

General Practice Inspection Report (Announced)

Meddygfa Albany Surgery, Cardiff
and Vale University Health Board

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our values

We place people at the heart of what we do.

We are:

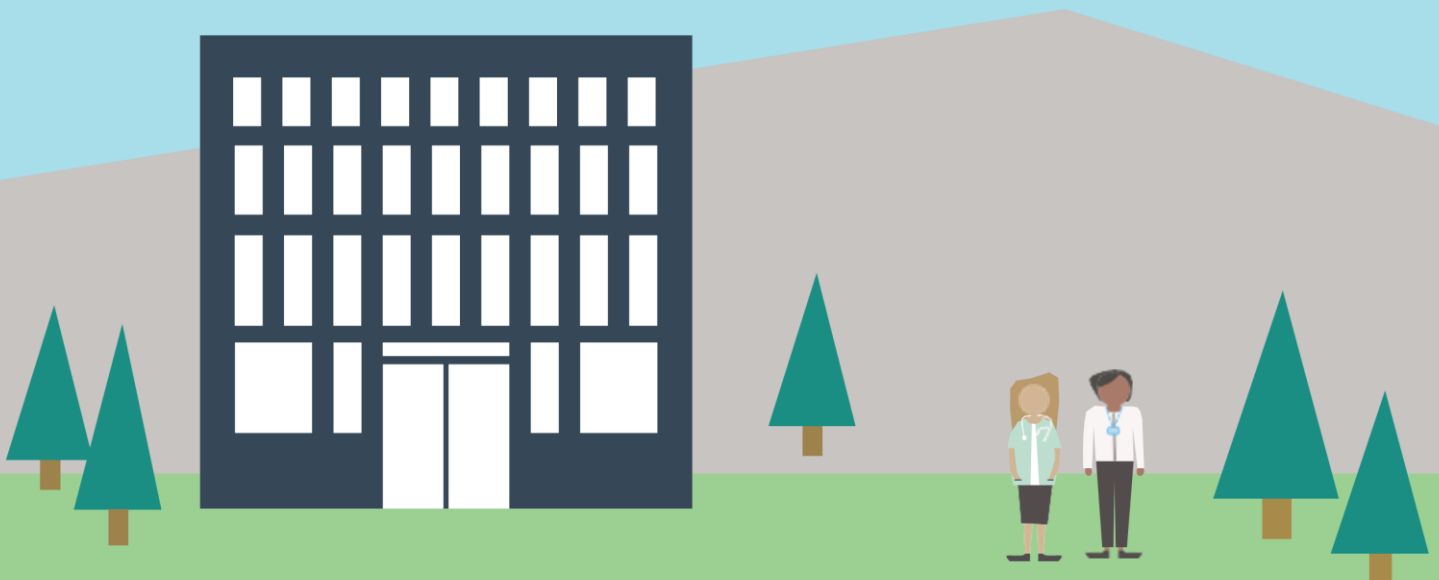
- Independent - we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

Our goal

To be a trusted voice which influences and drives improvement in healthcare

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.



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1. What we did

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

Healthcare Inspectorate Wales (HIW) completed an announced inspection of Meddygfa Albany Surgery, Cardiff and Vale University Health Board on 01 January 2026.

Our team for the inspection comprised of three HIW healthcare inspectors, one clinical peer reviewer and a 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 seven questionnaires were completed by patients and five were completed by staff. Feedback we received appears throughout the report.

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:

In general patients provided positive feedback about the practice, reporting good standards of care, cleanliness and infection prevention and control measures.

A range of health promotion materials were seen within the practice premises. However, the website needed updating to provide more information. The practice access policy also required updating to ensure patients were fully informed about services available at the practice. Language support and signposting could also be improved at reception.

The practice premises were accessible to people of varying needs and positive feedback regarding the practice environment had been received from disabled students who had been on placement within the service.

This is what we recommend the service can improve:

- Strengthen signposting to 111 press 2 and other services through the practice website and care navigation
- Promote the offer of a separate room for confidential discussions and self-check-in at reception and develop the language support available outside of consultations
- Implement a clear procedure for the handling of urgent letters received to ensure letters are kept safe and responded to efficiently.

This is what the service did well:

- Generally tidy environment which offered suitable hand hygiene facilities to patients and staff
- Triage first model ensured appointments were offered according to assessed clinical need.

Delivery of Safe and Effective Care

Overall summary:

Suitable medicines management systems were in place and noteworthy practice was found regarding the documentation of prescription collections. However, prescription pads required logging in and out for security. Comprehensive records of medical equipment checks and servicing were available and devices were seen to be in good condition.

Staff were aware of the designated safeguarding person for the practice and had completed suitable safeguarding training. However, clearer guidance was required to underpin the recording of safeguarding concerns and ensure appropriate information sharing with other agencies.

The practice worked as part of a cluster with the aim of providing patients with quality care within the primary and community care settings.

This is what we recommend the service can improve:

- Strengthen fire safety arrangements including training fire marshals and ensuring signs indicating the locations of medical gases are accurate
- Ensure cleaning schedules are detailed and consistently implemented
- Ensure that weekly checks of emergency equipment and drugs include a review of expiry dates to enable reordering of items before they have expired.

This is what the service did well:

- Communication within the cluster to with the aim of avoiding hospital admission and ensuring quality clinical care
- Processes in relation to death certification were considered to be robust with mortality and unexpected deaths being discussed within clinical or partnership meetings
- Flexibility in how practice nurses offered their appointments supported efficiency.

Quality of Management and Leadership

Overall summary:

Leadership was visible and staff reported to be clear on lines of reporting, able to speak up with concerns or suggestions and that overall they felt the practice provided a positive workplace. Staff undertook appraisals and were kept up to date regarding changes in the practice. However, practice clinical meetings were not multiprofessional, limiting the opportunity for shared learning, and some multidisciplinary meetings with practitioners based outside of the practice had been reduced.

Role specific induction programmes for new starters and a clear statement of professional obligations and mandatory training and how these were maintained were missing. Policies and procedures also required reviewing to ensure they provided comprehensive operational guidance. An annual review of feedback, concerns and complaints would also embed quality improvement within the practice and sharing themes with patients would increase transparency regarding feedback and complaints processes and practice learning.

This is what we recommend the service can improve:

- Update all practice policies and procedures to ensure they contain sufficient detail for staff and clarity around professional obligations and mandatory training
- Review the membership of practice clinical meetings and frequency of wider multidisciplinary team meetings to bolster opportunity for shared learning and holistic care
- Embed quality improvement through annual review of feedback, concerns and complaints and sharing themes with patients.

This is what the service did well:

- Performance measures reporting on GP activity were completed monthly via the annual Quality Assurance and Improvement Framework process
- Leaders were visible and supportive and staff felt enabled to deliver a quality service to patients.

3. What we found

Quality of Patient Experience

Patient feedback

In general, respondents to the HIW patient questionnaire rated the service as 'good' or 'very good'. All respondents felt the practice was clean and there was a high level of agreement that infection prevention and control (IPC) measures were available and implemented.

All respondents reported they felt listened to during consultations and to have received information to support them to pursue a healthy lifestyle. However, there were more mixed opinions regarding how well clinical information was explained and how involved patients felt in decisions about their healthcare.

One person felt they were unable to talk at reception without being overheard. However, privacy and dignity during consultations was considered to be protected during consultations.

Some patients reported to be aware of feedback mechanisms to the practice, including patient surveys and complaints processes. However, others were not.

Person-centred

Health promotion

We saw a range of health promotion information was available to patients and their carers within the practice waiting area. However, the practice website lacked health promotion and information on support services. Notably missing was information regarding urgent mental health support via NHS 111 press 2.

The practice should ensure that health promotion information is available to patients on both the practice premises and website and includes signposting to urgent mental health support via NHS 111 press 2.

The practice premises provided a range of services to patients additional to core GP and nursing. The practice had worked with Public Health Wales to complete their annual flu vaccination programme. Cluster initiatives were also in place to support patient access to third sector support. We were told practice reception staff had been trained in care navigation and were aware of when to signpost patients away from primary care to emergency services. However, we found

limited pathways and policy to support non-clinical staff in the timely signposting of patients to other appropriate sources of support. Non-clinical staff had also not completed mental health awareness training, which would support the care navigation role.

The practice should further enable staff through suitable policy, pathways and training to signpost patients to services available from the most appropriate healthcare professional and wider sources of care and support.

Processes were in place to follow-up with patients who had not attended surgery or other health appointments and ensure relevant clinicians were informed.

Dignified and respectful care

We found patients were provided with an appropriate level of privacy throughout their patient journey. Measures were in place to preserve patient confidentiality at reception and within consultation rooms. However, better promotion of a separate room that was available for confidential discussions with reception staff or the option of self-check-in is advised.

The practice should better inform patients that self-check-in or a separate room for more in-depth discussions with reception staff are available if preferred to preserve confidentiality.

A quiet room away from the main waiting area was available to support patients who required this.

A chaperone policy was in place and notices offering this service to patients were available in reception and clinical rooms. We noted that there was limited availability of male chaperones.

Timely

Timely care

The practice operated a triage first model with the facility to then book urgent same-day or advanced appointments as most appropriate. GP home visits could be offered if identified through clinical triage. All triage was completed by GPs. A health board Urgent Primary Care Centre was also located nearby and patients would be advised to attend there if Meddygfa Albany Surgery urgent capacity was exceeded.

Patients could contact the surgery by telephone or in person. Information on the NHS App was also provided on the practice website and the practice had plans to develop the website further to include appointment request forms. The practice

answerphone message was also in the process of being updated to a more detailed script to support timely and equitable access to healthcare.

An access policy was in place but this needed updating to include all methods of contact, appointment options and information on access to other services associated with the surgery. This could then be provided to patients within the waiting area and on the practice website to ensure patients were fully informed.

The practice should ensure that the access policy includes all relevant information and is available to patients on the practice premises and the website.

All respondents to the HIW patient survey were aware of how to access healthcare outside of the practice opening hours should they need to. However, there were mixed levels of satisfaction with practice opening times and the availability and timeliness of appointments, including for on-going health concerns.

We were told that patients presenting in mental health crisis were signposted to 111 press 2 or referred onto relevant local mental health services who would generally respond the same day. The practice would be informed when mental health services could not respond so that patients could be redirected to an emergency department to maintain their safety.

Patients presenting with non-urgent psychological symptoms were signposted to third sector services.

Communication between the practice and mental health services ensured relevant clinicians remained informed of patient needs and treatments to provide clinical oversight and continuity of care.

We were informed that a cluster primary care mental healthcare practitioner role had recently been discontinued due to resource constraints. The end of this role was considered a barrier to the practice robustly responding to high demand for mental health services from the patient population, a number of whom were reportedly asylum seekers who would likely require trauma informed care.

Equitable

Communication and language

We saw information about the practice was displayed within the patient waiting area. Some information was also available via the practice website. However, updates were required to ensure this was detailed and accurate. Changes were initiated on the day of the inspection.

Patient records and letters we reviewed indicated a high degree of patient-centred information was provided to patients and that communication with other services was satisfactory. Clinicians took responsibility for making onward referrals, ordering tests and relaying results to patients and would review and action any patient-related letters or messages received. However, we found that the safe keeping of urgent letters was compromised as letters were not scanned into an electronic version before actioning, and that delegation to administrative staff to deal with urgent letters would enhance efficiency.

The practice should develop a clear procedure for the handling of urgent letters received to ensure letters are kept safe and responded to efficiently.

We were told that a high proportion of the practice patient list did not speak English or Welsh as their first language, and that as such language line was frequently used during patient consultations. Double-length appointments would be booked when reception staff identified that the language line was required. However, as language preference was not systematically noted within patient records the need for language line could be missed. Reception also did not have access to language line, which could be a hindrance to initial patient conversations, for example, when patients were registering with the practice or booking appointments. A self-check-in screen which had a wide range of language selections was available to patients to ease the appointment check-in process.

The practice should:

- **develop the language support available for conversations between patients and administrative staff outside of consultations**
- **ensure that language preference is routinely captured within patient records such that appropriate language support is identified and arranged.**

‘Iaith Gwaith’ signage was sourced on the day of the inspection to ensure the practice were implementing the Welsh Language Active offer.

Rights and equality

We saw that an equality and diversity policy was in place and linked to other documents to protect rights and equality throughout patient-facing and staff processes. A robust practice consent policy ensured patient rights were upheld through informed consent or best interest support should a clinician assess a patient as lacking the mental capacity to engage in decision-making regarding their care. Care was provided to patients seeking specialist gender services and pronouns and names could be updated to enable appropriate communication.

The practice was situated on the first floor of the building and a lift and stairs were available to enable patient access. Both reception and the self-check-in desks were suitable for patients to access from either standing or sitting heights, and an accessible toilet, suitable seating and baby care facilities were also available to support patients with varying needs. Flooring was secure and internal access to all practice rooms was level.

Staff reported they felt supported in the workplace and that reasonable adjustments could be accessed if required. For example, a height adjustable desk was available should staff need to access this. We were told that positive feedback regarding the practice environment had been received from disabled students who had been on placement within the service.

Delivery of Safe and Effective Care

Safe

Risk management

We observed that the practice was tidy, free of clutter and generally well maintained. Emergency button systems were available for staff to summon rapid assistance if required. Suitable fire safety equipment, action notices and escape routes were in place. However, there were no trained fire marshals and the practice floor plan and warning signs did not accurately indicate the locations of medical gases.

The practice should ensure all fire safety measures are in place to support patients, staff and fire service personnel in the event of a fire.

A Business Continuity Plan was available to all staff to refer to as required. However, this required updating to include partnership risk.

The practice should review and update the Business Continuity Plan.

Clear processes were in place to ensure staff cover and the use of the health board sustainability framework and escalation reporting were being developed.

Practice managers had responsibility for receiving safety alerts and distributing to relevant personnel. Incidents would be reported via the Practice Manager and Significant Adverse Events that occurred within the practice would be analysed and discussed within partners meetings or additional learning events using a standard template to guide reflection and action planning. However, no formal policy was in place to underpin this process.

The practice should create and implement a suitable Significant Events policy.

Staff were clear on the expectation for safety reporting on leaving patient's homes.

Infection, prevention and control (IPC) and decontamination

A practice Infection Prevention and Control policy was in place and available to all staff. However, only generic cleaning schedules were seen which did not specify equipment that required cleaning or what cleaning products should be used for different purposes.

The practice should ensure cleaning schedules are sufficiently detailed to support the effective cleaning of clinical areas.

Gaps were also noted in the standard of cleaning and cleaning equipment storage:

- Dust and general build-up was seen in some high and low level areas throughout the practice
- Mops were stored with mop heads in buckets. These should be stored separately

The practice should ensure that cleaning and cleaning equipment storage are completed to a consistently high standard.

No Control of Substances Hazardous to Health (COSHH) data sheets were seen for cleaning products or other chemicals used within the practice.

The practice should ensure that relevant COSHH data sheets are available to all staff for the safe use and storage of chemicals at the practice.

A dedicated isolation area was available for patients with symptoms of infectious diseases to wait for appointments away from others. Practice protocol was that clinical staff would deep clean this room after use.

Hand hygiene facilities and personal protective equipment were available for patients and staff. Single-use items ensured that clinical equipment was sterile.

A recent IPC audit had been undertaken by the health board and the practice were working through actions including implementing monthly in-house handwashing and bare below the elbow audits.

Monthly waste management audits were undertaken in line with practice policy. We were told that a wider range of bins and bags were being ordered for different categories of waste. Sharps bins were available within clinical rooms. However, we saw that these were not consistently signed on assembly or kept closed when not in use.

The practice should ensure clear procedures for the assembly, use and temporary locking of sharps bins are available and consistently implemented to protect staff and patients within clinical areas.

Blood-borne virus and needlestick policies were seen. However, no needlestick flowcharts were available in clinical rooms.

The practice should display needlestick flow charts to support clinical staff to take appropriate action in the event of sustaining a needlestick injury.

All relevant staff were offered appropriate vaccinations to maintain and promote their own and patients' health and evidence of clinical staff Hepatitis B immunity was seen. Staff had also completed relevant IPC training.

Medicines management

Processes were in place to ensure the safe prescription and management of medicines.

Prescribing clerks were trained to issue repeat prescriptions. Medication reviews were completed by pharmacists, GPs, and nurses for diabetes medications. Pharmacists and GPs provided oversight to prescription clerks and nurses as required. However, we found that the prescription policy to instruct staff on processes and support lacked detail and no formal scope of practice agreement regarding the pharmacist's role within the practice was available.

The practice should review the prescribing policy and the scope of practice agreement for the pharmacist's role to ensure clarity regarding prescribing responsibilities, processes and support.

We noted that an entry would be placed in patient records when a prescription had been collected, which is considered noteworthy practice.

Prescription pads were stored in a locked cupboard. However, pads were not being logged in and out of the storage area, which would provide an audit trail of location for additional security.

The practice ensure that prescription pads are logged in and out.

We reviewed the equipment and drugs used to manage medical emergencies. Charts were seen demonstrating weekly checks of emergency items were completed. However, the checking process and documentation did not prompt practitioners to consider the expiry date of consumables.

The practice should ensure that weekly checks of emergency equipment and drugs include a review of expiry dates to enable reordering of items before they have expired.

All sizes of Guedel airways, nebuliser masks for adults and children and tubing for portable suction machines had expired. In date masks were available but old stock had not been removed which could result in it being used in error. Unsuitable

items were removed and replacements sourced from spare stock or reordered on the day of the inspection. Further information on the issues we identified, and the actions taken by the service, are provided in [Appendix A](#).

Staff were made aware of the location of emergency items via staff induction. However, we found that the storage of emergency equipment and drugs needed to be reconsidered:

- Emergency items were stored within a clinical area that although rarely used would be locked for privacy if in use for patient consultations
- Emergency drugs and equipment were not all stored together, which would hinder practitioners from quickly gathering items in the event of an emergency
- Storage did not ensure confidence that emergency items had not been tampered with or removed in between weekly checks
- Some signage indicating location of emergency items inaccurate.

The practice should ensure emergency equipment and drugs are kept all together in an accessible and accurately signposted location, inside tamper-evident storage.

Oxygen cylinders were available for use at the practice and were suitably maintained. However, cylinders were not kept within a safety stand or other protective holder.

The practice should ensure that oxygen cylinders are kept within a suitable safety stand or holder.

Clinical staff were aware of the safe use of oxygen cylinders and formal training to support this was in progress. A poster was also displayed to remind staff of correct cylinder use.

No controlled drugs were kept within the practice. Inventories were kept of non-controlled, non-emergency drugs kept on the premises and these drugs were kept within a locked cupboard or suitably stored within a dedicated drugs fridge as required. Fridge temperatures were regularly checked and manually recorded. An automatic data logger had been purchased to improve efficiency but this had been faulty on arrival and was being replaced to ensure accurate recording could continue. No out of range temperatures had been recorded. A cold chain policy and an easy read flow chart for staff to follow in the event of any cold chain breaches were readily available. However, these documents did not match as the policy lacked detail.

The practice should review the cold chain policy and ensure details correspond to the flow chart.

Suitable arrangements were in place for the safe disposal of expired or partially used drugs.

We were told that the Yellow Card scheme was used for the reporting of any adverse effects of medications prescribed or administered from the practice. Any medication incidents or errors would be used to inform practitioner training needs. Training in relation to medicines and prescribing was also available to staff on request or as identified through appraisals.

Safeguarding of children and adults

We considered the safeguarding procedures in place at the practice. We found that staff were aware of the designated safeguarding person for the practice and of the processes to follow up with patients who had missed appointments or whom the practice had been notified had attended emergency departments on multiple occasions. Patients reporting domestic abuse were also signposted to appropriate organisations.

A safeguarding policy and the Wales Safeguarding Procedures were available for staff to access. However, there were no clear arrangements for sharing safeguarding information with other relevant agencies, for example, health visitors. The documentation of safeguarding within patient records also required improvement to ensure patients at risk could be readily identified and supported:

- Looked After Children were not easily identifiable from patient records
- Household contacts for each child on the child protection register were not highlighted through the use of digital flags or clinical coding within the clinical records system
- No collated list was available of children registered with the practice and on the child protection register or other patients who had safeguarding concerns identified, hindering routine monitoring and multidisciplinary review of these vulnerable patients.

The practice must comprehensively review their safeguarding arrangements in line with national standards.

Appropriate safeguarding training was in place for all staff.

Management of medical devices and equipment

We found responsibility for medical devices and equipment was appropriately delegated and that suitable maintenance contracts were in place. Comprehensive

records of all checks and servicing were available and devices were seen to be in good condition.

Effective

Effective care

Practice professionals engaged in appropriate networks for continuous professional development and to ensure awareness of best practice guidelines.

The practice also engaged with the cluster to improve patient care through shared discussions, innovation and training. Multidisciplinary cluster meetings promoted a focus on avoiding hospital admission through enabling patients to have their health needs met within the community.

Processes in relation to death certification were considered to be appropriate. Mortality and unexpected deaths were discussed by GPs in clinical or partnership meetings.

Patient records

We examined a sample of ten electronic patient records which were kept within a secure IT system. Paper records held on site were also secure and well-organised to ensure ease of clinician access as required.

Records reviewed were generally considered to be of a high standard in terms of presenting clinical findings and rationale for decision making within the patient narrative while providing clarity to support continuity of care. Records indicated appropriate monitoring of patients with long-term conditions. However, a very low rate of medications being linked with a health problem code was noted.

The practice should ensure that medication and health problem codes are routinely linked within patient records.

Documentation of a chaperone being offered for intimate examinations was also frequently missing, suggesting that the chaperone policy was not consistently implemented placing both patients and practitioners at risk.

The practice should ensure that the chaperone policy is fully implemented and the offer of a chaperone is documented in relation to all intimate examinations in line with General Medical Council guidelines.

Evidence of high quality notes summarising was seen. However, although the practice told us they often employed medical students to produce summaries for

the clinical record no regular audits to ensure consistency in summary quality were undertaken.

The practice should undertake annual audits of the quality of notes summaries.

Efficient

Efficient

We found that flexibility in how the practice nurses offered appointments supported efficient service delivery at the practice.

Cluster services such as physiotherapy, community pharmacists, community connectors and frailty nurses aimed to ensure patients received the right care at the right time. Concerns were reported regarding ambulance waiting times, given its designation by the Welsh Ambulance Service Trust as a place of safety. The practice is advised to ensure that these concerns are escalated to their health board primary care team and through use of Datix, as required.

Quality of Management and Leadership

Staff feedback

All respondents to the HIW staff questionnaire strongly agreed that they were satisfied with the quality of care and support given to patients, that patient care was the practice's top priority, and that they would be happy with the standard of care provided for themselves, friends and family.

Overall respondents strongly agreed they would recommend the practice as a good place to work.

Leadership

Governance and leadership

We found that practice management and partners provided clear and visible leadership. Responsibility for certain areas of service delivery and quality improvement, for example, IPC, vaccinations, and complaints, had also been appropriately delegated to different members of staff which team members were aware of.

Discussions with staff indicated a stable, positive and well-supported team who were clear on their lines of reporting and felt comfortable to approach the management team with any issues or concerns. Staff could access practice policies and procedures. However, we noted that several policies needed updating to ensure they contained all relevant details staff required.

The practice should regularly review and update all practice policies and procedures to ensure these provide comprehensive information to guide staff.

Separate GP and practice nurse meetings would allow clinical updates to be discussed. However, the opportunity for clinical learning and development across professional groups was limited as GPs and nurses did not regularly meet together.

The practice should implement multiprofessional clinical meetings to enable learning and development to be shared across professional groups.

Regular partners meetings considered broader practice issues and staff received relevant information around these via messaging systems or verbal updates.

Workforce

Skilled and enabled workforce

Staff we spoke with told us they felt enabled to deliver a quality service to patients. Workloads allocated were aligned with job role expectations and scope of practice and staff felt able to seek assistance and support one another as required. New practice management had recently reviewed staff training and appraisals and planned to continue with regular monitoring of skill mix, competencies and continuing professional development to ensure the practice remained able to deliver services relevant to the local population. Staff files we reviewed contained up-to-date evidence of professional obligations. However, there was no clear practice statement specifying how professional obligations were maintained or setting out the mandatory training expectations for different staff groups.

The practice should create and implement policies to ensure that:

- **Staff self-declaration of good character is completed on an annual basis**
- **Formal Disclosure and Barring Service checks are completed at pre-determined intervals**
- **Training requirements for staff groups are clearly defined based on the expectations of professional registration bodies and NHS standards.**

A recruitment policy and pre-employment checklist were in place and an induction pack was provided to highlight policies and procedures to new staff at the practice. However, no job specific induction programmes had been developed.

The practice should develop job specific induction programmes to ensure new staff are fully supported to develop into their particular role.

Culture

People engagement, feedback and learning

We saw a suggestion box in the waiting area to collect patient feedback and that the national patient survey was also promoted.

Staff we spoke with reported they felt able to speak up with any concerns and encouraged to put forward ideas for practice improvement. A whistleblowing policy was available. However, this was not clear regarding expectations of staff and managers or relevant bodies for staff to contact should they need to raise concerns for externally.

The practice should review their whistleblowing policy to ensure it provides staff with all relevant information.

Information

Information governance and digital technology

A data protection officer was in place via Digital Healthcare Wales. Practice staff responsibilities with respect to information governance were clearly defined through robust policies and procedures and a privacy notice was available to patients.

Performance measures reporting on GP activity were completed monthly via the annual Quality Assurance and Improvement Framework process.

Learning, improvement and research

Quality improvement activities

A complaints procedure in line with NHS Putting Things Right was available to patients and staff were clear on the process to follow should a patient express a concern or wish to make a complaint. The practice manager was responsible for working with GP partners to investigate any complaints received. A summary of investigations and outcomes was available which provided assurance that complaints were responded to and investigated within expected timeframes. However, completion of an annual review of complaint themes for practice learning and improvement was not yet embedded.

The practice should conduct an annual review of complaint themes to support learning and improvement.

Robust information regarding Duty of Candour was also available within the practice and the practice manager would report incidents via the Datix system and liaise with the health board should near misses or patient harm occur.

We observed a positive attitude to continuous learning and improvement activity within the practice.

Whole-systems approach

Partnership working and development

We found practice management were aware of how the practice contributed to wider health care provision via relevant health board pathways. Regular collaborative meetings within the cluster supported holistic care, consistency in service delivery and peer support. However, we were told that some local multidisciplinary meeting activity in relation to diabetic and palliative care had reduced.

The practice should review their links with other services and seek to reintroduce regular communication where this would enhance current service delivery and holistic care.

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
All sizes of Guedel airways, nebuliser masks for adults and children and tubing for portable suction machines expired. In date masks were available but old stock had not been removed which could result in it being used in error.	Equipment unsuitable for use in the event of an emergency, impacting on patient safety.	Discussed the issue with relevant clinical and management staff.	Unsuitable items were removed and replacements sourced from spare stock or reordered on the day of the inspection.

Appendix B - Immediate improvement plan

Service: Meddygfa Albany Surgery

Date of inspection: 08 January 2026

The table below includes any immediate 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.

Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1. No immediate assurance issues were found on this inspection					

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

Service representative:

Name (print):

Job role:

Date:

Appendix C - Improvement plan

Service: Meddygfa Albany Surgery

Date of inspection: 08 January 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. Health promotion information lacking on the practice website, and NHS 111 press 2 not included.	Health promotion information should be available to patients on both the practice premises and website and include signposting to urgent mental health support via NHS 111 press 2.	Health and Care Quality Standard (2023) - Timely	New website being built to be fully complaint- estimated go live date- 1 st April 2026	Jikke Perry PM	1 month- 1 st April
2. Limited evidence of training, policy and standard pathways in place to support non-clinical staff in signposting patients to the most appropriate health	Policy, standard pathways and training offer to be developed to support non-clinical staff with signposting.	Health and Care Quality Standard (2023) - Timely	Refresher CareNav training given to all non-clinical staff- SOP created and shared with all staff Flowchart created shared with all staff.	Jikke Perry PM	Completed

	care professional and wider sources of support.			Policy written and shared with all staff		
3.	Limited promotion of self-check-in or a separate room for confidential conversations between patients and reception staff.	Increased information to be available to patients regarding options for self-check-in or a separate room for more in-depth discussions with reception staff are available if preferred to preserve confidentiality.	Health and Care Quality Standard (2023) - Person-centred	Posters put up in waiting room. Notice to be added to website	Jikke Perry PM	Completed 1 st April 2026
4.	Access policy lacking detail.	Access policy to include all relevant information and be available to patients on the premises and website.	Health and Care Quality Standard (2023) - Person-centred	Access policy updated and put up in waiting room and will add to website	Jikke Perry PM	Completed
5.	Limited language support available for conversations between patients and reception staff.	Develop the language support available for conversations between patients and reception staff.	Health and Care Quality Standard (2023) - Person-centred	Using language line for reception SOP created and shared with staff	Jikke Perry PM	Completed
6.	Language preference not routinely captured within patient records.	Language preference to be routinely captured within patient records such that appropriate language support can be identified and arranged.	Health and Care Quality Standard (2023) - Person-centred	Added to registration on EMIS, now a mandatory field to complete	Jikke Perry PM	Completed

7.	Not all fire safety measures in place, including accurate signposting of medical gasses or trained fire marshals.	All fire safety measures to be in place to support patients, staff and fire service personnel in the event of a fire.	Health and Care Quality Standard (2023) - Safe	Signposting of medical gasses now in place. Fire Marshall training to be arranged	Jikke Perry PM	Completed In the next 3 months
8.	Generic cleaning schedules only.	Cleaning schedules to be sufficiently detailed to support the effective cleaning of clinical areas.	Health and Care Quality Standard (2023) - Safe	Cleaning schedules updated	Marta Pietka Cleaning	Completed
9.	Cleaning and cleaning equipment storage not completed to a consistently high standard: <ul style="list-style-type: none"> Dust and general build-up seen in some high and low level areas throughout the practice. Mops stored with mop heads in the bucket. 	Cleaning and cleaning equipment storage to be completed to a consistently high standard.	Health and Care Quality Standard (2023) - Safe	Meeting had with cleaners re standard of cleaning. Daily cleaning as normal. Added: 1 deep clean a month Cleaners will ensure cleaning materials will be stored appropriately	Jikke Perry PM	Completed

10.	No COSHH data sheets for cleaning products or other chemicals used within the practice.	Relevant COSHH data sheets to be available to all staff at the practice.	Health and Care Quality Standard (2023) - Safe	COSHH folder updated	Nikita Lewis Lead receptionist Marta Pietka Cleaning	Completed
11.	Sharps bins not signed on assembly or kept closed between uses	Clear procedures for the assembly, use and temporary locking of sharps bins to be available and consistently implemented.	Health and Care Quality Standard (2023) - Safe	Sharp Bin Set up and Safe us SOP created and shared with all staff. Posters of Sharp bin usages put up in all clinical rooms.	Jikke Perry PM	Completed
12.	Needlestick flow charts not displayed.	Needlestick flow charts to be displayed alongside all sharps bins.	Health and Care Quality Standards (2023) - Safe & Timely	Needlestick flow charts already available in all rooms used for phlebotomy and immunisations. Needlestick flow charts now placed in all clinical rooms.	Jo Pearce Lead nurse	Completed
13.	Formal scope of practice agreement regarding the pharmacist's role within the practice not available.	Formal scope of practice agreement regarding the pharmacist's role within the practice to be in place.	Health and Care Quality Standard (2023) - Safe	Locum pharmacist scope of practice now in place.	Jikke Perry PM Dr Raluca Capatana Senior Partner	Completed

14.	Prescription pads not logged in and out.	Prescription pads to be logged in and out.	Health and Care Quality Standard (2023) - Safe	Log created and now in use	Nikita Lewis Lead Receptionist	Completed
15.	Weekly checks of emergency equipment and drugs did not include a review of expiry dates.	Weekly checks of emergency equipment and drugs to include a review of expiry dates to enable reordering of items before they have expired.	Health and Care Quality Standard (2023) - Safe	Now added and updated on check list	Jo Pearce Lead Nurse	Completed
16.	Storage of emergency equipment and drugs needed to be reconsidered to ensure access and security.	Emergency items to be kept together in an accessible and accurately signposted location and in tamper-evident storage.	Health and Care Quality Standard (2023) - Safe	Tamper bag ordered estimated delivery date 24/02/2026 Equipment is already in a well signposted and accessible location.	Jikke Perry PM	Completed
17.	Oxygen cylinders not kept within a safety stand or other holder.	Oxygen cylinders to be kept within a suitable safety stand or holder.	Health and Care Quality Standard (2023) - Safe	Ordered and estimated delivery date 24/02/2026	Jikke Perry PM	Completed
18.	No clear arrangements for recording or sharing safeguarding information with other relevant agencies.	Safeguarding arrangements to be comprehensively reviewed in line with national guidelines.	Health and Care Quality Standard (2023) - Safe	SOP and Safeguarding policy updated in line with national guidelines and shared with staff	Jikke Perry PM	Completed

19.	Medication and health problem linkages not routinely included in patient records.	Medication and health problem codes to be routinely linked within in patient records.	Health and Care Quality Standards (2023) - Safe / Effective / Efficient	Discussed with all clinical staff and this will now be implemented as routine actions when updating patients notes.	Jikke Perry PM	Completed
20.	Documentation of the offer of a chaperone for intimate examinations frequently missing suggesting the offer may not be made and placing patients and practitioners at risk.	The offer of a chaperone to be documented in relation to all intimate examinations.	Health and Care Quality Standard (2023) - Safe	Email sent to all staff to remind them of the importance of correct coding of chaperone attendance. List of trained chaperones included in email. This will be audited going forward.	Jikke Perry PM	Completed
21.	No audits of the quality of notes summaries undertaken although summaries are completed by various	Regular audits of the quality of notes summaries to be completed.	Health and Care Quality Standard (2023) - Safe	Now implemented	Dr Sofia Ahmad	Completed

	personnel including medical students.					
22.	Clinical meetings profession-specific only limiting opportunity for shared learning across professional groups.	Multiprofessional clinical meetings to be implemented.	Health and Care Quality Standard (2023) - Effective	Meetings are being re-introduced now new management is in place.	Jikke Perry PM	Next meeting 17/03/2026
23.	Generic induction programme only.	Job specific induction programmes to be developed to ensure new staff are fully supported to develop into their particular role.	Health and Care Quality Standard (2023) - Efficient	Currently in development as changes within the team are gradually being rolled out.	Jikke Perry PM	30 th April 2026
24.	Annual review of complaint themes to ensure practice learning and improvement not embedded.	Annual review of complaint themes to be conducted.	Health and Care Quality Standard (2023) - Effective	SOP created and meetings to recommence in April 2026	Jikke Perry PM	
25.	Some multidisciplinary meeting activity reduced.	Links with other services to be reviewed with a view to reintroducing regular communication where this would enhance current	Health and Care Quality Standard (2023) - Effective	Cluster MDT meetings taken place two weekly currently. Inhouse MDT meetings to	Jikke Perry PM	Completed April 2026

		service delivery and holistic care.		commence in April 2026		
26.	<p>Several policies and procedures lacking the relevant detail to fully support staff within their roles:</p> <ul style="list-style-type: none"> • Business Continuity Plan • Prescribing Policy • Cold chain policy • Whistleblowing policy. 	Review and update of policies and procedures to ensure all relevant details included and refreshed on a regular basis.	Health and Care Quality Standard (2023) - Effective	Policies in the process of being updated.	Jikke Perry PM	April 2026
27.	<p>Some policies and procedures missing:</p> <ul style="list-style-type: none"> • Procedure for the handling of urgent letters • Significant Events policy • Maintenance of professional obligations policy 	Policies and procedures to be created, implemented and reviewed on a regular basis.	Health and Care Quality Standard (2023) - Effective	Policies in the process of being created.	Jikke Perry PM	April 2026

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| <ul style="list-style-type: none">• Comprehensive Mandatory training expectations relevant to different roles. | | | | | |
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The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print): Jikke Perry

Job role: Practice Manager

Date: 26/02/2026