First Practice Management

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What the HIW Recommends: Poor practice to avoid

	INSPECTION COMMENTS
Safe	
Risk management	• Some areas of **paintwork appeared tired and required renewal**. We also **found a screw protruding through the tiles above the sink** in the male toilet located near the waiting area. • The significant-event process recorded identified learning, actions and responsible persons. However, it did not include a documented later review confirming that actions had been completed and that identified improvements had been implemented and embedded. The practice should strengthen its existing significant-event process by introducing a documented follow-up review to confirm that agreed actions have been completed and that identified improvements have been implemented and embedded. • 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**. • The practice had an up-to-date business continuity plan. However, the plan did not include arrangements relating to partnership risk or risks associated with the practice operating from leased premises. **The practice should update its business continuity plan to include appropriate consideration of partnership risk and risks associated with the leased premises.**
Infection prevention and control (IPC) and decontamination	• Elbow-operated taps were not available in every clinical room. We also found plugs in handwashing sinks. **The practice must: review and update hand wash facilities within a reasonable timeframe and where**

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	feasible to ensure compliance with current infection prevention standards, and remove any plugs to ensure they function as dedicated hand hygiene sinks. • We did not see signed checklists to confirm when cleaning had been completed. The practice should introduce signed cleaning checklists to provide assurance that cleaning is completed consistently and in line with the schedule. The practice should **update needlestick injury posters to include who staff should report incidents to and where staff should attend for urgent advice or treatment**, including relevant telephone numbers and addresses, such as the local emergency department. • 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.** • Our inspection found that sharps boxes were not fully labelled as required and that this was a recurrent issue. 12 The practice should **ensure that procedures for the labelling of sharps boxes on assembly and closure are fully implemented.** • 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. Information is available regarding who staff should contact in the event of a needlestick injury for relevant monitoring and support.** • Daily cleaning records were not available for review. Consequently, we were unable to verify whether routine environmental cleaning had been completed consistently and in accordance with the agreed schedule. We also observed dust underneath some clinical examination benches, which indicated that cleaning standards were not always being maintained. **The practice must ensure that the scheduled cleaning programme is delivered in accordance with the cleaning contract. Cleaning schedules should be consistently followed and documented**, with regular audit undertaken to monitor and maintain cleaning standards.
Medicines management	• The practice did not maintain a log for boxes of prescription stationery. **The practice should introduce a log for boxes of prescription stationery to provide a clear audit trail and strengthen prescription security.** • When reviewing more than 20 patient records, we were unable to find evidence of recent, formal medication reviews, despite many patients being prescribed multiple medications. The practice should **ensure that**

	formal medication reviews are undertaken at appropriate intervals and clearly documented, particularly for patients taking multiple medicines or with complex health needs. • We found that a urine sample was being stored in the vaccine refrigerator on a middle shelf, and that the fridge was overstocked and disorganised, with vaccines and drugs stored on the bottom shelf. This was not in line with the practice's Medicines Storage and Cold Chain Policy. The practice should **consider whether an additional fridge is required to support safe storage, particularly where overstocking may block the fridge fan and affect temperature control.** • We did not see a room thermometer to monitor ambient storage temperatures. The practice should **carry out and record ambient room temperature checks to ensure medicines are stored under recommended conditions.** • We found two oxygen cylinders at the practice: a large freestanding oxygen cylinder and a BOC CD integrated valve oxygen cylinder. The large cylinder was not secured, which presented a risk of falling over. Staff had also not received training on the use of the 23 BOC CD integrated valve oxygen cylinder. The practice should: **secure the large oxygen cylinder to prevent it from falling over; ensure relevant staff complete appropriate online training on the use of the BOC CD integrated valve oxygen cylinder.** • 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.** • 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.** • We reviewed two prescribing policies. One was the current policy, while the other was a comprehensive draft policy. The draft policy had not yet been formally adopted. The practice should **formally adopt the draft prescribing policy and ensure it is reviewed and updated as required.**
Safeguarding of children and adults	• The safeguarding policy for adults did not include sufficiently detailed processes to guide staff on when to refer, who to refer to, or how to seek appropriate advice. The policy for children and young persons also lacked essential contact information and should be updated to reflect local safeguarding pathways. The practice must **ensure that the safeguarding policies are revised to include clear referral processes, escalation routes, local safeguarding pathways and essential contact information.** • We found multiple adult patients remained coded as being on the child protection register and had not been removed when their circumstances changed. The practice should **introduce a formal process to regularly review child protection coding, update records appropriately and apply a specific clinical code to indicate when a child protection marker has been removed.**

	• We found that the safeguarding policy did not include a relevant code for a family member. The practice should **update the policy to include relevant safeguarding coding guidance, including coding for family members where appropriate.** • 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.** • We reviewed five records relating to children included on the child protection register. Two of these records did not contain evidence of appropriate linked records or safeguarding alerts. Following discussion with the safeguarding lead, it was considered likely that this had resulted from the practice's migration to a new clinical system during the preceding three months. **The practice should review its coding arrangements to ensure that safeguarding information, including linked records and appropriate alerts, is consistently and accurately recorded within patients' medical records.** • Staff told us that safeguarding training requirements were set according to role, with level one training expected for administrative staff, level two for managers and level three for clinicians. However, our review of training records identified incomplete safeguarding training records for more than half of the GPs. The practice must **ensure that all staff complete safeguarding training at a level appropriate to their role and that complete, accurate and up-to-date training records are maintained.**
Management of medical devices and equipment	• Staff told us that responsibility for checking medical devices and equipment was shared, with staff checking items as they were used. However, we did not see formal records documenting that these checks had been completed. The practice should **maintain a formal record of checks of medical devices and equipment.** • During the inspection, expired items were found in clinical areas that had not been removed from use. These included blood collection bottles, needles and swabs. The presence of expired items poses a potential risk to patient and staff safety, as such items may no longer be effective or safe for use. The practice should **review and strengthen the system in place for regularly checking and removing expired items from clinical areas to ensure that only in date and safe equipment is available for use.**
Timely	
Timely care	• **Inspectors did not see a dedicated feedback or suggestions box**. We did not observe 'You said, we did' information during the period in which the waiting-room television display was reviewed. The practice subsequently confirmed that this information formed part of the wider television reel. The practice should **improve the visibility and accessibility of its existing feedback 17 arrangements by clearly promoting**

	how patients can provide general feedback or suggestions, considering whether an additional accessible mechanism is needed in the waiting area, and ensuring that 'You said, we did' information is sufficiently prominent and regularly visible to patients. • We noted that the number of abandoned calls was high; however, there **was uncertainty about whether this data included patients selecting options to request a call back rather than waiting on the line**. The practice should **review how telephone data is collected and interpreted** to ensure it has an accurate understanding of telephone access and patient experience. • 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.**
Effective	
Effective care	• We did not see a workflow policy which clearly set out how correspondence should be delegated, which staff were responsible for different types of letters, which letters needed to be reviewed by a doctor, and which letters could be filed without further clinical action. The practice **should develop a written workflow policy to support consistent and safe management of incoming correspondence.** • We did not see a formal process to ensure that tests requiring repetition or re-booking were monitored to confirm that appointments had been made or that tests had been completed. The practice should **strengthen and document its existing test-results and follow up process to ensure that tests requiring repetition or re-booking are tracked through to booking and completion, with proportionate escalation where patients do not respond or attend.** • 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.** • A workflow policy was available; however, it did not contain sufficient detail to provide the administrative team with clear guidance on individual responsibilities and required actions. The practice should **review and update its workflow policy to ensure staff have clear guidance on the management of correspondence**, including how information should be reviewed, recorded and escalated to clinicians where appropriate.
Patient records	• The practice should strengthen arrangements for documenting diagnostic imaging referrals arising from remote consultations. **Clinical records should clearly demonstrate the assessment undertaken, the rationale for the referral, and why a face-to-face examination was not considered necessary. This will**

	support continuity of care, provide assurance that patients are assessed using the most appropriate consultation method for their presentation, and ensure that referrals contain sufficient clinical information to support justification under IR(ME)R. • We found limited evidence in the records reviewed that patients' preferred language was documented. The practice should **ensure that patients' preferred language is recorded consistently to support effective communication and delivery of the Active Offer.** • Where non-clinical staff were used to summarise information, staff had received training to recognise what needed to be added to the record and how information should be coded. However, the practice did not currently have a process in place to review the quality of case records and summaries. The practice should **introduce a regular audit of the summarising of records to provide assurance that entries are accurate, complete, appropriately coded and contain sufficient clinical context.** • 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.** • 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.** • We also found that prescribed medicines were not consistently linked to the relevant clinical problem within patients' records. This reduced the clarity of the relationship between a patient's diagnosis and their current treatment and may also have been affected by the recent system migration**. The practice should review clinical coding and active problem lists following the recent clinical system migration. This should ensure that duplicate entries are removed, historic conditions are no longer recorded as active** where this is inappropriate, and prescribed medicines are linked to the relevant clinical problems. • Non-clinical staff involved in summarising patient information had received training in the practice's workflow and clinical coding processes. However, the practice did not undertake a formal review or audit of the quality of record summarisation. Consequently, the practice could not fully demonstrate that summaries were 22 consistently accurate, complete, appropriately coded and supported by sufficient clinical context. **The practice should introduce regular audits of patient records and clinical summaries to provide assurance that entries are accurate, complete, appropriately coded and contain sufficient clinical context.**

	• Overall, the quality of patient records was satisfactory, and the information recorded would generally allow a clinician unfamiliar with the practice to understand and safely use the records when providing care. However, **the level of narrative detail varied. Some entries were concise and lacked context, for instance where a clinician unfamiliar with the patient may need to understand the reasoning behind clinical decisions.**
Equitable	
Communicating and language	• 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.** • 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.** • Our review of patient records found that patients' preferred languages were not consistently recorded. This could limit the practice's ability to identify and meet patients' individual communication needs. The practice should **ensure that each patient's preferred language and communication needs were consistently recorded within their medical record.**
Rights and equality	• Many staff had completed equality and diversity training. However, the sample reviewed identified incomplete or out-of-date equality and diversity training for some staff. Autism-awareness training was not evidenced in the sampled records, and learning-disability training had not yet been incorporated consistently into the practice training programme. The practice should **review the rights and equality training required for each staff group, ensure that relevant equality and diversity, autism-awareness and learning disability training is completed, and maintain accurate records for monitoring and renewal.** • We identified some areas where accessibility could be improved. **The front entrance door was not automated**, which may make access more difficult for patients using wheelchairs, patients with limited mobility, or patients attending with children in pushchairs. **We also found that the double doors between the waiting room and consulting rooms were narrow when only one door was opened.** • We found that the disabled toilet did not have an emergency call bell. **The practice must ensure that the accessible toilet is safe and suitably equipped for patients with disabilities by installing an emergency pull cord without delay**. Regular checks should also be implemented to ensure that this safety feature remains in place and functional.

Person-centred	
Health promotion	• Some information displayed on the waiting room screen was not relevant to patients in Wales and some information was out of date. For example, **bowel screening information displayed on the screen stated that the programme applied to people aged 60 to 75. This is not consistent with current Welsh guidance**, which states that bowel screening is offered every two years to people aged 50 to 74 who are registered with a GP in Wales. • Some **information displayed on the screen linked to England specific websites and included outdated COVID-19 information**. The content observed on the waiting-room screen during the period reviewed by inspectors was in English only. The practice subsequently confirmed to us that some Welsh-language material formed part of the wider television reel. • QR codes on the large poster displayed next to reception mostly did not work. This limited the effectiveness of the poster as a health promotion resource and may prevent patients from accessing relevant information or support. **Check all QR codes and links displayed on posters in the waiting room and update or replace any broken links to ensure they are functioning correctly** • we noted that the health promotion information displayed on the television screens was not available in Welsh. The practice should ensure health promotion information displayed on waiting room television screens is available in both Welsh and English. • The practice had an up to date "Was Not Brought" procedure incorporated within its safeguarding policy. However, there did not appear to be a clearly defined process for reviewing and managing adults who did not attend appointments. **The practice should develop and implement a documented process for reviewing and managing adult patients who do not attend appointments.**
Dignified and respectful care	• The evidence reviewed did not provide consistent assurance that all relevant staff acting as chaperones had completed appropriate training. The practice should **ensure that all staff acting as chaperones receive appropriate training and that completion of this training is recorded, monitored and refreshed at suitable intervals.** • Our review of patient records identified that verbal consent for intimate examinations was not always documented. The offer of a chaperone, whether the patient had accepted or declined the offer, and the details of any chaperone present were also not consistently recorded. **The practice must ensure that verbal consent for intimate examinations, the offer of a chaperone, the patient's decision to accept or decline the offer, and the details of any chaperone present are consistently recorded in the patient's medical record, in accordance with General Medical Council guidance.**
Quality of Management and Leadership	
Leadership	

Governance and leadership	• **The policies and procedures reviewed were inconsistent**. Most did not include effective document control arrangements, such as a version number, date of issue or scheduled review date. Some required policies were also unavailable, including a Duty of Candour policy**. The practice should review its policy framework to ensure that all policies and procedures are current, complete, readily accessible and subject to effective document control. This should include the use of version numbers, issue dates and review dates, and the development and adoption of any missing policies**, including those relating to patient consent and the **Duty of Candour.**
Workforce	
Skilled and enabled workforce	• The practice should **consider introducing interim annual DBS self-declaration as part of the appraisal process, to provide ongoing assurance that staff remain suitable to work for the service.** • While we saw evidence of vaccination and immunisation histories for clinical staff, we did not see evidence of pre-employment health screening. The practice should **ensure that pre-employment health screening is completed for all new staff, with appropriate risk assessments undertaken where health issues are identified.** • 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.** • We saw evidence that annual staff appraisals had recently been completed. However, **Disclosure and Barring Service (DBS) checks were only undertaken when staff commenced employment and were not repeated at regular intervals**, as determined by a practice policy position. There was also no formal process in place for staff to make an ongoing declaration regarding any changes that could affect their suitability to work. The practice should: **• adopt a clear policy position on when Disclosure and Barring Service checks for staff should be renewed and at a level appropriate to their role • implement a process requiring staff to declare any changes that may affect their ongoing suitability to work**, such as criminal offences, cautions or investigations. This could be completed annually as part of the appraisal process. • We reviewed the training records of clinical and administrative staff. The records showed **mixed levels of compliance with training requirements, with the GP workforce demonstrating the lowest level of compliance.** This meant that the practice could not demonstrate that all staff had completed and remained up to date with the training required for their roles. The practice must: **• ensure that all staff complete and remain compliant with training relevant to their roles • implement robust governance arrangements to monitor training compliance continuously** and identify promptly when training or refresher updates are required.

Culture	
People engagement, feedback, learning	• The practice had an up-to-date Duty of Candour policy available. However, only one of the five staff training records we reviewed showed that Duty of Candour training had been completed. The practice should **ensure all staff complete Duty of Candour training appropriate to their role.** • 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 **consider mechanisms for providing patients with information regarding practice learning in response to feedback received. This could be via a 'You said, we did' board within the practice, a notice on the website, or other means.** • Information about the Listening to People process was available to patients through leaflets displayed in the waiting area. However, **the practice's complaints policy had not been updated to reflect the new procedure**. This meant that the written policy did not provide staff with current guidance on the handling, investigation and response to complaints and concerns. **The practice should update its complaints policy to ensure that it aligned with the 26 NHS Wales Listening to People process and accurately reflected the procedures followed by staff.**
Information	
Information governance, digital tech	• The practice appeared to have processes in place for handling data appropriately. A privacy notice was available on the practice website. However, this was not displayed in the waiting room at the time of the inspection. This meant that **patients who did not use digital services, or who were not aware of the website, may not have had easy access to information about how their personal data was used.** • 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 did not see evidence of a systematic annual audit programme covering clinical and internal audit activity across the practice. The practice should **consider developing an annual audit schedule, with a clear process for recording audit findings, sharing learning and following up actions where required.** • 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.**

What the HIW Praised: Good practice to aim for

	INSPECTION COMMENTS
Safe	
Infection prevention and control (IPC) and decontamination	• An up-to-date blood-borne virus policy and a needlestick and sharps injury policy were in place. Posters and flowcharts setting out the action staff should take following a needlestick or sharps injury were displayed in accessible areas. We also reviewed the practice's hepatitis B immunisation register and confirmed that **relevant clinical staff had received appropriate immunisation.**
Medicines management	• The practice had a **clear and well-structured workflow for managing repeat prescription requests**. The process supported the safe and consistent handling of prescriptions and was identified as noteworthy practice. Medication reviews were also undertaken to ensure patients' medicines remained appropriate for their clinical needs.
Safeguarding of children and adults	• **Vulnerable adults were clinically coded and flagged within their medical records**. The practice had also **appointed a lead and deputy lead for named patients receiving palliative care**. This supported continuity, oversight and coordination of care and was identified as **noteworthy practice.**
Effective	
Effective care	• Processes were in place for urgent referrals, routine referrals and urgent suspected cancer referrals. Staff told us that **once urgent suspected cancer referrals were made, administrative staff checked within two weeks to confirm that patients had been offered an appointment. We identified this as noteworthy practice.** • New guidance from the National Institute for Health and Care Excellence (NICE) was **shared with staff via WhatsApp and discussed at partner meetings** where appropriate. A process was also in place for reporting and reviewing incidents.
Equitable	
Communicating and language	• For patients who were older or did not have digital access, **information about services and changes to the practice was primarily communicated through posters in the waiting area.** Staff told us that letters were sent to housebound patients, and that palliative care and frailty nurses working in the community also shared relevant information with patients during their visits.

	• Welsh language training was available through the health board, and language requirements were considered as part of recruitment and workforce planning, including the option for interviews to be conducted in Welsh. **We saw bilingual signs and posters available in the practice. We also saw staff wearing "Iaith Gwaith" badges to show patients, staff and visitors that they spoke Welsh.**
Rights and equality	• Patients with a learning disability were offered double appointments to allow additional time. Staff also told us that **neurodivergent patients could be offered appointments at quieter times, where this would better meet their needs.**
Person-centred	
Health promotion	• One GP's website contained comprehensive information about services available to patients, including support provided through external organisations. **The practice worked with Swansea Bay University Health Board to support patients at risk of developing diabetes through access to pre-diabetes services**. • The practice and wider cluster worked with a range of services and agencies to improve access, prevent disease and promote health. These included public health screening programmes, flu, COVID-19, RSV and shingles vaccination programmes, the **Jac Lewis Foundation, social prescribing services, cluster pharmacy support, physiotherapy through Swansea Bay University Health Board, Mind mental health services and frailty support.** The practice also funded and employed two frailty and palliative-care nurses to support older and housebound patients and local care homes.
Quality of Management and Leadership	
Leadership	
Governance and leadership	• Leaders were visible and approachable to the wider practice team. **Staff described an open-door approach, and senior team members used Microsoft Teams each day to inform staff which members of the leadership team were available.** • We saw evidence of clinical meetings and dissemination of information to staff. Clinical information was shared through weekly meetings and daily escalation meetings, helping ensure that relevant clinical issues could be discussed in a timely way. • The practice also had arrangements in place for the governance of cluster projects and initiatives. A cluster governance document was in place. Staff told us that **projects were discussed, presented to the cluster and agreed before implementation. Projects were monitored through meetings held at least four times a year**, and they were also discussed during fortnightly practice manager meetings.
Culture	
People engagement, feedback, learning	• The practice was working within the new NHS "Listening to People" process. We saw that the previous "Putting Things Right" process was retained on file for 2025/26, with **the current "Listening to People"**

	process and patient complaints information placed at the front of the complaints file for 2026/27. The practice had an up-to-date complaints policy which aligned with the NHS Listening to People procedures. Information about the procedure was displayed in the patient waiting area.
Whole-systems approach	
Partnership working and development	• The practice engaged with a range of system partners. Staff told us the practice received funding from two health boards and was subject to review arrangements from both organisations. This required the practice to work across different health board processes and maintain awareness of the expectations and pathways relevant to each**. The practice also participated in collaborative meetings and practice manager meetings, which supported communication, shared learning and discussion of operational issues across the system.**