Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Healthcare Inspection Report (Announced)

The Independent General Practice, Newport

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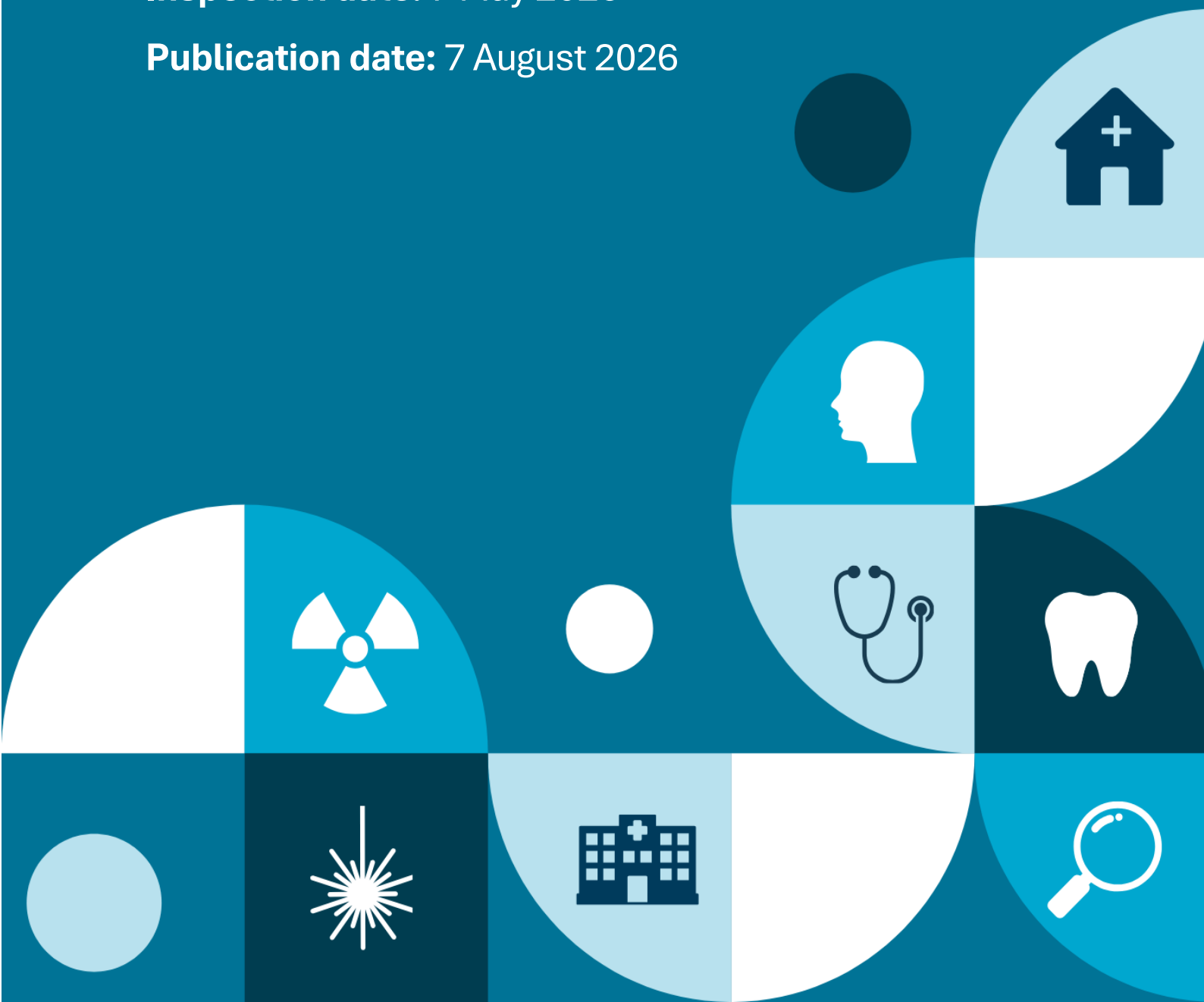

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Healthcare Inspectorate Wales (HIW) is the independent regulator and inspectorate of healthcare in Wales

Our Purpose

We check the safety and quality of healthcare across Wales.

Our 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 Vision

A future where healthcare in Wales is safe, effective, and high-quality for everyone.

Our Priorities

Putting People First - We will focus on the biggest risks facing people and communities as they access healthcare services now and in the future.

Learning and Working Together - We will collaborate with partners to share learning and drive lasting improvements.

Investing in Our People - We will ensure our people feel supported, valued, and empowered.

Taking Action That Matters - We will take action to improve the quality and safety of healthcare for the future of Wales.

Contents

1. What we did

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 The Independent General Practice, Newport on 7 May 2026.

Our team for the inspection comprised of a HIW healthcare inspector and two clinical peer reviewers.

During the inspection we invited patients to complete a questionnaire to tell us about their experience of using the service. A total of seven were completed. We also spoke to staff working at the service during our inspection. Feedback and some of the comments we received appear throughout the report.

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

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

2. Summary of inspection

Quality of Patient Experience

Overall summary:

Overall, we found that the service had suitable arrangements in place to support a positive patient experience. Information about services and opening times was available through the website and patient information materials. We found arrangements to support patients' dignity and privacy during consultations and examinations, including chaperone information, an up-to-date policy and staff training. Consent arrangements were clear and well established, supported by current policies, standardised templates and online systems. Welsh language support was visible within the setting and Welsh-speaking clinicians were available. Practical arrangements were also in place to support accessibility, including parking, ground floor facilities and an accessible toilet. Overall, the service demonstrated appropriate arrangements to support patient experience, but improvement was required to strengthen confidentiality and ensure written information was consistently available bilingually.

This is what we recommend the service can improve:

- Ensure written patient information, including appointment information in the Newport patient guide, is available bilingually
- Strengthen arrangements to protect patient confidentiality where reception or administrative calls may be overheard from the waiting area.

This is what the service did well:

- We found clear and robust consent arrangements, supported by up-to-date policies, standardised templates and online consent systems
- We found good arrangements to support patients' dignity, privacy and access, including chaperone arrangements, closed consulting room doors, ground floor facilities and visible Welsh language support.

Delivery of Safe and Effective Care

Overall summary:

Overall, we found that the service had a number of suitable arrangements in place to support safe and effective care. The environment was clean, clear and appropriately equipped, and there was evidence of risk assessment, audit activity and systems to support safeguarding, records management and the communication of safety alerts. Digital systems supported care delivery and clinical records were well documented. However, we identified areas for improvement. Immediate assurance was required in relation to the storage and transportation of vaccines and medicines, including fridge storage practices and medicines being removed from their original packaging. We also found that medicines management policies and arrangements for emergency medicines and the defibrillator required stronger oversight. In addition, blood results governance required improvement in relation to staff training, defined roles and responsibilities, and audit. Overall, while the service had established systems to support safe care, improvement was required in relation to medicines management, policy oversight and aspects of clinical risk management.

Immediate assurances:

- Immediate assurance was required in relation to the storage and transportation of vaccines and medicines, including fridge storage practices and medicines being removed from their original packaging. This was resolved during the inspection.

This is what we recommend the service can improve:

- Update policies to reflect local arrangements for emergency medicines and defibrillator management and provide clear oversight of these arrangements.
- Strengthen governance of blood results management by ensuring appropriate staff training, clear roles and responsibilities, and an audit plan.

This is what the service did well:

- We found a clean, clear and appropriately equipped environment, with suitable handwashing facilities and infection prevention information displayed
- We found evidence of audit activity and well-documented clinical records, supporting oversight and improvement.

Quality of Management and Leadership

Overall summary:
Overall, we found that the service had established management and leadership arrangements in place to support governance, staff development and the management of concerns. Structured clinical and management meetings supported oversight of quality, safety and operational matters. We also found systems in place to record and manage complaints and significant events, with learning identified and shared as appropriate. Staff told us they felt respected and supported by colleagues, and training and appraisal arrangements were well established. However, we identified areas for improvement. Routine re-checking of professional registration, including Nursing and Midwifery Council registration in line with revalidation requirements, was not consistently evidenced. In addition, wider inspection findings identified the need for stronger policy oversight in some areas of service delivery. Overall, the service demonstrated a structured approach to management and leadership, but improvements were required to strengthen assurance and oversight.

This is what we recommend the service can improve:

- Ensure professional registration is re-checked routinely where required, including Nursing and Midwifery Council registration in line with revalidation requirements.
- Strengthen governance oversight by ensuring policies are kept up to date and reflect local operational arrangements.

This is what the service did well:

- We found structured clinical and management meetings in place, supporting oversight of quality, safety and operational matters.
- We found well-established training and appraisal arrangements, with compliance monitored through a dashboard and appraisal coverage reported as 100%.

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

All seven respondents to the HIW survey rated this service as very good, with consistently positive feedback about their experience. Patients reported being treated with dignity and respect, with staff described as kind, professional and attentive, and said they were given clear explanations and involved in decisions about their care. The setting was reported to be very clean, with appropriate infection prevention and control measures in place, and most patients considered the premises accessible. All respondents who answered felt they could access the right healthcare at the right time, and no one reported experiencing discrimination.

Patient comments included:

> *"The service is nothing short of excellent... staff are very kind and helpful."*
>
> *"Lovely friendly staff... made me feel very welcome and listened to."*

Health promotion, protection and improvement

We were told that health and wellbeing information was available to support patients to make informed choices, including information relating to healthy lifestyles such as smoking cessation, healthy weight and alcohol. We also heard that leaflets were available.

The practice offered a range of services to include private medicals, vaccinations, testing, occupational health, physiotherapy, cardiology, counselling and private GP services.

Patients with internet access can find information about the range of services available on the practice's website.

Information relating to practice opening times was available on the practice website and in the patient leaflet. The practice did not offer out of hours services.

Dignity and respect

We found that arrangements were in place to support patients' dignity and choice during consultations and examinations. Chaperone information was displayed, and reception staff were trained to act as chaperones when required. An up-to-date written policy was in place in relation to the use of chaperones and staff had received training.

There was no formal reception in place however clear signage was in place as to where patients should attend. The receptionist / administrator had the potential to be heard by patients waiting in the waiting area. We were told, where possible, calls were taken away from this area.

Doors to consulting rooms were closed when patients were being seen by GPs or other healthcare staff, promoting their privacy and dignity.
We also noted that the clinical environment appeared clean, clear and accessible, and that patients were able to approach staff for support.

Patient information and consent

We found that the service had clear and robust arrangements in place to support consent to care and treatment, underpinned by up-to-date policies and embedded practice. A dedicated Consent and Consent Withdrawal Policy set out how valid consent is obtained, recorded and reviewed, including the requirement for consent to be freely given, informed, specific and documented prior to consultations or procedures. The policy also makes clear that patients have the right to refuse or withdraw consent at any time, with appropriate recording in the patient record.

Appropriate arrangements were in place to assess capacity and competence to consent, supported by a Clinical Competence to Consent Policy aligned with the Mental Capacity Act (2005). This includes guidance on best-interest decision-making where a person lacks capacity, as well as consent arrangements for children and young people, including the application of Gillick/Fraser competence.

During the inspection, we found that consent processes were effectively implemented in practice. The service used online consent systems and standardised templates, including for procedures such as blood tests, supporting a consistent and auditable approach to documenting consent within clinical records.

Communicating effectively

A patient brochure was available in hard copy as well as digitally. This provided information on services, appointments, practice teams and opening times. It also clearly detailed feedback from patients. We found that Welsh language support was visible and promoted within the setting, including posters to raise awareness. We were told that Welsh-speaking clinicians were available, and that translation services were rarely required.

However, we identified that not all written patient information was available bilingually, as the standard appointment information in the Newport patient guide was not bilingual.

The practice manager should consider options to make the patient guide available in Wales to meet the needs of Welsh speaking patients.

Staff told us they could access a translation service to help communicate with patients whose first language is not English.

Care planning and provision

We were told that the service offered timely appointments and had systems in place to support access. We also noted that patients could access staff for support when needed. Treatment information was appropriately recorded in patient files.

Equality, diversity and human rights

We found evidence of practical measures to support accessibility. There was parking available directly outside of the practice and good access to the main entrance. All facilities, including the reception desk, waiting room, patients' toilet and consulting rooms were located on the ground floor. There was an accessible toilet with a pull cord, which was linked to St Joseph's.

Citizen engagement and feedback

We found that patient engagement was supported through multiple feedback routes, including the on-site QR code and the service's use of patient guidance material that signposted people to HIW.

Delivery of Safe and Effective Care

Environment

We found that the environment was suitable to support the delivery of safe care. Clinical rooms were clean, clear and appropriately equipped for the services provided. Both clinical rooms had sinks and handwashing posters displayed, supporting good infection prevention practice.

Managing risk and health and safety

We found that arrangements were in place to manage risks associated with the delivery of care. Facilities management arrangements, including cleaning and waste, were managed through St Joseph's. We were told that, where accidents involving bodily fluids occur, cleaning staff are available to respond appropriately.

The premises were fit for purpose, and we saw ample documentation confirming that risks, both internally and externally, to staff, visitors and patients had been considered We saw a general risk assessment was in place, covering fire, environmental and health and safety which was current and regularly reviewed.

However, during the inspection we identified that the clinical waste area was not locked. This was escalated to the service during the inspection and action was requested to ensure this was addressed.

The service must ensure that arrangements with St Joseph's Hospital for the provision and security of clinical waste facilities are effective, and that the clinical waste storage area is kept securely locked at all times.

We found that the location of oxygen storage was not clearly signposted. Clear signage would support prompt access in the event of an emergency.

The service should ensure the location of oxygen storage is clearly signposted to enable prompt access in the event of an emergency.

Safety alerts, including MHRA alerts, are received centrally and disseminated systematically to all clinicians via Microsoft Teams and email, with records retained to provide traceable assurance that relevant staff have been informed. Significant events are logged and learning is shared through established governance arrangements, including clinical and management meetings, supporting a culture of safety and continuous improvement. While these operational arrangements demonstrate that safety alerts are actively managed and communicated, the inspection evidence did not demonstrate a standalone, formal policy setting out the end-to-end management and periodic review of safety alerts.

The service should ensure there is a formal policy in place for the management of safety alerts, setting out how alerts are received, reviewed, disseminated, actioned and periodically monitored to provide assurance of safe and consistent oversight.

We noted the service saw patients on the day for acute illness. However, visual prompts to support the recognition of sepsis red flag symptoms were not evident within the reception area. The display of such information would support early identification and escalation where patients may present with signs of deterioration. Consideration should be given to ensuring that non-clinical staff, including reception staff, are appropriately trained to recognise potential signs of sepsis and escalate concerns in a timely manner. **The service should ensure that non-clinical staff, including reception staff, are appropriately trained to recognise potential signs of sepsis and escalate concerns in a timely manner.**

Infection prevention and control (IPC) and decontamination

Infection prevention and control arrangements were generally well established, with clinical rooms appropriately equipped with sinks and handwashing facilities, IPC posters displayed, and personal protective equipment readily available. IPC training formed part of the mandatory training programme and compliance was overseen through a training dashboard, providing assurance that staff had received training appropriate to their roles. Governance oversight of IPC was evident through audit activity and action-focused clinical and management meetings. We noted that visual prompts to support the management of needlestick injuries were not clearly displayed within treatment areas. Displaying such information would support staff awareness and safe response following exposure incidents.
The service should ensure that guidance to support the management of needlestick injuries is clearly displayed within treatment areas to support staff awareness and safe response following exposure incidents.

Inspection findings identified immediate improvements required in relation to the storage and transportation of vaccines and medicines, including fridge storage practices and medicines being removed from their original packaging. **These issues presented risks to cold-chain integrity and infection prevention and control standards. Action was taken during the inspection, and the concerns were resolved at that time. (see appendix A)**

Medicines management

Medicines management arrangements included a number of established safeguards. No medicines were routinely stored on site, and controlled drug prescribing and storage arrangements were clearly described, with medicines held securely off site. Patient

Group Directions were available, in date and accessible to staff, supporting safe administration where required. Prescribing systems supported both face-to-face and remote consultations, and medicines management formed part of wider clinical governance arrangements. However, inspection findings identified immediate improvements required in relation to the storage and transportation of vaccines and medicines, which were addressed and resolved during the inspection.

Safeguarding children and safeguarding vulnerable adults

Safeguarding arrangements were supported by clear leadership and governance oversight. A designated safeguarding lead was identified, and safeguarding policies and procedures were available to guide staff practice. Safeguarding training formed part of the mandatory training programme, with clear expectations set for clinical staff to complete safeguarding training to an appropriate level, and compliance monitored through a training dashboard. Staff demonstrated awareness of safeguarding processes and routes for escalating concerns, and safeguarding issues were discussed within governance meetings where appropriate. These arrangements provided assurance that safeguarding risks were recognised and managed, although continued oversight was required to ensure ongoing compliance with training requirements and clarity of roles and responsibilities across all staff groups.

Medical devices, equipment and diagnostic systems

We found that clinical equipment was available to support safe care delivery. Emergency equipment arrangements were in place, with policies available to guide staff response. Arrangements for emergency medicines and defibrillator management were locally specific and required clearer policy oversight to provide assurance of safe and consistent management.

The service must ensure the policy relating to emergency medicines and defibrillator arrangements is updated to reflect the specific arrangements at this location and provide clear guidance for staff.

Safe and clinically effective care

We found that systems were in place to support the delivery of clinically effective care. Online consent processes and templates were used for procedures such as blood tests, supporting consistent documentation.

Blood results were processed through an established workflow, with practice nurses reviewing results and escalating concerns to a GP where required. However, we noted that there was no documented process or policy in place defining roles and responsibilities, alongside an audit plan.

The service must ensure blood results management is supported by a documented process that clearly defines staff roles and responsibilities and includes an audit plan to provide assurance of safe and consistent oversight.

Participating in quality improvement activities

We found evidence that clinical audit and records audit activity was taking place. Documentation reviewed during the inspection demonstrated that audit activity was used to support monitoring and improvement of care.

Information management and communications technology

We found that digital systems were used to support care delivery, including remote consultations and digital prescribing options where appropriate. Policies were available to support remote consultations.

We also found that safety alerts, including MHRA alerts, were received, collated and shared systematically with clinicians via email and digital platforms, providing traceable communication.

Records management

We found that clinical records were well documented and followed recognised documentation principles. Records audit activity was in place and evidenced during the inspection, supporting oversight of record-keeping practice.

Quality of Management and Leadership

Governance and accountability framework

We found that governance arrangements were in place to support oversight of the service. Structured clinical and management meetings were held, and minutes reviewed during the inspection demonstrated that meetings were agenda-led and action focused. This supported clear oversight of quality, safety and operational matters.

We also found that significant events were recorded, with learning captured and shared, demonstrating a structured approach to governance and learning.

Dealing with concerns and managing incidents

We observed staff working and communicating well together during the inspection. Staff were positive about the working environment and told us that they felt well respected and supported by their colleagues.

We found that systems were in place to record and manage complaints and concerns. Documentation reviewed during the inspection showed that complaints and concerns were logged, responded to, and discussed within management meetings, with learning shared as appropriate.

We also saw that significant events were recorded using individual logs, and that learning from these events was identified and discussed. This supported a culture of reflection and improvement.

Workforce recruitment and employment practices

We were told that recruitment checks were completed at the point of appointment, including verification of professional registration where applicable. However, we identified that routine re-checking of professional registration, such as Nursing and Midwifery Council (NMC) registration in line with revalidation requirements, was not consistently evidenced. This was identified as an area for improvement.
The service must ensure arrangements for routine re-checking of professional registration are in place and evidenced, including Nursing and Midwifery Council registration in line with revalidation requirements.

Workforce planning, training and organisational development

We found that workforce training and development was supported through a structured mandatory training programme. Training compliance was monitored through a training dashboard, overseen by the practice manager. Mandatory training covered a wide range

of topics, including safeguarding, infection prevention and control, equality and diversity, fire safety, basic life support and information governance.

We were told that safeguarding leadership was clearly identified, with a lead clinician in place, and that clinicians were expected to complete safeguarding training to the appropriate level on an annual basis.

We also found that staff appraisal arrangements were well established, with appraisal coverage reported as 100%, supporting performance oversight and staff development.

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
Immediate improvements were required in relation to the storage and transportation of vaccines and medicines, including fridge storage practices and medicines being removed from their original packaging.	These issues presented risks to cold-chain integrity and infection prevention and control standards, which could affect the safe storage and handling of vaccines and medicines.	The concerns were escalated to the service during the inspection and immediate action was requested.	Action was taken by the service during the inspection, and the concerns were resolved at that time. Vaccine and medicines were moved and stored appropriately, travel guidance updated and policy and process updates shared with staff.

Appendix B – Immediate improvement plan

Service: **The Independent General Practice, Newport**

Date of inspection: **7 May 2026**

The table below includes any immediate non-compliance concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Findings			
Improvement needed		**Standard / Regulation**	
1.	No immediate non-compliance issues noted		
Service Action:		**Responsible officer**	**Timescale**

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: The Independent General Practice, Newport

Date of inspection: 7 May 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.	Not all written patient information was available bilingually, including standard appointment information in the Newport patient guide.	The service should consider options to make the patient guide available in Welsh to meet the needs of Welsh-speaking patients.	Regulation 15 – Information for patients	Create a welsh language version of our Patient Guide and make available in the practice	Kieran Reynolds	4 weeks
2.	The clinical waste storage area was not locked, creating a risk of unauthorised access.	The service must ensure arrangements with St Joseph's Hospital for the provision and security of clinical waste facilities are effective, and that the clinical waste storage area is kept securely locked at all times.	Regulation 26 – Safety of premises	The maintenance manager was spoken to on the day and the importance of this being locked at all times was highlighted. We were informed it normally is and this was a "one off" incident. On subsequent checks the bins have been locked.	Kieran Reynolds	Complete

3.	Inspection evidence did not demonstrate a formal policy for the end-to-end management and periodic review of safety alerts.	The service should ensure there is a formal policy for the management of safety alerts, setting out how alerts are received, reviewed, disseminated, actioned and periodically monitored.	Regulation 28 – Quality of service provision	We already do have this policy named: CENTRAL ALERTS SYSTEM & OTHER ALERTS POLICY.	Kieran Reynolds	Complete
4.	The policy relating to emergency medicines and defibrillator arrangements did not fully reflect local arrangements at this location.	The service must ensure the policy relating to emergency medicines and defibrillator arrangements is updated to reflect the specific arrangements at this location and provide clear guidance for staff.	Regulation 15 / Regulation 28	Update to policy	Kieran Reynolds	2 weeks
5.	Blood results management was not supported by a documented process setting out staff roles and responsibilities, with an audit plan.	The service must ensure blood results management is supported by a documented process that clearly defines staff roles and responsibilities and includes an audit plan.	Regulation 28 – Quality of service provision	Update to policy	Kieran Reynolds	2 weeks
6.	Routine re-checking of professional registration was not consistently evidenced, including Nursing and Midwifery Council registration in line with revalidation requirements.	The service must ensure arrangements for routine re-checking of professional registration are in place and evidenced, including Nursing and Midwifery Council registration in line with revalidation requirements.	Regulation 19 – Persons employed for the purposes of the service	Update to staff file matrix	Kieran Reynolds	Complete

7.	The location of oxygen storage was not clearly signposted, which may delay access in an emergency.	The service should ensure the location of oxygen storage is clearly signposted to enable prompt access in the event of an emergency.	Regulation 26 – Safety of premises	Add accurate oxygen signage on consultation room door that stores the oxygen	Kieran Reynolds	2 weeks
8.	Visual prompts to support the recognition of sepsis red flag symptoms were not evident within the reception area, despite the service seeing patients for acute illness on the day. Non-clinical staff, including reception staff, may not be supported through training to recognise potential signs of sepsis and escalate concerns appropriately.	The service should ensure that information to support the recognition of sepsis red flag symptoms is clearly displayed within the reception area to support early identification and timely escalation of potentially deteriorating patients. The service should ensure that non-clinical staff, including reception staff, are appropriately trained to recognise potential signs of sepsis and escalate concerns in a timely manner.	Regulation 28 – Quality of service provision	Creation of a dedicated sepsis policy, including staff training and appropriate signage for staff across the practice	Kieran Reynolds	2 weeks

9.	Guidance to support the management of needlestick injuries was not clearly displayed within treatment areas.	The service should ensure that guidance to support the management of needlestick injuries is clearly displayed within treatment areas to support staff awareness and safe response following exposure incidents	Regulation 28 – Quality of service provision	Creation of wall mounted signage and guidance re needlestick injuries	Kieran Reynolds	2 weeks

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): Kieran Reynolds

Job role: Practice Manager **Date: 22/06/2026**