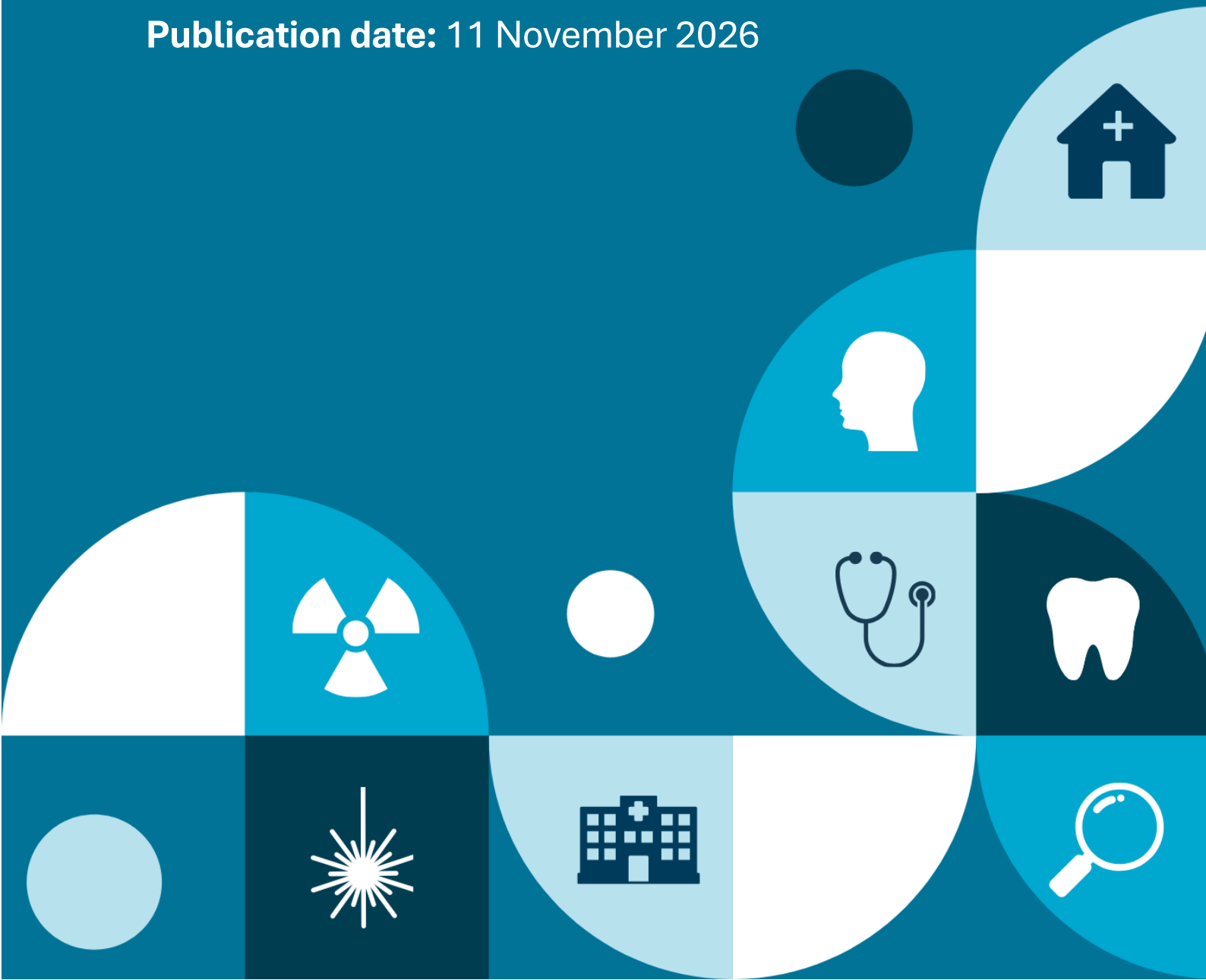
Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report (Announced)

Afan Valley Group Practice, Swansea Bay University Health Board.

Inspection date: 11 August 2026

Publication date: 11 November 2026



This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager
Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

Or Via:

Phone: 0300 062 8163
Email: hiw@gov.wales
Website: www.hiw.org.uk

Digital ISBN 978-1-80853-701-1

© Crown copyright 2026



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.



Contents

1. What we did 5

2. Summary of inspection 6

3. What we found 12

Quality of Patient Experience 12

Delivery of Safe and Effective Care 18

Quality of Management and Leadership 29

4. Next steps 34

Appendix A – Summary of concerns resolved during the inspection .. 35

Appendix B – Immediate improvement plan 36

Appendix C –improvement plan 37



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 Afan Valley Group Practice, Swansea Bay University Health Board on 11 August 2026.

Our team for the inspection comprised of a HIW healthcare inspector, 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 13 questionnaires were completed by patients or their carers and two were completed by staff. The number of completed staff questionnaires was too low to provide reliable or representative findings. Because of this, the staff feedback cannot be used in this report.

Patient feedback and some of the comments we received appear throughout the report.

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

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

2. Summary of inspection

Quality of Patient Experience

Overall summary:

Overall, we found that patients received respectful, person-centred care and were supported to access services in ways that reflected their individual needs. Patients could access health promotion information and a broad range of services, including support for long-term conditions, mental health and vaccination programmes. The practice offered several routes for accessing appointments and advice, including AskMyGP, telephone and in-person contact, and staff described suitable arrangements for people who were older, vulnerable or digitally excluded. Urgent requests were clinically triaged, with children requiring urgent assessment seen on the same day.

We observed staff treating patients with dignity, respect and discretion. The practice also demonstrated a positive approach to equality and reasonable adjustments, including quieter waiting arrangements for neurodivergent patients, access to translation services and a hearing loop at reception. However, some improvements were required. Information about the chaperone service was not prominently displayed, and the emergency pull cord alarm in the accessible toilet did not work when tested. The practice was required to repair the alarm and ensure regular checks were introduced.

The practice had arrangements to meet differing communication and language needs, but most information displayed within the premises was available in English only. The practice therefore needed to strengthen its approach to the Welsh language by ensuring patient-facing information was available bilingually and by actively promoting the Welsh Government's Active Offer.

This is what we recommend the service can improve:

- Ensure the disabled toilet emergency pull cord alarm is repaired and subject to regular checks to confirm it remains functional
- Improve the provision and promotion of bilingual Welsh and English information, including actively promoting the Welsh Government’s Active Offer
- Improve the visibility of information about the availability of the chaperone service so that patients are aware they can request a chaperone.

This is what the service did well:

- The practice demonstrated a flexible approach to meeting patients’ individual needs, including offering reasonable adjustments for neurodivergent patients and alternative access arrangements for people who were digitally excluded

- The practice took a proactive approach to vaccination uptake, including repeated follow-up of eligible patients who did not attend
- Patients reported very positive experiences of accessing care and receiving treatment from the practice.

Delivery of Safe and Effective Care

Overall summary:

Overall, we found that the practice had arrangements in place to support the safe and effective delivery of care. Staff demonstrated awareness of their responsibilities in relation to risk management, safeguarding, infection prevention and control, medicines management and incident reporting. Suitable processes were also in place for referrals, follow-up of investigations, management of information received from secondary care and support for patients experiencing mental health difficulties. Patient records were generally of a good quality and provided clear evidence of clinical assessment, decision-making and ongoing management.

The dispensary was generally well managed, with suitably qualified staff, appropriate stock controls and governance arrangements. Vaccines were stored appropriately, prescription stationery was secure and processes were in place for medication reviews and the management of controlled drugs. We also found appropriate safeguarding arrangements, including an identified safeguarding lead and systems to identify children at risk. However, not all staff had completed safeguarding training at the level required for their role.

Several improvements were required to strengthen patient safety. These included updating expired Patient Group Directions, improving the monitoring and storage of emergency medicines and equipment, and ensuring that all medical devices were appropriately calibrated. We also identified expired clinical consumables and reusable equipment which could not be appropriately sterilised. Some of these matters required immediate action, including an expired oxygen cylinder and the frequency of emergency equipment checks, and were addressed during the inspection through our concerns resolved during inspection process.

Improvements were also required in relation to the environment and infection prevention and control. These included outdated fire, health and safety and legionella risk assessments, the absence of regular IPC audits, carpeted flooring in most clinical rooms, insufficient records relating to cleaning and water flushing, and inadequate monitoring of fabric privacy curtains and cleaning equipment. The practice was also required to strengthen clinical coding following its recent migration to a new clinical IT system and introduce regular audits of patient records.

This is what we recommend the service can improve:

- Strengthen infection prevention and control arrangements, including routine IPC audits, appropriate clinical flooring, cleaning records and assurance around the cleaning and replacement of privacy curtains
- Improve medicines and emergency equipment governance by ensuring Patient Group Directions are current, emergency equipment is checked at the required

frequency, and medicines and vaccines are stored and monitored appropriately

- Strengthen systems for managing clinical equipment and consumables to ensure expired items are removed promptly and all relevant devices are appropriately serviced and calibrated before use.

This is what the service did well:

- Patient records reviewed during the inspection were of a good quality, with clear clinical histories, examination findings, management decisions and plans for ongoing care
- The dispensary demonstrated positive governance arrangements, including appropriately qualified staff, annual review of standard operating procedures and participation in the Dispensing Services Quality Scheme
- The practice demonstrated good links with wider services, including access to a cluster mental health nurse.

Quality of Management and Leadership

Overall summary:

Overall, we found that the practice was well led, with clear roles, responsibilities and lines of accountability. Senior staff were visible and approachable, and staff described a positive culture where they were encouraged to contribute ideas and raise concerns. Regular team and clinical meetings supported communication, and designated leads were in place for key areas such as safeguarding and infection prevention and control. The workforce was experienced and multi-skilled, with good compliance with training, annual appraisals and appropriate arrangements for professional registration and supervision.

The practice demonstrated a commitment to learning and improvement. Complaints, incidents, mortality reviews and external reviews were used to identify learning, and staff provided an example where patient feedback had resulted in a change to practice. The practice also undertook clinical, dispensary and waste audits and was seeking to re-establish a Patient Participation Group. Information governance arrangements were generally appropriate, with clear processes for managing patient information and oversight provided by Digital Health and Care Wales.

However, some governance arrangements required improvement. Some policies did not have effective document control, and clinical meetings were not always formally minuted. The complaints policy had not yet been updated to align with the NHS Listening to People procedure, and the practice needed to improve how it communicated to patients the actions taken in response to their feedback. We also found that DBS checks were not routinely repeated following recruitment and there was no formal process for staff to declare changes that could affect their ongoing suitability to work.

This is what we recommend the service can improve:

- Update the complaints process and policy to ensure it aligns with the NHS Listening to People procedure
- Strengthen governance arrangements by ensuring all policies are subject to effective document control and that clinical meetings are consistently minuted
- Improve workforce assurance by repeating DBS checks at appropriate intervals and introducing a formal process for staff to declare any changes that may affect their ongoing suitability to work.

This is what the service did well:

- Senior staff promoted an open and supportive culture, with staff encouraged to contribute ideas, raise concerns and participate in service improvement
- The practice demonstrated a strong commitment to staff development, with

good compliance with mandatory training and completed annual appraisals

- The practice demonstrated positive learning from feedback and incidents.

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.

We received 13 questionnaire responses from patients, relatives and carers who had used the service. Overall, patient feedback was highly positive, with all respondents who answered the overall experience question rating the service as “Very Good”.

Patients were particularly positive about access to services. All respondents reported being satisfied with the practice opening hours, stated they could contact the practice when required and reported being able to obtain both urgent same-day appointments and routine appointments when needed.

Patients also reported positive experiences of appointments and the care they received. All respondents were satisfied with the appointment type offered and felt they were given sufficient time to explain their health needs. Patients told us that GPs explained matters clearly, answered questions and involved them in decisions about their care to the extent they wished. All respondents reported that they felt listened to and were treated with dignity and respect.

Feedback about the practice environment was very positive. Patients reported that the building was accessible, there were sufficient seats available in the waiting area and suitable toilet and handwashing facilities were provided. All respondents who answered the cleanliness question described the practice as very clean. Patients also expressed confidence in the infection prevention and control measures in place and reported that healthcare staff washed their hands before and after treatment.

Patients provided positive feedback regarding privacy and dignity. Respondents told us they were able to speak with reception staff without being overheard and that appropriate measures were taken to protect their privacy during consultations, examinations and treatment. Feedback relating to equality was also positive, with all respondents who answered the question reporting that they were able to access the right healthcare at the right time regardless of their personal circumstances. No respondents reported experiencing discrimination while using the service.

Person-Centred

Health promotion

We found that patients were able to access a range of information and services to help promote and improve their health and support them to lead healthier lifestyles.

Staff told us that health promotion and healthy lifestyle advice were discussed with patients through several routes. This included when patients registered with the practice, during chronic condition reviews and as part of routine consultations with GPs and nursing staff. Staff were able to provide patients with relevant leaflets and could print health information during consultations where required. Patients were also directed to information available on the practice website.

Patients had access to a range of healthcare professionals and services to support their health and wellbeing. This included a cluster mental health nurse and cluster pharmacist, who attended the practice weekly, and social prescribers who attended when required. Patients could also access primary care audiology appointments through reception and chronic condition management provided by the practice nurse.

Staff described suitable preparations for the Respiratory Syncytial Virus (RSV) vaccination and immunisation programme. This included liaison with the health board immunisation coordinators to support the implementation of the programme.

The practice also participated in the winter vaccination programme. Staff described the arrangements in place for influenza and COVID-19 vaccinations. Immunisation coordinators from the health board contacted eligible patients by letter, and the practice followed up patients who did not attend by telephone and letter. Staff told us that they aimed to make up to three attempts to contact eligible patients. The practice nurse and healthcare support worker also provided vaccinations to housebound patients.

We found that arrangements were in place to ensure that health promotion and vaccination information remained accessible to older people and those who did not have digital access. Information was provided through letters, telephone contact and posters displayed within the waiting area. Similar arrangements were used to inform patients about the wider range of services and healthcare professionals available through the practice.

The practice provided a broad range of services aimed at improving access, preventing disease and promoting health. These included joint injections, frailty services, diabetes care, contraception, travel vaccinations, INR testing, phlebotomy, adult and childhood immunisations, cervical cytology, spirometry and shared care services, including monitoring for patients prescribed medicines such as methotrexate and direct oral anticoagulants (DOACs). Patients were informed about these services through the practice website, information and leaflets in the waiting area, reception staff and discussions during consultations.

We reviewed an up to date Was Not Brought policy. Staff described the processes followed when patients did not attend, or children and other patients were not brought to, scheduled appointments. Staff also described the arrangements in place to monitor instances where patients did not attend hospital appointments.

The primary route for accessing practice services was the AskMyGP application. Staff told us that patients who were older or who did not have access to, or were unable to use, digital services were supported to access services in alternative ways. Staff provided assistance with using AskMyGP either by telephone or in person at reception and could also provide information through leaflets or advice during consultations.

Dignified and respectful care

We found that patients were treated with dignity and respect by staff at the practice. During the inspection, we observed interactions between staff and patients and found that patients were treated respectfully and professionally.

Clinical rooms provided appropriate levels of privacy to protect patients' dignity and confidentiality during consultations and examinations. We also observed that clinical and non-clinical staff were discreet and sensitive when speaking with patients and when discussing patient information with other members of staff.

The practice offered both male and female chaperones to patients. Information about the availability of the chaperone service was displayed on a poster in the waiting area and was also promoted on the practice website. However, we noted that the poster was not prominently displayed and may not be easily visible to all patients using the service.

The practice should take steps to improve the visibility of information about the chaperone service to ensure all patients are aware that a chaperone can be requested for consultations and examinations.

We saw evidence that staff undertaking the chaperone role had received suitable training to ensure they understood their roles and responsibilities. The practice also had an up-to-date chaperone policy in place.

Staff told us that clinicians recorded verbal consent for intimate examinations and any requests for a chaperone within the patient's medical record.

Timely

Timely care

We found that processes were in place to support patients to access care through an appropriate route and, where required, to be directed to the most appropriate

healthcare professional.

Patients were able to request appointments and advice through the AskMyGP application, by telephoning the practice or by attending reception in person. The practice had an up-to-date access policy in place.

The practice gathered feedback from patients about the appointment system. We saw examples of positive feedback submitted through the AskMyGP application, and staff told us that patient views were also obtained through the annual patient survey. To help ensure that the views of patients who were digitally excluded were also captured, paper questionnaires were available for patients to complete when attending the practice. A feedback facility was also available on the practice website.

Reception staff had clear care navigation pathways to support them in directing patients to the appropriate service or healthcare professional. We reviewed training records which demonstrated that relevant staff had received care navigation training.

Clinical triage was undertaken by a GP each day using requests received through AskMyGP. A written process was available to staff to support this arrangement. Staff told us that decisions about whether a patient required a face-to-face consultation took account of the patient's preference and clinical needs.

We found that arrangements were available to accommodate the needs of older people, vulnerable patients and those who experienced communication difficulties. Staff told us that patients could be offered face-to-face, telephone or video consultations according to their individual needs and circumstances.

Where no routine appointments remained available and a patient contacted the practice with an urgent need, staff described appropriate arrangements for managing the request. Children requiring urgent assessment were seen on the same day, including where this resulted in the practice operating above its usual appointment capacity. Adults requiring urgent care were clinically triaged to determine the most appropriate course of action.

We also found that suitable processes were in place to support patients experiencing urgent mental health needs or a mental health crisis. Staff described processes for referring both adults and children to secondary mental health services. While patients were awaiting acceptance or treatment, risks were managed through access to GPs and other available support. The practice promoted the use of NHS 111 Option 2 for urgent mental health support, and a cluster mental health nurse attended the practice once a week.

Equitable

Communicating and language

We found that the practice communicated with patients through a range of methods and had processes in place to support patients with differing communication and language needs.

Information about the services provided by the practice was available through its website, leaflets and posters displayed within the practice. Staff told us that information could also be provided in large print on request. Important changes relating to the practice were communicated through the website and, due to the nature of the small local community, by word of mouth. Staff told us that patients who were older or did not have access to digital services could also be informed directly about relevant changes.

The practice had an up-to-date patient consent policy in place. Staff told us that they were able to accommodate known language and communication needs and were familiar with the use of translation services, such as Language Line. The practice website could also be viewed in multiple languages, including Welsh and English.

We were told that there were no fluent Welsh-speaking staff working at the practice, although staff had access to Welsh language training. We saw that some signage and posters were available bilingually in Welsh and English. However, most information displayed within the practice was available in English only. While the number of Welsh-speaking staff was considered appropriate for the language needs of the local population, the practice was required to ensure that patients were actively offered the opportunity to communicate and receive services in Welsh in accordance with the Welsh Government's Active Offer principles.

The practice should:

- **review the information displayed throughout the premises to ensure that any new patient-facing signs are bi-lingual and that there is an equitable display of posters and other information in both Welsh and English**
- **ensure that the Active Offer of the Welsh language is promoted to patients.**

Rights and equality

We found that the practice had arrangements in place to support equality, diversity and the individual rights of patients. Equality and diversity were promoted through practice policies, staff training and consideration of feedback received from patients.

Staff had undertaken training in equality, diversity and inclusion, together with autism awareness training. This included Paul Ridd Foundation training to promote awareness and understanding of the needs of people with learning disabilities.

The practice building was accessible from street level and all patient areas were located on the ground floor. The entrance had wide doors to support access for people

with mobility needs. A hearing loop was available at reception to support patients with hearing impairments.

An accessible toilet was available and was fitted with an emergency pull cord to summon assistance. However, when we tested the alarm during the inspection, it did not work. This presented a potential risk to patients who may require assistance while using the facility.

The practice must ensure that the disabled toilet emergency pull cord alarm is repaired and that regular checks are implemented to ensure it remains functional.

Staff provided examples of reasonable adjustments that could be made to meet patients' individual needs. For example, neurodivergent patients could be offered a quieter area in which to wait or could wait in their car until contacted by staff when the clinician was ready to see them. Appointments could also be arranged during quieter periods where appropriate. Other adjustments included communicating with patients by email, using Language Line where translation support was required, and offering later appointments for school-aged children.

Staff described how the rights and individual preferences of transgender patients were respected. This was supported by relevant policies and staff training. Staff told us that patients were addressed by their preferred name and treated in accordance with their expressed preferences. Relevant information could also be flagged within the patient's record to help ensure their preferences were recognised consistently by staff.

Delivery of Safe and Effective Care

Safe

Risk management

We found that the practice had arrangements in place to identify and manage a range of risks to the health, safety and wellbeing of patients and staff.

The practice premises were owned by Swansea Bay University Health Board and had recently been redecorated. We noted that, following the recent repainting of the practice, some strip light covers had not been replaced and remained absent at the time of the inspection. The flooring within the waiting area had also recently been replaced.

The practice should ensure that all strip light covers removed during recent redecoration are replaced securely in their correct position.

We saw fire, health and safety, and legionella risk assessments which had not been reviewed or updated recently by the health board. Staff also told us that they were awaiting fire warden training to be provided by the health board. These arrangements did not provide sufficient assurance that relevant risks were being reviewed and managed in a timely manner.

The practice should liaise with the health board to ensure that fire, health and safety, and legionella risk assessments are reviewed and updated at appropriate intervals, and that relevant staff complete fire warden training as soon as practicable.

The practice had an up-to-date business continuity plan, which was available electronically for staff to access. We found that the plan appropriately addressed risks associated with the business partnership and included arrangements for responding to a significant health emergency. Staff told us that contingencies were also in place to manage prolonged staff absence, with staff being multi-skilled and able to undertake a range of duties to provide cover where required.

A named member of staff was responsible for receiving and accessing patient safety alerts. However, there was no additional named member of staff identified to undertake this responsibility in the event of prolonged absence.

The practice should identify an additional named member of staff who is able to access and manage patient safety alerts if the designated member of staff is unavailable for an extended period.

Suitable processes were in place for reviewing and discussing significant events, including patient safety incidents. Staff described the arrangements during the inspection and provided examples of significant events that had been reviewed.

The practice had an induction process in place for new members of staff. We also found that there was a mechanism available for staff to summon urgent assistance should help be required within the practice.

An up-to-date risk assessment relating to home visits was available, together with a documented process which staff could access to support the safe management of home visits.

Infection prevention and control (IPC) and decontamination

We found that the practice had arrangements in place to support infection prevention and control (IPC) and to protect patients and staff from the risk of infection.

The practice had an appointed IPC lead in place. Staff told us that they understood their individual roles and responsibilities in maintaining appropriate IPC standards. A site-specific infection prevention and control policy was available, and staff knew where to locate this when required.

Staff told us that they kept their IPC knowledge up to date through mandatory training and regular updates. Where further advice was required, staff said they would seek appropriate specialist guidance. During the inspection, we observed staff washing their hands following contact with patients. Hand hygiene facilities were available within the practice. However, not all sinks within clinical areas were fitted with elbow-operated taps.

The practice should review and update handwashing facilities within a reasonable timeframe and ensure they meet current infection prevention and control standards.

The practice had appropriate arrangements in place for the management and segregation of healthcare waste. We saw a healthcare waste audit dated July 2026 which identified several recommendations for improvement.

The practice should address the recommendations identified within the July 2026 healthcare waste audit at the earliest opportunity.

Suitable facilities were available to enable patients to be separated from others where required, to help reduce the risk of healthcare-associated infection.

We saw that an up-to-date blood-borne virus policy was available. Relevant clinical staff had received Hepatitis B immunisations, and there was a process for staff to follow in the event of a needlestick or sharps injury.

An up-to-date needlestick and sharps policy was also available. However, we found that the policy would benefit from additional practical information to support staff in the event of an incident, including clear reporting arrangements and details of where staff should attend for further assessment and support.

The practice should strengthen the needlestick and sharps policy by including a

clear flowchart, relevant contact details, reporting arrangements and information on where staff should attend for further assistance, such as occupational health or the emergency department.

We did not see evidence that regular IPC audits were being undertaken by the practice. Without routine auditing, the practice could not fully demonstrate that IPC standards were being consistently monitored and maintained.

The practice should undertake regular infection prevention and control audit, including as a minimum a comprehensive annual IPC audit, and take appropriate action in response to any findings.

Staff told us there were outstanding estates issues within the practice. We observed that all but one of the clinical rooms had carpeted flooring. As the practice provides minor surgery services, this type of flooring was not considered suitable for all clinical areas because it may hinder effective cleaning and decontamination. Staff informed us that previous requests to replace the flooring had been raised but had not been progressed.

We found that fabric curtains were in use within clinical rooms. Fabric privacy curtains do not represent best practice from an infection prevention and control perspective unless appropriate arrangements are in place for their regular cleaning and replacement. The practice was unable to provide documentation demonstrating when curtains had last been changed, laundered or scheduled for replacement. As a result, we could not be assured that appropriate monitoring and maintenance arrangements were in place.

The practice must ensure that:

- **regular cleaning of fabric curtains occurs in accordance with current IPC guidelines or consider transitioning to disposable alternatives to support effective infection control**
- **Clear documentation is maintained to evidence the frequency and dates of curtain changes or laundering.**

Cleaning services for the practice were provided by the health board. Clinical rooms were generally tidy and free from unnecessary clutter. However, we identified some areas where standards of cleanliness could be improved, including dust on top of the vaccine refrigerator.

We did not see cleaning checklists displayed or available within rooms throughout the practice. A cleaning schedule was provided by the cleaning team during the inspection. Although this included provision for recording that water outlets had been run daily for two minutes, these records had not been completed. The absence of completed records made it difficult to verify that routine environmental cleaning and water flushing arrangements had been undertaken as intended.

The practice should ensure that cleaning records are maintained and available to demonstrate that cleaning has been completed in accordance with the agreed schedule. The practice should also ensure that all relevant water outlets are run in accordance with the practice risk assessment and this activity is recorded as part of its legionella control arrangements.

During the inspection, we observed that disposable mop heads in the cleaner's storeroom were stored head-down in water within the mop bucket. This did not support appropriate storage and drying of cleaning equipment and could increase the risk of microbial contamination. We also noted that the bucket had not been emptied after use. Only blue and red disposable mop heads were available at the time of the inspection.

The practice should:

- **ensure that cleaning equipment is stored appropriately after use, with mop buckets emptied and mop heads stored in a manner that allows them to dry effectively**
- **review the availability and use of colour-coded cleaning equipment to ensure that appropriate equipment is available for different areas of the premises.**

Medicines management

We found that arrangements were generally in place to support the safe prescribing, storage and management of medicines.

Prescription pads were stored securely and a record was maintained to account for their use. Staff described the process followed for managing repeat prescriptions and gave examples of occasions where blood tests or blood pressure checks were arranged before medication was reauthorised or reviewed, where clinically indicated.

The practice had an up-to-date prescribing policy in place. Staff told us that medication reviews were usually undertaken by GPs when medicines were reauthorised. In some cases, the pharmacist had also undertaken medication reviews, including reviews for patients prescribed gabapentin.

We reviewed the Patient Group Directions (PGDs) in use within the practice and found that a number had not been updated and had passed their review or expiry date. Current PGDs are required to ensure that medicines are supplied and administered in accordance with approved protocols and governance arrangements.

The practice must ensure that all Patient Group Directions are current, authorised and reviewed within the required timescales. Arrangements should also be implemented to routinely monitor PGD review and expiry dates and ensure expired

PGDs are promptly removed from use.

Suitable arrangements were in place to maintain the cold chain for vaccines and immunisations. The practice had one dedicated clinical refrigerator, and we found that vaccines were stored correctly and in accordance with relevant guidance. Refrigerator temperatures were checked twice daily from Monday to Friday, and the refrigerator was serviced annually. An up-to-date cold chain policy was also available.

Although refrigerator temperatures were monitored during the working week, there was no continuous monitoring in place to provide assurance that temperatures remained within the required range during weekends or in the event of a power interruption.

The practice should consider introducing a data logger or other continuous temperature-monitoring system to provide assurance that vaccine refrigerator temperatures remain within the required range outside normal working hours and during any power disruption.

A named member of staff was responsible for checking medicines, and we saw a checklist which showed that these checks were undertaken monthly. Staff also described appropriate processes for reporting adverse drug reactions and for disposing of and replacing expired medicines, syringes and needles.

A named member of staff was responsible for checking emergency medicines and equipment, including the automated external defibrillator (AED). We found that most of the emergency medicines and equipment expected under the minimum primary care standards outlined by the Resuscitation Council UK were available. Checks of emergency medicines and equipment, including the AED and oxygen cylinder, had been completed monthly rather than weekly. This issue was addressed through our concerns resolved during inspection process, as detailed in Appendix A.

A portable oxygen cylinder was available; however, it had passed its expiry date and was therefore not suitable for use. This issue was also addressed through the concerns resolved during inspection process, as detailed in Appendix A. We additionally found that the oxygen cylinder was not secured to prevent it from falling and was stored separately from the other emergency medicines and equipment.

The practice should ensure that the oxygen cylinder is stored securely to prevent it from falling and should consider storing it with the other emergency medicines and equipment, in a location that enables prompt access in an emergency.

An AED was available for use. This was a community AED located externally at the entrance to the building. However, paediatric pads were not available with the emergency equipment held within the practice. Therefore, while most of the expected emergency medicines and equipment were available, the practice could not demonstrate full compliance with the minimum primary care standards at the time of the inspection.

The practice should obtain paediatric AED pads and store them with the emergency equipment within the practice to ensure they are readily available when required.

Staff described the process for obtaining replacements when emergency medicines or equipment expired and were aware of where the emergency equipment was stored. However, there was no signage on the door to identify the location of the emergency medicines and equipment.

The practice should place clear signage on the door of the room where emergency medicines and equipment are stored to support prompt access in an emergency.

Dispensary

We found that appropriate processes, systems and staffing arrangements were generally in place to support the safe and effective provision of dispensing services.

The practice had an identified GP dispensing lead. All dispensary staff were qualified to at least NVQ Level 2 in Pharmacy Services, which met national standards. Staff told us that new members of the dispensary team received an induction and were expected to complete an NVQ Level 2 qualification, or equivalent, where this had not already been achieved.

Dispensary staff were responsible for ordering medicines through identified supply channels. Staff described the arrangements in place to manage medicine shortages. Where medicines were unavailable, patients were informed and clinicians could consider suitable alternatives or issue a prescription for the medicine to be dispensed elsewhere. The practice also had support arrangements in place with local pharmacies.

Medicine deliveries were received and signed for by dispensary staff. Staff described the process followed for receiving and managing controlled drugs within deliveries.

Monthly stock checks were undertaken within the dispensary. Refrigerator temperatures were recorded twice daily and medicines requiring temperature-controlled storage were appropriately stored in the refrigerator. However, we found that ambient room temperatures were not being monitored for medicines stored at room temperature. Without this monitoring, the practice could not fully demonstrate that all medicines were consistently stored within appropriate temperature ranges.

The practice should undertake and record regular ambient room temperature checks within the dispensary to provide assurance that medicines are stored under appropriate conditions.

Patients were able to request repeat medicines using reorder forms, online services or by attending the practice in person. Staff described the systems in place to support the safe dispensing of the correct medicine, strength and dose to the correct patient.

Expiry-date monitoring formed part of the monthly stock checks, and medicines approaching their expiry date were identified and removed as appropriate. Suitable arrangements were also in place for the recording and witnessed destruction of controlled drugs.

Dispensing errors were managed through the practice's significant event process. Staff told us that incidents were reviewed with the GP dispensing lead and that relevant learning was shared with the wider practice team. Staff also described how the causes of errors were discussed and measures were identified to reduce the risk of recurrence.

The practice was a member of the Dispensing Doctors' Association. Governance and oversight of the dispensary were provided by the dispensary manager and senior GP partner through standard operating procedures, audits, stock controls and reviews of safety issues.

The practice did not employ a pharmacist specifically to oversee the dispensary. However, support was available from a cluster pharmacist and through periodic visits from the health board's primary care team.

Standard operating procedures were reviewed annually, and the practice participated in the annual Dispensing Services Quality Scheme.

Safeguarding of children and adults

We found that the practice had suitable arrangements in place to support the safeguarding of children and adults and to enable staff to identify, report and respond to safeguarding concerns.

The practice had an identified safeguarding lead in place, and staff we spoke with were aware of who held this responsibility. An up-to-date safeguarding policy was also available to support staff in responding appropriately to concerns.

Systems were in place to identify children included on the child protection register, together with relevant parents, carers and siblings, through their family records. Staff also confirmed that children at risk and looked-after children were appropriately clinically coded within their medical records.

The practice had a Was Not Brought policy in place to support the monitoring and management of repeated non-attendance, including where this may indicate a safeguarding concern. Staff described the arrangements used to monitor relevant attendance patterns, including attendances at emergency departments and repeated instances where appointments were not attended or a child was not brought to an appointment.

Most staff had completed safeguarding training at a level appropriate to their role. However, this was not the case for all staff.

The practice must ensure that all staff complete safeguarding training at a level appropriate to their role and that this training is kept up to date.

Management of medical devices and equipment

We found that the practice had processes in place to support the safe use, maintenance and monitoring of medical devices and equipment.

The practice used single-use equipment wherever possible.

Staff told us that responsibility for checking medical devices and equipment was allocated to different members of staff depending on the type of device. For example, a member of the nursing team was responsible for checking the glucometer, with records of these checks maintained in a folder on the practice shared drive.

During our inspection, we found a number of expired medical consumables within clinical areas. These included partially used dressings that had been opened, blood collection tubes and other consumable items that had exceeded their recommended expiry or use-by date but remained within clinical stock. We also identified some reusable clinical equipment that remained available for use despite the practice not having access to appropriate sterilisation facilities.

The practice must:

- **undertake a review of all clinical consumables and equipment to ensure expired items are removed from use and safely disposed of**
- **ensure that any reusable equipment requiring sterilisation is removed from use and replaced with suitable alternatives**
- **implement a system to routinely monitor stock expiry dates and provide assurance that only safe and appropriate equipment is available for clinical use.**

The medical devices and equipment we observed during the inspection appeared to be in good condition. The practice also had arrangements in place for the servicing and maintenance of medical devices and equipment.

However, we found that an oxygen saturation probe and thermometer included within the emergency equipment had been omitted from the most recent calibration checks. As a result, the practice could not provide assurance that these devices were accurate and safe for continued use.

The practice must ensure that the oxygen saturation probe and thermometer are fit for use and are included in routine practice calibration checks.

Staff also described the process followed when equipment required urgent repair or replacement.

Effective

Effective care

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

New information relevant to staff was communicated through email and team meetings. Staff told us that new clinical guidance, including guidance issued by the National Institute for Health and Care Excellence (NICE), could be discussed during the weekly clinical meetings attended by clinicians and the practice manager.

The practice used the Datix system to report and record incidents and significant events. Staff had access to a form to support the reporting process.

Suitable processes were in place for making urgent, routine and urgent suspected cancer referrals. Staff told us that urgent suspected cancer referrals were completed by the GP responsible for the patient's care. Referral rates and any variation between clinicians were discussed at cluster level, enabling the practice to consider whether referral patterns were consistent with those of other practitioners within the local area.

We found that suitable processes were in place for receiving, recording and acting upon information received from secondary care. Where further action was required following a patient's discharge from secondary care, staff told us that patients could be contacted by telephone, letter or email, or referred to an appropriate service. Processes were also in place to respond to requests or actions arising from secondary care correspondence.

Staff told us that information about a patient's condition, investigations and management options was communicated directly to the patient and, where appropriate and with relevant consent, their carer. This supported older patients and those who were digitally excluded to understand information about their health and care.

All incoming and outgoing telephone calls were recorded, and callers were informed of this through the recorded telephone message. Internal messages between staff were communicated using the instant messaging function within the clinical IT system, which maintained an audit trail of communications.

We found that processes were in place to ensure that incoming correspondence was reviewed promptly and relevant information was appropriately recorded within the patient's medical record. Requests for home visits were clinically triaged by a GP. Staff told us that decisions took account of the patient's clinical needs, their ability to access the practice and any disability or other relevant individual circumstances.

Staff confirmed that information relating to patients' interactions with out-of-hours

services was recorded within their medical records. Suitable processes were also in place to follow up patients who required further investigations or tests.

For patients receiving end-of-life care, the practice had a system in place to ensure that it was notified when a patient had died, allowing relevant records and ongoing care arrangements to be updated appropriately.

We found that arrangements were in place to support patients who required mental health support. Staff told us that they had undertaken mental health awareness training and described the support available to patients experiencing poor mental health or a mental health crisis.

Patients experiencing a mental health crisis could be supported by GPs at the practice and through the cluster mental health nurse. Staff also encouraged patients to access NHS 111 Option 2 for urgent mental health support. However, we found that information about NHS 111 Option 2 was not promoted on the practice website.

The practice should add information and appropriate links for NHS 111 Option 2 to its website to improve awareness and access to urgent mental health support.

Staff described some challenges in accessing timely mental health support for patients, including waiting lists and difficulties with transport to the local hospital due to the practice serving a remote community.

The practice was informed when a patient had received mental health crisis intervention through discharge correspondence from relevant services or directly by the patient.

Patient records

We reviewed a sample of 10 patient records and found that, overall, they were of a good quality. Records were up to date, complete, understandable and contemporaneous. They provided clear evidence of the clinical history, examination undertaken, management decisions and plans for ongoing care.

We found that records generally contained sufficient information to support the clinical decisions made and the reasoning relating to patient care. However, we identified some inconsistencies in the way clinical information had been coded. Prescribed medicines were not always linked to the relevant clinical problem within the patient's record. We also found examples where diagnoses had been recorded as free text within the history field rather than being entered within the appropriate problem field. Staff told us that these issues may have been associated with the practice's recent migration to a new clinical IT system.

The practice should review clinical coding and patient problem lists following the recent migration to the new clinical IT system. This should include ensuring that prescribed medicines are linked to the relevant clinical problems and that

diagnoses are recorded within the appropriate field.

Paper records, including patient correspondence, were stored securely within a locked room. We found that the arrangements in place supported the secure storage and confidentiality of patient information in accordance with relevant data protection requirements.

Where non-clinical staff were involved in summarising patient records, staff told us that they had undertaken a summarising training course to support them in identifying relevant information and coding this appropriately within the clinical record.

However, staff told us that the quality of data entry within patient records and summaries was not routinely audited. Regular review would help provide assurance that records remained accurate, complete and consistently coded.

The practice should introduce regular audit of patient medical records to monitor the quality, accuracy and completeness of data entry and clinical coding.

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, and to support the sustainable delivery of safe and effective care.

Staff told us that they were clear about their individual roles, responsibilities and reporting arrangements, and understood the importance of working within their scope of practice. Senior staff described an open-door approach and told us that they remained visible and approachable to the wider practice team.

Whole-team meetings were held quarterly. Staff were able to contribute items for discussion to the meeting agenda, and minutes were subsequently circulated to all staff by email. Information, including changes to policies and procedures, was shared through team meetings, clinical meetings and email communication.

Policies and procedures were readily accessible to staff and were generally reviewed and updated as required. However, we found that some documents, including the Blood Borne Virus Policy and Needlestick/Sharps Policy, did not include effective document control information, such as a version number or review date. Without consistent document control, there was a risk that staff could refer to information that was no longer current.

The practice should review its policies and procedures to ensure that they are current, complete and subject to effective document control. This should include the use of version numbers, issue dates and review dates.

Staff had access to wellbeing support through the Wellbeing at Work programme and occupational health services provided by the health board.

Staff identified the condition and age of the premises as one of the main challenges facing the practice. This included estates-related concerns and tree branches outside the building which were sweeping against the premises.

Designated leads were in place for specific areas of practice, including safeguarding, infection prevention and control and other areas requiring oversight. This provided staff with identified individuals from whom they could seek advice and support. Clinical oversight of the practice was provided by a GP partner.

Clinical information and new initiatives were shared through regular meetings. Weekly clinical meetings were attended by GP partners, clinicians and the practice manager, and relevant information was also shared by email where appropriate. We saw evidence that clinical meetings took place and that information was disseminated to staff. However, staff told us that clinical meetings were not always formally minuted.

The practice should ensure that all clinical meetings are appropriately minuted to provide a clear record of discussions, decisions and agreed actions.

We found that there were clear lines of accountability for maintaining and improving service standards. The practice also participated in cluster projects and initiatives, which supported collaborative working with other local primary care services.

Workforce

Skilled and enabled workforce

We found that the practice had arrangements in place to help ensure that staff had the appropriate knowledge, skills and experience to carry out their roles safely and effectively.

An up-to-date recruitment policy was available. The recruitment process included appropriate pre-employment checks, including confirmation of identity, Disclosure and Barring Service (DBS) 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. Staff told us that professional registrations were checked annually to ensure they remained current.

We saw evidence that annual staff appraisals had been completed. Staff told us that appraisals, training updates and Protected Learning Time sessions were used to support ongoing learning and professional development. We reviewed a sample of training records for clinical and administrative staff and found good levels of compliance with training requirements.

However, we found that DBS checks were undertaken when staff commenced employment but were not subsequently repeated at regular intervals, as determined by a practice policy position. There was also no formal process in place requiring staff to make ongoing declarations regarding any changes in circumstances 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**
- **introduce a process requiring staff to declare any changes that may affect their ongoing suitability to work, such as criminal offences, cautions or relevant investigations. This could be incorporated into the annual appraisal process.**

An up-to-date induction policy and programme were available to support staff when commencing employment at the practice.

Staff told us that the workforce was multi-skilled, which enabled team members to undertake a range of duties and provide cover where required. This helped the practice to maintain appropriate capacity and skill mix to respond to service demands.

We saw evidence of appropriate medical indemnity arrangements, including relevant medical indemnity certificates. Staff told us that responsibilities for management, administration, accountability and reporting were clearly defined and understood within the team.

Current job descriptions were available and set out staff roles and responsibilities. We also found evidence that staff worked within an appropriate scope of practice, supported by their qualifications, skills, knowledge and experience. Appropriate prescribing scopes of practice were in place for independent prescribers, and suitable arrangements were in place for direct and indirect clinical supervision.

Culture

People engagement, feedback and learning

We found that the practice had arrangements in place to enable patients, relatives and carers to provide feedback about the service and to support learning from complaints, concerns and other feedback received.

The practice maintained a spreadsheet to record and monitor complaints and concerns. We saw that this included information which enabled themes and trends to be identified and monitored. We also reviewed examples of complaints and responses issued by the practice, which demonstrated that complaints were being considered and responded to.

A named member of staff was responsible for managing complaints and concerns. However, the practice's complaints policy had not yet been updated to reflect the NHS Listening to People procedure. Information about the NHS Listening to People procedure was displayed within the waiting area and was accessible to patients.

The practice must update its complaints process and policy to ensure that it aligns with the NHS Listening to People procedure.

Staff provided examples of occasions where patient suggestions had been welcomed and acted upon. However, there was no established process for communicating to patients how their feedback had been considered or what changes had been made as a result.

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

Staff told us that learning arising from complaints, concerns and other feedback could be discussed at team meetings where appropriate. This provided an opportunity for learning to be shared with relevant members of the practice team and for changes to be considered where required.

Staff told us that they were encouraged to speak openly and contribute new ideas. They were also aware of how to raise concerns and could approach the practice manager or another appropriate member of staff if they had any concerns.

An up-to-date whistleblowing policy was available to staff. The practice also had an up-to-date Duty of Candour policy in place, and staff had completed relevant Duty of Candour training. Staff told us that the Duty of Candour process had not needed to be applied recently.

Information

Information governance and digital technology

We found that the practice had arrangements in place to support the effective management of information and ensure compliance with information governance requirements. An up-to-date information governance policy was available to staff and provided guidance on the handling, storage and processing of information.

Staff told us that the practice had clear processes for managing information and understood their responsibilities when processing patient data. Digital Health and Care Wales acted as the practice's Data Protection Officer, providing support and oversight in relation to data protection responsibilities.

Staff told us that clear processes were in place for handling and managing data appropriately. The practice used its clinical IT system effectively to support the accuracy and quality of information held within patient records.

We also found that the practice monitored a range of performance measures. Staff were able to provide examples of areas that were monitored and reviewed, demonstrating that information was used to support oversight of services and inform decision-making.

Learning, improvement and research

Quality improvement activities

We found that the practice engaged in a range of quality improvement activities aimed at maintaining and improving the quality of services provided to patients. Staff described how complaints, concerns and feedback were used as opportunities for

learning and service development. Depending on the nature of the issue raised, complaints could be discussed with the individual concerned or shared more widely within team meetings. Staff provided an example of a complaint that had resulted in a change to practice processes, demonstrating that feedback was used to inform improvement. Meeting discussions were recorded and shared with staff through meeting minutes.

The practice sought to involve patients in service improvement. Staff told us that they were working to re-establish a Patient Participation Group, and we saw a poster displayed near the reception desk inviting patients to volunteer. Patient views were also gathered through surveys and the feedback facility available on the practice website.

A programme of audit activity was undertaken to monitor aspects of quality and safety. This included clinical audits, dispensary audits and healthcare waste audits.

The practice had arrangements in place to support organisational learning from both internal and external sources. Staff told us that learning arising from incidents, complaints, external reviews and mortality reviews was included as a standing agenda item at whole-practice meetings held every three months.

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 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.
We found an oxygen cylinder that had passed its expiry date.	An expired oxygen cylinder may not provide assurance that the equipment remains safe, fit for purpose and ready for use in an emergency. This could increase the risk of delays in treatment if the cylinder is found to be unusable, damaged or requires replacement at the point it is needed.	This was raised with the practice manager.	The practice manager ordered a new cylinder for delivery the following day.

Appendix B – Immediate improvement plan

Service: **Afan Valley Group Practice**

Date of inspection: **11 August 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 were no immediate assurance issues identified during this inspection.		
Improvement needed		**Standard / Regulation**	
1.			
Service Action:		**Responsible officer**	**Timescale**

Appendix C –improvement plan

Service: **Afan Valley Group Practice**

Date of inspection: **11 August 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 chaparone poster was not prominently displayed and may not be easily visible to all patients using the service.	The practice should take steps to improve the visibility of information about the chaperone service to ensure all patients are aware that a chaperone can be requested for consultations and examinations.	Health & Care Quality Standards (2023) – Person-centred, Equitable.	Posters have now been placed on all doors of consulting rooms about requesting chaperones	Practice Manager	Completed

2.	We saw that some signage and posters were available bilingually in Welsh and English. However, most information displayed within the practice was available in English only	The practice should: • review the information displayed throughout the premises to ensure that any new patient-facing signs are bi-lingual and that there is an equitable display of posters and other information in both Welsh and English • ensure that the Active Offer of the Welsh language is promoted to patients.	Health & Care Quality Standards (2023) – Equitable, Person-centred.	All bilingual posters we have receive since our visit are displayed on notice boards	Practice Manager	Completed
3.	An accessible toilet was available and was fitted with an emergency pull cord to summon assistance. However, when we tested the alarm during the inspection, it did not work.	The practice must ensure that the disabled toilet emergency pull cord alarm is repaired and that regular checks are implemented to ensure it remains functional.	Health & Care Quality Standards (2023) – Safe, Equitable, Person-centred.	Was reported to the trust who have been out to inspect, there is a problem with the transformer, and they have one on order a replacement awaiting fitting	NHS Trust	3 months

4.	We noted that, following the recent repainting of the practice, some strip light covers had not been replaced and remained absent at the time of the inspection.	The practice should ensure that all strip light covers removed during recent redecoration are replaced securely in their correct position.	Health & Care Quality Standards (2023) – Safe.	Was reported to the trust who have been out to inspect, awaiting replacement covers	NHS Trust	6 months
5.	We saw fire, health and safety, and legionella risk assessments which had not been reviewed or updated recently by the health board. Staff also told us that they were awaiting fire warden training to be provided by the health board.	The practice should liaise with the health board to ensure that fire, health and safety, and legionella risk assessments are reviewed and updated at appropriate intervals, and that relevant staff complete fire warden training as soon as practicable.	Health & Care Quality Standards (2023) – Safe, Leadership, Workforce.	Reports have now sent to PM and are available. Fire warden training to be arranged in practice	NHS Trust Practice Manager	Completed 6 months

6.	A named member of staff was responsible for receiving and accessing patient safety alerts. However, there was no additional named member of staff identified to undertake this responsibility in the event of prolonged absence.	The practice should identify an additional named member of staff who is able to access and manage patient safety alerts if the designated member of staff is unavailable for an extended period.	Health & Care Quality Standards (2023) – Safe, Leadership, Workforce.	Auto forward setup on PM email account for all alerts to be copied to GP's and Dispensers	Practice Manager	Completed
7.	Not all sinks within clinical areas were fitted with elbow-operated taps.	The practice should review and update handwashing facilities within a reasonable timeframe and ensure they meet current infection prevention and control standards.	Health & Care Quality Standards (2023) – Safe, Effective.	Staff from the Trust have been up to assess, nothing done yet	NHS Trust	6 months
8.	We saw a healthcare waste audit dated July 2026 which identified several recommendations for improvement.	The practice should address the recommendations identified within the July 2026 healthcare waste audit at the earliest opportunity.	Health & Care Quality Standards (2023) – Safe, Effective, Leadership.	Healthcare waste audit to be reviewed	Practice Manager	3 months

9.	We found that the needlestick and sharps policy would benefit from additional practical information to support staff in the event of an incident.	The practice should strengthen the needlestick and sharps policy by including a clear flowchart, relevant contact details, reporting arrangements and information on where staff should attend for further assistance, such as occupational health or the emergency department.	Health & Care Quality Standards (2023) – Safe, Workforce.	Policy has been updated and Version number added	Practice Manager	Completed
10.	We did not see evidence that regular IPC audits were being undertaken by the practice.	The practice should undertake regular infection prevention and control audits, including as a minimum a comprehensive annual IPC audit, and take appropriate action in response to any findings.	Health & Care Quality Standards (2023) – Safe, Leadership, Learning, improvement & research, Effective.	IPC Audits have been adapted and the PN is undertaking them	Practice Nurse	Completed

11.	The practice was unable to provide documentation demonstrating when curtains had last been changed, laundered or scheduled for replacement.	The practice must ensure that: • regular cleaning of fabric curtains occurs in accordance with current IPC guidelines or consider transitioning to disposable alternatives to support effective infection control • Clear documentation is maintained to evidence the frequency and dates of curtain changes or laundering.	Health & Care Quality Standards (2023) – Safe, Leadership, Effective.	Disposable curtains installed, fabric curtains laundered. Audit log being kept since visit	Practice Manager	Completed

12.	We did not see cleaning checklists displayed or available within rooms around the practice. The absence of completed records made it difficult to verify that routine environmental cleaning and water flushing arrangements had been undertaken as intended.	The practice should ensure that cleaning records are maintained and available to demonstrate that cleaning has been completed in accordance with the agreed schedule. The practice should also ensure that all relevant water outlets are run in accordance with the practice risk assessment and this activity is recorded as part of its legionella control arrangements.	Health & Care Quality Standards (2023) – Safe, Effective, Learning, improvement & research, Leadership.	Reply from hotel services cleaning records have now been updated and more information is written on their plans. The water outlets don't sit with hotel Services, this sits with estates but they did say that this is usually only done in rooms not being used.	NHS Trust	Ongoing

13.	During the inspection, we observed that disposable mop heads in the cleaner's storeroom were stored head-down in water within the mop bucket. We also noted that the bucket had not been emptied after use. Only blue and red disposable mop heads were available at the time of the inspection.	The practice should: • ensure that cleaning equipment is stored appropriately after use, with mop buckets emptied and mop heads stored in a manner that allows them to dry effectively • review the availability and use of colour-coded cleaning equipment to ensure that appropriate equipment is available for different areas of the premises.	Health & Care Quality Standards (2023) – Safe, Effective, Workforce.	Hotel services advised that they have discussed water left in the mop bucket with all staff. Also, they only use red and blue mops in gp clinics, but have now put in yellow ones	NHS Trust	Completed

14.	We reviewed the Patient Group Directions (PGDs) in use within the practice and found that a number had not been updated and had passed their review or expiry date.	The practice must ensure that all Patient Group Directions are current, authorised and reviewed within the required timescales. Arrangements should also be implemented to routinely monitor PGD review and expiry dates and ensure expired PGDs are promptly removed from use.	Health & Care Quality Standards (2023) – Safe, Effective, Leadership, Workforce.	All PGD's have been updated and out of date ones removed from folder. PN now has a schedule in her folder with the date of expiry at the front of each page for ease of checking on a monthly basis	Practice Nurse	Completed
15.	There was no continuous temperature monitoring in place to provide assurance that temperatures remained within the required range during weekends or in the event of a power interruption.	The practice should consider introducing a data logger or other continuous temperature-monitoring system to provide assurance that vaccine refrigerator temperatures remain within the required range outside normal working hours and during any power disruption.	Health & Care Quality Standards (2023) – Safe, Effective, Leadership.	Practice is in the process if purchasing a data logger. Checking compliancy with current fridges	Practice Manager	3 months

16.	We found that the oxygen cylinder was not secured to prevent it from falling and was stored separately from the other emergency medicines and equipment.	The practice should ensure that the oxygen cylinder is stored securely to prevent it from falling and should consider storing it with the other emergency medicines and equipment, in a location that enables prompt access in an emergency.	Health & Care Quality Standards (2023) – Safe, Timely.	Oxygen cylinder has been re-allocated to a room where the emergency equipment/trolley are all kept together and has been fixed to the wall with a bracket and strap	Practice Manager	Completed
17.	Paediatric pads were not available with the emergency equipment held within the practice.	The practice should obtain paediatric AED pads and store them with the emergency equipment within the practice to ensure they are readily available when required.	Health & Care Quality Standards (2023) – Safe, Timely, Effective.	Paediatric pads have been purchased	Practice Manager	Completed
18.	There was no signage on the door to identify the location of the emergency medicines and equipment.	The practice should place clear signage on the door of the room where emergency medicines and equipment are stored to support prompt access in an emergency.	Health & Care Quality Standards (2023) – Safe, Timely, Effective.	Sign has now been put on the door where emergency equipment and medicines are stored	Practice Manager	Completed

19.	We found that ambient room temperatures were not being monitored for medicines stored at room temperature.	The practice should undertake and record regular ambient room temperature checks within the dispensary to provide assurance that medicines are stored under appropriate conditions.	Health & Care Quality Standards (2023) – Safe, Effective, Leadership.	Room thermometer has been purchased and placed in the dispensary stock room	Practice Manager	Completed
20.	Most staff had completed safeguarding training at a level appropriate to their role. However, this was not the case for all staff.	The practice must ensure that all staff complete safeguarding training at a level appropriate to their role and that this training is kept up to date.	Health & Care Quality Standards (2023) – Safe, Workforce, Leadership.	GP has completed training, PN and ANP awaiting further course to be able to complete	Practice Manager	3 months

21.	We found a number of expired medical consumables within clinical areas. These included partially used dressings that had been opened, blood collection tubes and other consumable items that had exceeded their recommended expiry or use-by date but remained within clinical stock. We also identified some reusable clinical equipment that remained available for use despite the practice not having access to appropriate sterilisation facilities.	The practice must: • undertake a review of all clinical consumables and equipment to ensure expired items are removed from use and safely disposed of • ensure that any reusable equipment requiring sterilisation is removed from use and replaced with suitable alternatives • implement a system to routinely monitor stock expiry dates and provide assurance that only safe and appropriate equipment is available for clinical use.	Health & Care Quality Standards (2023) – Safe, Effective, Leadership, Workforce.	All expired consumables removed and disposed of safely Reuseable equipment no longer used removed and disposed of safely Any new stocks delivered are entered onto a spreadsheet with expiry dates with most recent expiry at the top for ease of destruction	Practice Nurse	Completed

22.	We found that an oxygen saturation probe and thermometer included within the emergency equipment had been omitted from the most recent calibration checks.	The practice must ensure that the oxygen saturation probe and thermometer are fit for use and are included in routine practice calibration checks.	Health & Care Quality Standards (2023) – Safe, Effective.	The items were purchased new recently so had not been calibrated along with our other equipment, will include in the annual calibration	Practice Nurse	Annually
23.	We found that information about NHS 111 Option 2 was not promoted on the practice website.	The practice should add information and appropriate links for NHS 111 Option 2 to its website to improve awareness and access to urgent mental health support.	Health & Care Quality Standards (2023) – Timely, Person-centred, Equitable, Effective.	Information has now been added to the practice website	Practice Manager	Completed
24.	Prescribed medicines were not always linked to the relevant clinical problem within the patient's record. We also found examples where diagnoses had been recorded as free text within the history field rather than being entered within the appropriate problem field.	The practice should review clinical coding and patient problem lists following the recent migration to the new clinical IT system. This should include ensuring that prescribed medicines are linked to the relevant clinical problems and that diagnoses are recorded within the appropriate field.	Health & Care Quality Standards (2023) – Effective, Safe, Information.	Clinicians are now linking problems to prescribed medications during and opportunistically	Clinicians	Completed

25.	Staff told us that the quality of data entry within patient records and summaries was not routinely audited.	The practice should introduce regular audit of patient medical records to monitor the quality, accuracy and completeness of data entry and clinical coding.	Health & Care Quality Standards (2023) – Information, Learning, improvement & research, Effective, Safe.	An audit will take place on a quarterly basis where a sample of 5 records will be checked by the PM	Practice Manager	ongoing
26.	We found that some documents, including the Blood Borne Virus Policy and Needlestick/Sharps Policy, did not include effective document control information, such as a version number or review date.	The practice should review its policies and procedures to ensure that they are current, complete and subject to effective document control. This should include the use of version numbers, issue dates and review dates.	Health & Care Quality Standards (2023) – Leadership, Information, Safe, Workforce.	Version numbers have now been added to the policies	Practice Manager	Completed
27.	Staff told us that clinical meetings were not always formally minuted.	The practice should ensure that all clinical meetings are appropriately minuted to provide a clear record of discussions, decisions and agreed actions.	Health & Care Quality Standards (2023) – Leadership, Information, Learning, improvement & research, Safe.	The clinical meetings that take place are mostly discussions. All discussions will now be minuted	Practice Manager	Completed

28.	We found that DBS checks were undertaken when staff commenced employment but were not subsequently repeated at regular intervals. There was also no formal process in place requiring staff to make ongoing declarations regarding any changes in circumstances 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 • introduce a process requiring staff to declare any changes that may affect their ongoing suitability to work, such as criminal offences, cautions or relevant investigations. This could be incorporated into the annual appraisal process.	Health & Care Quality Standards (2023) – Workforce, Safe, Leadership, Information.	Policy adopted, checks will be taking place over the next few months. Annual appraisals will now include the opportunity for staff to declare if any changes in regard to their ongoing suitability to work	Practice Manager	Completed
29.	The practice's complaints policy had not yet been updated to reflect the NHS Listening to People procedure.	The practice must update its complaints process and policy to ensure that it aligns with the NHS Listening to People procedure.	Health & Care Quality Standards (2023) – Person-centred, Leadership, Learning, improvement & research, Information.	Practice complaints process has now been updated to include Listening to People	Practice Manager	Completed

30.	There was no established process for communicating to patients how their feedback had been considered or what changes had been made as a result.	The practice should introduce a suitable process to demonstrate how patient feedback has been considered and acted upon. This could include publishing information on the practice website, displaying updates within the waiting area or introducing a 'You said, we did' approach.	Health & Care Quality Standards (2023) – Person-centred, Learning, improvement & research, Information.	Waiting room notice board to be purchased where we can put Large, clear posters detailing recent changes.	Practice Manager	3 months

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): Phillipa Thomas

Job role: Practice Manager **Date: 22.10.2026**