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Healthcare Inspectorate Wales

General Practice Inspection Report (Announced)

Ty'r Felin Surgery, 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 Vision

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

Our Values

We place people at the heart of what we do.

We are:

Independent – we are impartial, deciding what work we do and where we do it.

Objective - we are reasoned, fair and evidence driven.

Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find.

Inclusive - we value and encourage equality and diversity through our work.

Proportionate - we are agile and we carry out our work where it matters most.

Our Priorities

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

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

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

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



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1. What we did

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

Healthcare Inspectorate Wales (HIW) completed an announced inspection of Ty'r Felin Surgery, Swansea Bay University Health Board on 28 July 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 two questionnaires were completed by patients or their carers and three were completed by staff. The number of completed questionnaires was too low to provide reliable or representative findings. Because of this, the feedback cannot be used in this report.

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

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

2. Summary of inspection

Quality of Patient Experience

Overall summary:

We found that patients received care in an environment that promoted dignity and respect. There was access to a wide range of health and wellbeing services. The practice offered comprehensive health promotion support, including access to vaccination programmes, mental health services, social prescribing initiatives and self-management resources. We identified noteworthy practice through the provision of a self-service health monitoring area, which enabled patients to check and record their blood pressure, height, weight and body mass index whenever the surgery was open.

We found that patients were generally able to access care in a timely manner through a range of appointment options, including same-day appointments, telephone triage, online consultations and face-to-face appointments. Staff demonstrated an awareness of the needs of older patients, vulnerable groups and those who were digitally excluded, and alternative methods of access were available.

The practice demonstrated a commitment to supporting equality, diversity and the Welsh language. Bilingual information was available, Welsh-speaking staff were employed, and reasonable adjustments were made to meet individual patient needs. The premises were generally accessible and staff were sensitive to the needs of patients requiring additional support.

We also identified areas where improvements were required. Health promotion information displayed on waiting room screens was not available in Welsh and some QR code links provided to patients were not functioning correctly. In addition, patients' preferred languages were not consistently recorded and the practice did not have a patient consent policy in place.

We found that patient privacy was respected and appropriate chaperone arrangements were available. However, patient records we reviewed did not consistently demonstrate that verbal consent for intimate examinations, the offer of a chaperone and the patient's decision had been documented. We also identified a safety concern within the accessible toilet, which did not have an emergency assistance pull cord installed.

This is what we recommend the service can improve:

- Ensure patients' safety and rights are protected by consistently recording verbal consent for intimate examinations, the offer and outcome of chaperone discussions, and the details of any chaperone present in patient records
- Improve accessibility and inclusivity by ensuring health promotion is available in

Welsh and English

- Strengthen patient safety and accessibility by installing an emergency assistance pull cord within the accessible toilet.

This is what the service did well:

- The practice demonstrated a strong commitment to health promotion and prevention
- The practice offered patients a range of appointment options and had effective systems in place to support timely access to care
- Staff demonstrated a commitment to equality, dignity and respect.

Delivery of Safe and Effective Care

Overall summary:

We found that the practice had appropriate systems in place to support the safe and effective delivery of care. Staff demonstrated an awareness of risk management processes, safeguarding responsibilities, infection prevention and control requirements, and the safe management of medicines and medical equipment. We found evidence of effective multidisciplinary working, established referral pathways and arrangements to support patients with both physical and mental health needs. The quality of patient records was generally good, with entries being clear, up to date and supported by appropriate clinical reasoning. Noteworthy practice was identified in relation to the management of repeat prescriptions and the arrangements in place to support continuity of care for patients receiving palliative care.

The practice had suitable arrangements for the storage and management of medicines, vaccines and emergency equipment. Infection prevention and control processes were largely well established, with trained staff, appropriate policies and suitable facilities available. Medical equipment was maintained appropriately and staff were able to access support for repairs and replacement where required. Safeguarding systems were also well developed, supported by a nominated lead and effective partnership working with other professionals and agencies.

However, we identified some areas requiring improvement. Cleaning records were not consistently available to demonstrate that cleaning schedules had been completed, and dust was observed in some clinical areas. We also identified weaknesses in the monitoring and completion of safeguarding training, with incomplete training records for a number of GPs. In addition, some safeguarding information was not consistently coded or flagged within patient records following the recent migration to a new clinical system.

Further improvements were required in relation to governance of risk assessments, business continuity arrangements, record coding and clinical workflow processes. Active problem lists and medication links within patient records were not always accurate or easy to interpret, and there was limited assurance regarding the quality of clinical summarising undertaken by non-clinical staff.

This is what we recommend the service can improve:

- Strengthen infection prevention and control arrangements by ensuring that cleaning schedules are completed, documented and routinely monitored
- Improve safeguarding and governance oversight by ensuring all staff complete safeguarding training appropriate to their role and that safeguarding information is accurately coded and flagged within patient records

- Enhance the quality and oversight of patient records by reviewing clinical coding following the recent system migration, ensuring active problem lists are accurate and introducing regular audits of patient records and clinical summaries.

This is what the service did well:

- The practice had a clear and well-structured repeat prescribing process, which supported the safe and consistent management of medication requests
- A lead and deputy lead had been appointed for named palliative care patients, supporting continuity, oversight and coordinated multidisciplinary care.

Quality of Management and Leadership

Overall summary:

We found that the practice had established governance, leadership and quality improvement arrangements that supported the delivery of services and promoted a culture of learning and continuous improvement. Staff understood their roles and responsibilities, described leaders as visible and approachable, and reported that they were encouraged to contribute ideas and feedback. The practice demonstrated positive engagement with the Quality Assurance and Improvement Framework, cluster initiatives and wider health system partners to improve services for patients.

The practice had effective recruitment processes, induction arrangements and appraisal systems in place. Staff had access to wellbeing support services, protected learning time and opportunities for professional development. We also found evidence of a range of audit and quality improvement activity, including the introduction of innovative approaches such as a health pod, the employment of a pharmacy technician and the use of digital technologies to support communication and clinical practice. Complaints, concerns and audit findings were discussed regularly and used to support learning and service development.

The practice had suitable arrangements for managing information and data, including information governance processes, performance monitoring and data-sharing agreements. Collaborative working arrangements with Swansea Bay University Health Board and the Llwchwr Cluster supported service development, coordinated care and a shared understanding of local healthcare needs.

However, we identified areas where governance arrangements required strengthening. Policy management processes were not sufficiently robust, with several policies lacking version control, issue dates and review dates, and some important policies not being available. In addition, compliance with training requirements was inconsistent, particularly among GPs, and there were limited arrangements to monitor ongoing staff suitability for work following appointment. Improvements were also required to ensure complaints documentation reflected current NHS Wales processes and to better demonstrate to patients how feedback had led to service improvements.

This is what we recommend the service can improve:

- Strengthen governance arrangements by reviewing and updating the practice's policy framework to ensure all policies are current, complete, subject to effective document control and include key policies
- Improve workforce assurance by ensuring all staff complete training relevant to their role, maintaining accurate training records and introducing robust systems to monitor ongoing compliance

- Enhance workforce safety and governance processes by introducing regular Disclosure and Barring Service checks and implementing a formal process for staff to declare any changes that may affect their ongoing suitability to work.

This is what the service did well:

- The practice had introduced several innovative approaches to improve service delivery, including a health pod, a pharmacy technician role and digital tools to support communication between patients and healthcare professionals
- The practice demonstrated a positive culture of learning and continuous improvement, using audits, complaints, quality improvement initiatives and new technologies, including a health pod and digital tools, to develop and improve services for patients.

3. What we found

Quality of Patient Experience

Person-Centred

Health promotion

We found that patients were able to access a range of information to support them in improving their health and maintaining a healthy lifestyle. Health promotion information was displayed on television screens in the waiting area and included advice about alcohol consumption, smoking cessation, blood pressure, diet and oral health. Leaflets were also available within the practice, and further healthy living information was provided on the practice website. However, we noted that the health promotion information displayed on the television screens was not available in Welsh.

The practice should ensure health promotion information displayed on waiting room television screens is available in both Welsh and English.

We reviewed the use of QR codes on posters displayed in the waiting room. Some of the QR codes on the QR Info Pod poster displayed next to reception did not work correctly. This limited the effectiveness of the poster as a health promotion resource and may prevent patients from accessing relevant information or support.

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.

Staff told us that clinicians were able to provide patients with health promotion and condition-specific information during consultations. This information could be printed for patients or sent by SMS text message and included healthy living and smoking cessation advice. Posters containing information and advice about domestic abuse and violence were displayed prominently throughout the practice.

Patients were able to access a range of healthcare professionals and additional clinical services at the practice. A midwife and health visitor attended the practice once a week. The practice also provided joint injection clinics and long-acting reversible contraception clinics.

The practice had taken steps to prepare for the rollout of the Respiratory Syncytial Virus vaccination and immunisation programme and would be offering the winter vaccination programme. Staff described plans to identify eligible patients and contact them by text message, letter or telephone, where appropriate. To ensure vaccination information was accessible to older people and those without digital access, the practice used posters within the surgery, written correspondence and telephone contact. Staff also

told us that information about available services was promoted during consultations and through information boards within the practice. The practice also delivered influenza, COVID-19 and shingles vaccination services.

Cluster-funded services included counselling for children and families and access to a complex needs worker who supported patients affected by domestic abuse, substance misuse and mental health concerns. Patients could be referred to the complex needs worker by a GP. Social prescribers and local area coordinators were also available to connect patients with community activities and support, including men's groups, walking groups and reading groups delivered in partnership with the local authority.

Other available services included podiatry self-referral, drug and alcohol support, audiology and earwax services. Information about these services was available on the practice website and through posters and leaflets displayed in the waiting area.

The practice also had several services available to support patients' mental health and wellbeing. These included SilverCloud support, dementia services, the complex needs worker and family and child therapy services.

In addition to these resources, the practice provided an area near reception where patients could independently check their blood pressure, height, weight, and BMI. Patients were able to hand in their results which would be recorded in their patient record. This is an area of noteworthy practice, since patients can access this anytime the surgery is open.

Staff told us that the practice had a low number of patients who did not attend their appointments. Where a child was not brought to an appointment, the clinician responsible for the appointment reviewed the circumstances. Where safeguarding concerns were identified, these were referred to the practice safeguarding lead. The practice had an up to date "Was Not Brought" procedure incorporated within its safeguarding policy. However, there did not appear to be a clearly defined process for reviewing and managing adults who did not attend appointments.

The practice should develop and implement a documented process for reviewing and managing adult patients who do not attend appointments.

Dignified and respectful care

We found that the practice environment and working arrangements supported patients' rights to be treated with dignity and respect. Clinical rooms provided patients with appropriate levels of privacy. Consultation room doors were kept closed during appointments, privacy curtains were available in examination rooms, and rooms with external windows had suitable frosted glass or coverings in place. We also observed that clinical and non-clinical staff communicated with patients, and discussed patient information with colleagues, in a discreet and sensitive manner.

Within the reception area, attempts had been made to protect patients' privacy using

barriers designed to reduce noise and restrict the view from the waiting area.

The practice offered access to both male and female chaperones. Information about the chaperone service was displayed at reception and was accessible to patients. Staff acting as chaperones had received training to ensure they understood their roles and responsibilities. An up-to-date chaperone policy was also available.

However, our review of patient records identified that verbal consent for intimate examinations was not always documented. The offer of a chaperone, whether the patient had accepted or declined the offer, and the details of any chaperone present were also not consistently recorded.

The practice must ensure that verbal consent for intimate examinations, the offer of a chaperone, the patient's decision to accept or decline the offer, and the details of any chaperone present are consistently recorded in the patient's medical record, in accordance with General Medical Council guidance.

Timely

Timely care

We found that the practice had a range of systems in place to support patients to access care through the most appropriate channel and in a timely manner. Information about the different ways patients could access appointments and obtain advice was available on the practice website, through social media and within the practice leaflet.

Patients were able to provide feedback about the appointment system through a feedback box located in the reception area. The practice also gathered patient views through surveys distributed by text message, paper copies made available in the waiting area and a QR code. Staff told us that they offered assistance to patients who needed help to complete the survey, which supported participation by older patients and those who may have experienced communication or digital barriers.

Reception staff received care navigation training as part of their induction. An up-to-date care navigation policy was available and included detailed processes to support staff in directing patients to appropriate services, including community pharmacy and other healthcare professionals. Staff confirmed that non-clinical staff were also able to seek advice from clinical colleagues when they were unsure about the most appropriate pathway for a patient.

Staff described arrangements to support older people and other vulnerable patients who required a face-to-face appointment or who experienced communication difficulties. Patients who were unable or did not wish to use digital systems could contact the practice by telephone or attend the reception desk to request an appointment.

Staff told us that most appointments were made available on the same day and that

most presenting concerns were managed on the day they were raised. Appointments could be arranged by telephone, through an online consultation system or in person at reception. Some appointments were pre-booked for follow-up discussions, test results or reviews of ongoing conditions.

The appointment system included a range of appointment slots, including pre-booked appointments, electronic consultations and telephone triage appointments. Staff told us that most patients initially received telephone triage and, where a face-to-face assessment was required, were provided with a time to attend the practice.

Staff confirmed that a process was in place for managing patients when all routine GP appointments had been filled. There was also a process for determining which patients required a face-to-face consultation and which patients could be appropriately managed through an alternative consultation method.

Staff told us that patients requiring urgent mental health support were managed in the same way as patients presenting with other urgent health concerns. Reception staff were able to signpost patients to NHS 111 Option 2 services and, where a patient required urgent clinical assessment, arrangements were made for them to be reviewed by a GP.

Processes were in place for referring adults and children to secondary mental health services. While patients were waiting for their referral to be accepted or for treatment to begin, risks could be managed through further review by a GP or by signposting the patient to NHS 111 Wales Option 2.

Equitable

Communicating and language

We found that the practice communicated information to patients through a range of methods. Information about the services provided was available through the practice website, social media, the practice information leaflet and posters and leaflets displayed in the waiting areas.

Patients were informed of important changes to the practice through its website, social media channel and posters displayed within the waiting areas. Staff told us that patients who were older or did not have access to digital services could be informed of changes by letter or telephone.

The practice website could be translated into a range of languages, and staff had access to a translation service when required. However, our review of patient records found that patients' preferred languages were not consistently recorded. This could limit the practice's ability to identify and meet patients' individual communication needs.

The practice should ensure that each patient's preferred language and

communication needs were consistently recorded within their medical record.

We saw evidence that consent forms were completed for some clinical procedures and interventions. However, the practice did not have a patient consent policy in place.

The practice should develop and implement a Patient Consent Policy to ensure patients are informed appropriately and consent is obtained consistently for all relevant procedures and processes. The policy should include arrangements for patients who lack capacity and those who are regarded as minors.

Staff told us that they were aware of, and supported to deliver, the Welsh language Active Offer. The practice aimed to greet patients in Welsh where possible and that a Welsh-speaking GP and pharmacist were available. Staff had access to Welsh language training, and Welsh language requirements were considered as part of recruitment and workforce planning. We also saw bilingual signs, posters and reading material displayed within the practice.

Rights and equality

We found that the practice had arrangements in place to promote equality, diversity and inclusion. An equality, diversity and inclusion policy was available, and staff had completed relevant training. Staff had also undertaken autism awareness training to support them in meeting the needs of neurodivergent patients.

The practice was accessible to patients with mobility needs. All patient areas were located on the ground floor, and step-free access was available from the car park and street. The main entrance had an automated door, and designated disabled parking spaces were provided. Unisex toilet facilities were also available.

However, the accessible toilet did not have an emergency assistance pull cord. This could limit a patient's ability to call for help in the event of an emergency.

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.

Staff provided examples of reasonable adjustments that had been made to meet patients' individual needs. We were told that efforts were made to support patients who may have found busy environments difficult.

The practice had arrangements in place to uphold the equality rights of transgender patients. Staff confirmed how patients wished to be addressed, including their preferred name and pronouns, and this information could be recorded within patient records. Staff also confirmed patients' preferences regarding how they wished to be addressed in written correspondence.

Delivery of Safe and Effective Care

Safe

Risk management

We found that the practice had a range of arrangements in place to identify, manage and respond to risks. Appropriate signage was displayed to alert staff and patients to potential hazards, and there was a mechanism in place for staff to summon urgent assistance when required.

Most areas of the practice were maintained appropriately. However, some clinical spaces were cluttered. For example, one GP consulting room was being used to store several bulky items of non-clinical equipment. We also noted that the paintwork within the pharmacy staff office required refreshing.

The practice should ensure that clinical rooms are kept tidy and free from unnecessary equipment and that areas requiring maintenance are addressed promptly.

The practice had an up-to-date business continuity plan. However, the plan did not include arrangements relating to partnership risk or risks associated with the practice operating from leased premises.

The practice should update its business continuity plan to include appropriate consideration of partnership risk and risks associated with the leased premises.

We reviewed recent fire, health and safety, and disability risk assessments. We saw evidence that some of the actions identified within the assessments had been completed. However, for a number of actions, it was not clear whether these had been addressed, as records of progress and completion were not consistently maintained.

The practice should review the findings of these risk assessments and implement any outstanding actions without delay. It should also strengthen its arrangements for recording, monitoring and evidencing the actions taken in response to identified risks.

The practice manager and deputy practice manager were aware of the relevant sustainability framework and associated escalation levels. A designated member of staff was responsible for receiving patient safety alerts, and arrangements were in place to provide cover during periods of leave of absence. Staff described a process for reviewing, actioning and distributing alerts to relevant members of the practice team.

Significant events, including patient safety incidents, were discussed as a standing agenda item at practice meetings. The practice also undertook an annual review of significant event analyses to identify themes and learning.

Staff knew where emergency medicines and equipment were stored and how to access them. However, these items were stored in a treatment room that was occasionally used to see patients. This matter was addressed through the concerns resolved during inspection process, as detailed in Appendix A.

The practice had a home visit policy in place. Staff told us that risks associated with home visits were assessed on a case-by-case basis using clinical judgement. Alerts were used within patient records to highlight known risks, and we saw evidence that relevant risk assessments had been completed.

Infection prevention and control (IPC) and decontamination

There was an appointed infection prevention and control lead, and staff were aware of who held this role. Staff we spoke with understood their responsibilities in maintaining infection prevention and control standards. The practice also had a site-specific infection prevention and control policy in place.

Suitable hand hygiene facilities were available throughout the practice. Arrangements were also in place to enable patients to be segregated, where required, to reduce the risk of healthcare-associated infection.

The practice had appropriate waste management procedures in place, supported by a waste management policy and a completed healthcare waste audit.

An up-to-date blood-borne virus policy and a needlestick and sharps injury policy were in place. Posters and flowcharts setting out the action staff should take following a needlestick or sharps injury were displayed in accessible areas. We also reviewed the practice's hepatitis B immunisation register and confirmed that relevant clinical staff had received appropriate immunisation.

A cleaning contract was in place for the practice premises, and we saw cleaning schedules. However, daily cleaning records were not available for review. Consequently, we were unable to verify whether routine environmental cleaning had been completed consistently and in accordance with the agreed schedule. We also observed dust underneath some clinical examination benches, which indicated that cleaning standards were not always being maintained.

The practice must ensure that the scheduled cleaning programme is delivered in accordance with the cleaning contract. Cleaning schedules should be consistently followed and documented, with regular audit undertaken to monitor and maintain cleaning standards.

Medicines management

We found that the practice had suitable arrangements in place to support the safe prescribing, storage and management of medicines.

Prescription pads were stored securely, and a comprehensive log was maintained to record their use. An audit trail was also in place to record when controlled drug prescriptions were collected and by whom.

The practice had a clear and well-structured workflow for managing repeat prescription requests. **The process supported the safe and consistent handling of prescriptions and was identified as noteworthy practice.** Medication reviews were also undertaken to ensure patients' medicines remained appropriate for their clinical needs.

We reviewed two prescribing policies. One was the current policy, while the other was a comprehensive draft policy. The draft policy had not yet been formally adopted.

The practice should formally adopt the draft prescribing policy and ensure it is reviewed and updated as required.

Vaccines were stored in dedicated clinical refrigerators that maintained temperatures within the recommended range. The refrigerators were serviced regularly, and staff completed daily temperature checks to ensure they remained fit for use. Vaccines were stored appropriately, and the refrigerators were not overstocked. An up-to-date cold chain policy was also available.

The nursing team was responsible for completing routine checks of medicines held at the practice. Records of these checks were stored on the shared electronic filing system, and checks were completed monthly. All medicines inspected were within their expiry dates.

The nursing team was also responsible for checking the emergency medicines and equipment, including the automated external defibrillator and oxygen cylinder. The emergency equipment contained the items required to meet the minimum primary care standards outlined by Resuscitation Council UK. However, checks of emergency medicines and equipment had been completed monthly rather than weekly. This issue was addressed through the concerns resolved during inspection process, as detailed in Appendix A.

Portable oxygen cylinders were available and ready for use, and suitable arrangements were in place for reporting incidents involving oxygen cylinders. An automated external defibrillator was also available and ready for use, with appropriate signage displayed to identify its location.

The practice did not store controlled drugs on site.

Safeguarding of children and adults

We found that the practice had established arrangements in place to safeguard children and adults. A nominated safeguarding lead had been appointed, and all staff

we spoke with were aware of who held this responsibility. An up-to-date safeguarding policy was available, and staff knew how to access the All Wales Child Protection Procedures.

Staff told us that a cluster-funded safeguarding peer support group was available, which provided an opportunity for professionals to discuss safeguarding matters and share learning.

We reviewed five records relating to children included on the child protection register. Two of these records did not contain evidence of appropriate linked records or safeguarding alerts. Following discussion with the safeguarding lead, it was considered likely that this had resulted from the practice's migration to a new clinical system during the preceding three months.

The practice should review its coding arrangements to ensure that safeguarding information, including linked records and appropriate alerts, is consistently and accurately recorded within patients' medical records.

The practice had processes in place to monitor attendance at accident and emergency departments and to review patients who did not attend, or children who were not brought to, appointments.

We saw evidence of multi-agency and multidisciplinary working. Safeguarding meetings were held with health visitors, and staff communicated with practice nurses and district nurses by email where appropriate. Palliative care meetings involved specialist nurses, district nurses and administrative staff.

Vulnerable adults were clinically coded and flagged within their medical records. The practice had also appointed a lead and deputy lead for named patients receiving palliative care. **This supported continuity, oversight and coordination of care and was identified as noteworthy practice.**

Staff told us that safeguarding training requirements were set according to role, with level one training expected for administrative staff, level two for managers and level three for clinicians. However, our review of training records identified incomplete safeguarding training records for more than half of the GPs.

The practice must ensure that all staff complete safeguarding training at a level appropriate to their role and that complete, accurate and up-to-date training records are maintained.

Management of medical devices and equipment

We found that the practice had suitable arrangements in place to support the safe use, maintenance and replacement of medical equipment and devices. Staff told us that single-use equipment was used wherever possible to reduce the risk of cross-infection.

The nursing team was responsible for checking medical equipment and devices and for reporting any items that required repair or replacement. These checks were recorded on a spreadsheet. The equipment and devices we reviewed appeared to be in a good condition and suitable for use.

The practice had contracts in place for the servicing and maintenance of medical devices and equipment, which we reviewed during the inspection. There was also a process in place to arrange the urgent repair or replacement of equipment when required.

Effective

Effective care

We found that the practice had processes in place to support the delivery of safe and effective treatment and care, with appropriate links to wider primary care services.

The practice used a range of methods to remain up to date with best practice, national and professional guidance, and new ways of working. The practice manager attended practice manager and cluster meetings, and staff completed relevant training. Staff also described arrangements for circulating new information to appropriate members of the practice team.

There were established arrangements for internal communication. Clinical messages were communicated through the clinical system, while non-clinical information was shared using secure NHS email.

New guidance from the National Institute for Health and Care Excellence (NICE) was shared with staff via WhatsApp and discussed at partner meetings where appropriate. A process was also in place for reporting and reviewing incidents.

The practice had established processes for managing urgent, routine and urgent suspected cancer referrals. Urgent suspected cancer referrals were completed by the doctor responsible for the patient's care. Referrals were also discussed within the practice, which supported the identification of variation and any areas requiring further review.

Staff told us that correspondence received by the practice was scanned, clinically coded and directed to the appropriate team through the workflow process. A workflow policy was available; however, it did not contain sufficient detail to provide the administrative team with clear guidance on individual responsibilities and required actions.

The practice should review and update its workflow policy to ensure staff have clear guidance on the management of correspondence, including how information should be reviewed, recorded and escalated to clinicians where appropriate.

Information received following a patient's contact with out-of-hours services was recorded within their medical record. The practice also had processes in place to ensure that patients requiring further investigations or tests were followed up appropriately. Staff described the arrangements for ordering tests, communicating results to patients and ensuring results were followed up when the requesting clinician was unavailable.

A system was in place to notify the practice when a patient had died, enabling records and relevant administrative processes to be updated appropriately.

Processes were also in place to support patients experiencing poor mental health or a mental health crisis. Patients could be signposted to the NHS 111 Option 2 mental health service or referred for counselling. Cluster-funded counselling services were available for both children and adults.

Patient records

We reviewed a sample of nine patient records to assess the general quality of record keeping within the practice. Overall, the records reviewed were clear, up to date, complete and understandable. They contained appropriate evidence and reasoning to support decisions made about patients' care, and entries were recorded contemporaneously.

We saw evidence that patients with chronic conditions were included on appropriate disease registers and that relevant reviews, including diabetes reviews, had been completed and documented.

However, active problem lists were not always easy to interpret. Some contained duplicate entries, and historic conditions sometimes remained recorded as active problems when this was no longer appropriate. Staff told us that this may have been associated with the practice's recent migration to a new clinical system.

We also found that prescribed medicines were not consistently linked to the relevant clinical problem within patients' records. This reduced the clarity of the relationship between a patient's diagnosis and their current treatment and may also have been affected by the recent system migration.

The practice should review clinical coding and active problem lists following the recent clinical system migration. This should ensure that duplicate entries are removed, historic conditions are no longer recorded as active where this is inappropriate, and prescribed medicines are linked to the relevant clinical problems.

Non-clinical staff involved in summarising patient information had received training in the practice's workflow and clinical coding processes. However, the practice did not undertake a formal review or audit of the quality of record summarisation. Consequently, the practice could not fully demonstrate that summaries were

consistently accurate, complete, appropriately coded and supported by sufficient clinical context.

The practice should introduce regular audits of patient records and clinical summaries to provide assurance that entries are accurate, complete, appropriately coded and contain sufficient clinical context.

Efficient

Efficient

The practice had systems in place to support the efficient delivery of care and to help patients move through care and treatment pathways. Patients could be referred to external clinics where this was clinically appropriate, and self-referral options were available for a range of services.

Staff also described systems for reporting and learning from significant events. This indicated a culture of continuous improvement and supported the practice to identify opportunities to improve the efficiency and safety of care delivery.

Quality of Management and Leadership

Leadership

Governance and leadership

We found that the practice had operational systems and processes in place to support effective governance, leadership and accountability.

Staff told us that they understood their individual roles, responsibilities and reporting lines, and the importance of working within their scope of practice. A named individual was responsible for clinical oversight, and designated leads were in place for key areas, including safeguarding, nursing, infection prevention and control, and complaints management. Staff were aware of these arrangements and knew who to approach for advice.

Leaders operated an open-door policy and were described as visible and approachable to the wider practice team.

Regular team meetings were held, and we saw evidence of these through meeting minutes. Staff told us that they were encouraged to contribute items to meeting agendas. Minutes were made available to staff through the practice shared drive.

Information, including changes to policies and procedures, was shared during staff meetings and by email. The electronic human resources platform also recorded when the practice handbook had been updated and enabled the practice to monitor whether staff had read the revised information.

Safety notices and guidance received from organisations such as the Medicines and Healthcare products Regulatory Agency and Welsh Government were disseminated and discussed at practice and team meetings.

However, the policies and procedures reviewed were inconsistent. Most did not include effective document control arrangements, such as a version number, date of issue or scheduled review date. Some required policies were also unavailable, including a Duty of Candour policy.

The practice should review its policy framework to ensure that all policies and procedures are current, complete, readily accessible and subject to effective document control. This should include the use of version numbers, issue dates and review dates, and the development and adoption of any missing policies, including those relating to patient consent and the Duty of Candour.

Staff had access to a range of wellbeing support services. These included occupational health services provided through the health board, counselling services, the Wellbeing Through Work programme and an employee assistance programme.

Staff identified the size of the premises as a significant challenge. As the practice continued to register new patients, the available space was becoming increasingly limited. This had resulted in some GPs working remotely on occasions and created difficulties in managing demand for face-to-face consultations. Staff also described challenges associated with adapting to the recent migration to a new clinical IT system.

We saw evidence that the practice had arrangements in place to meet the requirements of the Quality Assurance and Improvement Framework. This included work relating to the optimisation of care for patients with chronic kidney disease.

There were clear lines of accountability for service standards and required improvements. The practice also demonstrated effective engagement with the wider cluster and described a number of positively developed cluster projects and initiatives.

Workforce

Skilled and enabled workforce

We found that the practice had arrangements in place to support the recruitment, development and ongoing management of its workforce. An up-to-date recruitment policy was available. The recruitment process included appropriate pre-employment checks, such as confirmation of identity, Disclosure and Barring Service checks at a level appropriate to the role, a full employment history, written references, evidence of relevant qualifications and, for healthcare professionals, confirmation of registration with the appropriate regulatory body.

An up-to-date induction policy and programme were also in place. Staff told us that management, administrative, accountability and reporting responsibilities were clearly defined and understood.

We saw evidence that annual staff appraisals had recently been completed. However, Disclosure and Barring Service (DBS) checks were only undertaken when staff commenced employment and were not repeated at regular intervals, as determined by a practice policy position. There was also no formal process in place for staff to make an ongoing declaration regarding any changes that could affect their suitability to work.

The practice should:

- **adopt a clear policy position on when Disclosure and Barring Service checks for staff should be renewed and at a level appropriate to their role**
- **implement a process requiring staff to declare any changes that may affect their ongoing suitability to work, such as criminal offences, cautions or investigations. This could be completed annually as part of the appraisal process.**

Senior staff told us that the practice encouraged staff training and professional

development. Staff had access to protected learning time sessions, and there was evidence of ongoing development within the clinical team. For example, one nurse was undertaking a Master of Science qualification to become an advanced nurse practitioner.

We reviewed the training records of clinical and administrative staff. The records showed mixed levels of compliance with training requirements, with the GP workforce demonstrating the lowest level of compliance. This meant that the practice could not demonstrate that all staff had completed and remained up to date with the training required for their roles.

The practice must:

- **ensure that all staff complete and remain compliant with training relevant to their roles**
- **implement robust governance arrangements to monitor training compliance continuously and identify promptly when training or refresher updates are required.**

Staff were working within roles that reflected their qualifications, skills, knowledge and experience. Appropriate clinical supervision arrangements were in place.

The skill mix and competencies of the workforce were reviewed through annual appraisals and partner meetings. Staff told us that workforce requirements were also considered on an ongoing basis to ensure that the skills available within the practice continued to meet the needs of the patient population.

Culture

People engagement, feedback and learning

We found that the practice had arrangements in place to support patients, relatives and carers to provide feedback about the services it delivered.

A named member of staff was responsible for managing complaints and concerns. The practice monitored the number and type of complaints received using a spreadsheet. Staff told us that the practice was in the process of implementing the NHS Wales Listening to People process, and we saw evidence that complaints and concerns had been managed in accordance with the new arrangements.

Information about the Listening to People process was available to patients through leaflets displayed in the waiting area. However, the practice's complaints policy had not been updated to reflect the new procedure. This meant that the written policy did not provide staff with current guidance on the handling, investigation and response to complaints and concerns.

The practice should update its complaints policy to ensure that it aligned with the

NHS Wales Listening to People process and accurately reflected the procedures followed by staff.

A patient suggestion box was available in the waiting area, which provided patients with an opportunity to share their views. However, the practice did not have a clear process for informing patients about the actions taken in response to feedback. Introducing a visible feedback mechanism would help demonstrate that patients' views were valued and had contributed to service improvements.

The practice should introduce a suitable process to demonstrate how patient feedback had been considered and acted upon. This could include publishing information on the practice website, displaying updates in the waiting area or introducing a "you said, we did" approach.

Complaints, concerns and other feedback were discussed at practice meetings, and the meeting minutes were shared with staff. This supported the dissemination of learning and enabled the practice to consider whether changes to services or working practices were required.

Staff told us that employees at all levels were encouraged to speak openly and contribute new ideas. An up-to-date whistleblowing policy was also available to support staff who wished to raise concerns about the service.

Information

Information governance and digital technology

We found that the practice had suitable arrangements in place to support the safe and effective management of information. An information governance policy was available and covered the information processed by the practice. Digital Health and Care Wales acted as the practice's Data Protection Officer.

The practice had clear processes in place for handling patient information. Information about data protection and how information was managed was available to patients in the waiting area and on the practice website.

Staff told us that audits were undertaken to monitor the quality of data held by the practice and to help ensure that information was accurate and suitable to support the delivery of safe and effective care.

The practice also had performance monitoring arrangements in place. GP activity reports were completed and information was published on the practice website.

The practice had arrangements in place to ensure that required data and notifications were submitted to external organisations. Appropriate information-sharing agreements were available, including agreements relating to the sharing of data across the primary care cluster.

Learning, improvement and research

Quality improvement activities

We found that the practice undertook a range of audit and quality improvement activities to support the ongoing delivery of safe and effective care.

Complaints and concerns were used as opportunities for learning and service improvement. These were included as a standing agenda item at meetings, where all complaints were reviewed and discussed. Staff told us that learning from complaints could result in changes to practice processes or additional staff training where required.

The practice had introduced a number of initiatives to improve the way care was delivered. These included the introduction of a health pod and the employment of a pharmacy technician. Doctors were also using an artificial intelligence tool, alongside a software platform that enabled communication between patients and healthcare professionals.

A range of clinical and internal audits was undertaken across the practice. These included pharmacy audits and audits completed by the practice manager, GPs and GP registrars. The findings and learning from audits were discussed at practice meetings to identify opportunities for improvement.

Learning from complaints, audits and other quality improvement activity was shared through team meetings. Feedback was provided to relevant team leads and GPs, and meeting minutes were maintained to support communication and oversight of agreed actions.

Whole-systems approach

Partnership working and development

We found that the practice demonstrated an understanding of its role within the wider health and care system and had established arrangements to work collaboratively with partner organisations. Staff told us that the practice followed Swansea Bay University Health Board clinical pathways to support consistent decision-making and help ensure that care was delivered in line with local service arrangements.

The practice engaged regularly with system partners through attendance at cluster meetings and multidisciplinary team meetings. Staff described these forums as important opportunities to share information, discuss service developments and coordinate care for patients with complex needs.

We found evidence of positive collaborative working with the Llwchwr Cluster and Swansea Bay University Health Board. Staff told us that these relationships helped the practice develop a shared understanding of the challenges facing local services and the

needs of the patient population. They also supported the delivery of services and initiatives designed to improve patient care and access to support within the local area.

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
Emergency drugs and equipment in treatment room where patients were occasionally seen	Storing emergency medicines and equipment in a treatment room that was occasionally in use could have delayed staff access during a medical emergency. This could also have compromised the privacy and dignity of a patient undergoing an examination or procedure in the room.	This was raised with the practice manager.	The practice manager identified a more appropriate and accessible location for the emergency drugs and equipment, and arrangements were made to relocate them accordingly.
Emergency drug and equipment checks were completed monthly	This could have resulted in essential emergency medicines or equipment being unavailable or unsuitable for use when required, potentially delaying or compromising the response to a medical emergency and increasing the risk of harm to patients.	This was raised with the practice manager.	The practice immediately introduced weekly checks of emergency medicines and equipment in line with Resuscitation Council UK guidance.

Appendix B – Immediate improvement plan

Service: **Ty'r Felin Surgery**

Date of inspection: **28 July 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	There was no immediate assurance issues identified on this inspection.		
Improvement needed		**Standard / Regulation**	
1.			
Service Action:		**Responsible officer**	**Timescale**

Appendix C – Improvement plan

Service: **Ty'r Felin Surgery**

Date of inspection: **28 July 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.	We noted that the health promotion information displayed on the television screens was not available in Welsh.	The practice should ensure health promotion information displayed on waiting room television screens is available in both Welsh and English.	Health & Care Quality Standards (2023) – Information, Person-centred, Equitable.	Update screens with Welsh alternative	Deputy practice manager	December 2026
2.	Some of the QR codes on the QR Info Pod poster displayed next to reception did not work correctly.	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.	Health & Care Quality Standards (2023) – Information, Person-centred, Equitable.	QR poster was removed that day from the reception area and others available in reception were checked	Practice Manager	Completed

3.	There did not appear to be a clearly defined process for reviewing and managing adults who did not attend appointments.	The practice should develop and implement a documented process for reviewing and managing adult patients who do not attend appointments.	Health and Care Quality Standards (2023) – Safe, Person-centred.	Liaise with Safeguarding lead to produce a vulnerable adult DNA policy	Safeguarding Lead	31.01.2027
4.	Our review of patient records identified that verbal consent for intimate examinations was not always documented. The offer of a chaperone, whether the patient had accepted or declined the offer, and the details of any chaperone present were also not consistently recorded.	The practice must ensure that verbal consent for intimate examinations, the offer of a chaperone, the patient's decision to accept or decline the offer, and the details of any chaperone present are consistently recorded in the patient's medical record, in accordance with General Medical Council guidance.	Health and Care Quality Standards (2023) – Information. GMC guidance on Intimate examinations and chaparones.	Update policy to include clear guidelines and expectations of coding. Arrange further audit.	GP	31.01.2027
5.	Our review of patient records found that patients' preferred languages were not consistently recorded.	The practice should ensure that each patient's preferred language and communication needs were consistently recorded within their medical record.	Health and Care Quality Standards (2023) – Information, Equitable, Person-centred.	Audit language recording on new patient questionnaire	Office Supervisor	31.03.2027

6.	The practice did not have a patient consent policy in place.	The practice should develop and implement a Patient Consent Policy to ensure patients are informed appropriately and consent is obtained consistently for all relevant procedures and processes. The policy should include arrangements for patients who lack capacity and those who are regarded as minors.	Health and Care Quality Standards (2023) – Equitable, Person-centred, Safe, Effective.	Adopted policy from Network for Practices	Deputy practice manager	Complete
7.	The accessible toilet did not have an emergency assistance pull cord.	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	Sought electrician and in place	Practice manager	Completed

8.	Some clinical spaces were cluttered. We also noted that the paintwork within the pharmacy staff office required refreshing.	The practice should ensure that clinical rooms are kept tidy and free from unnecessary equipment and that areas requiring maintenance are addressed promptly.	Health and Care Quality Standards (2023) – Safe, Efficient.	Remind all staff that their workstations and areas or for use of work purposes and to not have personal effects that clutter the environment	Practice Manager	31.01.2027
9.	The Business Continuity Plan did not include arrangements relating to partnership risk or risks associated with the practice operating from leased premises.	The practice should update its business continuity plan to include appropriate consideration of partnership risk and risks associated with the leased premises.	Health & Care Quality Standards (2023) – Safe, Leadership.	To be discussed at Practice meeting and arrangements be put in place to update the BC plan	Practice Manager and all Partners	31.01.2027
10.	We reviewed recent fire, health and safety, and disability risk assessments. We saw evidence that some of the actions identified within the assessments had been completed.	The practice should review the findings of these risk assessments and implement any outstanding actions without delay. It should also strengthen its arrangements for recording, monitoring and evidencing the actions taken in response to identified risks.	Health & Care Quality Standards (2023) – Safe, Leadership. Health and Safety at Work etc. Act 1974	Action points to be reviewed	H&S Officer	31.03.2027

11.	We also observed dust underneath some clinical examination benches, which indicated that cleaning standards were not always being maintained.	The practice must ensure that the scheduled cleaning programme is delivered in accordance with the cleaning contract. Cleaning schedules should be consistently followed and documented, with regular audit undertaken to monitor and maintain cleaning standards.	Health & Care Quality Standards (2023) – Safe.	A regular monthly audit to maintain standards will now be conducted by our Health and Safety Officer	H&S Officer	31/12/2026
12.	We reviewed two prescribing policies. One was the current policy, while the other was a comprehensive draft policy. The draft policy had not yet been formally adopted.	The practice should formally adopt the draft prescribing policy and ensure it is reviewed and updated as required.	Health & Care Quality Standards (2023) – Safe, Leadership.	The medicines management team will be adopting the draft policy	Prescribing lead / Clinical Pharmacist	31.03.2027

13.	We reviewed five records relating to children included on the child protection register. Two of these records did not contain evidence of appropriate linked records or safeguarding alerts.	The practice should review its coding arrangements to ensure that safeguarding information, including linked records and appropriate alerts, is consistently and accurately recorded within patients' medical records.	Health & Care Quality Standards (2023) – Safe, Leadership.	Meeting arranged to put process in place to review records	Safeguarding Lead	31.03.2027
14.	Our review of training records identified incomplete safeguarding training records for more than half of the GPs.	The practice must ensure that all staff complete safeguarding training at a level appropriate to their role and that complete, accurate and up-to-date training records are maintained.	Health & Care Quality Standards (2023) – Safe, Information.	We will ensure that the remaining GPs will complete the Safeguarding Level 3 training	GP's	31.03.2027
15.	A workflow policy was available; however, it did not contain sufficient detail to provide the administrative team with clear guidance on individual responsibilities and required actions.	The practice should review and update its workflow policy to ensure staff have clear guidance on the management of correspondence, including how information should be reviewed, recorded and escalated to clinicians where appropriate.	Health & Care Quality Standards (2023) – Leadership, Information.	We are currently producing a policy for workflow.	Senior Admin Team, Practice manager.	31.03.2027

16.	Active problem lists were not always easy to interpret. Some contained duplicate entries, and historic conditions sometimes remained recorded as active problems when this was no longer appropriate. We also found that prescribed medicines were not consistently linked to the relevant clinical problem within patients' records.	The practice should review clinical coding and active problem lists following the recent clinical system migration. This should ensure that duplicate entries are removed, historic conditions are no longer recorded as active where this is inappropriate, and prescribed medicines are linked to the relevant clinical problems.	Health & Care Quality Standards (2023) – Safe, Information.	Review patient records on a case-by-case basis as necessary	All GP's and coding team	Ongoing
17.	The practice did not undertake a formal review or audit of the quality of record summarisation	The practice should introduce regular audits of patient records and clinical summaries to provide assurance that entries are accurate, complete, appropriately coded and contain sufficient clinical context.	Health & Care Quality Standards (2023) – Information, Safe.	We will review our summarising procedure to put in place routine audit	Practice manager	31.03.2027

18.	The policies and procedures reviewed were inconsistent. Most did not include effective document control arrangements, such as a version number, date of issue or scheduled review date. Some required policies were also unavailable, including a Duty of Candour policy.	The practice should review its policy framework to ensure that all policies and procedures are current, complete, readily accessible and subject to effective document control. This should include the use of version numbers, issue dates and review dates, and the development and adoption of any missing policies, including those relating to patient consent and the Duty of Candour.	Health & Care Quality Standards (2023) – Leadership, Information, Culture.	Review current policies documentation and update and produce a control document	Deputy practice manager	31.03.2027

19.	Disclosure and Barring Service (DBS) checks were only undertaken when staff commenced employment and were not repeated at regular intervals. There was also no formal process in place for staff to make an ongoing declaration regarding any changes that could affect their suitability to work.	The practice should: • adopt a clear policy position on when Disclosure and Barring Service checks for staff should be renewed and at a level appropriate to their role • implement a process requiring staff to declare any changes that may affect their ongoing suitability to work, such as criminal offences, cautions or investigations. This could be completed annually as part of the appraisal process.	Health & Care Quality Standards (2023) – Workforce, Safe, Information.	We will revisit DBS checks on an annual basis and will renew any outstanding checks that are required	Deputy practice manager	31.03.2027

20.	The records showed mixed levels of compliance with training requirements, with the GP workforce demonstrating the lowest level of compliance.	The practice must: • ensure that all staff complete and remain compliant with training relevant to their roles • implement robust governance arrangements to monitor training compliance continuously and identify promptly when training or refresher updates are required.	Health & Care Quality Standards (2023) – Workforce, Safe, Leadership.	We will continue to monitor and ensure staff / GPs update their training as required	Deputy practice manager	31.03.2027
21.	The practice's complaints policy had not been updated to reflect the new Listening to People procedure.	The practice should update its complaints policy to ensure that it aligned with the NHS Wales Listening to People process and accurately reflected the procedures followed by staff.	Health & Care Quality Standards (2023) – Workforce, Safe, Leadership.	This has now been updated	Practice manager	Completed

22.	The practice did not have a clear process for informing patients about the actions taken in response to feedback.	The practice should introduce a suitable process to demonstrate how patient feedback had been considered and acted upon. This could include publishing information on the practice website, displaying updates in the waiting area or introducing a “you said, we did” approach.	Health & Care Quality Standards (2023) – Culture.	We will look at options for displaying ‘you said, we did’ on feedback supplied by our patients	Deputy practice manager	31.07.2027

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): Mrs Michelle Gray

Job role: Practice manager **Date: 28 September 2026**