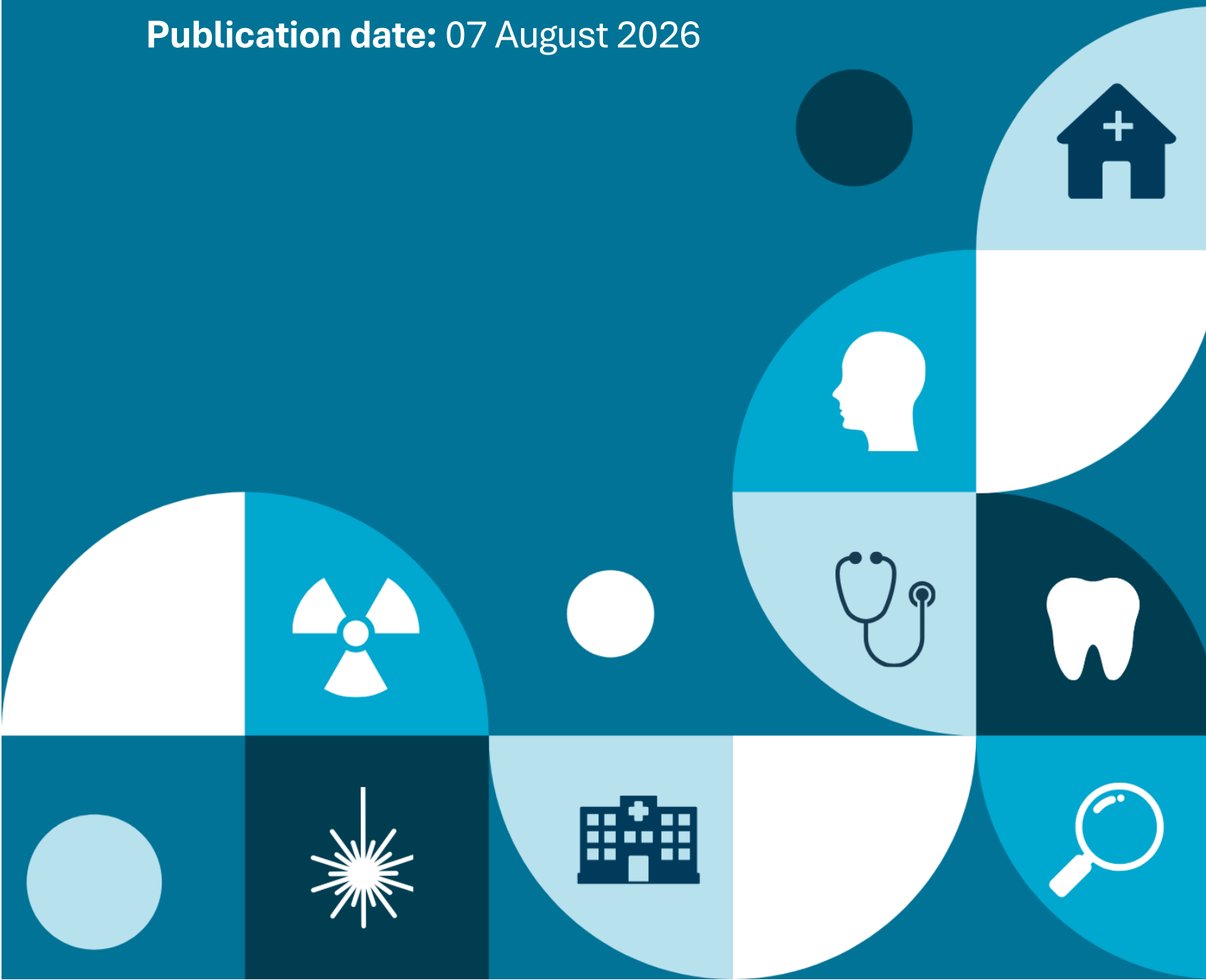
Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report (Announced)

Meddygfa Gelligaer, Aneurin Bevan University Health Board

Inspection date: 07 May 2026

Publication date: 07 August 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 978-1-80853-177-4

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 Vision

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

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 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 Meddygfa Gelligaer, Aneurin Bevan University Health Board on 07 May 2026.

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

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of seven questionnaires were completed by patients and one was 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:

We observed patients being treated with dignity and respect by all staff at the practice. A range of health promotion information was available and we found examples of patient care that indicated positive working between the practice, patients and other professionals to provide a service that was responsive to patient need. Non-clinical staff had undertaken care navigation training and confirmed they could seek advice from clinicians if unsure regarding signposting or offering an appointment. However, one patient commented that they can experience difficulties in staff understanding the nature of their concerns.

The practice provided both urgent and routine appointments. Patients were able to contact the practice for appointments by phone, in person or by email. A patient information leaflet was available and we were told that reasonable adjustments were made to support communication with patients.

Patient feedback was limited. However, all respondents to the HIW patient questionnaire were satisfied with the accessibility of the building and seating in the waiting area, were aware of how to contact out of hours services and were aware of how to raise a concern or complaint about the practice. One patient also provided some suggestions for practice improvements.

This is what we recommend the service can improve:

- Ensure health promotion materials are safely displayed, kept up to date, and include information on NHS 111 press 2 mental health support.
- Confirm appointment access systems align with practice policies and patient materials.
- Increase visibility of communication support options, including the practice hearing loop, interpreter services, and the Welsh language active offer.

This is what the service did well:

- Aimed to promote healthy lifestyles through a Making Every Contact Count approach to patient interactions.
- Displayed posters promoting the offer of a chaperone for examinations.

Delivery of Safe and Effective Care

Overall summary:

We found the practice demonstrated a commitment to delivering safe and effective care, with generally clean premises, appropriate clinical processes, and supportive multidisciplinary working. Auditable processes were in place for the safe prescribing of medication and staff were well informed regarding safeguarding procedures at the practice. However, a number of areas required strengthening to ensure consistent and robust governance. These included improving risk management, embedding fire safety processes, and enhancing the consistency and some aspects of patient records. Workload pressures and reliance on limited clinical capacity were noted as risks to sustainability. Addressing these areas would support safer, more effective and more consistent delivery of care.

This is what we recommend the service can improve:

- Improve infection prevention and control arrangements, including updating policies, cleaning schedules, and correct use and storage of cleaning equipment.
- Identify resource to address a backlog in the summarising of notes and review coding within the EMIS electronic patient record system.
- Develop and implement a Did Not Attend policy to support patient engagement and service efficiency.

This is what the service did well:

- Maintained appropriate processes for emergency care and monitoring of emergency equipment and medicines.
- Provided generally clear and comprehensive clinical narratives within patient records.
- Were beginning to implement formalised opportunities for learning from significant event analysis and multidisciplinary meetings.

Quality of Management and Leadership

Overall summary:

Staff reported experiencing positive working relationships at the practice and that practice and health board managers were supportive and visible. At the time of inspection the practice was hosted by the health board and we were told that the health board aim was to invest in the practice so that it would be ready for any new partnership agreed through a tender process in the coming months. Despite many changes to the practice over recent years staff confirmed they had been consistently supported to work within their scope of practice and develop into broader aspects of their roles through relevant training and peer support. Leadership for specific functions had been delegated appropriately throughout the practice team.

Staff training and appraisals had recently begun to be refreshed and processes for ensuring regular updates were completed on an on-going basis were being embedded. We were told that skill mix was regularly reviewed at the practice and locum and bank staff employed to support the provision of services in line with the needs of the local population.

Practice policies were in place. However, many of these required updates to content and version control to ensure staff were accessing the most up to date information.

This is what we recommend the service can improve:

- Review and update all practice policies to ensure they are current, accurate, and supported by effective version control. Strengthen processes for policy review through use of a structured system or schedule.
- Continue embedding consistent training, appraisal, and workforce governance processes.

This is what the service did well:

- Promoted patient feedback and complaint mechanisms, maintained comprehensive records of complaints and complaints handling and shared learning with patients and staff.
- Demonstrated effective communication systems within the team, including email and in person updates.
- Fostered a positive staff culture, with staff reporting feeling supported and fairly treated.

3. What we found

Quality of Patient Experience

Patient feedback

As the HIW patient questionnaire received a low number of responses, findings should be interpreted with care and may not be considered representative of the wider practice patient population. However, it was noted that there were mixed views about the overall quality of service at the practice. All respondents were satisfied with the accessibility of the building and seating in the waiting area, were aware of how to contact out of hours services and were aware of how to raise a concern or complaint about the practice.

Patient comments included:

> "*Digital check-in screens would benefit the practice to help manage queues and appointment times.*
>
> *Doctors etc. should be able to book appointments when follow-ups are required. E.g. a GP I saw today told me I needed a follow-up appt. in 4 weeks, but I am unable to book in advance. I have to call a week beforehand and hope for the best.*
>
> *An external repeat prescription box would be useful - one which can be accessed when the practice is closed. Restrictions around calling for repeat prescriptions and test result are extremely limiting, with lines open only a few hours a day, and not every day.*
>
> *I feel it would be helpful to view the names of the GPs at the practice, online and in person.*"

Person-Centred

Health promotion

We saw a range of health promotion materials and information regarding support services available to patients. These included information regarding specific symptoms and conditions, the role of emergency and primary care services, smoking cessation and an alcohol unit tracking app and signposting to carers support services. Information on the practice premises was available in posters or leaflets to take away. However, we found that as leaflets were not arranged in racking these were easily knocked to the floor during the day, presenting a slip hazard. Some information displayed was out-of-date and QR codes displayed on a large health promotion board did not link with the intended information. Information regarding the NHS 111 press 2 service for mental health support was also not available.

The practice should ensure that:

- **A suitable system for displaying information leaflets or checking leaflets remain safely stacked is implemented**
- **Information displayed is kept up to date**
- **Information regarding the NHS 111 press 2 service for mental health support is available to patients.**

A recent practice self-assessment indicated that the practice aimed to promote healthy lifestyles through a Making Every Contact Count approach to patient interactions. The practice worked within a cluster and closely with the health board. Physiotherapy, psychological healthcare practitioner support, well-being connectors and health board vaccination clinics were offered within the practice premises. Referral or signposting enabled patients to access a range of other community and secondary care based services according to their needs. We were told that there was strong multi-agency frailty provision which focused on supporting patients to remain within their own home and avoid admissions to hospital.

Dignified and respectful care

We observed patients being treated with dignity and respect by all staff and that measures were in place to preserve patient confidentiality at reception and within consultation rooms.

Posters promoting the offer of a chaperone for examinations were displayed. However, we discussed the practice relocating these to be more obvious to patients. We were told that the chaperone role would be undertaken by health care professionals as far as possible. A chaperone policy advised non-clinical staff regarding the expectations of the role. However, non-clinical staff had not undertaken formal chaperone training.

The practice should ensure all staff who act as chaperones have undertaken appropriate training, in line with General Medical Council guidelines.

Timely

Timely care

We were told that administrative and clinical staff worked together to offer patients the care they required. Non-clinical staff had undertaken care navigation training and confirmed they could seek advice from clinicians if unsure regarding signposting or offering an appointment. However, one patient commented that they can experience difficulties in staff understanding the nature of their concerns. The appointments management policy needed reviewing to ensure that detailed written information was available to support non-clinical staff in their care navigation role and provide suitable

pathway options that would not delay patient care, particularly with respect to conditions requiring urgent medical attention.

The practice should review written information underpinning care navigation to ensure this provides clear direction for non-clinical staff and provides suitable pathway options that will not delay patient care.

Patients were able to contact the practice for appointments by phone, in person or by email. Patients contacting by phone were informed that calls were recorded. An access to care poster also informed patients they could book appointments and manage prescriptions through the NHS Wales app. However, staff were not aware the practice was offering this mechanism of appointment access.

The practice should confirm their mechanisms for appointment access and ensure these match access policies and any patient materials.

Staff informed us that most patient appointments were provided in person at the practice. Patients could request a telephone appointment if they preferred and this would be provided if the care navigator or clinician agreed telephone would be a suitable consultation format for the patient's need.

The practice provided both urgent and routine appointments. We found examples of patient care that indicated positive working between the practice, patients and other professionals to provide a service that was responsive to patient need. In the event that the practice could not provide a same day appointment for an identified urgent need patients would be signposted to an urgent primary care centre or the NHS 111 service, including 111 press 2 for mental health support.

There was concern expressed by the practice that urgent secondary care mental health referrals discussed by GPs with the relevant team over the phone would not always be accepted. Patients waiting for secondary mental health assessments would be referred to the psychological healthcare practitioner or other community health services to support risk management. GPs would follow up with patients discharged from secondary care services if required.

Equitable

Communicating and language

We were told that reasonable adjustments were made to support communication with patients. A patient information leaflet was available and written information provided during consultations could also be printed out or sent to patients by email if required. GPs told us they would use also models and diagrams to help explain medical conditions and treatment options to patients.

A hearing loop was available and a language line and British Sign Language interpreters could be accessed for patient consultations. However, there was no information displayed to raise patient awareness of these options. We also saw very limited evidence of the Welsh language active offer.

The practice should ensure that patients are fully informed regarding reasonable adjustments for communication that are available at the practice and the Welsh language active offer.

Rights and equality

We saw that an equality, diversity and inclusion policy was in place to assist staff consideration of protected characteristics when working with patients and within the team. The consent policy also provided specific guidance in line with the Mental Capacity Act (2005) regarding supporting patients who were unable to make decisions regarding their healthcare.

The practice environment was accessible to patients of a range of needs. Patients could use onsite parking and wheelchairs were available for patient use if required while on the practice premises. An automatic door enabled access to the property from outside and internal flooring and thresholds were level and secure throughout. An accessible toilet and separate breastfeeding and nappy changing facilities were also provided for patients requiring these. Bariatric couches were also available in some consultation rooms.

Delivery of Safe and Effective Care

Safe

Risk management

We found the practice premises to be generally clean and in a good state of repair. However, there were some sandbags by the front door which could present a trip hazard to patients accessing the practice.

The practice should ensure that all areas of the practice are kept tidy and free of clutter which could present a slip, trip or other hazard.

We reviewed signage in place to alert patients, staff or other individuals accessing the practice of any dangers or control measures. We were told that as a precaution following a recent legionella test practice tap water should not be drunk. However, we did not see any signs highlighting this. Some fire action plan cards were not completed indicating the meeting point should evacuation from the building be required. Signs within clinical rooms indicated the location of the defibrillator. However, the location on signage was inconsistent and did not provide clarity to support temporary staff or other visitors to the building to know easily where the defibrillator was kept. Signage indicating the location of the defibrillator and oxygen cylinders also required placing on the door of the room where these items were kept.

The practice should review all signage intended to raise awareness of any dangers or control measures within the practice to ensure these are appropriately positioned and provide clear and consistent information.

Monthly fire risk assessments had recently been started. Fire extinguishers had been identified as overdue their maintenance service. Emails were available to evidence that the practice had been in contact with a relevant contractor to ensure these services were completed as soon as possible.

The practice, in conjunction with the health board, should continue to ensure that fire risk assessments and fire safety measures continue to be embedded in a timely manner, according to their level of risk.

A Business Continuity Plan (BCP) was in place. However, this required reviewing to ensure it was relevant to the current practice situation whereby there were no practice partners in place.

The practice should review their Business Continuity Plan to ensure this is relevant to the current practice situation.

The practice manager had responsibility for receiving patient safety alerts and distributing these to relevant members of the practice team. At the time of inspection support of the practice manager from another practice would ensure that the practice team would be made aware of any urgent patient safety alerts should the practice

manager be absent from the workplace. However, as this informal support was not intended to be a long term arrangement an alternative deputy for the practice receiving and distributing patient safety information should be identified.

The practice should ensure that long term cover arrangements are identified to ensure information continues to be received and distributed as required in the practice manager absence.

A template was in place to support Significant Event Analysis (SEAs) discussions between relevant members of the practice team. Learning from SEAs was also then shared by email for future reference. At the time of inspection standardised agendas for SEA discussions, safeguarding, palliative care and information governance meetings had been recently created and a schedule of regular meetings was being established.

Digital flags within patient records were used to highlight any risks identified in relation to the individual patient. These included safeguarding concerns or risks for practitioners when visiting the patient at home. We were told that where there were safety alerts for staff, home visits would not be completed by individual team members on their own. However, there was no formal risk assessment to support with identifying risks or planning visits and practitioners were not aware of the practice home visit policy.

The practice should review their home visit policy and embed its use to ensure that practitioners are supported with safe planning and completion of patient care within the community.

Practitioners told us of instances when patient condition required referring for secondary care assessment or had deteriorated while being seen by the practice team. Suitable processes were in place to ensure patients would be kept under appropriate clinical assessment while awaiting emergency transport. The practice told us they had escalated a significant delay for emergency transport to the Welsh Ambulance Services NHS Trust. Datix should also be used when the practice determines that an incident or opportunity for learning has occurred.

Infection prevention and control (IPC) and decontamination

We saw that suitable hand hygiene facilities were available throughout the practice for staff and patients to use. A separate room away from the main waiting area was also available for patients attending the practice with suspected transmissible illnesses to prevent the spread of infections. All flooring, fixtures and surfaces within clinical areas were wipeable. Most respondents to the HIW patient questionnaire indicated they believed the practice premises were clean.

A suitable decontamination policy was in place. An Infection Prevention and Control (IPC) lead had just been appointed and trained to cascade information regarding safe IPC practices throughout the team. However, a different IPC lead was named within the

IPC policy. The IPC policy also lacked sufficient detail to support staff to implement IPC requirements. Guidance regarding the cleaning or replacement of curtains within clinical areas was missing.

The practice should review their Infection Prevention and Control (IPC) policy to ensure that this provides clear guidance to support staff to implement IPC requirements and accurately identifies the IPC lead.

We reviewed the arrangements for the safe disposal of sharps and policies relating to the management of sharps incidents and blood borne viruses. Sharps boxes were found to be suitably dated and positioned within clinical rooms. A sharps spillage policy was in place and needlestick action cards were displayed within clinical rooms. A Hepatitis B register of clinical staff was available for us to view along with evidence of immunity for some practitioners. However, the blood borne virus policy was due to be reviewed.

The practice should review their blood borne virus policy to ensure this is in date and continues to provide relevant guidance.

Clinical waste awaiting collection was kept secure and segregated and processes were in place to evidence what was being disposed of from the practice. A recent waste management audit had been completed by an external contractor. By the time of our inspection many of the identified actions had been addressed.

The practice employed a private cleaner to ensure the building was ready for patient use each day. Cleaning schedules were available in each room. However, we saw that these had only been completed in toilets and not other areas. Completion of cleaning records was not seen within the practice cleaner job description.

The practice should:

- **review the practice cleaner job description to ensure this covers all expected aspects of the role**
- **ensure that cleaning schedules are completed to confirm what cleaning has been done in each area.**

Cleaning products were kept in a suitable locked cupboard and Control of Substances Hazardous to Health data sheets were available for review. However, we found that yellow mop heads were not available as required for the cleaning of clinical areas. Blue and red mop heads for the cleaning of general and hygiene facilities respectively also looked discoloured and in need of replacement. Mops were kept head up. However, mop buckets were stacked which could encourage bacterial growth and biofilm formation within the buckets and any residual water in them.

The practice should ensure that:

- **Specific mops are available for use in different areas of the practice in line with relevant IPC guidance to prevent cross-contamination**

- **Mop heads are suitably maintained and replaced when identified they are no longer fit for purpose**
- **Mop buckets are stored separately not stacked and are off the floor and/or inverted when not in use.**

Filters had been fitted to taps to address legionella contamination found in the water and documented daily flushes were also being completed. Facilities maintenance was currently being supported by the health board to support health and safety and suitability of the premises for the commencement of any new partnership arrangement.

Medicines management

Auditable processes were in place for the safe prescribing of medication. Patients could request repeat prescriptions via electronic platforms or manual forms handed into the practice or a community pharmacy. However, signs displayed at the practice to inform patients of how repeat prescriptions were processed and made available provided inconsistent information regarding these processes and timescales.

The practice should ensure that all information provided to patients regarding the processes and timescales for the request and receipt of repeat prescriptions are consistent.

A suitably trained prescription clerk was employed to ensure patients received a timely response to repeat prescription requests. Close working with GPs ensured that any indications of medication over or under use were escalated for medical review. However, due to limited prescriber capacity medication reviews were not being carried out on a regular basis. The practice had started considering different options for developing routine medication reviews and these were discussed during our inspection.

We saw that prescription forms were securely stored and an audit log maintained. Prescriptions were signed for on collection by a pharmacy service and signed out by practice staff when patients collected prescriptions themselves. This is considered noteworthy practice. However, all prescriptions were computer generated and we queried whether a small amount of stationery that could be completed by hand should be available at the practice to allow for continuity of service in the case that there was disruption to the IT system or the premises electrical supply.

We were told that only medications prescribed for individuals or required for the management of medical emergencies were stored on the practice premises. A schedule was in place to indicate what emergency drugs and equipment should be available in line with Resuscitation Council UK guidelines. Records were kept documenting the completion of weekly checks of emergency items and their expiry dates. However, we found one blood ketone testing strip that had expired and spare masks and tubing with no expiry date marked on them. This was escalated to the

practice for items to be taken out of clinical areas and replaced with other suitable stock on the day of the inspection. Further information on the issues we identified and the actions taken by the practice are provided in Appendix A.

Oxygen cylinders were available and suitable for use. We were informed that for relevant staff completed training regarding the use of oxygen cylinders was embedded into the health board online Basic Life Support training. Clinical staff told us that they had been exploring a storage solution to ensure oxygen cylinders were suitably secured but that procurement through health board suppliers was proving challenging.

The practice should continue to explore for options for securing oxygen cylinders and procure a suitable solution when this becomes available.

No ambient room temperature monitoring was undertaken in the area where emergency drugs and equipment were kept to ensure the environment remained suitable for the storage of oxygen, non-refrigerated temperature sensitive medications or other items.

The practice should implement ambient room temperature monitoring in any areas where medical gases, non-refrigerated medications or other temperate sensitive items are kept.

We were told that no controlled drugs were kept on the premises. Practitioners indicated that they were aware of the additional safety measures required should this situation change.

We saw that vaccinations were refrigerated in line with guidelines. Twice daily, documented, fridge temperature checks and data loggers were used to confirm fridge temperatures remained within range or would be quickly noted if temperatures became too high or too low. However, no cold chain flow chart was available within the cold chain policy or seen within clinical areas to support staff in following the appropriate action should a cold chain breach occur.

The practice should review their cold chain policy to ensure this contains a quick read flow chart and ensure this is displayed alongside vaccination fridges to support staff to follow the appropriate action should a cold chain breach occur.

Should the practice become aware of any patient that had experienced an adverse reaction to a prescribed medication this would be reported via the yellow card scheme. A poster was also displayed in the waiting area to raise patient awareness of this scheme for self-reporting.

Safeguarding of children and adults

We considered the safeguarding procedures in place at the practice. A clear safeguarding policy was available. All staff were aware to escalate any safeguarding concerns to the newly appointed practice safeguarding lead and were also able to

contact other relevant services for advice if required. Processes were in place for the relevant sharing of safeguarding information between the practice and wider healthcare services. Posters displayed throughout the practice reminded staff and informed patients of appropriate actions to take should they identify a safeguarding concern that required reporting.

Suitable processes for the documentation of safeguarding concerns within patient records and the use of digital flags for individuals and relevant contacts were in place. Look After Children were coded. However, other safeguarding concerns had not been coded since the recent migration of the electronic patient record to the EMIS system.

The practice should ensure that all safeguarding concerns are coded within patient records in line with the Royal College of General Practitioners safeguarding toolkit.

Management of medical devices and equipment

We were told that single use equipment was used whenever possible. Medical devices at the practice were clean and we saw documents indicating that these had been calibrated. However, conflicting dates were provided within this documentation regarding when calibration would next be required so this needed checking with the contractor.

The practice should confirm that the last completed calibration of medical devices remains valid and when calibration is next due.

Practitioners were clear on the processes for escalating any faults with medical devices within the practice. One fridge had recently been taken out of use due to the gases it had been emitting.

Effective

Effective care

We found that a person-centred and holistic approach to clinical care underpinned effective practice. Clinicians told us they aimed to be aware of best practice and national clinical guidance through professional reading, receiving health board updates and attending Neighbourhood Care Networks with other practices. We were told that, in general, a 'listen and learn' approach was adopted as actively implementing innovative practices was challenging within the current environment, given service pressures, patient demand and the presence of only one permanently employed GP.

Workflow processes and protected time were in place for the practice GP, supported by administrative staff, to receive and action incoming information and test results. However, while these seemed effective they represented a heavy workload for the individual GP and arrangements for cover should the permanent GP be absent from the

practice were not robust. We also noted that information received regarding children's care or patients' emergency department or hospital attendances was not processed in line with practice policy.

The practice should review their arrangements for actioning and receiving information and test results to the practice and ensure that:

- **Suitable support and cover are in place for the practice GP and workload**
- **Follow up procedures with children and other patients who have attended emergency departments or hospital are reviewed and consistently implemented.**

Suitable processes and timescales were in place for generating urgent and routine referrals required for patient care. A locum pack and administrative support ensured locums working at the practice were able to instigate referrals appropriately.

Palliative care meetings with relevant supportive teams were scheduled to take place on a regular basis. The Out of Hours GP service would be notified regarding any updates to patients Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) status and would provide information to the practice should a patient pass away outside of practice times. Suitable pathways for confirming the cause of death via the Medical Examiners Service or coroner were also in place. Any unexpected patient deaths were reviewed by the practice GP.

Patient records

Electronic patient records had recently been migrated into a new programme which the practice was continuing to learn about through its use. Some historical paper records were kept on the premises for summarising. These were securely stored to prevent unauthorised access. We examined a sample of eight electronic patient records within the secure IT system.

Electronic records were kept up to date with new information. Narratives were generally clear and provided good evidence of consultations and patient's presenting problems. Examination findings and treatment plans were also comprehensive.

Some evidence of verbal consent for examination and use of a chaperone was seen. However, there were also examples of intimate examinations being undertaken without documentation demonstrating verbal consent for examination or regarding the offer or use of a chaperone.

The practice should ensure that consent and the offer of a chaperone is consistently documented within patient notes as applicable, in line with General Medical Council guidelines.

Medications prescribed were rarely linked to an identified medical problem. It was discussed that the electronic records did not make this easy. However, reasoning for discontinuing medications should be provided.

The practice should ensure that all patient records provide comprehensive reasoning regarding the discontinuation of medications.

Presenting problems and chronic diseases were not always clearly coded. This meant that minor problems could mask more significant or chronic issues within the patient record, making it more difficult for clinicians to understand the patient's overall health picture. A large backlog of summarisation also meant that not all patient records would contain full information regarding chronic diseases which could affect patient care when self-presenting, and result in some patients not being recalled for chronic disease management reviews.

The practice should ensure that:

- **resource for the summarising of notes is identified to reduce the backlog**
- **problem coding is reviewed, with additional support being gained from another practice who has already embedded the new electronic patient record programme if available.**

We saw some evidence of patient language choice being recorded. However, this was lacking in the majority of cases.

The practice should ensure that language preference is routinely recorded to ensure effective patient consultations conducted in the language of their choice.

Efficient

Efficient

At the time of inspection a new appointment booking system had recently been introduced from book on the day only to prior booking for non-urgent appointments. We noted good availability of appointments. However, it was too soon for information to be available regarding the longer term impact of this change.

No Did Not Attend policy was in place. This would be beneficial to reduce lost appointments and support practice efficiency. Linking this to Was Not Brought and safeguarding policies would also ensure suitable contact was maintained with vulnerable patients.

The practice should develop and implement a Did Not Attend policy.

Quality of Management and Leadership

Staff Feedback

As the HIW staff questionnaire received only one response findings may not be considered representative of the wider practice workforce.

Staff we spoke with during the inspection were positive about working at the practice and the support available from practice management and the health board. Staff reported feeling fairly treated but that time could often feel pressured due to staff shortages.

Leadership

Governance and leadership

At the time of inspection the practice was hosted by the health board. Health board representatives were visible throughout the inspection process and we were told that the health board aim was to invest in the practice so that it would be ready for any new partnership agreed through a tender process in the coming months.

We found that practice managers and health board representatives provided visible leadership and staff confirmed they felt able to approach managers with any concerns. Staff we spoke with were clear about their roles. We were told that despite many changes to the practice over recent years staff had been consistently supported to work within their scope of practice and develop into broader aspects of their roles through relevant training and peer support. Leadership for specific functions had been delegated appropriately throughout the practice team.

We saw that practice policies were in place. However, many of these required updates to content and version control to ensure staff were accessing the most up to date information.

The practice should ensure that all policies referenced in this report are reviewed for content and that all policies are reviewed for version control.

We discussed the practice using a matrix or other tool to help with regular scheduling and completion of policy reviews.

Workforce

Skilled and enabled workforce

We saw that staff training and appraisals had recently begun to be refreshed. Processes for ensuring regular updates were completed on an on-going basis were being embedded. A buddy practice confirmed they would share their template and

process for staff annual declaration of good character for this to also be adopted.

A recruitment policy outlining pre-employment check requirements and an induction programme for new staff were both in place. We were told that skill mix was regularly reviewed at the practice and locum and bank staff employed to support the provision of services in line with the needs of the local population.

A variety of well-being support was promoted for staff to access should they require. We were also told that following incidents or complaints, one-to-one and team feedback and discussions would enable relevant de-brief and support.

General updates for staff were shared via email and through in person discussions and staff and managers both confirmed these channels of communication worked well.

Culture

People engagement, feedback and learning

We examined practice feedback and complaint mechanisms and records of recent patient complaint handling. A high number of complaints had been identified as a risk for the practice resulting in a policy being developed setting out how systems could reduce the number of complaints received.

We saw that a suggestion box was available on site for patients. A 'You said we did' poster was displayed within the patient waiting area and the results from the most recent patient survey had also been printed for patients to view at reception.

The patient information leaflet informed patients of how they could raise a concern or complaint. However, we found that this required updating in line with Listening to People which had come into effect from April 2026.

The practice should ensure that they develop their procedures for patients to raise concerns or complaints in line with Listening to People (2026).

Records of communication with patients regarding the investigations of concerns and complaints they had raised and a spreadsheet provided evidence of complaints handling at the practice. The spreadsheet prompted the appointed complaint manager to consider whether Duty of Candour should be triggered in relation to every concern and complaint raised and enabled themes for practice development to be easily extracted for a quarterly report which was shared within the practice team. We also noted that timeframes for the practice provision of a response to patients had improved since the beginning of 2026.

The whistleblowing policy in place at the practice required reviewing to ensure it provided accurate information regarding who staff should contact should they have a concern they formally wished to report in relation to the workplace.

The practice should review their whistleblowing policy to ensure this clearly signposts staff to relevant contacts should they have a concern they formally wished to report in relation to the workplace.

Information

Information governance and digital technology

Suitable data protection processes and an appointed Data Protection Officer were in place. This enabled oversight within the practice in relation to data protection and information governance arrangements and ensured any queries were appropriately handled within the required timescales. Ad hoc information governance audits had commenced to identify areas for further practice development. However, the practice information governance policy required updating to ensure it provided accurate information regarding key contacts for data protection and information governance.

The practice should review their information governance policy to ensure this provides up to date information regarding relevant contacts for information governance and data protection within the practice.

Learning, improvement and research

Quality improvement activities

We saw evidence that a systematic programme of clinical and internal audit to monitor quality was in place, for example, quality improvement projects regarding Chronic Kidney Disease, Cardiovascular Disease and Continuity of Care.

4. Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions, they are taking to address these areas.

The improvement plans should:

- Clearly state how the findings identified will be addressed
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

Appendix A – Summary of concerns resolved during the inspection

The table below summarises the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns Identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
One ketone testing stick that had expired and spare masks and tubing with no expiry date marked on them found within the emergency equipment.	Potential for false readings from use of the ketone testing stick. Use of masks and tubing with unknown expiry date could present a patient safety risk of contamination from unsuitable equipment.	The identified equipment was discussed and shown to the practice's nursing representative.	The identified items were removed from the emergency equipment stock and alternative, in date, items made available for use. We discussed returning any items received without expiry dates to suppliers and requesting replacements to ensure items available for use at the practice continued to be suitable.

Appendix B – Immediate improvement plan

Service: **Meddygfa Gelligaer**

Date of inspection: **07 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	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: Meddygfa Gelligaer

Date of inspection: 07 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.	Some health promotion information was out of date and leaflets were not maintained in an orderly manner. There was also no information displayed regarding NHS 111 press 2 service for mental health support.	The practice should ensure that: • A suitable system for displaying information leaflets or checking leaflets remain safely stacked is implemented • Information displayed is kept up to date • Information regarding the NHS 111 press 2 service for mental health support is available to patients.	Health and Care Quality Standard (2023) – Person centred / Safe	- Trays for leaflets installed in reception area - Part of reception role to check leaflets in date – review monthly - NHS 111 press 2 leaflets displayed prominently	Practice Team	Implemented w/c 18.05.26
2.	No formal training completed by non-clinical staff who may be required to undertake the chaperone role.	All staff who act as chaperones to have undertaken appropriate training, in line with General Medical Council guidelines.	Health and Care Quality Standard (2023) – Person centred / Safe	- Process updated – only clinical staff to act as chaperones, always a second clinician on site	Nursing Team	Implemented w/c 18.05.26

3.	The appointments management policy needed reviewing to ensure that detailed written information to support non-clinical staff in their care navigation role and provide suitable pathway options that would not delay urgent patient care.	Written information underpinning care navigation to be reviewed to ensure this provides clear direction for non-clinical staff and to provide suitable pathway options that will not delay patient care.	Health and Care Quality Standard (2023) – Safe / Timely	- Policy under review and updated policy due to be signed off by 31 July 2026	Practice Manager	31.07.26
4.	An access to care poster informed patients they could book appointments and manage prescriptions through the NHS. However, staff were not aware the practice was offering this mechanism of appointment access.	The practice should confirm their mechanisms for appointment access and ensure these match access policies and patient materials.	Health and Care Quality Standard (2023) – Person centred / Effective	- Part of reception role to check leaflets in date and relevant – review monthly - Review of correspondence - Updated communications to staff	Practice Team	w/c 18.05.26

5.	No information regarding reasonable adjustments to support patient communication available.	Reasonable adjustments for communication to be promoted for patients to access these if required.	Health and Care Quality Standard (2023) – Person centred	- Language line and type talk used as required - Reminder issued to all staff - Information also held within reception in health promotion leaflet tray	Practice Manger	w/c 13.07.26
6.	Limited evidence of the Welsh language active offer.	The Welsh language active offer to be fully embedded within the practice.	Health and Care Quality Standard (2023) – Person centred	- Review of Welsh language training opportunities for staff - Information on Welsh language support offer is available in the health promotion leaflet tray	Practice Team	30.09.26
7.	Some slip and trip hazards noted within the practice premises.	All areas of the practice to be kept tidy and free of clutter which could present a slip, trip or other hazard.	Health and Care Quality Standard (2023) – Safe	- Review of sand bags storage completed and hazards removed	Practice Team	w/c 11.05.26

8.	Signage regarding dangers or control measures within the practice not positioned in relevant locations and some not completed with enough detail to effectively support safety.	The practice should review all signage intended to raise awareness of any dangers or control measures within the practice to ensure these are appropriately positioned and provide clear and consistent information.	Health and Care Quality Standard (2023) – Safe	- Signage reviewed on the day and updated to ensure clarity for core and locum staff	Nursing Team	07.05.26
9.	Fire extinguishers overdue their service by several years. Some fire action cards not completing to inform patients of evacuation procedures should a fire occur. Monthly risk assessments just commenced.	The practice, in conjunction with the health board, should continue to ensure that fire risk assessments and fire safety measures are embedded in a timely manner, according to their level of risk.	Health and Care Quality Standard (2023) – Safe	- Booked and servicing completed	Head of Service	Fire extinguisher and sensor servicing carried out on 13th May 2026
10.	The Business Continuity Plan (BCP) did not reflect the current practice situation whereby there were no practice partners.	BCP to be reviewed to ensure this is relevant to the current practice situation.	Health and Care Quality Standard (2023) –Effective	- Business Continuity Plan under review for update by 31 July 2026	Practice Team	31.08.26

11.	No long term cover arrangement identified for receiving and distributing information within the practice in the absence of the practice manager.	Long term cover arrangements to be identified.	Health and Care Quality Standard (2023) – Safe	- Process in place for Team Leader to distribute in absence of practice manager	Practice Manager and Team Leader	Already in place
12.	The practice home visit policy did not guide practitioner risk assessments regarding visits.	Home visit policy to be reviewed and embedded.	Health and Care Quality Standard (2023) – Safe / Effective	- Review of policy ongoing to be completed by 30th September 2026	Practice Manager and Salaried GP	30.09.26
13.	The practice Infection Prevention and Control (IPC) policy lacked sufficient detail to support staff to implement IPC requirements and did not accurately identify the IPC lead.	IPC policy to be reviewed.	Health and Care Quality Standard (2023) – Safe / Effective	- Policy lead identified as substantive nurse - Nursing team all undertaken AITT training - Policy to be updated by 15th September 2026	Nursing Team	15.09.26

14.	The practice blood borne virus policy was due to be reviewed.	Blood borne virus policy to be reviewed to ensure this is in date and continues to provide relevant guidance.	Health and Care Quality Standard (2023) – Safe / Effective	- Policy review and development SOP in progress, incorporating policy matrix to be complete and in place by 15th September 2026.	Nursing Team	15.09.26
15.	The practice cleaner job description did not include record keeping and no cleaning schedules had been completed for areas other than the toilets.	• Practice cleaner job description to be reviewed to ensure it covers all expected aspects of the role. • Cleaning schedules to be completed to confirm what cleaning has been done in each area.	Health and Care Quality Standard (2023) – Safe / Effective	- Job description reviewed - Cleaning schedules reviewed and updated and archived to maintain records	Practice Manager	31.07.26

16.	Mop heads required for effective practice cleaning either unavailable or not fit for purpose. Mop buckets not suitably stored.	• Mops to be available, maintained and replaced in line with relevant IPC guidance to prevent cross-contamination • Mop buckets to be stored separately not stacked and to be off the floor and/or inverted when not in use.	Health and Care Quality Standard (2023) – Safe	- Already ordered and in use - Mop buckets now inverted when not in use	Head of Service	09.05.26
17.	Signs displayed at the practice to inform patients of how repeat prescriptions were processed and made available provided inconsistent information regarding these processes and timescales.	All information provided to patients regarding the processes and timescales for the request and receipt of repeat prescriptions to be consistent.	Health and Care Quality Standard (2023) – Safe / Effective	- Reviewed and amended 9th May 2026	Prescription Clerks	09.05.26

18.	Oxygen cylinders not secured.	Suitable storage solution to continue to be explored and procured when available.	Health and Care Quality Standard (2023) – Safe	- Storage on order, delay in availability and order has been chased.	Head of Service	30.09.26
19.	No ambient room temperature monitoring undertaken in the area where emergency drugs and equipment were kept to ensure the environment remained suitable for the storage of oxygen, non-refrigerated temperature sensitive medications or other items.	Ambient room temperature monitoring to be implemented in any areas where medical gases, non-refrigerated medications or other temperate sensitive items are kept.	Health and Care Quality Standard (2023) – Safe	- Thermometer ordered for room 13th July 2026 for urgent delivery - Regular checks in place	Nursing Team	31.07.26

20.	No cold chain flow chart available within the cold chain policy or seen alongside vaccination fridges.	• The practice should review their cold chain policy to ensure this contains a flow chart • Ensure flow chart is displayed alongside vaccination fridges for easy access for staff in the event of a cold chain breach.	Health and Care Quality Standard (2023) – Safe / Effective	Displayed and visible within each room	Nursing Team	07.05.26
21.	Safeguarding concerns had not been coded within electronic patient records since recent migration to the EMIS system.	All safeguarding concerns to be coded within patient records in line with the Royal College of General Practitioners safeguarding toolkit.	Health and Care Quality Standard (2023) – Safe	Acknowledged and measures in place to action moving forward to comply with Snomed coding	Salaried GP	Ongoing

22.	Conflicting dates provided in calibration documentation regarding when calibration would next be required.	Confirm that the last completed calibration of medical devices remains valid and when calibration is next due required from contractor.	Health and Care Quality Standard (2023) – Safe	Calibration in place and within date	Practice Manager/Operations Manager	08.07.26

23.	Only one permanent GP employed by the practice who was central to receiving and actioning clinical information from other services and test results. This represented a heavy workload and cover arrangements were not robust. Follow up procedures with children who had attended other services and patients who had attended emergency departments or hospital were also not consistently implemented.	The practice should review their arrangements for actioning and receiving information and test results to the practice and ensure that: • Suitable support and cover are in place for the practice GP and workload • Follow up procedures with children and other patients who have attended emergency departments or hospital are reviewed and consistently implemented.	Health and Care Quality Standard (2023) – Safe	- Process already in place for on call GP for the day to action - This element wasn't raised with the team on the day to discuss process	Practice Manager / Operations Manager	07.07.26

24.	Some issues with patient records found: • Examples seen of intimate examinations being undertaken without documentation demonstrating verbal consent for examination or regarding the offer or use of a chaperone • Reasoning for discontinuing medications not provided • Large backlog of summarisation • Issues with coding • Language choice not routinely recorded.	All patient records to be maintained in line with General Medical Council guidelines.	Health and Care Quality Standard (2023) – Safe / Effective / Person-centred	- Reviewed and communication sent to GPs - Challenge with high volume of locums and minimal salaried GPs. Locum pack has been reviewed and updated to ensure process is communicated with locums.	Operations Manager/Salaried GPs	Ongoing

25.	No Did Not Attend policy was in place to reduce lost appointments ensure suitable contact is maintained with vulnerable patients.	The practice should develop and implement a Did Not Attend policy.	Health and Care Quality Standard (2023) – Safe / Efficient	- Did not attend policy in place at practice - Also practice link with partner agencies if patient within community unable to be contacted – example given by inspectors on the day of patient not able to be reached by community pharmacy driver, practice team attended address and support patient	Practice Team	In place

26.	Many policies required content and version control to be updated to ensure staff were accessing the most up to date information.	The practice should ensure that all policies referenced in this report are reviewed for content and that all policies are reviewed for version control.	Health and Care Quality Standard (2023) – Safe / Effective	- Policy review and development SOP in progress, incorporating policy matrix to be complete and in place by 15th September 2026.	Graduate Trainee supported by Head of Service	15.09.26
27.	Complaints policy and procedures required updating in line with Listening to People which had come into effect from April 2026.	The practice should ensure that they develop their procedures for patients to raise concerns or complaints in line with Listening to People (2026).	Health and Care Quality Standard (2023) – Person-centred	- Policy has been reviewed and updated. Discussed on the day with assessors around timescales. - Also now have 'Listening to People' leaflets for patients within health promotion tray in reception	Practice Manager / Operations Manager	9th May 2026

28.	Whistleblowing and information governance policies required reviewing to ensure they provided accurate information regarding key contacts in relation to these functions.	Whistleblowing and information governance policies to be reviewed.	Health and Care Quality Standard (2023) – Safe / Effective	- Policy review and development SOP in progress, incorporating policy matrix. To be reviewed and in place by 15th September 2026	Practice Manager / Operations Manager	15th September 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: Head of Service

Name (print):Rebecca Pearce

Job role:Head of Service **Date: 13.07.26**