additional actions taken to strengthen them. 1. Timely access and appointments The Practice already provides same-day, pre-bookable and clinician follow-up appointments, with patients able to request care by telephone, online or	Managing Partner, supported by Deputy Managers, Clinical Partners, Patient Liaison Officer and Carers Lead.	Completed: Private-conversation signage – 14 th of July 2026. Carers information review - July 2026 Patient feedback form – July 2026 Complaints/accessibility arrangements review – July 2026 By 30th of September 2026: Clinical/care-navigation

	combined evidence identifies an opportunity or need for improvement, with clear responsible leads, timescales and arrangements for reporting progress to patients and staff. This should include: • considering options and opportunities to improve the overall timely access to GP services and its appointment system • reviewing feedback in relation to use of telephone consultations and ensuring patients are offered face-to-face appointments		in person. Reception staff also have access to a Clinical Buddy for immediate clinical advice to support appropriate care navigation and signposting. Appointment availability, demand and telephone activity will be reviewed to identify any further opportunities to improve timely access and appointment choice. Findings and any actions identified will be documented and reviewed by the management team. 2. Telephone and face-to-face consultations Existing arrangements provide face-to-face appointments where examination, communication needs, clinical complexity or patient preference indicate this is appropriate. These arrangements will be reinforced with relevant clinical and care-navigation staff, including the		reminders completed and recorded. Appointment, telephone-demand and equitable-access reviews completed, with resulting actions documented. By 14th of October 2026: Reception carers training completed. By 19th of November 2026: Carers Lead/relevant senior staff training completed.
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		where examination, communication needs, complexity or patient preference indicate this is appropriate • reminding clinical staff of the importance of listening to patients, explaining decisions clearly, answering questions and involving patients in decisions about their care. • ensuring that patients are made aware through signage that conversations can be held in private, if requested • reviewing how carers are identified, how the carers register is promoted, and how carers are offered		importance of recording patient preference and the agreed consultation method. 3. Listening to and involving patients Clinical staff will be reminded of the importance of listening to patients, clearly explaining decisions, answering questions and involving patients in decisions about their care. This will be communicated through a clinical meeting and recorded within the meeting minutes. Patient feedback will continue to be reviewed through the Practice's established complaints, patient survey and learning arrangements. 4. Private conversations A notice informing patients that they may request to speak with reception staff privately was displayed in the waiting area on 14th of July 2026. A Welsh-language version has been requested and will also be displayed.	
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		or signposted to assessments and information about local support organisations • improving visibility of the complaints process by displaying clear information in the waiting area • reviewing access arrangements to ensure equitable access for all patients, including those with long-term conditions and vulnerable groups.		Routine waiting-area checks will confirm that the signage remains visible and in place. 5. Identification and support of carers The Practice already had a Carers Lead, carers register, carers information board and processes through which patients can identify themselves as carers. Following inspection, the carers information board was reviewed with Health Board support and updated during the week commencing 13th of July 2026. Additional external carers training has been arranged for all reception staff, with completion by 14th of October 2026. Further Understanding Carers' Needs training has been arranged for the Carers Lead and relevant senior staff for 19th of November 2026. Completion will be evidenced through training		
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				records and the Practice training matrix. 6. Complaints and patient feedback Prior to the inspection, information about the NHS Wales Listening to People complaints process was already displayed within the waiting area, with information leaflets available to patients. The Practice also had established routes for patients to raise concerns and provide feedback. Following the inspection, these arrangements have been further strengthened through the introduction of a dedicated general patient feedback form, available both online and within the waiting area. Feedback and complaints will continue to be reviewed through the Practice's established governance arrangements, with identified learning and resulting improvements communicated to patients		
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				through the Practice’s “You Said, We Did” arrangements. 7. Equitable access Existing access arrangements for patients with disabilities, long-term conditions, sensory or communication needs and other vulnerabilities have been reviewed. These include accessible entrances, staff assistance, hearing-loop provision, longer appointments where appropriate, interpreting or translation support and reasonable adjustments according to individual need. These arrangements will be communicated to relevant staff and reviewed to identify any additional reasonable improvements required. Completion of the review and any resulting actions will be documented.		
2	We found that some information displayed on the	The practice should: Ensure that relevant patient	Health & Care Quality Standards (2023) –	Existing arrangements The Practice already provided health-promotion and patient information	Operational Manager	Completed: Full review – week commencing 6th of July 2026.

waiting room screen was not relevant to patients in Wales and some information was out of date. We also found that some information displayed on the screen linked to England-specific websites and included outdated COVID-19 information.	information displayed on the waiting-room screen is current, applicable to Wales and made available bilingually with sufficient frequency and prominence Remove or update outdated COVID-19 information and links to England-specific resources where these are not applicable to patients in Wales.	Information, Person-centred, Equitable, Culture, Leadership, Learning, improvement & research.	through the waiting-room television, information boards, leaflets, website and direct patient communications. Welsh and English information was displayed within the waiting area and on the waiting-room television. Action completed A full review of waiting-room television content and displayed patient information was completed during the week commencing 6th of July 2026. This included: - removal of outdated COVID-19 information; - removal or replacement of England-specific information where this was not applicable to patients in Wales; - checking links and resources for	Supported by: Operational Supervisor	Ongoing assurance: Formal review quarterly, next review due October 2026.
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				relevance to patients in Wales; • updating information identified as outdated; and • reviewing the accessibility and Welsh/English content of displayed information. This review confirmed that patient information is current, relevant to Wales and appropriately presented. Completion is evidenced through the updated waiting-room television content and patient-information displays. Ongoing assurance Displayed patient information will be reviewed quarterly by the Operational Manager. The review will be recorded, and any information identified as outdated, inaccurate or not applicable to patients in Wales will be updated or removed.		
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3	QR codes on the large poster displayed next to reception mostly did not work. We found that the information available in the waiting room did not fully reflect the comprehensive information available on the practice website.	The practice should: • check all QR codes and links displayed on posters in the waiting room and update or replace any broken links to ensure they are functioning correctly • ensure that patients have access to a reasonable range of current and relevant information in the waiting room, particularly those who	Health & Care Quality Standards (2023) – Information, Person-centred, Timely, Equitable, Leadership, Learning, improvement & research.	Existing arrangements The Practice already provided patient information within the waiting area through the waiting-room television, information boards, posters and printed leaflets, alongside information available through the Practice website. Printed information and staff support/signposting were available for patients who were unable to access digital information. Action completed A review of QR codes, links and patient information displayed within the waiting area was completed during the week commencing 6th of July 2026. Non-functioning or outdated QR codes were removed or covered to prevent their use, and affected links were identified for updating or replacement. The range of posters, leaflets and other	Operational Manager Supported by: Operational Supervisor and relevant administrative staff	Completed: Initial review – week commencing 6th of July 2026. Ongoing assurance: Quarterly review commencing October 2026.
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		are unable to access information through the practice website.		non-digital information was also reviewed to ensure a reasonable range of current and relevant information was available to patients who do not access the Practice website. Where QR codes are used, key information or an alternative way of accessing that information will also be available for patients who do not use smartphones or digital services. Completion is evidenced through the updated waiting-room displays, functioning QR codes/links and the range of printed patient information available. Ongoing assurance QR codes, links and waiting-room information will be included within the Practice's quarterly patient-information review, with any non-functioning, outdated or irrelevant information removed or updated promptly.		
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4	Staff told us that chaperone training was provided in-house, and chaperone-related entries were included within the practice training matrix. However, the evidence reviewed did not provide consistent assurance that all relevant staff acting as chaperones had completed appropriate training.	The practice should ensure that all staff acting as chaperones receive appropriate training and that completion of this training is recorded, monitored and refreshed at suitable intervals.	Health & Care Quality Standards (2023) – Workforce, Safe, Leadership, Learning, improvement & research.	Existing arrangements The Practice already had a chaperone policy and provided in-house chaperone training to staff undertaking the role, with training dates recorded on the Practice training matrix. Action taken Following the inspection, the Practice reviewed its chaperone training arrangements to strengthen the evidence of training completion. All staff who may act as chaperones will complete appropriate chaperone training, with completion formally recorded on the Practice training matrix. The training matrix will be monitored to identify when refresher training is due and ensure training remains current. Completion will be evidenced through training records/certificates and the Practice training matrix.	Deputy Manager	By October 2026: Chaperone training completed and recorded for all staff who may undertake the role. Ongoing assurance: Training status and refresher requirements monitored through the Practice training matrix.
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5 The practice had routes through which patients could provide comments or feedback, including a general practice email address and a comment or appreciation form. However, these were not clearly promoted as a general feedback or suggestions mechanism in the waiting area. Inspectors did not see a dedicated feedback or suggestions box. Inspectors did not observe “You said, we did” information during the period in which the waiting-room	The practice should improve the visibility and accessibility of its existing feedback arrangements by clearly promoting how patients can provide general feedback or suggestions, considering whether an additional accessible mechanism is needed in the waiting area, and ensuring that “You said, we did” information is sufficiently prominent and regularly visible to patients.	Health & Care Quality Standards (2023) – Equitable, Person-centred, Information, Leadership, Learning, improvement & research.	Existing arrangements Prior to the inspection, the Practice already provided several routes for patients to give feedback, including annual patient questionnaires, verbal and written feedback, compliments and the NHS Wales Listening to People process. Patient-facing “You Said, We Did” information was also displayed on the waiting-room television and Practice website. Action taken Following the inspection, the Practice strengthened its feedback arrangements by introducing a dedicated patient feedback form, available through the Practice website and in paper format within the waiting area. A feedback/suggestions box will be provided within the waiting area, giving patients	Patient Liaison Officer Supported by: Deputy Managers and Operational Supervisor	Timescale Completed: Dedicated feedback form introduced – week commencing 13th of July 2026. Feedback/suggestions box: September 2026 Ongoing assurance: Feedback reviewed and “You Said, We Did” information updated when resulting improvements are identified.
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	television display was reviewed.			a clear non-digital route to submit feedback and suggestions. “You Said, We Did” information will continue to be displayed within the waiting area and updated to show patients how feedback has informed changes and improvements. Completion will be evidenced through the website and paper feedback forms, feedback/suggestions box and displayed “You Said, We Did” information. Ongoing assurance Feedback will continue to be reviewed through the Practice’s established governance arrangements. Identified learning and improvements will be recorded and communicated to patients through updated “You Said, We Did” information.		
6	Practice activity data indicated a	The practice should review how	Health & Care Quality	Existing arrangements	Operational Manager	Completed: Provider review and clarification

	poor level of call answering, although at the time of the inspection there were no calls waiting.	telephone data is collected and interpreted to ensure it has an accurate understanding of telephone access and patient experience.	Standards (2023) – Timely, Equitable, Person-centred, Information, Leadership.	The Practice already monitored telephone access through a live telephone wallboard showing call volumes, queue levels and waiting times. This is monitored throughout the working day, alongside monthly review of telephone activity and performance. A call-back facility is also available to patients. Action completed Following the inspection, the Practice contacted its telephone-system provider to review the activity data presented during the inspection. The provider identified an error within the reporting information and clarified how the data should be reported and interpreted. The Practice has reviewed its telephone reporting arrangements following this clarification to ensure future activity data provides an accurate and consistent understanding of telephone	Supported by: Operational Supervisor, Senior Receptionist and telephone-system provider	of reporting error – July 2026. Ongoing assurance: Daily live monitoring and monthly documented review of telephone activity.
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				access and patient experience. Completion is evidenced through the provider correspondence/clarification and subsequent telephone activity reports. Ongoing assurance Live telephone demand and queue performance will continue to be monitored daily. Telephone activity data will be formally reviewed monthly by the management team, including call volumes, queue/waiting times, call-answering performance and use of the call-back facility. Any unusual trends or reporting issues identified will be investigated and resulting actions recorded.		
7	The practice maintained a training matrix and many staff had completed equality and	The practice should review the rights and equality training required for each staff group, ensure that	Health & Care Quality Standards (2023) – Workforce, Equitable,	Existing arrangements The Practice already had an established mandatory training programme which included Treating Me Fairly (Equality) training, with	HR Manager Supported by: Operational Supervisor and relevant clinical leads	Completed: Rights and equality-focused training requirements reviewed and programme expanded following inspection.

diversity training. However, the sample reviewed identified incomplete or out-of-date equality and diversity training for some staff. Autism-awareness training was not evidenced in the sampled records, and learning-disability training had not yet been incorporated consistently into the practice training programme.	relevant equality and diversity, autism-awareness and learning-disability training is completed, and maintain accurate records for monitoring and renewal.	Person-centred, Culture, Leadership.	completion and renewal requirements monitored through the Practice training matrix. At the time of inspection, 80% of staff were in date, with outstanding renewals identified. Action Following the inspection, the Practice reviewed its rights and equality-focused training requirements and expanded the programme to include autism awareness and Paul Ridd Learning Disability Awareness training for relevant staff. Outstanding equality training renewals and the additional identified training are being completed and recorded on the Practice training matrix. Completion will be evidenced through training records/certificates and the updated training matrix, which will also be used to	In progress: 65% of relevant staff have completed the identified additional training. 93% have completed the Equality training. Target completion: October 2026 Ongoing assurance: Completion and future refresher requirements monitored through the Practice training matrix.
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				monitor future refresher requirements.		
8	The front entrance door was not automated and patients were not able to summon assistance at the front door or access ramp (ie via a bell) . We also found that the double doors between the waiting room and consulting rooms were narrow when only one door was opened.	The practice should review the physical accessibility of the premises to identify and address barriers to improve accessibility for all patients.	Health & Care Quality Standards (2023) – Equitable, Person-centred, Safe, Leadership. Welsh Health Building Note 36	Existing arrangements The Practice already had arrangements to support patients with mobility and accessibility needs. These included accessible front access, a step-free rear entrance and ramp, staff assistance where required and an on-site wheelchair. The internal double doors between the waiting area and consulting rooms can be opened fully and are fitted with magnetic door retainers to provide wider access. Clinicians collect patients from the waiting area and provide assistance where required. Action Following the inspection, the Practice completed a review of the physical accessibility of the premises, including the front entrance, rear accessible entrance and	Managing Partner and Operational Manager Supported by: Operational Supervisor	Completed: Physical accessibility review – July 2026. Any actions identified: Completed by 1st of October.

				ramp, internal access routes and arrangements for patients requiring assistance. The review considered the barriers identified during the inspection alongside the existing accessibility arrangements and identified any additional reasonable and practicable improvements required. Any actions arising from the review will be documented, allocated to a responsible lead and monitored to completion. Completion of this action will be evidenced through the documented accessibility review and records of any resulting actions. Ongoing assurance Physical accessibility will continue to be considered through routine premises checks and feedback from patients, staff and visitors, with any new barriers identified addressed through		
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				the Practice's premises-management arrangements.		
9	Some areas of paintwork appeared tired and required renewal. We also found a screw protruding through the tiles above the sink in the male toilet located near the waiting area.	The practice should: • aim to refresh tired paintwork within the premises where required • remove or make safe the protruding screw above the sink in the male toilet near the waiting area.	Health & Care Quality Standards (2023) – Safe, Effective, Leadership, Learning, improvement & research.	Existing arrangements The internal painting programme had already been identified within the Practice's 2026 estates improvement plan prior to the inspection. A quotation had been obtained and a contractor appointed. Action The protruding screw identified above the sink in the male toilet was removed within days of the inspection. The remaining holes were filled and the area made good. The planned painting programme is now booked for October 2026 and includes the areas highlighted during the inspection together with other areas already identified through the Practice's estates improvement programme.	Managing Partner Supported by: Deputy Managers	Completed: Protruding screw removed and area made good – June 2026. Scheduled: Painting programme to be completed by 31st of October 2026.

				Completion will be evidenced through maintenance records and confirmation of completion of the painting works.		
1	The significant-event process identified learning, actions and responsible persons. However, it did not clearly include a documented later review confirming that identified actions had been completed and that learning and improvements had been implemented and embedded.	The practice should strengthen its existing significant-event process by introducing a documented follow-up review to confirm that agreed actions have been completed and that identified improvements have been implemented and embedded.	Health & Care Quality Standards (2023) – Safe, Effective, Leadership, Culture, Learning, improvement & research.	Health & Care Quality Standards (2023) – Safe, Effective, Leadership, Culture, Learning, improvement & research.	Existing arrangements The Practice already had an established Significant Event Analysis (SEA) process through which significant events were reviewed, learning identified, actions agreed and responsible leads and timescales recorded. Action completed Following the inspection, the SEA process was strengthened in June 2026 through the introduction of a central significant event matrix and a documented follow-up review for all significant events. The follow-up review confirms that identified actions have been completed, learning has been implemented and any	Clinical Governance Lead Supported by: Managing Partner, Deputy Managers and relevant action leads

					resulting improvements have been embedded. The central matrix records significant events, identified learning and actions, responsible leads, target dates and progress through to completion. Completion is evidenced through the revised SEA process, significant event matrix and completed follow-up reviews. Ongoing assurance The significant event matrix and follow-up reviews will be monitored through the Practice's clinical governance arrangements. Actions will remain open until completion and implementation of identified learning have been confirmed and recorded.	
1	Elbow-operated taps were not available in every clinical room. We also found	The practice must: • review and update hand wash facilities within a	Health & Care Quality Standards (2023) –	Action completed All plugs were removed from clinical handwashing sinks	Managing Partner Supported by: Deputy Managers and Infection	Completed: Plugs removed from all clinical handwashing sinks on

plugs in handwashing sinks.	reasonable timeframe and where feasible to ensure compliance with current infection prevention standards • remove any plugs to ensure they function as dedicated hand hygiene sinks.	Safe, Effective, Leadership, Information, Learning, improvement & research.	on the day following the inspection. Replacement elbow-operated taps have been ordered and a suitable contractor appointed to complete the installation. Further action Replacement elbow-operated taps will be installed in the identified clinical rooms by 30th of September 2026. Completion will be evidenced through confirmation of the completed works and associated contractor/maintenance records. Ongoing assurance Clinical handwashing facilities will continue to be monitored through routine premises and infection prevention and control arrangements, with any further maintenance	Prevention and Control Lead	the day following inspection. In progress: Replacement elbow-operated taps ordered and contractor appointed. Target completion: 30th of September 2026.
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				requirements identified and addressed as required.		
1.	We did not see signed checklists to confirm when cleaning had been completed.	The practice should introduce signed cleaning checklists to provide assurance that cleaning is completed consistently and in line with the schedule.	Health & Care Quality Standards (2023) – Safe, Information, Leadership, Learning, improvement & research.	Existing arrangements The Practice already had an established cleaning schedule, with routine cleaning undertaken by its contracted cleaning provider. Action Following the inspection, signed cleaning checklists have been introduced to provide a clear record that scheduled cleaning has been completed. The checklists identify the cleaning undertaken, date of completion and confirmation by the person completing the work. Completed checklists will be retained by the Practice and periodically reviewed to provide assurance that cleaning is being completed consistently in accordance with the agreed schedule.	Operational Manager Supported by: Operational Supervisor and contracted cleaning provider	Completed: Signed cleaning checklists introduced – July 2026. Ongoing assurance: Checklists completed following scheduled cleaning and periodically reviewed by the Practice.

				Completion will be evidenced through completed and signed cleaning checklists.		
1.	Needlestick posters were displayed in consulting and treatment rooms, providing limited guidance for staff in the event of a sharps injury.	The practice should update needlestick injury posters to include who staff should report incidents to and where staff should attend for urgent advice or treatment, including relevant telephone numbers and addresses, such as the local emergency department.	Health & Care Quality Standards (2023) – Safe, Workforce, Information, Leadership.	Existing arrangements The Practice already had an established needlestick/sharps injury procedure setting out the action, reporting and escalation requirements following a sharps injury. Needlestick posters were also displayed within consulting and treatment rooms. Action completed Following the inspection, the needlestick posters were updated to provide clearer immediate guidance for staff. The revised posters include who incidents should be reported to, where staff should attend for urgent advice or treatment, and the relevant telephone numbers and addresses.	IPC Lead Supported by: Deputy Managers	Completed: Needlestick posters updated and displayed – July 2026. Ongoing assurance: Posters checked through routine IPC arrangements and updated when contact or escalation information changes.

				Updated posters have been displayed in all relevant clinical and treatment areas. Completion is evidenced through the revised posters and confirmation that these are displayed in the relevant areas. Ongoing assurance Needlestick information will be included within routine IPC checks to ensure posters remain visible, current and consistent with the Practice procedure.		
1.	The practice did not maintain a log for boxes of prescription stationery.	The practice should introduce a log for boxes of prescription stationery to provide a clear audit trail and strengthen prescription security.	Health & Care Quality Standards (2023) – Safe, Information, Leadership.	Action completed Following the inspection, a prescription stationery log has been introduced to strengthen the security and audit trail for prescription stationery. The log records the receipt and movement of boxes of prescription stationery and is maintained by designated staff. Completed records will be retained by the Practice and reviewed as part of	Deputy Manager Supported by: Prescribing/administrative team	Completed: Prescription stationery log introduced – July 2026. Ongoing assurance: The log will be maintained and reviewed through routine prescription stationery checks.

				routine prescription stationery checks. Completion and ongoing compliance will be evidenced through the prescription stationery log and completed records.		
1	We were unable to find evidence of recent, formal medication reviews, despite many patients being prescribed multiple medications.	The practice should ensure that formal medication reviews are undertaken at appropriate intervals and clearly documented, particularly for patients taking multiple medicines or with complex health needs.	Health & Care Quality Standards (2023) – Effective, Safe, Person-centred, Information, Leadership.	Existing arrangements The Practice already had arrangements in place for clinicians to review patients' medication as part of their ongoing clinical care, including patients prescribed multiple medicines and those with complex health needs. Action Following the inspection, the Practice has reviewed and strengthened its medication review process to ensure formal medication reviews are clearly and consistently documented within the patient record. The strengthened process includes identification of patients requiring	Clinical Governance Lead Supported by: GPs and appropriate prescribing clinicians	Completed: Medication review and documentation process reviewed and strengthened – August 2026. Monitoring: Sample audit of medication reviews to be completed by November 2026, with any identified actions addressed through clinical governance.

				medication review, completion of the review by an appropriate clinician and clear recording of the review and any resulting actions within the clinical record. Compliance will be monitored through a sample audit of patient records to confirm that medication reviews are being completed and appropriately documented. Evidence will include the agreed medication review process and the results of the completed record audit.		
1	We found only one vaccine fridge in use. The fridge was locked, but it was overstocked and disorganised, with vaccines and drugs stored on the bottom shelf.	The practice should consider whether an additional fridge is required to support safe storage, particularly where overstocking may block the fridge fan and affect temperature control.	Health & Care Quality Standards (2023) – Safe, Effective, Information, Leadership.	Existing arrangements The Practice has five vaccine fridges across its sites, including three supporting the relevant contract. All vaccine fridges are subject to daily temperature monitoring. Records available at the time of inspection confirmed temperatures remained within the required range	Senior Nurse Supported by: Deputy Managers and relevant nursing staff	Completed: Inspected fridge reorganised following inspection. Completed: Vaccine-storage capacity reviewed and existing capacity confirmed as sufficient. Completed: Health Board Pharmacy review undertaken – 13th of July 2026.

				with no recent cold-chain breach identified. Action completed Following the inspection, the stock within the inspected fridge was immediately reviewed and reorganised to ensure appropriate spacing, airflow and stock rotation. The Practice also reviewed its existing vaccine-storage capacity and determined that sufficient refrigeration capacity is available across its sites to support safe storage without the need for an additional fridge at present. On 13th of July 2026, Swansea Bay University Health Board Pharmacy Department attended the Practice to review cold-chain arrangements and provide further guidance and assurance. Completion is evidenced through temperature-monitoring records, the documented review of fridge		Ongoing assurance: Daily temperature monitoring and routine cold-chain checks will continue, with storage capacity reviewed where requirements change.
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				capacity and the Health Board Pharmacy review. Ongoing assurance Fridge temperatures, stock levels, stock rotation, expiry dates and fridge organisation will continue to be monitored through the Practice's established cold-chain arrangements. Vaccine-storage capacity will be reviewed if stock levels or service requirements change.		
1	We did not see a room thermometer to monitor ambient storage temperatures.	The practice should carry out and record ambient room temperature checks to ensure medicines are stored under recommended conditions.	Health & Care Quality Standards (2023) – Safe, Effective, Information, Learning, improvement & research.	Action completed Following the inspection, room thermometers have been installed in the relevant clinical medicine-storage areas and a documented ambient temperature monitoring process has been introduced. Ambient room temperatures are recorded to provide assurance that medicines are being stored within recommended temperature conditions. Where a	Senior Nurse Supported by: Deputy Managers and relevant nursing staff	Completed: Room thermometers installed and ambient temperature monitoring introduced – June 2026. Ongoing assurance: Ambient temperatures recorded and reviewed routinely, with any readings outside recommended storage conditions escalated and action documented.

				temperature falls outside the recommended range, this will be escalated and appropriate action taken and recorded. Completion and ongoing compliance will be evidenced through the ambient temperature monitoring records.		
1	We found two oxygen cylinders at the practice: a large freestanding oxygen cylinder and a BOC CD integrated valve oxygen cylinder. The large cylinder was not secured. Staff had not received training on the use of the BOC CD integrated valve oxygen cylinder.	The practice should: - secure the large oxygen cylinder to prevent it from falling over - ensure relevant staff complete appropriate online training on the use of the BOC CD integrated valve oxygen cylinder.	Health & Care Quality Standards (2023) – Safe, Workforce, Information, Learning, improvement & research.	Existing arrangements The Practice already had established emergency equipment arrangements, including routine checks of emergency oxygen equipment. Action completed A purpose-designed securing attachment was obtained for the large freestanding oxygen cylinder and installed on 30th of July 2026. The cylinder is now securely restrained in its designated storage position. Following the inspection, the Practice contacted BOC and arranged model-specific online training on the BOC	Senior Nurse Supported by: Deputy Managers and relevant clinical staff	Completed: Large oxygen cylinder securely restrained – 30th of July 2026. In progress: BOC model-specific online training arranged for relevant staff. Target completion: Relevant staff to complete training by 30th of September 2026. Ongoing assurance: Training completion and refresher requirements will be monitored through the Practice training matrix, with oxygen storage

				CD integrated valve oxygen cylinder for relevant staff. Further action Relevant staff will complete the BOC model-specific training by 30th of September 2026. Completion will be recorded on the Practice training matrix and monitored through the established training arrangements. Completion will be evidenced through confirmation of the secured cylinder and staff training records/certificates.		monitored through routine emergency equipment checks.
1	The safeguarding policy for adults did not include sufficiently detailed processes to guide staff on when to refer, who to refer to, or how to seek appropriate advice. The policy for	The practice must ensure that the safeguarding policies are revised to include clear referral processes, escalation routes, local safeguarding pathways and essential contact information.	Health & Care Quality Standards (2023) – Safe, Information, Effective, Learning, improvement & research.	Existing arrangements The Practice already had established safeguarding policies for adults and children and young people, including arrangements for reporting, escalating and referring safeguarding concerns. Action completed Following the inspection, the Practice reviewed and	Practice Safeguarding Lead Supported by: Clinical Governance Lead and Management Team	Completed: Adult and children and young people's safeguarding policies reviewed and updated – July 2026. Completed: Revised policies communicated to staff – July 2026. Ongoing assurance: Safeguarding policies, pathways and contact information will be

children and young persons also lacked essential contact information.			updated both safeguarding policies to strengthen the information available to staff. The revised policies now clearly set out: • when and how safeguarding concerns should be referred; • internal and external escalation routes; • relevant local safeguarding pathways and arrangements for seeking advice; and • up-to-date contact details for relevant safeguarding services. The revised policies have been made available to staff and the changes communicated to the Practice team. Completion will be evidenced through the revised safeguarding policies and records confirming		reviewed routinely and updated when changes are identified.
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				communication of the changes to staff. Ongoing assurance The safeguarding policies will be reviewed routinely and following any changes to local safeguarding pathways or contact information.		
2	We found multiple adult patients remained coded as being on the child protection register and had not been removed when their circumstances changed.	The practice should introduce a formal process to regularly review child protection coding, update records appropriately and apply a specific clinical code to indicate when a child protection marker has been removed.	Health & Care Quality Standards (2023) – Safe, Information, Effective, Learning, improvement & research.	Existing arrangements The Practice retains historic safeguarding information within the clinical record to ensure relevant safeguarding history remains available to clinicians. Action completed The safeguarding process was reviewed on 16th of July 2026 and strengthened to ensure that child protection coding clearly distinguishes between historic and current safeguarding status. A specific clinical code has been identified for use where a child protection marker is no longer active. This allows the patient's current status to be clearly recorded while	Practice Safeguarding Lead Supported by: Clinical Governance Lead, Management Team and relevant administrative staff	Completed: Safeguarding process reviewed and appropriate code for inactive child protection markers confirmed – 16th of July 2026. In progress: Review of identified adult records containing historic child protection codes. Target completion: Record review completed by 30th of September 2026. Ongoing assurance: Safeguarding coding reviewed at transition to adulthood, following notification of a change in safeguarding status

				retaining the relevant historical safeguarding information. Further action Existing adult records containing historic child protection codes are being reviewed. Where a child protection marker is no longer active, the appropriate status code will be added while retaining the historical safeguarding information. Safeguarding coding will also be reviewed when a patient reaches adulthood, when the Practice is notified of a change in safeguarding circumstances, and where a record review identifies that the current status is not clearly recorded. Completion will be evidenced through the revised safeguarding process and completion of the identified record review.		and where issues are identified through record review.
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2	We found that the safeguarding policy for children did not include a relevant code for a family member.	The practice should update the policy to include relevant safeguarding coding guidance, including coding for family members where appropriate.	Health & Care Quality Standards (2023) – Leadership, Safe, Information, Learning, improvement & research.	Action completed As part of the safeguarding policy review completed on 16th of July 2026, the children and young people's safeguarding policy was updated to provide clearer guidance on safeguarding coding, including the appropriate coding of relevant family members where required. The revised guidance has been incorporated into the safeguarding policy and communicated to relevant staff. Completion will be evidenced through the updated safeguarding policy and associated coding guidance. Ongoing assurance Safeguarding coding guidance will be reviewed as part of the Practice's routine safeguarding policy review and updated where coding requirements or	Practice Safeguarding Lead Supported by: Clinical Governance Lead and relevant clinical/administrative staff	Completed: Safeguarding policy and coding guidance updated – 16th of July 2026. Ongoing assurance: Coding guidance reviewed through the Practice's established safeguarding policy review arrangements.
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				safeguarding guidance change.		
2	We did not see formal records documenting that checks of medical devices and equipment had been completed.	The practice should maintain a formal record of checks of medical devices and equipment.	Health & Care Quality Standards (2023) – Leadership, Safe, Information, Learning, improvement & research.	Existing arrangements The Practice already had established arrangements for checking and maintaining medical devices and equipment. A designated management lead was responsible for oversight, and records were maintained including servicing certificates, maintenance records and completed equipment checks. Additional assurance following the inspection Following the inspection, the Practice reviewed the way completed equipment checks are recorded and retained to ensure there is a clear and readily identifiable audit trail demonstrating when checks have been undertaken. Existing recording arrangements will continue to document the date of the	Deputy Manager Supported by: Senior Nurse and Nursing Team	Existing arrangement: Medical device and equipment checks and associated records were in place prior to inspection. Reviewed: Recording and oversight arrangements reviewed following inspection – July 2026. Ongoing assurance: Completed equipment check records will continue to be retained and monitored, with any identified actions followed through to completion.

				check, equipment reviewed, any action identified and confirmation of completion. Evidence will include completed equipment check records together with relevant servicing and maintenance documentation. Ongoing assurance Medical device and equipment checks will continue at the required frequency, with records retained and any identified maintenance or remedial actions monitored through to completion.		
2	Expired items were found in clinical areas that had not been removed from use. These included blood collection bottles, needles and swabs.	The practice should review and strengthen its existing system for regularly checking and removing expired items from clinical areas, to ensure that only in-date and safe items	Health & Care Quality Standards (2023) – Safe, Effective, Leadership, Information.	Existing arrangements The Practice already had an established and documented stock-checking system in place prior to the inspection, with protected nursing time allocated for checking clinical stock and expiry dates. Any expired, damaged or unsuitable items	Senior Nurse Supported by: Deputy Managers and Nursing Team	Existing arrangement: Documented stock and expiry-date checking system in place prior to inspection. Completed: Expired items identified during inspection removed immediately. Completed: Weekly checking requirements

		are available for use.		identified are removed from use. The expired items identified during the inspection were removed immediately. Additional assurance following the inspection Following the inspection, the existing arrangements were strengthened by reinforcing weekly checks of clinical consumables and revising the stock-checking form in June 2026. The revised form provides a clearer audit trail, recording the date and location of the check, areas/items reviewed, expired items identified, any action required and taken, and the member of staff completing the check. Completed stock-check records will provide evidence of ongoing compliance. Further improvement A central clinical supply store is also being developed		reinforced and revised stock-checking form introduced – June 2026. In progress: Central clinical supply store being developed. Target completion: Central clinical supply store operational by November 2026. Ongoing assurance: Weekly clinical stock checks will continue, with completed records retained and expired or unsuitable items removed immediately.
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				to strengthen stock organisation, rotation and oversight across Practice sites. The store will be operational by November 2026 and will be checked weekly by the nursing team. Weekly checks of supplies held within individual clinical rooms will continue, with any expired or unsuitable items removed immediately and actions recorded.		
2	We did not see a workflow policy which clearly set out how correspondence should be delegated.	The practice should develop a written workflow policy to support consistent and safe management of incoming correspondence.	Health & Care Quality Standards (2023) – Leadership, Effective, Safe, Information.	Action completed The Practice developed and implemented a written workflow policy in June 2026, setting out the safe and consistent management of incoming correspondence. The policy clearly defines: • receipt and initial review of correspondence; • allocation and delegation to the appropriate clinical or administrative staff member;	Deputy Managers Supported by: Clinical Partners and relevant administrative leads	Completed: Written workflow policy developed and implemented – June 2026. Ongoing assurance: Compliance and outstanding workflow will be monitored through routine operational oversight, with the policy reviewed and updated where required.

				• recording and completion of required actions; • escalation of urgent, unclear or outstanding correspondence; • responsibilities of clinical and administrative staff; and • monitoring of outstanding workflow tasks. The policy is available to relevant staff and provides a clear framework for the consistent management of incoming correspondence. Completion will be evidenced through the implemented workflow policy. Ongoing assurance The policy will be reviewed through the Practice's established governance and document-control arrangements and updated		
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				where systems, responsibilities or workflow processes change. Compliance and outstanding workflow will continue to be monitored through routine operational oversight.		
2	The practice had an existing process for reviewing test results, initiating follow-up actions and contacting patients where required. However, we did not see a documented end-to-end process for tracking tests requiring repetition or re-booking through to confirmation that the appointment had been arranged and the	The practice should strengthen and document its existing test-results and follow-up process to ensure that tests requiring repetition or re-booking are tracked through to booking and completion, with proportionate escalation where patients do not respond or attend.	Health & Care Quality Standards (2023) – Safe, Effective, Timely, Information.	Existing arrangements The Practice already had established arrangements for identifying repeat blood tests and other investigations and contacting patients to arrange the required follow-up. Further action The existing process is being strengthened to include a documented tracking process for repeat investigations. When requesting a repeat test or investigation, the clinician will record the required timeframe and appropriate follow-up arrangements, taking	Clinical Governance Lead Supported by: Deputy Managers and relevant clinical and administrative staff	Existing arrangements: Repeat-test recall and patient-contact arrangements in place prior to inspection. In progress: Documented tracking and risk-based follow-up arrangements being incorporated into the repeat-test process. Target completion: Updated process implemented by 30th of September 2026. Ongoing assurance: Outstanding repeat investigations will be reviewed at the frequency defined within the updated process, with follow-up and

	investigation completed.			account of the clinical indication and level of risk. Outstanding repeat investigations will be reviewed regularly to confirm whether the investigation has been arranged and completed. Where it remains outstanding, further contact or escalation will be determined by the responsible clinician according to clinical risk, with actions and clinical decisions recorded in the patient record. This will provide a clear audit trail from the request for a repeat investigation through to completion or an appropriately documented clinical decision. Evidence will include the updated repeat-test process and records demonstrating tracking and follow-up of repeat investigations.		escalation documented according to clinical risk.
2	We reviewed one patient record in which a GP had	The practice should strengthen arrangements for	Health & Care Quality	Existing arrangements	Clinical Governance Lead	Existing arrangements: Clinical decision-making and remote consultation

requested an X-ray following a remote consultation without a face-to-face examination. The inspection team did not identify a concern about the clinical appropriateness of the decision. However, the record did not clearly document why a face-to-face examination was not considered necessary.	documenting diagnostic imaging referrals arising from remote consultations. Clinical records should clearly demonstrate the assessment undertaken, the rationale for the referral, and why a face-to-face examination was not considered necessary. This will support continuity of care, provide assurance that patients are assessed using the most appropriate consultation method for their presentation, and ensure that referrals contain sufficient clinical information to support	Standards (2023) – Safe, Person-centred, Effective. IR(ME)R 2017 – Regulation 10	The Practice already had established arrangements for remote consultations, with clinicians determining the most appropriate consultation method, examination and investigation according to the individual patient's presentation and clinical need. The finding related to one example identified during the inspection. This case was discussed with the GP Inspector during the inspection and the clinical management, including the decision to request diagnostic imaging following remote assessment, was agreed to be clinically appropriate. The area identified for improvement related to ensuring that the clinical reasoning supporting that decision was sufficiently clear within the patient record. Additional assurance following the inspection	Supported by: GP Partners	arrangements were in place prior to inspection. Completed: Documentation requirements reinforced with clinicians – July 2026. Monitoring: Sample review of diagnostic imaging referrals arising from remote consultations to be completed by November 2026. Ongoing assurance: Findings and any identified learning will be reviewed through the Practice's clinical governance arrangements.
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		justification under IR(ME)R		Following the inspection, documentation requirements for diagnostic imaging referrals arising from remote consultations have been reinforced with clinicians. Where relevant, records will clearly document the clinical assessment undertaken, the rationale for the investigation, and why a face-to-face examination was not considered necessary. Imaging referrals will also contain sufficient relevant clinical information to support review and justification by the imaging service. A sample of diagnostic imaging referrals arising from remote consultations will be reviewed to provide assurance that these documentation requirements are being consistently applied.		
2	We found limited evidence in the	The practice should ensure that	Health & Care Quality	Existing arrangements	Deputy Manager	Existing arrangements: Preferred Language

records reviewed that patients' preferred language was documented.	patients' preferred language is recorded consistently to support effective communication and delivery of the Welsh language Active Offer.	Standards (2023) – Person-centred, Equitable, Safe.	The Practice already had established arrangements to support the Welsh-language Active Offer, including a Preferred Language Policy, identification of Welsh-speaking staff, bilingual patient information and collection of preferred-language information through new-patient registration documentation. Action completed To strengthen the consistency of preferred-language recording within clinical records, a whole-team reminder was issued on 14th of July 2026, reinforcing the requirement to record and code each patient's preferred language appropriately. The 'More Than Just Words' Welsh-language awareness training has also been included within the Practice training programme, with completion recorded and	Supported by: Operational Supervisor and relevant clinical and administrative staff	Policy, Welsh-language arrangements and collection of preferred-language information through new-patient registration were in place prior to inspection. Completed: Whole-team reminder regarding preferred-language recording and coding issued – 14th of July 2026. In progress: More Than Just Words training monitored through the Practice training matrix. Monitoring: Sample review of preferred-language recording to be completed by 31st of October 2026. Ongoing assurance: Any gaps identified will be addressed and preferred-language recording will continue to be monitored through record-quality and
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				monitored through the training matrix. Further action and ongoing assurance Preferred-language recording will continue to be reinforced through new-patient registration and staff communication. A sample of patient records will be reviewed to provide assurance that preferred-language information is being consistently recorded and coded. Any gaps identified will be addressed with relevant staff and monitored through the Practice's record-quality and governance arrangements. Evidence will include the new-patient registration documentation, staff communication, training records and the completed sample record review.		governance arrangements.
2	The practice did not currently have a process in	The practice should introduce a regular audit of the	Health & Care Quality	Action completed The Practice introduced a Records Summarising and	Clinical Partners Supported by: Deputy	Completed: Records Summarising and Quality Assurance Policy

	place to review the quality of case records and summaries.	summarising of records to provide assurance that entries are accurate, complete, appropriately coded and contain sufficient clinical context.	Standards (2023) – Information, Effective, Safe, Learning, improvement & research.	Quality Assurance Policy in July 2026, setting out the required standards for accuracy, completeness, appropriate clinical coding, sufficient clinical context and relevant historical information. A monthly quality-assurance audit process has also been established. A Clinical Partner will review a sample of summarised and coded records against the standards within the policy. Further action and ongoing assurance Monthly audits will commence by 30th of September 2026, with protected Clinical Partner time allocated to undertake the reviews. Audit findings, recurring themes and any required actions will be recorded and reviewed through the Practice's clinical governance arrangements. Where improvement is	Managers and relevant coding and summarising staff	introduced and monthly audit process agreed – July 2026. In progress: Protected Clinical Partner time being allocated to undertake the audits. Target commencement: First quality-assurance audit completed by 30th of September 2026. Ongoing assurance: Audits undertaken monthly, with findings, themes and resulting actions documented and monitored through clinical governance.
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				identified, feedback and support will be provided to relevant staff, with further review undertaken where required. Evidence will include the Records Summarising and Quality Assurance Policy and completed monthly audit records, including any resulting actions.		
2	Some areas of staff awareness could be improved. Responses about carer support were mixed. Three respondents were not aware of occupational health and wellbeing support. Infection prevention and control responses were generally positive,	The practice should: • improve staff awareness of carer support arrangements • increase awareness of occupational health and wellbeing support • review how infection prevention and control cleaning arrangements are communicated to staff.	Health & Care Quality Standards (2023) – Workforce, Person-centred, Culture, Leadership, Learning, improvement & research.	Existing arrangements The Practice already had established arrangements for carer support, staff wellbeing and infection prevention and control, including a designated Carers Lead, access to occupational health and wellbeing services, and contracted cleaning arrangements with routes for staff to report concerns. Action completed A whole-team reminder was issued during the week commencing 20th of July 2026, setting out the	Deputy Managers Supported by: Carers Lead, Operational Supervisor and Infection Prevention and Control Lead	Completed: Occupational health and wellbeing information reinforced with the whole team – week commencing 20th of July 2026. In progress: Reception-team carer-support training – 20th of August, 15th of September and 14th of October 2026. Scheduled: Understanding Carers' Needs training for Carers Lead and relevant senior staff – 19th of November 2026.

although two respondents disagreed that there was an effective cleaning schedule.			occupational health and wellbeing support available to staff and how this can be accessed. Further action To strengthen staff awareness and confidence in supporting carers, dedicated external carer-support training has been arranged for reception staff across three sessions on 20th of August, 15th of September and 14th of October 2026, with each reception team member allocated to a session. The Carers Lead and relevant senior staff have also been allocated Understanding Carers' Needs training on 19th of November 2026. Staff will also be reminded of the Practice's cleaning and infection prevention arrangements, including how and to whom any cleaning or IPC concerns should be reported and escalated.		Target completion: Cleaning and IPC arrangements and reporting routes reinforced with staff by 30th of September 2026. Ongoing assurance: Awareness of carer support, staff wellbeing services and cleaning/IPC reporting arrangements will continue to be reinforced through induction, staff communication and relevant training.
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				Completion will be evidenced through staff communications and carer-training attendance/completion records.		
3	Staff told us the practice repeated DBS checks every three years.	The practice should consider introducing an annual interim DBS self-declaration as part of the appraisal process to provide additional assurance between formal DBS checks	Health & Care Quality Standards (2023) – Workforce, Safe, Leadership.	Existing arrangements The Practice already had an established DBS assurance process, with DBS checks renewed every three years and compliance monitored through a central DBS matrix maintained by the HR Manager. Renewal dates are tracked and staff are reminded in advance when checks are due. Action completed To provide additional assurance between formal DBS renewals, an annual interim DBS self-declaration was incorporated into the staff appraisal documentation on 11th of June 2026.	HR Manager Supported by: Relevant line managers and external HR provider	Existing arrangements: Three-yearly DBS renewal and central monitoring arrangements in place prior to inspection. Completed: Annual interim DBS self-declaration incorporated into staff appraisal documentation – 11th of June 2026. Ongoing assurance: Self-declarations completed as part of annual staff appraisals, with formal DBS renewals continuing to be monitored through the central DBS matrix.

				The declaration requires staff to confirm whether there have been any changes that may affect their suitability to undertake their role, with any disclosures reviewed and escalated appropriately. Completion will be evidenced through the revised appraisal documentation and completed annual self-declarations. Ongoing assurance The annual DBS self-declaration will form part of all future staff appraisals alongside the existing three-yearly DBS renewal process. Completion will be monitored through the appraisal process, with formal DBS renewal dates continuing to be monitored through the central matrix.		
3	We did not see evidence of pre-	The practice should ensure that pre-employment health screening is	Health & Care Quality	Action implemented Following the inspection, the Practice has formalised pre-	HR Manager Supported by: Relevant line	Implemented: Pre-employment health screening incorporated into the

employment health screening.	completed for all new staff, with appropriate risk assessments undertaken where health issues are identified.	Standards (2023) – Workforce, Safe, Leadership.	employment health screening within its recruitment process. All new staff will complete pre-employment health screening before commencing employment. Where information provided identifies a health issue that may require further consideration, an appropriate risk assessment and/or occupational health referral will be undertaken before the employee commences relevant duties. Completion will be recorded as part of the new-starter recruitment documentation to provide a clear audit trail. Evidence will include the revised recruitment/new-starter documentation and completed pre-employment health screening records. Ongoing assurance Completion of pre-employment health	managers and external HR provider	recruitment/new-starter process – June 2026. Ongoing assurance: Screening completed and recorded for all new staff prior to commencement, with appropriate risk assessment and/or occupational health referral undertaken where indicated.
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				screening will be monitored as part of the Practice's recruitment and new-starter checks, with any required risk assessments or occupational health advice documented and actioned appropriately.		
3	One of the five staff training records we reviewed showed that Duty of Candour training had been completed.	The practice should ensure all staff complete Duty of Candour training appropriate to their role.	Health & Care Quality Standards (2023) – Workforce, Safe, Leadership, Learning, improvement & research.	Existing arrangements Duty of Candour training already formed part of the Practice's established staff training programme, with completion and renewal requirements monitored through the Practice training matrix. Additional assurance following the inspection Following the inspection, the Practice commenced a coordinated renewal programme to ensure all staff complete the most up-to-date Duty of Candour training appropriate to their role. As at 29th of July 2026, 58% of staff had completed the	Deputy Manager Supported by: Relevant line managers and Clinical Governance Lead	Existing arrangements: Duty of Candour training formed part of the established staff training programme prior to inspection. In progress: Coordinated renewal programme underway; 58% completion as at 29th of July 2026. Target completion: All remaining staff to complete role-appropriate Duty of Candour training by 30th of September 2026. Ongoing assurance: Completion and future renewal requirements

				updated training. Outstanding staff have been allocated the appropriate training, with completion monitored through the Practice training matrix. Further action and ongoing assurance All remaining staff will complete the appropriate Duty of Candour training by 30th of September 2026. Completion and future renewal requirements will continue to be monitored through the training matrix, with outstanding requirements followed up with the relevant staff member and line manager. Evidence will include the updated training matrix and staff training records/certificates.		monitored through the Practice training matrix.
3	We did not see evidence of a systematic annual audit programme	The practice should consider developing an annual audit schedule, with a	Health and Care Quality Standards (2023) – Learning,	Existing arrangements The Practice already undertook a range of clinical, operational and governance audits throughout the year,	Clinical Governance Lead and Managing Partner Supported by: Deputy Managers, Clinical	Existing arrangements: Clinical, operational and governance audit activity undertaken prior to inspection.

covering clinical and internal audit activity across the practice.	clear process for recording audit findings, sharing learning and following up actions where required.	Improvement & Research, Leadership, Information, Effective, Safe.	with findings and resulting actions reviewed through the relevant clinical, management and governance arrangements. Further action To strengthen Practice-wide oversight, existing audit activity is being brought together within a single annual audit programme and central audit register. The register will record the audit or review, responsible lead, planned frequency or completion date, findings and learning, any resulting actions and timescales, and evidence of follow-up and completion. Audit findings and relevant learning will be shared through the appropriate Practice governance arrangements. Actions requiring further work will remain recorded on the central register until completion has been evidenced.	Partners and relevant departmental leads	In progress: Annual audit schedule and central audit register being developed. Target completion: Annual audit schedule and central register completed by 30th of September 2026, with formal implementation from October 2026. Ongoing assurance: Progress, findings, learning and outstanding actions reviewed through established governance arrangements, with the programme refreshed annually.
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				Evidence will include the annual audit schedule, central audit register and records of completed audits and resulting actions. Ongoing assurance Progress against the programme will be reviewed through the Practice's established governance arrangements. The programme will be reviewed and refreshed annually to reflect identified risks, priorities and assurance requirements.		
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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: