Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report (Announced)

Whitchurch Road Surgery, Cardiff and Vale 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 Whitchurch Road Surgery, Cardiff and Vale University Health Board on 29 July 2026.

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

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

The small number of respondents to the HIW patient questionnaire all rated the service as good or very good and inspection observations corroborated patient comments that staff at the practice were helpful.

The practice provided a range of services and health promotion materials to patients. Care navigation and an appointment triage system aimed to enable timely patient access to appropriate care based on clinical need. However, mixed responses were received from the patient questionnaire regarding whether appointments at the practice were delivered at the arranged time.

Language line & British Sign Language interpreters were available and double appointments ensured sufficient time for their use. However, signposting to inform patients of all communication support mechanisms available at the practice could be improved.

This is what we recommend the service can improve:

- Create a patient information leaflet and update the practice website to provide comprehensive and accurate information regarding all practice facilities and the team
- Strengthen implementation of the Welsh Language Active Offer.

This is what the service did well:

- All areas of the practice were accessible for people with a range of needs. Baby care areas were available. Home visits could be arranged to ensure patients unable to leave their home to attend appointments still had access to the care they required.
- An up-to-date equality and diversity policy was in place to support equitable service provision.

Delivery of Safe and Effective Care

Overall summary:

The building was purpose built and fit for purpose. However, some clutter and build-up of dust was found in staff only and storage areas.

An up-to-date business continuity plan was in place and staff were knowledgeable regarding emergency assistance systems at the practice.

Suitable processes were in place for the ordering, monitoring, storage and disposal of drugs kept within the practice premises. Practice staff were aware of the yellow card scheme for the reporting of adverse drug reactions and told us that GPs would also be notified to ensure the ongoing provision of appropriate care.

Correspondence relating to referrals, test ordering and results was managed in a timely manner within the practice, with patients, and externally with other healthcare providers. However, the practice had not fully defined formal protocols for managing the range of communications received and generated. This meant there was limited assurance that processes were applied consistently across the team, and audits could not be undertaken to confirm that these processes were operating effectively.

Entries in patient records created by the AI appointment system provided clinicians with a comprehensive note regarding the patient's presenting condition and objectives for consultation, enabling person-centred care from initial triage stage. Clinician's notes contained up-to-date, clear entries which included comprehensive details of patient discussions and good reasoning. However, systematic data entry quality assurance was limited.

This is what we recommend the service can improve:

- Review safeguarding procedures to ensure compliance with national standards and improve staff awareness of safeguarding arrangements
- Improve storage of clinical equipment to prevent expired items being retained and ensure that storage areas are suitably clean and tidy
- Strengthen waste management including full implementation of sharps box labelling procedures and ensuring waste bins are kept locked when stored.

This is what the service did well:

- Maintained effective systems for prescription security and collection. A pharmacy prescription collection log was identified as noteworthy practice.
- Engaged within the service and wider multidisciplinary team to support patient safety and coordination of care, monitor referral rates and review practice against expected standards.

Quality of Management and Leadership

Overall summary:

All staff we spoke with appeared committed to patient care. Both respondents to our staff questionnaire were positive although neither felt there were enough staff at the practice. Messaging systems, meetings and informal discussions enabled clear team communication. Staff were able to access policies and procedures and reported they would be made aware of any updates to these by practice management. Suitable rota planning, access to health board occupational health and an annual staff flu vaccination programme also supported staff well-being.

This is what we recommend the service can improve:

- Define and embed a core training programme and maintain comprehensive evidence of staff training. Ensure comprehensive personnel records are maintained, or suitable risk assessments are completed where information is unavailable
- Update the practice complaints procedures and patient information to fully reflect the Listening to People: the NHS Wales concerns, complaints and redress framework (2026) and provide “You said, we did” information to demonstrate learning and changes made in response to patient feedback
- Update information governance policies to provide greater assurance regarding the security of patient information within AI systems.

This is what the service did well:

- Worked as a team, with clear roles, responsibilities, lines of reporting, collaboration and support in place
- Displayed messages of thanks from patients and healthcare staff on a staff appreciation board.

3. What we found

Quality of Patient Experience

Patient feedback

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

Patient comments included:

> " Always very helpful and caring"

Person-Centred

Health promotion

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

The practice provided a range of services to patients, including enhanced services for contraception, the management of Type 2 Diabetes in adults, and immunisation programmes. Practice services were delivered by General Practitioners (GPs), nurses, one health care assistant and a pharmacist. Health board physiotherapists and a mental health team counsellor also regularly worked from the practice. Co-location within the building with a separate pharmacy service also enabled patients in accessing advice and collecting prescriptions.

Dignified and respectful care

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

Measures were in place to protect patients privacy at reception, when contacting the practice by phone and during consultations.

Posters informing patients of their right to be accompanied during examinations were visible to patients within clinical rooms. However, we found that training had not been completed by all staff who may undertake the chaperone role and that the chaperone policy needed updating to include the codes staff should use when documenting the offer and use of a chaperone within patient records.

The practice should review their chaperone policy and ensure that all staff who act as chaperones have undertaken appropriate training, in line with General Medical

Council guidance.

Timely

Timely care

Care navigation and an appointment triage system aimed to enable timely patient access to appropriate care based on clinical need. Responses from a practice patient survey in 2025 had indicated that many patients found it difficult to book appointments when they had needed to so an Artificial Intelligence (AI) system to assist with telephone call answering and appointment booking had been implemented at the beginning of 2026. We were told this answered up to 25% of phone calls received and practice management were working with the digital provider to optimise its use. Care navigators had received training and had access to clinical support if they were unsure of how best to respond to patient requests. We saw that the access policy reflected current practice. However, written information for care navigators required updating to include information on working alongside the AI system and standard pathway documents to more fully support this role.

The practice should ensure that care navigation is supported via provision of up-to-date information, including standard pathway documents, as a resource for non-clinical staff.

Patients requesting an urgent appointment at the practice were encouraged to telephone at 8am. Clinical triage would then determine whether a same day or routine appointment would best meet the patient's needs and the patient would be contacted back for an appointment to be offered accordingly. Pre-bookable appointments were available for patients to book in-person or by phone. However, we suggest the practice reflects on mixed responses received to the HIW patient questionnaire regarding whether appointments at the practice were delivered at the arranged time.

All respondents to the HIW patient questionnaire indicated they knew how to access out of hours services for medical assistance that could not wait until GP opening hours.

Equitable

Communicating and language

Patients were provided with information about the practice through the practice website, written information, texts and by staff when attending for appointments. However, we found that no patient information leaflet was available to provide comprehensive information within one easy to view document. The practice website required updating to ensure all members of the clinical team were listed for patient awareness.

The practice should review their patient information to ensure this is available in a variety of formats and provides all key information.

Digital flags within patient records were used to indicate patient communication needs so that measures to accommodate these could be implemented. A self-service- screen allowed patients to check-in for appointments in their preferred language. Language line and British Sign Language interpreter services were also available and double appointment slots would be booked to allow the time required for consultations involving these communication mechanisms. A hearing loop was available for patients experiencing hearing loss. This was publicised to patients via the practice website. Signage within the premises would further raise patient awareness and support access to these resources if required.

Staff were not aware of any Welsh speakers registered with the practice or working within the practice team. Some Welsh signage and leaflets were seen. However, the implementation of the Welsh Language Active Offer required further strengthening, for example, through making key documents available to patients in Welsh as well as English.

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

Rights and equality

We found all areas of the practice to be accessible for people with a range of needs. Baby care areas were also available.

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

Processes were in place to update patient records with any changes to name, pronoun or other personal information.

An up-to-date equality and diversity policy was in place to support equitable service provision to patients and a fair workplace for staff. Some staff had undertaken training regarding the principles of equality, diversity and inclusion.

Delivery of Safe and Effective Care

Safe

Risk management

The building was purpose built and fit for purpose. Most areas were well maintained. However, there had been a delay in decluttering staff only areas such that items remained stored in the same room as the boiler.

The practice should ensure that the boiler room is kept clear at all times to minimise fire risk.

We also found a large number of expired items within store cupboards, including cleansing wipes, syringes, diagnostic tests, dressings and oxygen administration tubing. We raised these issues with senior staff and the actions taken to resolve our concerns are provided in Appendix A.

An up-to-date business continuity plan was in place. Signs indicated the location of safety equipment and action plans in case of emergency. Staff were knowledgeable regarding emergency assistance systems in place and confident that these were effective. A suitable lone worker policy was in place to support staff safety when working on the premises and on home visits.

A suitable system for receiving and disseminating patient safety alerts to relevant team members was in place.

Infection prevention and control (IPC) and decontamination

Cleaning of clinical areas was suitably recorded. Most areas of the practice premises were visibly clean and there was evidence of good communication between practice staff and contracted cleaners. However, we saw some build-up of dust within storage areas, including where emergency equipment was kept, and that the availability, storage and cleanliness of mops required improvement.

The practice should ensure that:

- **Cleanliness is consistently maintained throughout all areas of the practice**
- **All required mops are available to clean general areas, toilet facilities and clinical areas and that mop heads are changed when dirty and stored head up and out of buckets.**

IPC support was available from the health board and a practice IPC lead had also been nominated to ensure staff were made aware of any IPC updates and oversee regular audits. A recent IPC and waste management audit had been completed. However, our inspection found that sharps boxes were not fully labelled as required and that this was a recurrent issue.

The practice should ensure that procedures for the labelling of sharps boxes on assembly and closure are fully implemented.

Waste was suitably segregated and secured while awaiting collection. However, as bins were kept within a storage area shared with another business these needed to be locked.

The practice should ensure that waste bins are kept locked.

Practice IPC and needlestick policies were available. However, these required more detail to support their implementation.

The practice should review their IPC and needlestick policies to ensure that:

- **Documented Legionella precautions are in place for all water outlets, including staff shower facilities**
- I**nformation is available regarding who staff should contact in the event of a needlestick injury for relevant monitoring and support.**

Annual flu vaccination was offered to staff for their protection and as a measure to prevent the transmission of flu to patients.

We saw that hand sanitiser and personal protective equipment was available to patients throughout the practice.

Medicines management

Suitable processes were in place for the ordering, monitoring, storage and disposal of drugs kept within the practice premises. All drugs on site were in date at the time of inspection. The temperature monitoring and maintenance of clinical fridges was comprehensive. A cold chain policy was in place and all appropriate actions had been followed in response to a recent breach. Temperatures were also monitored in rooms where non-refrigerated drugs were kept.

We saw that documented checks of emergency drugs and equipment were completed on a weekly basis and items were available in line with Resuscitation Council UK guidelines. However, the pulse-oximeter required calibration, Ambu bags looked old and were not in suitable packaging displaying expiry dates and oxygen cylinders were not secured in an upright position.

The practice should ensure that all emergency equipment is suitably maintained ready for use and that oxygen cylinders are secured.

Practice staff were aware of the yellow card scheme for the reporting of adverse drug reactions and told us that GPs would also be notified to ensure the ongoing provision of appropriate care.

Annual appraisals and team working supported all staff involved in the review and

prescribing of medications to work safely. Patients could request repeat prescriptions via written or online platforms. Staff indicated that the recent adoption of the electronic prescribing service had been mostly positive and reduced the number of paper prescriptions issued. Processes were in place for the suitable storage, monitoring and disposal of prescription pads when required and a log of pharmacy prescription collections was kept, which is noteworthy practice.

One Patient Group Direction for the contraceptive injection, Depo-Provera, was out of date and needed replacing or updating to ensure full legal compliance.

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

Safeguarding of children and adults

A safeguarding policy was in place. However, not all staff were aware of the designated practice safeguarding lead for the escalation of concerns. The safeguarding policy also required further detail to ensure it also provided contact details for external safeguarding agencies so that staff could rapidly access these if required, and the Wales Safeguarding Procedures required further embedding. In addition, the Did Not Attend and Was Not Brought policies required linking to ensure that concerns for the safety of children or other vulnerable patients reliant on others to attend appointments were not missed.

The practice should review their safeguarding procedures in line with national standards.

Communication pathways kept the practice aware of how frequently patients were presenting to emergency department and attending, or not attending, appointments with other services. Regular multidisciplinary meetings considered any patients identified as at risk to enable a team approach to maintaining patient safety within the community.

Management of medical devices and equipment

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

Effective

Effective care

We saw evidence of timely correspondence regarding referrals, test ordering and results within the practice, with patients, and externally with other healthcare providers, including secondary care and mental health services. However, formal protocols for the handling of the range of communications received and generated by the practice had not been defined to support consistent ways of working throughout the team or enable audits to ensure that processes were working well.

The practice should consider formally defining workflow protocols to support staff and enable audits to ensure that communication handling is working effectively.

Referral rates had recently been reviewed within a continuity of care project meeting. Clinical meetings provided a forum for discussions around clinical guidelines and also any patient deaths to review practice against expected standards.

Patient records

We reviewed a sample of 10 electronic patient records within the secure IT system. Entries created by the AI appointment system provided clinicians with a comprehensive note regarding the patient's presenting condition and objectives for consultation, enabling person-centred care from initial triage stage.

Clinician's notes contained up-to-date, clear entries which included comprehensive details of patient discussions and good reasoning.

A template was used to record the offer and use of a chaperone when relevant. However, templates for other procedures were not consistently used which would better standardise practice. The summary list in one patient record was also incomplete and an adverse drug reaction had not been documented within the relevant section to ensure clinician awareness in another. Delegated administrative staff had been trained to complete summaries and coding. However, systematic data entry quality assurance was limited. We suggested that further training on the new electronic patient records system may be beneficial as practice staff told us they were still getting used to this.

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

The information required for medication reviews was generally found to be recorded, and in one case there were clear linkages between the patient's medical conditions and their medications. However, routine medication reviews or audits did not appear to be being formally completed, which would be an area for development for the practice pharmacist.

The practice should consider the role of the pharmacist and how medication reviews and routine audits could be developed.

Quality of Management and Leadership

Staff Feedback

All staff we spoke with appeared committed to patient care. Whilst staff survey feedback was limited, both respondents to our staff questionnaire indicated they believed patient care was the practice's top priority, that patients were able to access practice services in a timely way, measures were in place to protect patient confidentiality, privacy and dignity, and that overall they would be happy with the standard care provided for themselves, friends or family.

Staff also reported feeling supported and suitably involved in the workplace. However, neither respondent to our questionnaire felt there were enough staff at the practice to allow them to do their job properly. We suggest that the practice reflects on this feedback.

Leadership

Governance and leadership

We observed good teamworking throughout our inspection and that the practice manager prioritised time on site to support the team. Staff we spoke with reported to feel supported within the workplace and were clear about their roles, responsibilities and lines of reporting. Messaging systems, meetings and informal discussions enabled clear communication. Staff were able to access policies and procedures and reported they would be made aware of any updates to these by practice management.

GP partners and practice managers had distributed accountability for clinical practice and quality assurance. We discussed prioritising improvements and working towards specific, measurable and timebound action plans as evidence suggested that progress made against the most recent clinical governance practice self-assessment was slow.

Flexibility within the practice team aimed to support timely, consistent and effective service delivery. However, recent staff turnover and overall reduction in working hours had presented challenges to sustainability. We were told that practice, primary care and health board representatives had recently met regarding the level of demand on the practice and the availability of resources in order to provide a comprehensive service.

Workforce

Skilled and enabled workforce

We reviewed a sample of personnel and training records and found these to contain a number of gaps.

The practice should ensure that:

- **Comprehensive personnel records are maintained or risk assessments completed where information is not available on recruitment or subsequently**
- **A core training programme is defined and embedded and comprehensive evidence of training maintained.**

A documented induction programme was in place to ensure any new employees and locums working at the practice were oriented to the environment and operational procedures. New starters would also undergo a period of probation to ensure they consolidated the skills and behaviours they required for their role within a defined timescale. Established staff were clear on their scope of practice and felt enabled to work within this. Suitable rota planning, access to health board occupational health and an annual staff flu vaccination programme also supported staff well-being.

Culture

People engagement, feedback and learning

Patients were able to provide feedback in person or through patient surveys and could raise formal complaints with the practice manager. Practice staff indicated they were open to feedback and resolving any concerns patients had at the time they were raised if possible. All concerns and complaints logged with the practice manager were recorded on a spreadsheet to support appropriate handling and enable learning from events. Response timescales were suitable. However, we noted that the complaints policy and patient information needed updating to fully embed Listening to People: the NHS Wales concerns, complaints and redress framework (2026).

The practice should ensure that complaints procedures fully embed and inform patients of the Listening to People: the NHS Wales concerns, complaints and redress framework (2026).

We were told that complaints were discussed for learning within the practice team and themes formally reviewed on an annual basis. Displaying ‘You said, we did’ information would also raise the profile of practice feedback mechanisms and changes implemented in response to feedback received.

The practice should consider mechanisms for providing patients with information regarding practice learning in response to feedback received. This could be via a 'You said, we did' board within the practice, a notice on the website, or other means.

A staff appreciation board also displayed messages of thanks received from patients and healthcare professionals.

Information

Information governance and digital technology

We saw that a suitable data protection officer had been appointed. Data protection incident reporting mechanisms were clear and had been suitably implemented when required. Staff were aware of their responsibilities with respect to information governance and patients were informed of the practice code of confidentiality. However, information governance policies required updating to provide more specific assurance regarding the security of patient information handled and stored within AI systems being introduced at the practice.

The practice should update their information governance policies regarding the use of AI systems for consultations and any other purpose.

Learning, improvement and research

Quality improvement activities

We saw that various clinical, practice and cluster meetings allowed for the consideration of best practice and improvement initiatives. Incident reporting and significant event analysis also underpinned learning. Engagement with Quality Assurance and Improvement Framework regular clinical audits were completed within the practice but these required organising into a more systematic programme. An audit of long-term steroid use would also be a positive addition.

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
Large number of expired items found within store cupboards, including skin cleansing wipes, syringes, diagnostic tests, dressings and oxygen administration tubing.	Potential for equipment to fail or present an infection control risk to patients.	Concern discussed with senior staff, including those responsible for stock monitoring and ordering.	Items removed from stocks. Agreed the practice would review what items are routinely used and how many to ensure appropriate reordering.

Appendix B – Immediate improvement plan

Service: **Whitchurch Road Surgery**

Date of inspection: **29 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	No Immediate Assurances were found on this inspection

Improvement needed	Standard / Regulation

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

Service representative:

Name (print):

Job role: **Date:**

Appendix C – Improvement plan

Service: **Whitchurch Road Surgery**

Date of inspection: **29 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.	Training had not been completed by all staff who may undertake the chaperone role and the chaperone policy needed updating to include the codes staff should use when documenting the offer and use of a chaperone within patient records.	• Appropriate chaperone training to be completed by all staff who may undertake the chaperone role • Policy to be updated to include codes.	Health and Care Quality Standard (2023) – Safe	1. Chaperone policy reviewed and updated to include specific clinical SNOMED CT / Read codes for documenting chaperone offered, accepted, and declined within EMIS Web. 2. Mandatory Chaperone training module will be booked for all current chaperones and any future 3. Chaperone training tracker established and incorporated into annual staff appraisals.	Assistant PM	Completed 31 August 2026
2.	Written information for care navigators required updating to include	Care navigation to be supported via provision of up-to-date information,	Health and Care Quality Standard (2023) – Safe / Timely	1. Care navigation standard operating procedures updated to	Assistant PM & PM	30 September 2026

	information on working alongside the AI system and standard pathway documents to more fully support this role.	including standard pathway documents, as a resource for non-clinical staff.		incorporate structured triage pathways and guidance on working alongside the InTouchNow AI telephone reception system. 2. Standardised care navigation directory and signposting quick-reference guide created for reception desks (including Common Ailments Scheme, Community Pharmacy, Optometry, and Dental services). 3. Care navigation training session conducted with all front-of-house staff.		
3.	No patient information leaflet was available and the practice website required updating to ensure all members of the clinical team were listed for patient awareness.	Published patient information to be available in a variety of formats and to include all key information.	Health and Care Quality Standard (2023) – Person-centred	1. Comprehensive bilingual Practice Information Leaflet published, printed, and made available at reception and in the waiting area. 2. Surgery website updated to include full profiles of all clinical staff (GP Partners, Salaried GPs, Practice Nurses,	PM & Assistant PM	30 November 2026

				Clinical Pharmacist). 3. Practice Leaflet uploaded in downloadable PDF format to the practice website.		
4.	Implementation of the Welsh Language Active Offer required further strengthening.	The Welsh Language Active Offer to be embedded.	Health and Care Quality Standard (2023) – Person-centred	1. Welsh Language 'Active Offer' (Iaith Gwaith) fully embedded across front-of-house: bilingual greeting ('Bore da / Prynhawn da') adopted by reception staff and recorded on phone auto-attendant. 2. 'Iaith Gwaith' lanyards and badges issued to Welsh-speaking team members. 3. Bilingual signage, posters, and new patient registration forms audited and made available in waiting areas and on the website.	Assistant PM	30 October 2026
5.	Items seen stored in the same room as the boiler.	Boiler room to be kept clear at all times.	Health and Care Quality Standard (2023) – Safe	1. Immediate clearance of all stored items, materials, and combustible supplies from the boiler room conducted.	PM	Immediate / Completed 31 August 2026

				2. Prominent 'Plant / Boiler Room — Keep Clear At All Times / No Storage' signage affixed to the access door. 3. Monthly environmental safety checklist implemented by Practice Management to ensure area remains strictly clear.		
6.	Some build-up of dust within storage areas, including where emergency equipment was kept, and the availability, storage and cleanliness of mops required improvement.	• Cleanliness to be consistently maintained throughout all areas of the practice • All required mops to be available to clean general areas, toilet facilities and clinical areas and that mop heads are changed when dirty and stored head up and out of	Health and Care Quality Standard (2023) – Safe	1. Deep clean completed across all storage and emergency equipment storage cupboards. 2. NHS Wales National Colour-Coding mop system fully replenished (red for washrooms, blue for general areas, yellow for clinical rooms). 3. Dedicated mop storage racks installed ensuring mop heads are stored inverted (heads up), dry, and out of buckets, with dirty heads laundered/replaced weekly. 4. Cleaning audit schedule updated to	IPC Lead	Completed / 15 August 2026

		buckets.		include weekly inspection of storage cupboards and cleaning equipment.		
7.	Sharps boxes not fully labelled as required which was a recurrent issue.	Procedures for the labelling of sharps bins on assembly and closure to be fully implemented.	Health and Care Quality Standard (2023) – Safe	1. Immediate spot-check and audit of all sharps bins across 13 clinical rooms completed. 2. Sharps bin standard operating procedure re-briefed to all clinical and phlebotomy staff: mandatory requirement to complete date, name, and room location on assembly, and date/signature on final closure at 2/3 full. 3. Weekly IPC sharps audit checklist introduced to monitor ongoing compliance.	IPC Lead	30 September 2026
8.	Bins kept within a shared storage area shared with another business were not locked.	Bins to be locked.	Health and Care Quality Standard (2023) – Safe	1. External waste storage area reviewed; padlocks and heavy-duty locking bars fitted to all clinical and confidential waste wheelie bins. 2. Waste compound security protocol reinforced with domestic	PM	31 August 2026

				and clinical staff ensuring bins remain securely locked at all times except during waste deposit. 3. External perimeter and bin locking checks integrated into daily opening and closing building security checklists.		
9.	IPC and needlestick policies were available. However, these required more detail to support their implementation.	IPC and needlestick policies to be reviewed to ensure that: • Documented Legionella precautions are in place for all water outlets, including staff shower facilities • Information is available regarding who staff should contact in the event of a needlestick injury	Health and Care Quality Standard (2023) – Effective	1. IPC Policy updated with a comprehensive Legionella written scheme: water outlet flushing logs established for all low-use outlets and staff shower facilities (weekly flushing, monthly temperature logging). 2. Needlestick / Inoculation Injury Policy revised to include clear emergency flowcharts, immediate first-aid guidance, Cardiff and Vale UHB Occupational Health contact details, and out-of-hours A&E escalation routes. 3. Updated policies and flowcharts laminated and	IPC Lead & PM	31 August 2026

		for relevant monitoring and support.		displayed in all 13 clinical rooms.		
10.	Within the emergency equipment, the pulse-oximeter required calibration, Ambu bags looked old and were not in suitable packaging displaying expiry dates and oxygen cylinders were not secured in an upright position.	All emergency equipment to be suitably maintained ready for use and that oxygen cylinders are secured.	Health and Care Quality Standard (2023) – Safe	1. Pulse oximeters sent for biomedical calibration and testing; calibration certificates on file. 2. Emergency Ambu bags replaced with brand-new, sealed, single-use resuscitator packs displaying clear expiry dates. 3. Oxygen cylinders securely anchored in purpose-built upright wall brackets and storage stands. 4. Weekly emergency trolley check protocol formalized and assigned to nursing staff.	Practice Nurses	30 October 2026
11.	One Patient Group Direction for the contraceptive injection, Depo-Provera, was out of date and needed replacing or updating to ensure full legal	All Patient Group Directions used at the practice to remain the most up-to-date versions.	Standard (2023) – Safe	1. Depo-Provera Patient Group Direction (PGD) immediately reviewed and replaced with the current, fully authorized NHS Wales / Cardiff and Vale UHB PGD. 2. All administering nurses	Practice Nurses	31 October 2026

	compliance.			re-signed the updated PGD authorization sheet, counter-signed by the Clinical Lead GP. 3. Central electronic PGD master register established with automatic 3-month expiry warning alerts.		
12.	Not all staff were aware of the designated practice safeguarding lead for the escalation of concerns. The safeguarding policy required further detail to ensure it also provided contact details for external safeguarding agencies so that staff could rapidly access these if required, and the National Safeguarding Procedures required further embedding. In addition, the Did Not Attend and Was Not Brought policies	Safeguarding procedures to be reviewed in line with national standards.	Standard (2023) – Safe / Effective	1. Practice Safeguarding Policy revised to clearly display the Designated Safeguarding Lead and Deputy Lead, with direct external contact numbers for Cardiff Children's Access Point and Adult Safeguarding. 2. National Safeguarding Procedures flowcharts laminated and posted in all clinical and administrative areas. 3. Did Not Attend (DNA) and Was Not Brought (WNB) policies integrated: mandatory flagging and GP review protocol implemented for any vulnerable child or adult	IPC Lead /Safeguarding Deputy Lead & GP Safeguarding Lead	31 August 2026

	required linking to ensure that concerns for the safety of children or other vulnerable patients reliant on others to attend appointments were not missed.			who is not brought to scheduled appointments.		
13.	No formal protocols for the handling of the range of communications received and generated by the practice to support consistent ways of working throughout the team or enable audits to ensure that processes were working well.	Formal workflow protocols to support staff and enable audits to be considered.	Standard (2023) – Safe / Effective	1. Standardised Practice Workflow Protocol created for all incoming and outgoing clinical correspondence (Docman / EMIS Web electronic document management). 2. Clear administrative roles defined for indexing, coding, GP pathology review, and urgent escalation. 3. Monthly random sample audit (50 documents) introduced to monitor indexing accuracy, turnaround times, and outstanding workflows.	Assistant PM & PM	30 September 2026
14.	Templates not consistently used within patient records which	These findings should be considered and formal mechanisms to provide	Standard (2023) – Safe / Effective	1. Standardised clinical consultation templates mandated in EMIS Web for	PM & nominated practice nurse	30 November 2026

	would better standardise practice. Instances of incomplete summary list and adverse drug reaction recording also found. Systematic data entry quality assurance was limited and further training on the new electronic patient records system would likely be beneficial.	data entry quality assurance identified and implemented on an on-going basis.		routine reviews, chronic diseases (Asthma/COPD/Diabetes), and medication monitoring. 2. Clinical coding protocol re-briefed to ensure summary problem lists and Adverse Drug Reactions (ADRs) / allergies are consistently documented. 3. Targeted EMIS Web refresher training arranged for clinical and administrative staff; quarterly clinical record peer-review audits implemented.		
15.	Routine medication reviews or audits did not appear to be being formally completed.	Consider the role of the pharmacist and how medication reviews and routine audits could be developed.	Health and Care Standards (2023) – Safe / Effective	1. Clinical Pharmacist role scope formalized with allocated dedicated sessions for structured medication reviews (SMRs) and high-risk drug monitoring. 2. Practice-wide medication audit plan agreed, focusing on DMARDs, Warfarin/DOACs, lithium,	PM & Pharmacist	30 September 2026

				and polypharmacy in patients aged 75+. 3. Monthly clinical meeting slot reserved for sharing prescribing audit findings and quality improvement learning.		
16.	Our review of a sample of personnel and training records identified a number of gaps.	• Comprehensive personnel records to be maintained or risk assessments completed where information is not available on recruitment or subsequently • A core training programme to be defined and embedded and comprehensive evidence of training maintained.	Health and Care Standards (2023) – Safe / Effective	1. Comprehensive HR audit of all staff personnel files completed; checklist created covering DBS certificates, employment references, professional registrations (GMC/NMC), and occupational health checks. 2. Risk assessments documented where historical recruitment documents could not be sourced. 3. Centralized Practice Training Matrix established on Bluestream / NHS Wales e-Learning tracking statutory and mandatory core training for all staff.	Assistant PM & PM	30 September 2026

17.	The practice complaints policy and patient information needed updating to fully embed Listening to People: the NHS Wales concerns, complaints and redress framework (2026).	Information regarding Listening to People: the NHS Wales concerns, complaints and redress framework (2026) to be made available to patients and the framework to be fully embedded.	Health and Care Standards (2023) – Person-centred / Effective	1. Practice Complaints & Concerns Policy updated to fully incorporate 'Listening to People: The NHS Wales Concerns, Complaints and Redress Framework (2026)'. 2. Patient feedback leaflets and posters updated in bilingual format and displayed in the waiting area. 3. Practice website updated with dedicated 'Listening to People / Raising a Concern' guidance, clear resolution timeframes, and advocacy contact information (Llais).	PM & Assistant PM	31 August 2026
18.	No mechanism in place to provide patients with information regarding practice learning in response to feedback received.	'You said, we did' board, a notice on the website, or other means to be considered.	Health and Care Standards (2023) – Person-centred / Effective	1. Physical 'You Said, We Did' display board mounted in the main patient waiting area to share practice learning and service changes arising from patient feedback. 2. Dedicated 'Practice Learning & Patient Feedback' section	Assistant PM	30 November 2026

				established on the surgery website, updated quarterly. 3. Patient feedback review agenda item added to monthly practice management team meetings.		
19.	Information governance policies required updating regarding the use of AI systems for consultations and any other purpose.	Information governance policies to be updated.	Health and Care Standards (2023) – Safe	1. Practice Information Governance Policy updated to incorporate an explicit AI Governance & Data Processing Addendum covering the InTouchNow AI telephone service. 2. Data Protection Impact Assessment (DPIA) and Data Processing Agreement (DPA) reviewed and formally placed on file. 3. Website Privacy Notice updated informing patients of AI-assisted telephony handling, data security safeguards, and GDPR compliance.	PM	30 November2026

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): Gareth Lucocq

Job role: Practice Manager

Date: 18 September 2026