Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report (Announced)

Pontypool Medical Centre, Aneurin Bevan University Health Board

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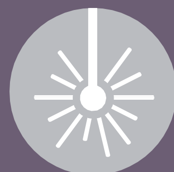

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

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:

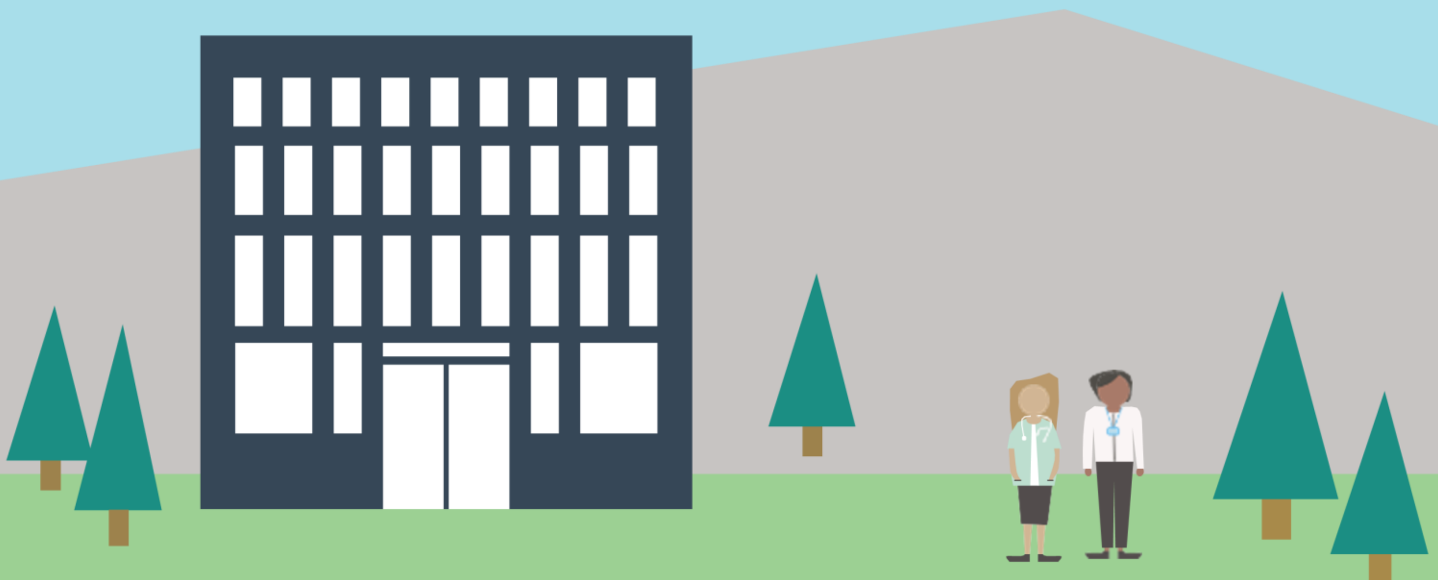
- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and 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 Pontypool Medical Centre, Aneurin Bevan University Health Board on 3 March 2026.

Our team for the inspection comprised a HIW senior healthcare inspector, a HIW healthcare inspector, two clinical peer reviewers and one practice manager peer reviewer.

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of eight questionnaires were completed by patients or their carers and 10 were completed by staff. Feedback and some of the comments we received appear throughout the report.

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

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

2. Summary of inspection

Quality of Patient Experience

Overall summary:
Health promotion advice was displayed throughout the practice. The information provided was of good quality and up to date. Patients were also offered clinical advice in a variety of formats to support their ongoing treatment and recovery.

The practice provides a range of GP and nurse-led clinics for the management of chronic conditions, as well as additional services including screening, psychological wellbeing support, substance misuse services, and vaccination clinics.

The 'Total Triage' appointment system had recently been implemented, with the aim of ensuring greater equity of access based on clinical need. Staff reported that improvements in access were beginning to emerge, and patients who responded to our survey generally reported good access.

All patients who responded to our survey confirmed that the GP explained things well, answered all questions, and ensured they felt listened to and involved in decisions about their care. All respondents also confirmed that they were treated with dignity and respect.

The practice was accessible and visibly clean. We observed friendly interactions between staff and patients, and reception staff were seen engaging with patients in a quiet and considerate manner. Posters were also displayed to advise patients that they can speak with reception staff in private. Despite this, some patients told us they were unable to speak with reception staff without being overheard.

Chaperone information was displayed in the practice waiting area to inform patients of their right to be accompanied during examinations. However, we recommend that posters are clearly displayed in clinical rooms.

This is what we recommend the service can improve:

- Visible chaperone information in all clinical rooms
- Reflection on any further measures that could protect patient privacy when speaking with reception staff.

This is what the service did well:

- There are a range of services to meet local population need and good provision of health promotion information, and care and treatment advice

- Patients provided positive feedback in relation to their interactions with clinicians during their appointments.

Delivery of Safe and Effective Care

Overall summary:
We reviewed a sample of patient records and found them to contain safe clinical assessment and completed to a good clinical standard. Whilst there was some variation between substantive and locum clinicians, most notes were appropriately coded, contained a comprehensive narrative, and would enable a good degree of continuity of care.

A number of clinical meetings took place, including safeguarding and palliative care meetings, with appropriate involvement from clinicians external to the practice to ensure that suitable care and treatment were provided. These meetings were well documented and contained clear actions and outcomes.

Clinical areas were visibly clean and well organised. This was supported by robust cleaning schedules, and a range of IPC-related audits were completed. Nursing staff had clear roles and responsibilities relating to infection prevention and control (IPC), which were well understood, and the IPC lead provided sound clinical oversight.

There were appropriate processes in place for the management of vaccines and other medications. This included the ordering, stock and fridge temperature checks, including an awareness of what to do in the event of any cold chain issues.

We reviewed a recent significant adverse event, which demonstrated a robust process for recording, reviewing, and identifying actions. This included clear application of learning, delivered verbally, in writing, through electronic system updates, and through updated patient advice.

Sound clinical leadership for safeguarding matters was observed. Safeguarding meetings took place regularly, with routine attendance from the health visitor. Clear actions and a chronology were maintained by the practice to ensure that tasks were completed appropriately by the relevant clinician.

The building was generally fit for purpose, with a range of audits and routine checks carried out. However, we identified that immediate action was required in relation to overdue fire extinguisher servicing and low water temperatures caused by inoperable boilers. These issues were addressed through our immediate assurance process, as outlined in Appendix A.

Staff were able to request emergency assistance from their individual clinical areas and in the event of a medical emergency, all emergency equipment, including the

defibrillator and oxygen, was readily accessible. Routine checks and logs of this equipment were up to date.

Immediate assurances:

- Servicing of fire extinguishers and remedial action regarding low water temperatures due to inoperable boilers.

This is what we recommend the service can improve:

- Ensuring that Read coding is consistently used and that the reason for discontinuation of medication is consistently recorded in patient records

This is what the service did well:

- Good clinical oversight of IPC matters
- Sound clinical oversight of safeguarding matters
- Robust processes for significant adverse event recording and learning.

Quality of Management and Leadership

Overall summary:
The practice has been through a period of instability, with changes in partnership arrangements to the eHarley Group, and is due to become a health board managed practice from 1 April 2026.

At the time of the inspection, the practice had been heavily reliant on locum GPs for some time. Although, these were long-term locum staff which provided consistency for staff and patients alike. Despite this and other pressures, the practice management team expressed optimism about the practice’s trajectory and its future. The practice and health board must ensure that clinical staff and skill mix is reviewed to ensure that the practice is able to deliver a sustainable service under its new health board arrangements.

The practice management and GP team demonstrated good knowledge in the safe and effective running of the practice. All staff we spoke with showed a strong understanding of their roles and responsibilities, and all appeared committed to patient care.

We reviewed a sample of staff files and found evidence that suitable pre-employment checks had been completed, except for a formal immunisation and Hepatitis B log.

Similarly, evidence of staff training was found to be up-to-date in key patient safety subjects. It was positive to note that efforts had been made to ensure training, learning and development were delivered in line with the goals, wishes

and development needs of staff. This included advanced practitioners working within a defined scope of practice. Encouragingly, all staff confirmed that they had received appropriate training to undertake their role and had received an appraisal within the last 12 months.

There were a number of ways for patients to submit concerns, compliments and feedback. We reviewed a sample of formal complaints, which were generally acknowledged and responded to in a timely manner. Although the number of formal complaints had decreased in recent times, we noted a large overall influx of feedback submitted to the practice. The practice collated all feedback and reviewed it for themes and trends to identify areas where improvements could be made.

The practice was involved in quality improvement activities, which were aligned with clinician specialties and relevant issues affecting the local population. This included hormone replacement therapy, vitamin B12, and chronic kidney disease. Overall, there was a good approach towards fostering an open dialogue amongst clinicians in order to aid reflection and to strengthen clinical practice.

This is what we recommend the service can improve:

- Review clinical staffing and skill mix to ensure that the practice is able to deliver a sustainable service under its new health board arrangements
- ensure that immunisation, including Hepatitis B, records are formally recorded, with any relevant actions taken.

This is what the service did well:

- Clinical meetings were found to be well documented, with a good focus on building an open dialogue, reflection and strengthening of clinical practice
- Staff feedback was overall positive.

Details of the concerns for patient's safety and the immediate improvements and remedial action required are provided in Appendix B.

3. What we found

Quality of Patient Experience

Patient feedback

We invited patients to complete a survey and received eight responses. Most respondents rated the overall service received as ‘good’ or ‘very good’. However, due to the low response rate, a full analysis cannot be provided in this report.

Patient comments included:

“The reception staff are exceptional and all the GPs are fab.”

“Sometimes clinics run late.”

Person-centred

Health promotion
Health promotion advice was displayed throughout the practice, including information on common illnesses, screening campaigns, and local support services. The information provided was of good quality and up to date. Patients were also offered clinical advice in a variety of formats to support their ongoing treatment and recovery.

The practice provides a range of GP and nurse-led clinics for the management of chronic conditions, as well as additional services including screening, psychological wellbeing support, substance misuse services, and vaccination clinics, in order to meet the needs of the local population.

Dignified and respectful care
All patients who responded to our survey confirmed that the GP explained things well, answered all questions, and ensured they felt listened to and involved in decisions about their care. All respondents also confirmed that they were treated with dignity and respect.

The practice was accessible and visibly clean. We observed friendly interactions between staff and patients, and reception staff were seen engaging with patients in a quiet and considerate manner. Posters were also on displaying advising patients that they could speak to reception staff in private if they wished to. Telephone calls for appointments were taken away from the reception area.

Chaperone information was displayed in the practice waiting area to inform patients of their right to be accompanied during examinations. However, we recommend that posters are clearly displayed in clinical rooms, and that the offer and uptake or decline of a chaperone is consistently recorded in patient notes, along with details of the chaperone present.

Chaperone posters should be displayed in clinical rooms and the practice must ensure that the offer and uptake or decline of a chaperone is entered into patient notes, in line with standards set out by the General Medical Council (GMC).

Timely

Timely care

The 'Total Triage' appointment system had recently been implemented, with the aim of ensuring greater equity of access based on clinical need. Staff reported that improvements in access were beginning to emerge, and patients who responded to our survey generally reported good access. This included satisfaction with the ability to book an appointment and with the type of appointment offered.

We noted that there are occasions however when demand for GP appointments exceeds capacity. We noted that the practice can re-direct certain patients to the health board run urgent primary care centre. However, this is not considered to be suitable long-term solution for patients.

For patients with chronic or ongoing medical needs, the majority confirmed that they were able to access care and support easily when required.

Pre-bookable appointments for blood tests, clinics, and routine monitoring with the practice nurse team were available. Patients whose needs could be met more appropriately through other healthcare services, such as the local community pharmacy, were directed there by Care Navigation-trained staff.

The practice also actively promoted and signposted patients to other national services, including NHS 111 and 111 Press 2 for mental health support.

Equitable

Communication and language

Staff confirmed that they would accommodate any known language or communication needs and were aware of services such as Language Line.

The majority of patient survey respondents stated that their preferred language was English, with one patient indicating that they would value receiving care through the medium of Welsh. While patient information and signage were available in both English and Welsh throughout the practice, there were limited numbers of staff who were able to confidently converse in Welsh.

The practice recorded patients who may benefit from additional support, including veterans, refugees, and patients with a learning disability, to ensure clinical staff were aware of their needs when providing care and treatment. The practice confirmed that they were part-way through inviting patients with a learning disability for their annual health check, although uptake was reported to be variable.

Delivery of Safe and Effective Care

Safe

Risk management
The building was generally fit for purpose, with a range of audits and routine checks carried out across areas including fire safety, health and safety, and waste management. Although we noted some inconsistencies, routine checks and follow-up actions were usually completed in a timely manner. However, we identified that immediate action was required in relation to overdue fire extinguisher servicing and low water temperatures caused by inoperable boilers. **These issues were addressed through our immediate assurance process, as outlined in Appendix A.**

Staff were able to request emergency assistance from their individual clinical areas. When asked, staff were familiar with this process and understood how to respond.

In the event of a medical emergency, all emergency equipment, including the defibrillator and oxygen, was readily accessible. Routine checks and logs of this equipment were up to date, and staff demonstrated awareness of the recent oxygen cylinder safety alert.

We reviewed the business continuity plan (BCP) and found it to be sufficiently detailed. Staff described a recent business continuity incident and the steps taken to maintain continuity of care for patients.

We confirmed that patient safety alerts are circulated to the appropriate staff. Any required changes for the practice are logged, and a failsafe system is in place for any periods of absence by the practice manager, who is responsible for receiving and managing these alerts.

Infection, prevention and control (IPC) and decontamination
Clinical areas were visibly clean and well organised. This was supported by robust cleaning schedules, which included daily checks and additional spot checks. A range of IPC-related audits were completed, including a review of each individual clinical room. Other audits included hand hygiene and bare-below-the-elbow compliance.

Nursing staff had clear roles and responsibilities relating to infection prevention and control (IPC), which were well understood, and the IPC lead provided sound clinical oversight. IPC training had been completed to help maintain staff skills and knowledge.

Clinical waste, including sharps, was appropriately segregated and securely stored both within the building and in external areas. Staff were aware of how to respond to a needlestick injury, and a clear process was in place to support this.

Medicines management

There were appropriate processes in place for the management of vaccines and other medications. This included the ordering, stock and fridge temperature checks, including an awareness of what to do in the event of any cold chain issues.

Prescribing clerks described good processes in order to effectively complete tasks associated with their role and duties. This included opportunities for learning and development, and good day-to-day support from the practice pharmacist.

Paper prescriptions and pads to be securely stored, which included a process for assigning pads to individual staff members.

We reviewed a sample of patient group directions (PGDs) and found these to be appropriately completed and signed, ensuring that staff have the delegated authority to administer certain medications to patients.

Safeguarding of children and adults

Sound clinical leadership for safeguarding matters was observed. Safeguarding meetings took place regularly, with routine attendance from the health visitor. Clear actions and a chronology were maintained by the practice to ensure that tasks were completed appropriately by the relevant clinician.

In the sample of records we reviewed, we confirmed that vulnerable children and other relatives were appropriately coded, and that system flags were applied correctly.

Training to the relevant level had been provided to staff according to their roles and responsibilities. A suitable policy and process were in place, along with a flow chart for staff to follow in the event of any immediate concerns.

Management of medical devices and equipment

Medical devices and equipment were found to overall be in good working order. There was evidence of calibration and through contracts with relevant manufacturers and suppliers. We confirmed that any failed equipment was immediately taken out of service and replaced.

Effective

Effective care

We found that workflow processes for managing incoming correspondence and other clinical documentation were generally timely and auditable. The system ensured that tasks assigned to the relevant clinician remained active until all required actions had been completed.

We reviewed a recent significant adverse event, which demonstrated a robust process for recording, reviewing, and identifying actions. This included clear application of learning, delivered verbally, in writing, through electronic system updates, and through updated patient advice.

A number of clinical meetings took place, including safeguarding and palliative care meetings, with appropriate involvement from clinicians external to the practice to ensure that suitable care and treatments were provided. These meetings were well documented and contained clear actions and outcomes.

Patient records

We reviewed a sample of patient records and found them to contain safe clinical assessment and completed to a good clinical standard. Whilst there was some variation between substantive and locum clinicians, most notes were appropriately coded, contained a comprehensive narrative, and would enable a good degree of continuity of care.

The practice should ensure that Read coding is consistently used and that the reason for discontinuation of medication is consistently recorded.

All paper and electronic records were found to be held securely and away from patient access and view.

Quality of Management and Leadership

Leadership

Governance and leadership

The practice has been through a period of instability, with changes in partnership arrangements to the eHarley Group, and is due to become a health board managed practice from 1 April 2026. One staff member commented:

"*The staff at the surgery have been through a very stressful 2 and a half years with enormous changes, including staff changes, instability in reliability of regular staffing and lots of temporary staff and outside pressures, but those remaining have stuck together and work well together. Many work well beyond the hours they are contracted to do. We need more stable and increased provision of regular GP's and nurses.*"

At the time of the inspection, the practice had been heavily reliant on locum GPs for some time. Although, these were long-term locum staff which provided consistency for staff and patients alike. Salaried GPs also worked well and in a constructive manner to help shape and deliver an effective and consistent service. Despite this and other pressures, the practice management team expressed optimism about the practice's trajectory and its future.

The practice and health board must ensure that clinical staffing and skill mix is reviewed to ensure that the practice is able to deliver a sustainable service.

The practice management team and GP team demonstrated good knowledge in the safe and effective running of the practice. All staff we spoke with showed a strong understanding of their roles and responsibilities, and all appeared committed to patient care.

Clinical meetings were found to be well documented, with a good focus on building an open dialogue, reflection and strengthening of clinical practice.

In response to our staff survey, whilst limited in number, most staff felt able to meet conflicting demands on their time at work and that they have adequate equipment to undertake their role. However, most staff did not consider there to be enough staff in order for them to do their job properly.

Just over half of staff felt that their job is not detrimental to their health, with most agreeing that positive action on health and wellbeing is taken and that a good work-life balance is achieved.

Whilst most staff agreed that they are able to make suggestions to improve service provision for staff and patients, less than half felt involved in deciding on changes introduced that affects their work. All respondents agreed that the practice encourages them to report errors, near misses or incidents and that action is taken to ensure these to not reoccur.

Workforce

Skilled and enabled workforce
We reviewed a sample of staff files and found evidence that suitable pre-employment checks had been completed, including proof of identification, confirmation of professional registration status, references, and health screening.

Although evidence of immunisation status, including Hepatitis B, was being collected, the process lacked formality. The practice should ensure that it maintains a clear log and that relevant risk assessments are in place for non-responders or where evidence of immunity is unavailable or refused.

The practice must ensure that immunisation, including Hepatitis B, records are formally recorded, with any relevant actions taken.

We reviewed a sample of staff training files and found recent evidence that a range of key patient safety training subjects had been completed, appropriate to staff roles and responsibilities. However, we noted that although staff due to complete a basic life support refresher had finished the online component, the face-to-face element had not yet been completed. We confirmed that these staff had been booked onto sessions in March and April 2026.

It was positive to note that efforts had been made to ensure training, learning and development were delivered in line with the goals, wishes and development needs of staff. This included advanced practitioners working within a defined scope of practice. Encouragingly, all staff confirmed that they had received appropriate training to undertake their role and had received an appraisal within the last 12 months.

Culture

People engagement, feedback and learning
There were a number of ways for patients to submit concerns, compliments and feedback. We reviewed a sample of formal complaints, which were generally acknowledged and responded to in a timely manner. Although the number of formal complaints had decreased in recent times, we noted a large overall influx of feedback submitted to the practice. The practice collated all feedback and

reviewed it for themes and trends to identify areas where improvements could be made.
Other routes for providing feedback well were advertised, including options to contact the local health board, Llais and the Public Services Ombudsman for Wales.

Information

Information governance and digital technology
All electronic and paper patient records were found to be securely stored and most staff agreed that they can access the IT systems they need to provide care and support to patients.

Learning, improvement and research

Quality improvement activities
The practice was involved in quality improvement activities, which were aligned with clinician specialties and relevant issues affecting the local population. This included hormone replacement therapy, vitamin B12, and chronic kidney disease.

As referenced above, there was a good approach towards fostering an open dialogue amongst clinicians in order to aid reflection and to strengthen clinical practice. This extended to the review of clinical incidents and adverse events, with a notable application of learning evidenced.

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
Not applicable			

Appendix B - Immediate improvement plan

Service: Pontypool Medical Centre

Date of inspection: 3 March 2026

Findings

We were not assured that effective systems were in place to manage hot water temperatures in line with Legionella control requirements. During the inspection, we reviewed the water temperature logs and found highly variable temperatures recorded, ranging from 17.9 degrees centigrade through to the required 50 degrees centigrade.

We further identified that two out of the three boilers were out of use, thereby impacting on the ability to maintain constant hot water. We noted that the practice management team had made active efforts to report this issue over an extended period without successful remedial action taken.

	Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
1.	The practice must ensure that hot water across the practice and in clinical handwash basins meets nationally recommended standards.	Health & Safety Executive (2024): HSG274 Welsh Health Technical Memorandum 04-01 (2016): Part B	We acknowledge the requirement of hot water across the practice, including clinical handwash basins, to meeting national recommended standards. A full review of the current boiler system has been scheduled for remedial action to be undertaken. We will continue to monitor hot water temperatures as part of our regular environmental checks.	Sam Clare - eHarley Street	By the 1st April 2026
	The practice must ensure that the Legionella audit / risk assessment is periodically reviewed (at least 2 yearly).	Health & Safety Executive (2024): HSG274 Welsh Health Technical	The practice acknowledges the requirement to ensure that the Legionella risk assessment is periodically reviewed, in line with national guidance recommending review at least every two years or sooner if	Sam Clare - eHarley Street	Booked for the 25th and 26th March 2026

		Memorandum 04-01 (2016): Part B	system changes occur. To address this, the following actions will be implemented: Legionella Risk assessment to be undertaken.		

Findings
We were not assured that effective fire safety systems were in place. We identified through a practice fire risk assessment (Dated December 2025) that fire extinguishers required servicing as soon as possible. During the inspection, we observed fire extinguishers to have last been tested in 2023 and due for their next service in 2024. We noted that the practice management team had made efforts to secure servicing by an external contractor.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
1.	The practice must ensure suitable fire safety controls exist, including access to fire extinguishers that have been serviced and deemed fully functional.	Regulatory Reform (Fire Safety) Order 2005 WHTM 05-01 & 05-02: 2014	We acknowledge the requirement to ensure that suitable fire safety controls are in place. We will have all fire extinguishes checked in the practices, to confirm they are in date, fully functional and positioned appropriately. Any equipment requiring services will be attended to and an updated service certificate obtained.	Sam Clare - eHarley Street	Booked for the 25th and 26th March 2026

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: **Maria Potter**

Name (print):	**MARIA POTTER**
Job role:	**Practice Manager**
Date:	**11th March 2026**

Appendix C - Improvement plan

Service: Pontypool Medical Centre

Date of inspection: April 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.	Risk to patient experience and workforce	Chaperone posters should be displayed in clinical rooms and the practice must ensure that the offer and uptake or decline of a chaperone is entered into patient notes	Health and Care Quality Standards - Person-centred	Following the HIW inspection, laminated chaperone posters were displayed in all clinical rooms to ensure patients are clearly informed of their right to request a chaperone. In addition, a discussion was held at a practice clinical meeting to reinforce the requirement that clinicians offer a chaperone for relevant	Maria Potter	23rd March 2026

			consultations and accurately record the offer and the patient's acceptance or decline in the clinical notes using the agreed coding process. Compliance will be monitored through quarterly clinical record audits, checking that chaperone offers and outcomes (accepted/declined) are documented where appropriate. Audit results will be recorded and reviewed at practice meetings. All clinicians have access to chaperone codes within the clinical system, and posters are permanently displayed		

			in every clinical room. The agreed process has been communicated to all clinical staff. These actions ensure compliance with HIW standards, promote patient dignity and safeguarding, and align with the practice's chaperone policy. Posters were displayed in all clinical rooms immediately following the HIW inspection. The clinical meeting took place within one month of the inspection, and the first audit of chaperone documentation will be completed within three months, with ongoing quarterly audits thereafter.		

2.	Risk to safe and effective care	The practice should ensure that Read coding is consistently used and that the reason for discontinuation of medication is consistently recorded.	Health and Care Quality Standards – Safe / Effective	Following the HIW inspection, a clinical meeting was held to address the consistent use of Read coding and the importance of recording clear reasons for medication discontinuation in patient records. Particular emphasis was placed on ensuring that all clinicians, including locum GPs, use appropriate Read codes and accurately document medication changes. Meeting minutes highlighting these expectations were circulated to all clinical staff. The practice now benefits from a stable	Maria Potter	23rd March 2026

				cohort of locum GPs over the last 12 months, allowing for improved consistency. All clinicians have been provided with written guidance and reminders via email on Read coding expectations, with training support offered where required. The pharmacy team will assist with identifying medication discrepancies and supporting accurate record updates. Compliance will be monitored through audit checks to confirm that medication discontinuations include a documented reason.		

				Accurate Read coding and clear documentation of medication discontinuation are essential for safe patient care, effective medicines management, and compliance with HIW standards. These actions also support continuity of care across the multidisciplinary team. • Initial discussions were completed within one month of the HIW inspection. • Written guidance and reminders have already been issued to clinicians.		

3.	Risk to workforce	The practice and health board must ensure that clinical staffing and skill mix is reviewed to ensure that the practice is able to deliver a sustainable service.	Health and Care Quality Standards - Workforce	The practice has already implemented a RAG-rated workforce planning tool to identify critical clinical roles and highlight risks to service delivery. The current clinical staffing model has been reviewed and agreed as sustainable. Under the current partnership, the skill mix comprises 58 GP sessions, 19 Advanced Nurse Practitioner (ANP) sessions, and 18 Pharmacist sessions. This same level of clinical staffing and sessional provision will be replicated when the practice transfers to Health Board hosting on 1 April 2026. There are no plans to reduce clinical sessions at	Maria Potter	1st April 2026

			Pontypool Medical Centre. Clinical staffing levels and skill mix will be reviewed through: • Ongoing scrutiny using the RAG workforce chart, • Regular monitoring of sessional numbers by role, and The established skill mix supports both core GP services and multidisciplinary working. Maintaining an appropriate and balanced clinical skill mix is essential to ensuring safe, effective, and		

				sustainable service delivery, meeting patient demand.		
4.	Risk to workforce	The practice must ensure that immunisation, including Hepatitis B, records are formally recorded, with any relevant actions taken.	Health and Care Quality Standards – Workforce	The practice will undertake a full review of the Hepatitis B immunisation status of all clinical staff. A formal Hepatitis B immunisation register will be maintained, clearly recording vaccination status, immunity levels, and any follow-up actions required. Where gaps are identified, staff will be offered either serology testing to confirm immunity or vaccination in line with occupational health guidance. Hepatitis B immunisation status will also be formally reviewed as part of	Charlotte Morris	1st June 2026

			the recruitment and induction process for all new clinical staff. Completion of the Hepatitis B register will be confirmed once 100% of clinical staff have documented immunisation or immunity status. Ongoing compliance will be monitored through annual register reviews and checks during staff induction. Responsibility for maintaining the register will sit with a nominated member of the management team. Maintaining accurate immunisation records, including Hepatitis B, is essential to staff and		

			patient safety, and infection prevention and control. Immunisation status for new staff will be reviewed at the point of appointment, with the register reviewed annually thereafter to ensure it remains current.		

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): MARIA POTTER

Job role: Practice Manager

Date: 17th April 2026