Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report

(Announced)

Brynmawr Medical practice, Aneurin Bevan University Health Board

Inspection date: 27 January 2026
Publication date: 29 April 2026

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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 978-1-83745-533-1

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.

Contents

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 Brynmawr Medical Practice, Aneurin Bevan University Health Board on 27 January 2026.

Following resignation of the General Medical Services (GMS) contract by the eHarley Group in early 2025, Brynmawr Medical Practice is now a health board managed practice within Aneurin Bevan University Health Board. The practice has since been in a period of transition and stabilisation with a newly appointed practice manager taking up position on 1 January 2026.

Our team for the inspection comprised of a HIW healthcare inspector and three clinical peer reviewers, 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 11 questionnaires were completed by patients or their carers. Unfortunately, we did not receive any completed questionnaires by staff. Feedback and some of the comments we received appear throughout the report.

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

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

2. Summary of inspection

Quality of Patient Experience

Patients reported a positive overall experience of care. Most felt clinicians explained things clearly, answered questions well, and involved them appropriately in decisions about their treatment. Patients reported being treated with dignity and respect during consultations.

The practice demonstrated a strong person-centred approach, with health promotion information widely available in the waiting area, on digital screens and via the practice website. Topics included mental health, wellbeing, smoking cessation and vaccinations, and most patients were aware of this information.

Privacy during consultations was well maintained. Clinical rooms offered good levels of privacy, and consultation areas were located away from reception. Staff were observed to be professional and friendly, and systems were in place to protect confidentiality, such as taking telephone calls away from the reception desk.

Access to care was partially viewed positively. The practice offered a range of appointment options, including same-day urgent appointments, routine appointments and telephone consultations. Online booking supported access, and trained staff carried out care navigation and triage effectively. Most patients felt appointments were timely and that they were given enough time. Some patients experienced difficulties accessing routine appointments, contacting the practice by phone, and obtaining ongoing support for long-term conditions.

Only a small proportion of patients reported being offered a choice of appointment type. While most were content with the appointment they received, greater choice could improve experience.

Communication with patients was clear and inclusive. Information was shared using a range of methods, including text messages, letters, phone calls and face-to-face discussions. Patients felt the building was accessible, clean and non-discriminatory.

Some patients reported concerns about privacy at reception, stating they felt unable to speak to reception staff without being overheard, despite good privacy during consultations.

Although chaperones were offered and notices were displayed, the practice did not have a practice-specific system for recording when chaperones were offered.

A patient pod room to enable private conversations. However, patients were not clearly informed that it could be used, and hygiene supplies such as hand gel and antibacterial wipes were not available.

Delivery of Safe and Effective Care

Overall, the practice demonstrated good systems to manage risk, protect patient safety and deliver effective care. A number of areas were identified where further improvements are required to strengthen governance and consistency.

The practice environment was clean, tidy and well maintained, with clinical areas free from clutter and equipment in good working order. Appropriate maintenance arrangements and safety checks were in place.

Robust systems were in place to manage risks and incidents. Patient safety alerts and significant events were logged, shared with staff and discussed appropriately. The business continuity plan was comprehensive and included arrangements to maintain patient care during major incidents.

Staff demonstrated good awareness of emergency procedures and the location of emergency equipment and medicines. Training compliance was strong, with staff completing required training in infection prevention and control, safeguarding, basic life support and medical emergencies.

Overall infection prevention and control arrangements were satisfactory. Cleaning schedules were in place, hand hygiene facilities were appropriate, sharps were managed safely and arrangements were in place to reduce the risk of cross-infection.

Medicines management systems were largely effective. Repeat prescriptions were processed in a timely way, vaccines were stored safely within required temperature ranges, and emergency equipment met national standards. The practice demonstrated excellent uptake of the Electronic Prescription Service.

Safeguarding arrangements for children and adults were in place and aligned with the All Wales Safeguarding Procedures. Named safeguarding leads were identified, staff were appropriately trained, and safeguarding concerns were recorded and managed correctly. However, there was no clear system to remove children who were no longer at risk from safeguarding registers. A formal review and monitoring process is required.

Although a home visiting policy was in place, a written risk assessment had not been developed to support staff safety before, during and after home visits.

During inspection, the clinical waste storage unit was found unlocked. Assurance is required that the unit remains locked when not in use to prevent public access.

Emergency medicines checks did not include expiry dates, and some emergency medicines were not routinely stocked. A risk assessment is required to support this arrangement. While staff were familiar with oxygen equipment, it was unclear whether formal training had been completed and recorded. A clear training record is required.

Systems to support effective care were well established, including the management of test results, referrals and follow-up. Patient records were maintained to a good clinical standard. Records were up-to-date, contained a good patient narrative, and clear reasons for decisions relating to care and treatment. A small number of aspects of record keeping could be strengthened.

Quality of Management and Leadership

Overall, the practice demonstrated clear leadership structures, a skilled and supported workforce, and a positive culture where staff felt able to raise concerns.

The practice had clear governance and leadership arrangements in place. Staff understood their roles, responsibilities and reporting lines and were clear about working within their scope of practice.

Information was shared with staff through meetings and a shared drive, ensuring policies and procedures were accessible. Management described an open-door approach, and staff said they felt comfortable raising concerns or ideas.

The practice had a skilled and enabled workforce. Recruitment followed a structured Health Board process, training records were maintained, and most staff had completed mandatory training. Staff had access to continuing professional development and there was a positive culture of learning.

An effective complaints process was in place and aligned with the NHS Wales Putting Things Right arrangements.

Information governance arrangements were generally effective. Staff understood their responsibilities for managing patient information securely, had completed relevant training, and patient data was stored securely.

Staff meetings were not held routinely and were not formally documented. There were no action logs to support accountability and follow-up, and regular recorded meetings are required.

Many policies were not practice-specific or were out of date. Governance arrangements need strengthening to ensure robust document control, regular review and version control.

Patient engagement mechanisms were limited. Few patients reported being asked about their experience, not all patients knew how to complain, and there was no formal way for patients to suggest improvements or see how feedback led to change.

Although staff felt able to speak up, the practice did not have practice-specific whistleblowing or Duty of Candour policies in place. These need to be developed and implemented.

Quality improvement activity was not systematic. There was no clear audit programme, and limited evidence of audits in some key areas.

3. What we found

Quality of Patient Experience

Patient feedback

HIW issued a questionnaire to obtain patient views on the care at Brynmawr Medical Practice for the inspection in January 2026.

In total, we received 11 responses from patients at this service. Some questions were skipped by some respondents, meaning not all questions had 11 responses. Most respondents rated the service as 'very good' (4/11) or 'good' (6/11).

Patients' comments can be found throughout this report but should be considered in light of the relatively low response rate.

Person-centred

Health promotion
The practice had a range of health promotion information available for patients. The information was displayed in the patient waiting area, via leaflet form and displayed via a screen, as well as promoted through the practice website. We saw health promotion information on a variety of topics including mental health and wellbeing services, smoking cessation and vaccinations.

We were told the practice engaged with several agencies to improve access to various healthcare professionals due to the practice being located within a Health and Wellbeing Centre. These services comprised of pharmacy, community dental, podiatry, district nursing, and screening.

Further services provided include:

- Midwifery
- GDAS (Gwent Drug and Alcohol Service)
- Citizens Advice
- Smoking Cessation
- Diabetes Specialist Clinic (insulin patients only)
- Diabetes Prevention Service
- NCN Pharmacist (Neighbourhood Care Network)
- NCN PHP (Psychological Health and Wellbeing Practitioner)

All except one of the respondents who answered the question on health promotion in our patient questionnaire felt that health promotion information was on display

at the practice. Over half of respondents said they were offered healthy lifestyle advice, with only three disagreeing.

Positively, all but one respondent agreed that their GP explained things well to them and answered their questions. In addition, most respondents felt they were listened to and involved as much as they wanted to be in decisions about their healthcare.

Dignified and respectful care

We found patients were treated with dignity and respect throughout their GP journey. Clinical rooms provided patients with an appropriate level of privacy, with doors kept closed during consultations. Privacy curtains and window blinds were also available in treatment and consulting rooms. Consultation and treatment areas were intentionally situated away from the main reception, thereby supporting patient privacy and dignity. All respondents to the staff questionnaire agreed that measures are taken to protect patient privacy and dignity.

Reception staff were observed welcoming patients in a professional and friendly manner. The reception desk was partitioned by glass, which offered some level of privacy from the waiting area. To protect confidentiality, telephone calls were taken in the administration office, away from the reception desk. There was also a notice via the screen in the waiting area to advise patients that they could request to speak with a member of staff in private if they wished to. However, from our patient questionnaire, many patients felt they could not talk to reception staff without being overheard, but privacy was maintained during consultations.

The practice told us they offered chaperones where appropriate however we found the practice was not using the clinical code in patient notes that indicates whether patients were offered a chaperone.

The practice should ensure the clinical code is recorded in patient notes that indicate whether patients were offered a chaperone

A chaperone policy is in place; however, this was a Health Board policy and not practice specific. Chaperone information notices were displayed in the waiting area and within all clinical treatment rooms, indicating that this service was available. Most respondents to our questionnaire stated that they had been offered a chaperone.

There was a patient pod room which could be accessed from the waiting area to enable patients to have conversations in private, if desired. However, there was no notice displayed to indicate patients could use this room if they wished to. We also suggested placing antibacterial wipes and hand gel in the area.

The practice should display a notice for patients so they are aware that they can use the patient pod if required, as well as providing antibacterial wipes and hand gel for patients.

Timely

Timely care

There were processes in place to ensure patients could access care in a timely way, with the most appropriate healthcare professional.

Trained administration staff carry out care navigation to support patients to access the most suitable healthcare professional or service. We found good patient pathways in place to guide staff and to support patient need.

The practice offers a mixture of appointments including urgent on the day consultations, telephone consultations and pre bookable routine appointments up to four weeks in advance. Patients can access a broad range of specialist professionals including GPs, Clinical Pharmacist, Advanced Nurse Practitioner and Specialist Mental Health Practitioner based on their clinical presentation. Patients who require an appointment outside of practice hours are automatically directed to the NHS Wales 111 service.

Patients can further access routine GP appointments via the NHS app to book directly online without the need to call the practice. Patients can also submit routine appointment requests via the practice website and via the practice generic enquiries inbox. All requests made via the practice website and generic email account are reviewed and actioned daily to ensure the practice maintains equitable access to appointments to patients choosing this mechanism to book appointments.

For patients requiring urgent mental health support or who were in crisis, following triage, a face-to-face assessment would be offered, if a referral to mental health services was considered likely. The practice also promoted use of NHS 111#2 as an alternative means of mental health support.

From our patient questionnaires, we found respondents were satisfied with the practices opening hours (88%). However, fewer respondents expressed satisfaction with the ability to book same-day urgent appointments (56%). Difficulties were also noted in contacting the practice and obtaining routine appointments. One comment received:

> “Had to wait for months and months for a doctor I felt actually listened to me rather than just giving me painkillers. Been trying to get xray for extreme back problems for years. This is why I waited for this specific doctor, because he listens to the actual problem and had time for me. Others just in an out”.

Half of respondents found accessing regular support for ongoing conditions challenging.

We also found that only 25% of respondents were offered a choice of appointment type; however, 75% were content with the appointment type received, with most appointments being in-person.

Most patients felt appointments were timely, they were given enough time, involved in decisions, and treated with dignity and respect. One comment received below said:

> "I feel things need to change with the waiting system. I have been waiting for an hour".

Equitable

Communication and language
We found that staff communicated in a clear manner and in language appropriate to patient needs. They also provided information in a way that enabled patients to make informed decisions about their care. The surgery had a hearing loop to support those with hearing difficulties.

Patients were usually informed about the services offered at the practice through the website, social media, the NHS app and the Health Boards communications team. The practice can also share information and updates via a text messaging service. Where patients were known not to have a mobile phone, letters would be sent to individuals, and communication through telephone calls.

We were told the practice reviewed incoming mail promptly to update patient medical summaries.

For patients without digital access, the practice ensured that information about their conditions, services and changes was communicated in a suitable manner, such as face to face, telephone or letter, considering any additional communication barriers.

The practice communicated service information and important changes through various methods, including a website and leaflets. Staff communicated patient-related information via tasks in the clinical system and used email for general correspondence.

We saw evidence of a Health Board Patient Consent policy in place; however, the practice should consider making this practice specific.

We were told there were some Welsh speaking clinical staff who could assist patients who wished to access care through the medium of Welsh. We saw a variety of bilingual material and notices. We were told lanyards to identify Welsh speakers had been provided by the Health Board; however, we did not observe these being worn during our inspection. The practice also had access to translation services through language line for patients with other language needs.

The practice should ensure that the active offer of Welsh language is promoted to patients.

Rights and equality
The practice offered good access for patients. We noted that patient areas including all treatment rooms, toilets and an accessible toilet were all located on the ground floor. All patients who responded to the questionnaire felt the building was easily accessible.

The practice also had a lowered reception desk, hearing loop and clear signage that was bilingual.

We saw evidence of a Health Board equality and diversity policy in place; however, the practice should consider making this practice specific. Staff had completed equality and diversity training.

The practice was proactive in upholding the rights of transgender patients. We were told transgender patients were treated with sensitivity and it was confirmed that their preferred names and pronouns would always be used.

The practice also has a GP representative who attends an inclusion forum.

All of those who answered our questionnaire told us they felt they could access the right healthcare at the right time. All 11 respondents felt that they had not faced discrimination when accessing the service due to various protected characteristics.

Respondents also felt that the building was generally seen as accessible and clean, but some patients noted limited seating, mixed views on child-friendliness, and varying availability of health promotion materials.

Delivery of Safe and Effective Care

Safe

Risk management
The practice was clean and tidy, free of clutter and in a good state of repair. However, the practice did not have the appropriate signage for hazards such as oxygen. This was rectified on the day of the inspection with an Oxygen sign being displayed on the door to where the oxygen was stored. There were processes in place to protect the health, safety and wellbeing of all who attended the practice.

We reviewed the business continuity plan (BCP), which adequately covered the business partnership risk, pandemic risk and appropriately detailed contingencies for long-term sickness absence. The practice also demonstrated cluster collaboration to ensure patient care could continue in the event of an extreme situation.

The process in place for managing patient safety alerts and significant incidents was robust. Patient safety alerts are received and disseminated to all staff electronically. Significant events were logged and discussed in meetings appropriately.

Staff were aware of emergency procedures and the location of emergency drugs and equipment, with the use of emergency equipment posters displayed throughout the practice which stated where it was stored.

The practice did have a Home Visiting policy in place however it lacked a written risk assessment for home visits.

The practice should develop and implement a home visit risk assessment to ensure staff are aware of the process required before, during and after a home visit, which should include maintaining the safety of both staff and patients.

All sharps bins we viewed in rooms were signed and dated, not overfilled and the lids were appropriately closed.

Infection, prevention and control (IPC) and decontamination
Overall, the IPC arrangements in place were satisfactory, but some arrangements required strengthening. The environment, staff training and governance arrangements upheld the standards of IPC and protected patients, staff and visitors using the service.

A cleaning contract was in place, and cleaning schedules were visibly posted in treatment rooms. Hand hygiene facilities included elbow-operated taps and wipeable surfaces, with staff practicing effective handwashing. Disposable single use equipment was also used for nursing procedures.

There was a Heath Board IPC policy in place, however it was not specific to the practice. This also applied to policies for the management of blood borne viruses, cold chain management, sharps management and needlestick injury, with some of these also needing review. Needlestick pathway posters are displayed in the treatment rooms with the contact details of who to contact completed if there has been a needlestick injury.

An appointed IPC lead was identified, and staff understood their IPC responsibilities. We found that all staff had completed IPC training relevant to their roles.

During our inspection we were assured about the practice's oversight for the Hepatitis B immunity status of clinical staff. A record was in place to evidence that clinical staff had received their Hepatitis B vaccinations and been checked for immunological response.

There was a process in place for the management and disposal of all waste, and a Health Board policy was in place to support this. However, at the time of our inspection we found the lockable clinical waste storage unit was inadvertently unlocked and was therefore accessible to the public.

The practice manager should ensure that the clinical waste unit is always locked, and all staff and the clinical waste contractors are made aware of the procedure

Suitable arrangements were in place to segregate people with transmissible infections to reduce the risk of cross infection.

This was reflected in our patient questionnaire were most patients agreed that signage about contagious conditions was present, staff washed hands appropriately, and hand sanitizers were generally available.

Medicines management
Processes were in place to ensure the safe prescribing and management of medication. The process for patients to request repeat medication was clear and prescriptions were processed in a timely manner.

During the inspection, we were told the practice used the Electronic Prescription Service (EPS). We were told all patients had been added to the Electronic

Prescription Service (EPS) and the practice had been acknowledged for achieving the highest number of patients signing up to this service.

On review of the Patient Group Directions in the practice, we found a sample where eligible staff had not been authorised by the authorising doctor. This was actioned immediately on the day of the inspection, and were satisfied that the practices PGDs are correctly and consistently authorised.

The practice had a practice specific medicine management, Prescribing and an EPS policy in place.

There were appropriate arrangements in place for the secure storage and logging of paper prescription pads.

We found that vaccines were stored in dedicated clinical refrigerators maintained within the required temperature range, with twice-daily temperature checks using data loggers. We found the fridges to be adequately stocked and not over filled. There was also a cold chain policy in place to manage temperature deviations. Nursing staff were aware of the upper and lower temperature limits and what to do in the event of a breach to the cold chain and who to report this to.

There was appropriate resuscitation equipment and drugs in place for use during a patient emergency, such as a cardiac arrest. Emergency drugs, oxygen cylinders and automated external defibrillators (AEDs) were checked weekly by a named nurse and all equipment met Resuscitation Council UK standards. AED pads and batteries were in date; staff knew how to use the equipment and its location.

However, during the inspection we found that there was not a medication checklist which included expiry dates, contained within the emergency drugs. We also found that there was no medication to treat seizures nor any Naloxone (for reversing overdose of opioids) in the emergency drugs. We were told that this was immediately accessible from the adjoining community pharmacy.

The practice should ensure that it has a documented risk-assessed approach towards determining which emergency drugs to stock.

The resuscitation policy is a Health Board policy. Staff had completed appropriate training for medical emergencies, and all clinical staff had undertaken appropriate basic life support training.

We saw that oxygen cylinders were in date and had appropriate stock levels. staff knew how to operate them, but it was unclear if they had completed formal British

Oxygen Company (BOC) training. The practice did not hold controlled drugs on site.

The practice must ensure a process is in place to check all staff working at the practice are suitably trained to operate oxygen cylinders. A record should be kept to evidence this.

Safeguarding of children and adults

We considered the safeguarding procedures in place at the practice and found a policy in place which included both adults and children. The policy referenced the all Wales safeguarding procedures and was available for all staff on the shared drive. The practice had named safeguarding leads which were recorded in the policy.

On review of patient records, we saw examples where people were appropriately flagged with any safeguarding concerns and followed a suitable safeguarding pathway. This included looked after children. However, there was no system to remove those no longer at risk off the child protection register.

The practice must establish a clear process to monitor children on the at-risk register and to ensure removal of those children who no longer require ongoing monitoring.

During the inspection we saw evidence that all staff had completed safeguarding training at the required level.

Management of medical devices and equipment

The practice had processes in place to safely maintain equipment. We found all equipment was in a good condition, well maintained with appropriate electrical checks had been carried out. There were contracts in place for maintenance and calibration of equipment as appropriate, and for any emergency repairs and replacement.

Effective

Effective care

The practice had processes in place to support safe and effective care, this included the provision of care at the practice or within the GP cluster and wider primary care services.

We found the process for ordering and relaying test results to patients was robust, with an individual GP holding overall responsibility for this. Follow up appointments and further testing would be arranged if required.

The practice circulated updates and national guidelines via email and meetings, used Datix for incident reporting and shared new NICE guidelines through the monthly clinical meetings.

Urgent, routine and suspected cancer referrals are managed by the GPs and the admin team are tasked with sending the referral letters and ensuring the task referral list is cleared daily.

The practice answerphone advised patients with 'red flag' symptoms suggesting a medical emergency to call 999 rather than wait on the phone. Reception staff were also trained to identify these symptoms and direct patients to call 999 when necessary and had access to a GP undertaking triage for further immediate advice.

All test results come back to a generic inbox which is reviewed on a daily basis by a lead GP who will allocate them based on clinical priority. When this GP is not available, it is undertaken by three other salaried GPs.

There is a mental health nurse full time in the practice, who is available for staff to refer patients to, and to confer. Staff were aware of the NHS 111 option 2 service for non-urgent mental health needs.

The practice also offers an enhanced service for drug and alcohol use, including provision of opioid substitution therapy, and support from the local community service is offered within the practice one day a week.

Patient records

We reviewed a sample of 10 electronic patient medical records and multiple consultations for each.

The quality of patient medical records was of good quality. Records were clear regarding evidence and reasoning for decisions made relating to patient care. They were up to date, complete, understandable and contemporaneous. There was a comprehensive recording of the history, examinations, investigations and planned treatment, with evidence of the use of diagnostic Read codes. However, we found the problem title lists were extensive and the linking of medication to specific problems could be strengthened.

The practice manager must ensure that medication is linked to a patients problem within the patients record and problem list recording strengthen.

We also found of one set of notes reviewed, the consultation entry was made by the nurse, despite the GP having seen the patient. There was no GP notes entered in this patient record.

The practice should ensure that all consultations by clinicians are entered into a patient record

Records were being stored securely and in compliance with the relevant data protection standards.

Efficient

Efficient
We found that services were arranged in an efficient manner and are person centred, to ensure people feel empowered in their healthcare journey.

Services were arranged to enable efficient patient movement through care and treatment pathways, for example by allowing self-referral for physiotherapy and Pharmacy First (Common Ailments Service). Staff coordinated care by signposting or referring patients to other specialties to promote optimal outcomes and reduce unnecessary hospital admissions.

During our inspection, we saw evidence of a number and scope of ongoing initiatives centred on reducing the number of hospital admissions which we found to be notable. We also saw evidence of at least 1 hour of reflection time per nurse which is conducted by the lead nurse each month.

Quality of Management and Leadership

Leadership

Governance and leadership
Whilst the practice has undergone a period of transition, there are now suitable processes in place to support effective governance, leadership and accountability.

Staff were clear about their roles, responsibilities and reporting lines, and the importance of working within their scope of practice.

The practice had a process in place for sharing information with staff, such as changes in policies or procedures. All policies and procedures were on the shared drive and all staff would be told about any changes via team meetings for example.

Management confirmed that there was an open-door policy for staff to share concerns and ideas for the practice.

We were told all staff meetings were not routine and as such were not formally recorded with a record of actions recorded to enable action owners to understand what was required of them. We were told clinical meetings, such as their multidisciplinary team meetings and administration team meetings were taking place.

The practice manager must ensure that regular staff meetings take place, with all meetings having a record kept and an action log maintained

We reviewed a comprehensive suite of policies and procedures. As already highlighted in this report, several policies had not been implemented to align with the specific needs of the practice, with some out of date.

The practice should ensure that localised policies and procedures are created, where required. This includes ensuring all staff are familiar with them and are dated and version controlled.

Workforce

Skilled and enabled workforce
The practice followed a structured Health Board recruitment process including verification of identity, disclosure barring service (DBS) checks, employment

history, references, qualifications and regulatory body registration. Training records were maintained with dates of completion noted.

The practice manager confirmed there were enough staff with the correct skill mix to carry out the services expected. From discussions with staff across a range of roles, all agreed they worked within their scope of practice and there was enthusiasm for study and opportunities to progress skills if desired.

Nursing staff advised us they had access to continuous professional development (CPD) opportunities, and this was supported. There was a positive ethos regarding knowledge and learning, with some staff working towards further clinical development. The practice manager also supported the progression of the overall workforce. Time was apportioned to enable attendance for relevant training. We were provided access to staff's training records which confirmed that most staff had completed all mandatory training and plans were in place for staff to renew their training where applicable.

Systems were in place to ensure continued staff suitability, including regular DBS updates, self-declarations, supervision and appraisals. Registered healthcare professionals' registration status was monitored to ensure their on-going fitness to work.

Culture

People engagement, feedback and learning
An effective complaints process and tracking system was in place to monitor, review and resolve complaints and feedback. This was aligned to the NHS Wales Putting Things Right process.

However, our patient questionnaire showed few patients had been asked about their service experience previously, and while several knew how to make a complaint, some did not.

We found that there was no way of patients providing the practice with any suggestions for change, for example a patient suggestion box in the waiting area. Although the practice said patient suggestions were welcomed there was no process to record these and communicate any changes to patients. The practice may wish to consider tools, such as 'you said, we did' board.

Staff we spoke told us that they felt comfortable to speak up regarding any concerns they may have. We spoke to staff about the arrangements in place regarding compliance with the Duty of Candour and records we reviewed showed staff had completed training on this topic. However, the practice did not have a

practice specific whistleblowing policy to support this nor a Duty of Candour policy in place.

The practice must ensure that a Whistleblowing policy and Duty of Candour policy specific to the practice is implemented and cascaded to staff

Information

Information governance and digital technology

The practice understood its responsibility when processing information and demonstrated that data is managed in a safe and secure way. A Health Board information governance policy was in place to support this; however, this was in need of review. We saw evidence that all staff had completed training on this topic.

We saw evidence of patient information being stored securely and the practice's process for handling patient data was available for review on their website.

Learning, improvement and research

Quality improvement activities

The practice engaged in audit and quality improvement activities to aid learning and service improvement. However, we did not see evidence of a systematic approach towards practice-based audits. For example, we did not see any IPC audits being completed except for hand hygiene audits.

The practice manager should ensure there is a systematic approach to audits, such as an annual audit programme.

We found the practice did not participate in research projects or accreditation schemes.

Whole-systems approach

Partnership working and development

We found evidence of partnership working through collaboration within their local GP cluster. The practice told us that they intend to be more engaged moving forwards but as a managed practice, participation in certain initiatives might be limited due to implications on time and resource.

The practice regularly engages with other members of the local Neighbourhood Care Network (NCN) and attends regular meetings.

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
On review of the Patient Group Directions in the practice, we found a sample where eligible staff had not been authorised by the authorising doctor.	Health and Care Quality Standards – Safe	HIW escalated this to the practice manager on the day of the inspection	This was actioned immediately on the day of the inspection, and were satisfied that the practices PGDs are correctly and consistently authorised.

Appendix B - Immediate improvement plan

Service: Brynmawr Medical Practice

Date of inspection: 27 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 assurances 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: Brynmawr Medical Practice

Date of inspection: 27 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.	The practice told us they offered chaperones where appropriate however we found the practice was not using the clinical code in patient notes that indicates whether patients were offered a chaperone.	**The practice should ensure the clinical code is recorded in patient notes that indicate whether patients were offered a chaperone**	Health and Care Quality Standards - Information	Communication to Staff with correct code sent.	Geraint Price (PM)	Complete
2.	There was a patient pod room which could be accessed from the waiting area to enable	**The practice should display a notice for patients so they are aware that they can use the patient pod if**	Health and Care Quality Standards - Person Centred -	Appropriate signage added to Jayex screen and Door. Antibacterial wipes	Geraint Price (PM)	Complete

	patients to have conversations in private, if desired. However, there was no notice displayed to indicate patients could use this room if they wished to. We also suggested placing antibacterial wipes and hand gel in the area.	**required, as well as providing antibacterial wipes and hand gel for patients.**	Dignified and Respectful Care	and hand gel available in room for patients to use		
3.	We were told there were some Welsh speaking clinical staff who could assist patients who wished to access care through the medium of Welsh. We saw a variety of bilingual material and notices. We were told lanyards to identify Welsh speakers had been provided by the Health Board; however, we did not	**The practice should ensure that the active offer of Welsh language is promoted to patients.**	Health and Care Quality Standards – Information	Lanyards to identify Welsh speakers have been procured to support patients to identify staff members who can converse in Welsh if required.	Geraint Price (PM)	Complete

	observe these being worn during our inspection. The practice also had access to translation services through language line for patients with other language needs.					
4.	The practice did have a Home Visiting policy in place however it lacked a written risk assessment for home visits.	**The practice should develop and implement a home visit risk assessment to ensure staff are aware of the process required before, during and after a home visit, which should include maintaining the safety of both staff and patients.**	Health and Care Quality Standards – Safe – Risk Management	The practice has a Home Visit Risk Assessment in place which can be found in Annex B of the lone working policy inc. home visits.	Geraint Price (PM)	N/A
5.	There was a process in place for the management and disposal of all waste, and a Health Board	**The practice manager should ensure that the clinical waste unit is always locked, and all staff and the clinical waste contractors**	Health and Care Quality Standards – Safe	Noted : the practice has safety netted its procedure to now make sure that the door was locked after	Geraint Price (PM)	Completed

	policy was in place to support this. However, at the time of our inspection we found the lockable clinical waste storage unit was inadvertently unlocked and was therefore accessible to the public.	**are made aware of the procedure**		the waste collection has taken place.		
6.	However, during the inspection we found that there was not a medication checklist which included expiry dates, contained within the emergency drugs. We also found that there was no medication to treat seizures nor any Naloxone (for reversing overdose of opioids) in the emergency drugs. We were told that this was	**The practice should ensure that it has a documented risk-assessed approach towards determining which emergency drugs to stock.**	Health and Care Quality Standards – Risk – Medication Management	Noted : the Practice will review its checklist template to include an expiry date column. The practice has since procured Naloxone for inclusion on its Resus trolley. This is now stocked. Noted : Regarding medication to treat seizures, the practice has a pharmacy located on site which	Cerys Sibley (ANP)	Within 3 Months. Naloxone Completed

	immediately accessible from the adjoining community pharmacy.			will provide the suitable medication.		
7.	We saw that oxygen cylinders were in date and had appropriate stock levels. Staff were aware of how to operate them, but it was unclear if they had completed formal British Oxygen Company (BOC) training.	**The practice must ensure a process is in place to check all staff working at the practice are suitably trained to operate oxygen cylinders. A record should be kept to evidence this.**	Health and Care Quality Standards – Risk - Management of medical devices and equipment	Noted : The practice has plans in place to ensure all staff are suitably trained to operate the on site oxygen cylinders and ensure this is recorded.	Cerys Sibley (ANP)	Within 1 Month
8.	On review of patient records, we saw examples where people were appropriately flagged with any safeguarding concerns and followed a suitable safeguarding pathway. This included looked after children.	**The practice must establish a clear process to monitor children on the at-risk register and to ensure removal of those children who no longer require ongoing monitoring.**	Health and Care Quality Standards – Risk - Safeguarding	Noted : the practice has monthly MDT safeguarding meetings to review both adult and children. This will establish new / existing and those to be removed.		Complete

	However, there was no system to remove those no longer at risk off the child protection register.					
9.	There was a comprehensive recording of the history, examinations, investigations and planned treatment, with evidence of the use of diagnostic Read codes. However, we found the problem title lists were extensive and the linking of medication to specific problems could be strengthened.	**The practice manager must ensure that medication is linked to a patient's problem within the patients record and problem list recording strengthen.**	Health and Care Quality Standards – Risk – Medication Management	Noted : process in development to ensure correct linking of medication, this will be cascaded via E-mail and in the Practice locum packs. This has already been discussed with regular practice staff and currently being addressed with opportunistic patients during their consultations.	Geraint price (PM)	Within 3 Months
10.	We found of one set of notes reviewed, the consultation entry was	**The practice should ensure that all consultations by**	Health and Care Quality Standards – Information	Noted : the practice has issued correspondence of the	Geraint Price (PM)	Complete

	made by the nurse, despite the GP having seen the patient. There was no GP notes entered in this patient record.	**clinicians are entered into a patient record**		importance of every contact to be recorded.		
11.	We were told all staff meetings were not routine and as such were not formally recorded with a record of actions recorded to enable action owners to understand what was required of them. We were told clinical meetings, such as their multidisciplinary team meetings and administration team meetings were taking place.	**The practice manager must ensure that regular staff meetings take place, with all meetings having a record kept and an action log maintained**	Health and Care Quality Standards – Information, Workforce	Noted : The Practice does hold monthly meetings and will all have formal notes and actions. These will be cascaded to the team for actions to be undertaken.	Geraint Price (PM)	Complete
12.	We spoke to staff about the	**The practice must ensure that a Whistleblowing**	Health and Care Quality Standards –	Noted	Geraint Price (PM)	Within 3 Months

	arrangements in place regarding compliance with the Duty of Candour and records we reviewed showed staff had completed training on this topic. However, the practice did not have a practice specific whistleblowing policy to support this nor a Duty of Candour policy in place.	**policy and Duty of Candour policy specific to the practice is implemented and cascaded to staff**	Safe – Risk Management			
13.	we did not see evidence of a systematic approach towards practice-based audits. For example, we did not see any IPC audits being completed except for hand hygiene audits.	**The practice manager should ensure there is a systematic approach to audits, such as an annual audit programme.**	Health and Care Quality Standards – Safe – Risk Management	Noted : the practice is currently developing an audit process.	Geraint Price (PM)	Within 6 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): **Geraint T Price**

Job role: **Practice Manager**

Date: **23.03.2026**