Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Healthcare Inspection Report (Announced)

Meddygfa Glandwr (Anglesey)

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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 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 Glandwr (Anglesey) on 11 May 2026.

Our team for the inspection comprised of two HIW healthcare inspectors and a clinical peer reviewer.

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

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:
Patient feedback obtained by the clinic indicated high levels of patient satisfaction, with comments describing the service as professional, friendly, efficient and of quality.

Health promotion included patients supported through accessible information, lifestyle initiatives and proactive care. Services included health checks, GP and healthcare assistant consultations and access to specialist support such as physiotherapy and podiatry. Tailored advice and digital resources supported ongoing self-management.

Patient dignity and respect were prioritised through measures such as private consultation spaces, use of screens, background noise for confidentiality and clear chaperone procedures with trained staff.

Patients were well informed about their care, with robust consent processes and bilingual materials supporting accessibility. Communication needs were generally met, although improvements were required in identifying language preferences and Welsh-speaking staff. Care was individualised and evidence-based, with effective systems for assessment, planning and timely management of results. Equality and diversity were promoted, though the absence of an accessible toilet was a limitation.

This is what we recommend the service can improve:

- Introduce a formal system to record patient language preference and identify Welsh-speaking staff
- Advising patients in advance of the lack of an accessible toilet
- Provide additional website information about facilities and feedback processes.

This is what the service did well:

- Actively supporting healthier lifestyles through leaflets, digital displays and group “keep fit” sessions, alongside proactive health checks and access to additional services such as GP, physiotherapy and podiatry
- Protecting patient privacy, including closed consultation doors, use of screens, background music and clear chaperone processes with trained staff
- Feedback systems were in place, with high satisfaction and positive comments consistently reported.

Delivery of Safe and Effective Care

Overall summary:
The environment at the clinic was generally safe, clean, secure and well maintained, with no obvious hazards to patients. The ground floor consulting room was spacious and although there was a step at the entrance, a ramp was available to support access. However, staff areas were cramped and worn carpeting in the top floor office presented a trip risk requiring replacement.

Fire safety arrangements were partially in place, including a fire risk assessment, maintained equipment and a recent drill. Nevertheless, improvements identified in the fire risk assessment, such as enhanced detection systems, clearer signage, staff training and formal record-keeping, had not been fully implemented or evidenced.

Policies and procedures supported health and safety management and staff were aware of emergency responsibilities. However, no business continuity plan was in place. Infection prevention arrangements were generally good, with a clean environment, appropriate waste disposal and use of personal protective equipment (PPE), though regular audits and hand hygiene signage were lacking.

Medicines management systems were appropriate, with emergency equipment available and safe prescribing supported. Safeguarding arrangements were robust, with trained staff and clear reporting processes.

Care was delivered safely using evidence-based guidance, supported by good governance and communication systems. However, quality improvement activity was limited, with minimal clinical audit. Record keeping was generally strong, though inconsistencies were noted in documenting consent and chaperone use.

This is what we recommend the service can improve:

- Implementing improvements identified in the fire risk assessment and recording them on the action plan
- Putting in place a process of ongoing clinical audit to monitor performance and drive continuous improvement
- Eliminating the inconsistencies identified in recording patient consent and the offer of chaperones.

This is what the service did well:

- There was a safe and well-maintained environment. Safety checks such as gas, electrical and PAT testing were up to date, ensuring equipment safety

- Strong safeguarding and emergency arrangements, with robust safeguarding policies, trained staff and clear reporting processes were in place. Emergency preparedness was supported by appropriate equipment and staff awareness
- The care was delivered using evidence-based guidance, supported by good communication systems, secure information management and generally high-quality, well-structured patient records.

Quality of Management and Leadership

Overall summary:
The inspection found that governance arrangements were in place but required strengthening to ensure effective oversight of risk, quality and compliance. Key documents, including the statement of purpose and patient guide, supported transparency and were available on-site, though not yet published on the clinic's website. Policies and procedures were comprehensive, regularly reviewed and version controlled, but were more aligned to dental services than medical provision, requiring rebalancing. Staff were informed of updates and understood accountability structures.

Plans to enhance governance through cross-site clinical meetings had not yet been implemented. Complaints management processes were well established, with clear procedures, timescales and escalation routes. Although no complaints had been received, systems for logging and learning were in place and staff were aware of reporting requirements.

Recruitment processes required improvement. While core checks such as disclosure barring service (DBS) checks, identification and professional registration were completed, gaps included missing references, incomplete employment histories and absence of contracts and job descriptions. A more robust compliance framework was needed, alongside annual staff suitability declarations.

Workforce arrangements were generally positive, with sufficient staffing, structured induction, regular appraisals and monthly meetings. Staff were supported with training and development, although a training matrix would improve oversight. Whistleblowing processes were also in place to support staff in raising concerns.

This is what we recommend the service can improve:

- Strengthen governance oversight and accessibility of information, including publishing key documents (statement of purpose and patient guide) on the website and implementing planned cross-site governance meetings
- Review and rebalance policies and procedures, to ensure they equally reflect both medical and dental services
- Recruitment compliance and workforce assurance. Recruitment records were incomplete. Processes could be strengthened to meet regulatory requirements, including introducing annual staff suitability declarations.

This is what the service did well:

- Clear governance structures and accountability, with defined roles and reporting lines, with staff understanding responsibilities and who they reported to
- Policies and procedures were in place, version controlled, regularly reviewed and communicated to staff, who were required to confirm they had read updates
- Clear complaints procedures, appropriate timescales and a culture of openness and learning.

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

HIW issued online questionnaires to obtain patient views on the services carried out at the Meddygfa Glandwr (Anglesey) to complement the HIW inspection. We received two responses from participants which were both positive. However, due to the low number of responses we were unable to draw any conclusions or themes from these replies.

Health promotion, protection and improvement

Health promotion was clearly embedded within the service. Patients were supported to adopt healthier lifestyles through a range of accessible information and initiatives. Smoking cessation and healthy lifestyle leaflets were available in the reception area, alongside a digital monitor displaying information about services offered including the practice payment plan set up and advertising keep fit evenings. In addition, group-based 'keep fit' sessions were actively advertised to encourage physical activity and wellbeing.

There were effective processes in place to support the early identification and management of health risks. The service operated a proactive model of care, whereby all patients enrolled in the dental plan were provided with access to additional private healthcare services. These included GP appointments and healthcare assistant (HCA) consultations, during which health checks could be undertaken.

Where clinical need was identified, patients were offered access to further specialist support, including podiatry and physiotherapy services. Patients with an elevated body mass index (BMI) were offered tailored nutrition and lifestyle advice from a suitably qualified healthcare assistant. Patients were also provided with an electronic guide to support ongoing lifestyle changes and self-management. Additionally, patients with blood pressure issues had the option to see the GP for an electrocardiogram (ECG) or the patient was offered a blood test.

Dignity and respect

Staff demonstrated a clear awareness of the importance of maintaining patient dignity and respect and appropriate measures were in place. We were told that the consultation room door was kept closed when patients were present to ensure confidentiality and also to respect patients' privacy and dignity. Additional privacy was provided using a mobile screen around the examination couch. There were no patients in the clinic to see medical staff at the time of the inspection. Music was played in the waiting area to make it difficult for patients to hear the conversations at reception.

Appropriate arrangements were in place for the use of chaperones. This included a notice of the availability of chaperones on the consultation room door. Reception staff had received chaperone training and were available to support this role.

The chaperone policy clearly outlined that only suitably trained staff could undertake this role. Clinical staff were required to record the offer and, where applicable, the presence or refusal of a chaperone within the patient's clinical record to ensure accurate documentation and accountability.

Patient information and consent

We found that the service had processes in place to provide patients with information about their care and to obtain consent for treatment. Patients were provided with information both verbally during consultations and through written materials such as leaflets.

An up-to-date consent policy was in place, clearly outlining the principles and processes for obtaining informed consent. Patients were required to review and sign relevant documentation prior to consultations, including consent to treatment and permission to access NHS records.

Information provided to patients was accessible, with bilingual leaflets available to support language needs. Patients' medical histories were routinely reviewed and updated during consultations to ensure care remained appropriate.

There were clear arrangements for sharing relevant information with other healthcare professionals. With patient consent, consultation summaries were shared with GPs via secure electronic systems, supporting continuity and coordination of care.

Communicating effectively

Information was provided in a way that aimed to meet patients' communication needs and bilingual written materials were available. Welsh-speaking staff were also available, including reception staff and clinicians. However, there was no system in place to formally identify Welsh-speaking patients or visibly indicate staff language skills.

The registered manager must ensure:

- **Patient preferred language is included in the patient medical notes**
- **Welsh speaking staff wear a 'iaith gwaith' logo to identify them as Welsh speaking staff.**

Arrangements were in place to support patients with additional communication needs. For example, large print information was available on request and alternative communication methods, such as written notes, were used where required. Access to a language interpretation service was also available. Whilst there was not a hearing loop available, staff described the alternative arrangements in place.

Information on treatment costs was provided through reception materials, the patient guide and during consultations. Information was available in paper format or delivered verbally, ensuring accessibility for patients without digital access. All appointments were arranged by telephone.

Care planning and provision

Patients received safe, individualised care and treatment, with systems in place to assess, plan and deliver care in line with best practice. Patients' health and wellbeing needs were appropriately identified through the completion of health screening questions and clinical observations at presentation. Care and treatment plans were developed in consultation with patients and aligned with relevant National Institute for Health and Care Excellence (NICE) guidance and local care pathways, supporting evidence-based practice.

Patients were provided with clear information about their care and treatment options. This included signposting to recognised resources, which provided patient information leaflets with clear clinically reviewed advice on conditions, symptoms and treatments, as well as information from professional bodies.

There were defined processes for managing and responding to test results. Results were reviewed daily, with urgent findings escalated promptly to the GP. Clear standard operating procedures were in place for the management of abnormal results, including same-day action where required. Non-urgent results were actioned within five working days and discussed directly with patients.

Equality, diversity and human rights

Equality and diversity were promoted within the service, supported by an up-to-date, version-controlled policy and staff training. The policy outlined the service's commitment to ensuring equality of care by removing potential discrimination and treating all patients fairly and with respect.

The service aimed to provide inclusive care, with staff reporting that all patients were treated equally, considering individual needs and preferences. This included respecting the rights of transgender patients by using their chosen name and allowing individuals to self-identify.

Reasonable adjustments had been considered to support accessibility, including the availability of a ground floor surgery and ramp access to the premises. However, there were limitations within the environment, as no accessible toilet facilities were available.

The registered manager must ensure the clinic's website includes reference to there not being a wheelchair accessible toilet at the premises.

Citizen engagement and feedback

The service demonstrated a proactive approach to seeking and using patient feedback to inform service development and improvement. Patients were routinely invited to provide feedback following each appointment through paper-based forms and additional opportunities were available via quick response (QR) codes linking to online reviews. A further patient survey was planned, demonstrating an ongoing commitment to engagement. However, information regarding feedback processes would benefit from being more clearly published on the website to enhance accessibility.

Feedback received to date was positive. A total of 31 responses indicated high levels of satisfaction, with all patients reporting that clinicians were helpful and that they received sufficient information to manage their condition. Overall satisfaction rates were 100%, with no negative comments recorded. Patient feedback highlighted themes such as 'professional', 'friendly', 'efficient' and 'excellent service', supported by a word cloud analysis.

Some examples of patient comments were displayed on the monitor in the reception area, enabling patients to view shared experiences. However, there was limited evidence of feedback outcomes being widely published. To strengthen transparency and patient engagement, the service should ensure that feedback results, along with any actions taken in response, are made readily accessible to patients, including through the website and on the patient guide.

The registered manager must ensure that the results of patient's feedback are made available to patients on the clinic website and included in the patient guide.

Delivery of Safe and Effective Care

Environment

The premises were generally safe, clean, secure and in good repair with no obvious patient hazards. The clinic consulting room was on the ground floor and was spacious. Whilst there was a step to access the setting, there was a ramp available if needed by patients

The building was secured by locks and an alarm system. The staff areas were cramped and the top floor office had numerous tripping risks due to worn carpeting. Safety checks included current gas and electrical certification and evidence of PAT testing, confirming equipment safety.

The registered manager must ensure the carpet in the top floor office is replaced to eliminate the risk of any trips, slips or falls.

An up-to-date fire risk assessment was in place. The assessment highlighted several recommended improvements, including upgrading the fire detection system with the installation of manual call points, implementing a formal system for recording fire safety checks, maintenance and ensuring regular staff fire safety training. However, there was no documented evidence confirming that these actions have been completed or recorded.

Fire safety measures were partially in place, fire-fighting equipment was maintained, a fire drill was conducted recently and 'No Smoking' signage was clearly displayed. Whilst fire exits were present and generally signposted, signage was inconsistent, particularly on the first and second floors and on some internal exit routes. There was also no clearly displayed overall evacuation notice.

The registered manager must ensure signage, staff training and formal recording of fire safety actions carried out are put in place to ensure full compliance with fire safety regulations.

Managing risk and health and safety

We found that the service had policies and procedures in place to support the management of risk and health and safety. A health and safety policy was available, version controlled and in date. An environmental risk assessment had also been completed and was documented. Fire safety arrangements were in place and included a fire risk assessment.

However, there was not a business continuity plan in place. This limited the service's ability to demonstrate preparedness for unexpected events.

The registered manager must ensure that a business continuity plan is written for the service.

Staff we spoke with were aware of their roles and responsibilities in the event of an emergency such as, a fire or a medical emergency or collapse. A first aid kit was available, which was suitable for use and there was always a member of staff on duty with up-to-date knowledge and skills

Infection prevention and control (IPC) and decontamination

The environment was visibly clean and free from clutter, the environment enabled effective infection control. Staff reported having access to personal protective equipment (PPE) and described appropriate use of PPE where required.

We found that arrangements were in place for the disposal of clinical waste. Sharps bins were used and waste was stored securely prior to collection. A waste management contract was in place.

There was no evidence of regular infection control audits including hand hygiene audits. This limited the ability of the service to monitor compliance and identify potential risks. We also noted that hand hygiene posters were not displayed in clinical areas, a requirement for reinforcing good practice.

The registered manager must ensure:

- **Regular infection control audits are carried out in the clinic**
- **Results of the audits are posted in the clinic**
- **Actions resulting from the audits are noted and corrected**
- **Hand hygiene posters are displayed in clinical areas, ideally above the sinks.**

There was an infection control policy available which was version controlled. Cleaning protocols were followed appropriately, with the examination couch and mobile curtain being cleaned using alcohol wipes between patients to maintain hygiene standards in the consultation room.

Medicines management

Medicines were not stored, administered or supplied within the service. Where appropriate, prescriptions were issued to patients. Repeat prescriptions were not given.

Appropriate arrangements were in place to respond to medical emergencies, including patient collapse. A resuscitation bag, shared with the dental setting, containing relevant algorithms, was available and accessible within the premises. Emergency equipment and drugs were in place and considered sufficient to respond to foreseeable emergencies.

Arrangements were in place to support staff in the safe use of medical equipment, including oxygen cylinders. Training requirements had been identified to ensure clinical staff were competent in the use of oxygen cylinders and how to report any related incidents that may occur.

Information to support safe medicines management was readily accessible to staff. This included online access to the British National Formulary (BNF) and electronic clinical systems which provided prompts, warnings and information on contraindications. These resources supported safe prescribing practices and clinical decision-making.

Safeguarding children and safeguarding vulnerable adults

There were appropriate safeguarding arrangements in place, supported by policies and procedures aligned with national legislation and local requirements, including the Wales Safeguarding Procedures. These documents were accessible to staff via the shared drive and included relevant contact details for the local safeguarding team.

Clear processes were in place for responding to safeguarding concerns. Where a concern was identified, staff would report this to the GP and inform the practice manager, who would escalate appropriately to the registered manager. This supported a structured and timely response to safeguarding risks.

Policies were in place for both child protection and the protection of vulnerable adults, outlining roles, responsibilities and reporting arrangements. Children were permitted to attend the service when accompanied by a responsible adult.

Training records confirmed that staff had completed safeguarding training at the appropriate level for their roles. The registered manager acted as the safeguarding lead and had received suitable training to fulfil this responsibility. In addition, the GP had safeguarding training to level three, supporting clinical oversight and appropriate management of safeguarding concerns.

Medical devices, equipment and diagnostic systems

The clinic had the relevant equipment to meet the needs of patients using the service. Any faults with this equipment were reported to the practice manager for repair or replacement.

Safe and clinically effective care

Patients were provided with safe and effective care, supported using evidence-based clinical guidance. Clinical decision-making was informed by recognised resources, including NICE guidelines, condition-specific tools such as hypertension traffic light guidance and professional learning platforms.

There were arrangements in place to ensure clinical guidelines and policies were communicated and implemented effectively. The service formed part of a wider group of four clinic sites, with an intention for GPs to meet quarterly to discuss clinical matters and share learning. Where new or revised policies and protocols were introduced, these were disseminated to clinical staff via an online messaging group to ensure awareness and consistent practice. The GP at this site acted as the lead GP, for the group, supporting clinical oversight.

The clinic received relevant safety alerts and bulletins, which were reviewed and shared with staff through established communication channels to ensure timely action where required.

Participating in quality improvement activities

There was limited evidence of structured quality improvement activity within the service. Audit activity had been undertaken in relation to referrals to another medical centre. This audit examined whether referrals were made correctly and whether appropriate information was provided. However there was no evidence of a broader programme of clinical audit or systematic review of clinical practice. The absence of regular audit activity meant that the service had limited ability to identify trends, monitor performance or demonstrate continuous improvement.

The registered manager must ensure that a programme of clinical audits is put in place to review clinical practice at the setting and to establish how these have led to treatment, care and service improvements.

We noted that there were some processes in place which evidenced quality improvement. As part of the health care assistant role they performed health checks prior to enrolment in the dental and healthcare plan, one of these picked up a medical condition which was referred immediately to the local emergency department.

We noted that the operation of the clinic itself was an example of quality improvement. The setting provided a combined dental and healthcare plan which provided combined access to dental, healthcare and certain consultant specialities.

The annual return required by the relevant regulations had been written and forwarded to HIW.

Information management and communications technology

Records were maintained using a combination of digital and paper systems. Clinical records were held electronically. Paper-based consent forms were scanned and stored within the digital record system. Consultation summaries would be printed and shared with patients' GPs where appropriate. Prescribing activity was limited, with occasional private prescriptions issued (for example, topical treatments), patients requiring ongoing medication were referred to their NHS GP.

A secure electronic system was used to manage patient data and information. Access to records was controlled through individual logins and password protection, ensuring that only authorised staff could access patient information.

Data protection arrangements were in place, the practice manager acted as the Data Protection Officer, with responsibility for overseeing compliance. An up-to-date data protection policy was in place, aligned with the Data Protection Act 2018 and the General Data Protection Regulations. This policy outlined how patient information was collected, stored, processed and protected.

Arrangements were also in place to monitor compliance with record retention requirements. This was overseen by the practice manager, ensuring that records were retained and disposed of in line with regulatory and legal requirements.

Records management

We checked a random sample of five patient care records. Patient records were generally well maintained and managed. Records reviewed were clear, accurate, legible and structured in a way that made them easy to follow. They included details of care and treatment provided, relevant clinical findings, investigations undertaken and management plans.

Entries consistently identified the clinician responsible, with dates of contact, decisions made and agreed actions clearly documented. Records were completed contemporaneously and contained appropriate summaries of patients' medical history, current medication, allergies and adverse reactions. Patient needs were appropriately assessed, with relevant observations recorded where required. There was also evidence of detailed discussions with patients regarding their condition, investigations and management options, supporting informed decision-making.

However, improvements were required in relation to the recording of consent and chaperone use. Documentation of valid consent, was not recorded in two of the five

records reviewed, including no documented evidence of consent for two intimate examinations. The offer of a chaperone was also not consistently recorded, with omissions identified in two cases. This presented a risk and needed be addressed to ensure full compliance with professional and regulatory standards.

The registered manager must ensure valid consent is recorded in all records and the offer of a chaperone consistently recorded.

Patient information was readily accessible when required through an electronic records system. Records were maintained securely online, supporting timely access by authorised staff while ensuring appropriate control over information.

Quality of Management and Leadership

Staff Feedback

HIW issued an online questionnaire to obtain staff views on services carried out by Meddygfa Glandwr (Anglesey) and their experience of working there. We received three responses from staff, which were all positive. Due to the low number of responses we were unable to draw any conclusions or themes from these replies.

Governance and accountability framework

We found that governance systems were present but required strengthening to ensure effective oversight of risk, quality and compliance.

The service had established a range of governance arrangements to support the delivery of care. Key documents including the statement of purpose and the patient guide which were available within the service. These documents provided information to patients about the services offered and supported transparency. These were available to patients at reception, although they were not currently accessible via the website.

The registered manager must ensure that the statement of purpose and patient guide are made available to patients on the clinic website.

Policies and procedures were in place covering a range of areas. The policies were version controlled and had defined review dates which demonstrated that the service had processes to keep documentation up to date. The policies applied to both the medical and dental aspects of the setting. However, they were predominantly aligned with, and more reflective of, the dental practice.

The registered manager must review the policies and procedures within the service and ensure they give equal prominence to the medical side of the operation in addition to the dental practice.

Staff reported that policies were reviewed regularly and that updates were communicated via email. Staff were required to confirm that they had read updated policies. This provided a mechanism to ensure that staff were aware of current procedures.

We found that the service had defined lines of accountability. The reporting structure included roles such as healthcare assistant, practice manager, registered manager and clinical lead. Staff were able to describe these lines of accountability and understood who they reported to.

The service operated multiple sites and there were plans to strengthen governance through meetings across sites where clinicians could discuss cases, share learning and address issues. At the time of inspection these meetings had not yet been fully implemented. Governance arrangements were further supported through regular meetings between practice managers across the four sites, facilitating discussion of operational and clinical issues.

We also found that the HIW registration certificates were displayed within the premises and details were correct. This indicated compliance with requirements to make registration information available to patients.

Dealing with concerns and managing incidents

The clinic has established effective processes for managing patient concerns and complaints. Patients were informed of the complaint's procedure through the patient information guide, documentation available within the practice and on the clinic's website.

A formal policy was in place should concerns arise. Complaints would be escalated internally in accordance with the clinic's policy, with an acknowledgement issued within two days of receipt. A full response would typically be provided within 10 working days, or an extension would be agreed if necessary.

The complaint's procedure was designed to ensure concerns were managed in a manner consistent with how the clinic would wish to be treated, promoting a culture of openness, learning and continuous improvement. Any lessons learned would be shared with relevant staff to improve service delivery. If a patient remained dissatisfied following the internal process, they would be advised of their right to escalate their complaint to the appropriate external organisations.

Overall responsibility for complaints arrangements rested with the registered manager. Day-to-day management was overseen by the practice manager.

Although no complaints had been received, a complaints log was maintained with no entries currently. Similarly, the clinic maintained an incident and accidents register. Staff we spoke with were aware of the requirement for notifying HIW of reportable events.

Workforce recruitment and employment practices

The service had a recruitment policy and associated procedures in place. However, these required updating to ensure they were current, comprehensive and appropriately dated. The policy outlined key requirements such as Disclosure and Barring Service

(DBS) checks, references and terms and conditions of employment. It should be further strengthened to explicitly include verification of the right to work, photographic identification and a full curriculum vitae.

A review of two employee records was undertaken to assess compliance with required pre-employment checks. The review confirmed that both files contained appropriate proof of identity, including a recent photograph and evidence of a DBS check at the appropriate level. Documentary evidence of relevant qualifications for the roles was also available. For registered healthcare professionals, evidence of current registration with the appropriate regulatory body was in place. However, several gaps in documentation were identified. There were no references from the individuals' two most recent employers and full employment histories were not available, including explanations for any gaps in employment. In addition, there was no evidence of a formal contract of employment or an up-to-date job description within the files reviewed.

The registered manager must ensure the recruitment requirements in both the policy and the documentation held comply with the requirements of the Independent Health Care (Wales) Regulations 2011, regulation 21 and Schedule 2.

Systems were established to ensure that healthcare professionals maintained current registration with their regulatory bodies. The business manager conducted annual checks of registration, supported by electronic diary reminders, providing evidence of ongoing compliance. There was currently no formalised system to routinely confirm that all staff remained suitable to work within the service. It is recommended that an annual declaration or certification process is introduced to address this gap.

The registered manager must ensure an annual declaration or certification process is introduced to confirm that all staff remain suitable to work within the service.

Workforce planning, training and organisational development

There were sufficient appropriately qualified, experienced and competent staff in place to ensure that patients received safe care and treatment. Staff appeared to be well supported in carrying out their roles. Appointments were only scheduled when the relevant clinician was available, ensuring safe staffing levels at all times.

A structured induction process was in place for new staff, supported by a standardised induction template which was completed and signed off appropriately. Although no formal induction policy was currently in place, the existing arrangements appeared to prepare staff to undertake their roles effectively.

Staff appraisal and validation processes were also in place, contributing to the maintenance of clinical standards and ongoing professional development.

Monthly staff meetings were held, with minutes viewed for the previous three months. Staff who were unable to attend received copies of the meeting notes. There was no formal agenda and staff were encouraged to contribute items for discussion. Recent meetings included topics such as fire safety drills and training compliance, demonstrating active engagement in safety matters. The regularity of staff meetings was a positive aspect.

Staff were supported to maintain and develop their knowledge and skills, with all staff aware of continuing professional development (CPD) requirements. We were told that the registered manager supported training opportunities and was open to funding relevant development courses. Mandatory training compliance was monitored. The introduction of a training matrix would provide a clearer, at-a-glance overview alongside existing training records.

Arrangements were in place to support staff in raising concerns. A current whistleblowing policy was available, encouraging staff to raise issues internally with the practice owner, practice manager or complaints officer. Where this was not appropriate, staff were signposted to external bodies such as trade unions, professional associations or independent organisations.

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
No immediate concerns were identified on this inspection.			

Appendix B – Immediate improvement plan

Service: **Meddygfa Glandwr (Anglesey)**

Date of inspection: **11 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 non-compliance concerns about patient safety were identified during the inspection.		
Improvement needed		**Standard / Regulation**	
1.			
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: **Meddygfa Glandwr (Anglesey)**

Date of inspection: **11 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.	Information was provided in a way that aimed to meet patients' communication needs and bilingual written materials were available. Welsh-speaking staff were also available, including reception staff and clinicians. However, there was no system in place to formally identify Welsh-speaking patients or visibly indicate staff language skills.	The registered manager must ensure: • Patient preferred language is included in the patient medical notes • Welsh speaking staff wear a 'iaith gwaith' logo to identify them as Welsh speaking staff.	National Minimum Standard (NMS) Communicating effectively Independent Health Care (Wales) Regulations 2011 (IHC) regulation 18	• We have already made provision on Patient files to note their preferred language. • Welsh speaking staff are now wearing badges to identify them as Welsh speaking.	Kate Edwards and Wendy Hutchinson	Already completed
2.	Reasonable adjustments had been considered to support	The registered manager must ensure the clinic's	NMS Equality, diversity and	Our website has already been amended	Kate Edwards and Wendy	Already Completed

	accessibility, including the availability of a ground floor surgery and ramp access to the premises. However, there were limitations within the environment, as no accessible toilet facilities were available.	website includes reference to there not being a wheelchair accessible toilet at the premises.	human rights	to explain that the toilet is not wheelchair accessible.	Hutchinson	
3.	Some examples of patient comments were displayed on the monitor in the reception area, enabling patients to view shared experiences. However, there was limited evidence of feedback outcomes being widely published. To strengthen transparency and patient engagement, the service should ensure that feedback results, along with any actions taken in response, are made readily accessible to patients, including through the website and on the patient guide.	The registered manager must ensure that the results of patient's feedback are made available to patients on the clinic website and included in the patient guide.	NMS Citizen Engagement	Results of patient feedback have now been made available to patients on our website and in the patient guide.	Kate Edwards and Wendy Hutchinson	Already Completed
4.	The staff areas were cramped and the top floor office had numerous tripping risks due to	The registered manager must ensure the carpet in the top floor office is	NMS Environment IHC regulation 26	The carpet tiles in the office are due to be replaced with a	Kate Edwards and Wendy Hutchinson	31/8/26

	worn carpeting. Safety checks included current gas and electrical certification and evidence of PAT testing, confirming equipment safety.	replaced to eliminate the risk of any trips, slips or falls.	(2) (a)	suitable alternative.	Also, Jonathan Pritchard (builder)	
5.	Whilst fire exits were present and generally signposted, signage was inconsistent, particularly on the first and second floors and on some internal exit routes. There was also no clearly displayed overall evacuation notice.	The registered manager must ensure signage, staff training and formal recording of fire safety actions carried out are put in place to ensure full compliance with fire safety regulations.	NMS Environment IHC regulation 26 (4)	Appropriate additional signage has already been added, and a formal recording of fire safety actions have been put in place.	Kate Edwards and Wendy Hutchinson	Already Completed
6.	There was not a business continuity plan in place. This limited the service's ability to demonstrate preparedness for unexpected events.	The registered manager must ensure that a business continuity plan is written for the service.	NMS Managing risk and health and safety	We are currently working on producing a Business Continuity Plan.	Kate Edwards and Wendy Hutchinson	31/8/26
7.	There was no evidence of regular infection control audits including hand hygiene audits. This limited the ability of the service to monitor compliance and identify potential risks. We also noted that hand hygiene	The registered manager must ensure: • Regular infection control audits are carried out in the clinic • Results of the audits	NMS Infection prevention and control (IPC) and decontamination IHC regulation 19 (2) (c)	We now have plans to carry out regular infection control audit. We already have in place audits for hand hygiene.	Kate Edwards and Wendy Hutchinson	31/8/26

	posters were not displayed in clinical areas, a requirement for reinforcing good practice.	are posted in the clinic • Actions resulting from the audits are noted and corrected • Hand hygiene posters are displayed in clinical areas, ideally above the sinks.				
8.	The absence of regular audit activity meant that the service had limited ability to identify trends, monitor performance or demonstrate continuous improvement.	The registered manager must ensure that a programme of clinical audits is put in place to review clinical practice at the setting and to establish how these have led to treatment, care and service improvements.	NMS Participating in quality improvement activities IHC regulation 19 (2) (c)	We have plans to conduct regular clinical audits and to establish how these have led to treatment, care and service improvements	Kate Edwards and Wendy Hutchinson	31/8/26
9.	Documentation of valid consent, was not recorded in two of the five records reviewed, including no documented evidence of consent for two intimate examinations. The offer of a chaperone was also not consistently recorded, with	The registered manager must ensure valid consent is recorded in all records and the offer of a chaperone consistently recorded.	NMS Records Management IHC regulation 9 (4) (a) (b)	Clinicians are now fully aware of the need to obtain valid consent and record this consent. They are also fully aware of the need to consistently offer a chaperone and to record this offer on the	Kate Edwards and Wendy Hutchinson	Already Completed

	omissions identified in two cases. This presented a risk and needed be addressed to ensure full compliance with professional and regulatory standards.			patient file.		
10.	Key documents including the statement of purpose and the patient guide which were available within the service. These documents provided information to patients about the services offered and supported transparency. These were available to patients at reception, although they were not currently accessible via the website.	The registered manager must ensure that the statement of purpose and patient guide are made available to patients on the clinic website.	NMS Governance and accountability framework IHC regulation 6 and 7	Our website has already been updated to include both the statement of purpose and patient guide.	Kate Edwards and Wendy Hutchinson	Already Completed
11.	The policies applied to both the medical and dental aspects of the setting. However, they were predominantly aligned with, and more reflective of, the dental practice.	The registered manager must review the policies and procedures within the service and ensure they give equal prominence to the medical side of the operation in addition to the dental practice.	NMS Governance and accountability framework IHC regulation 9	All policies and procedures have been reviewed to ensure that they give equal prominence to both medical and dental sides of the practice.	Kate Edwards and Wendy Hutchinson	Already completed

12.	There were no references from the individuals' two most recent employers and full employment histories were not available, including explanations for any gaps in employment. In addition, there was no evidence of a formal contract of employment or an up-to-date job description within the files reviewed.	The registered manager must ensure the recruitment requirements in both the policy and the documentation held comply with the requirements of the Independent Health Care (Wales) Regulations 2011, regulation 21 and Schedule 2.	NMS Workforce recruitment and employment practices IHC, regulation 21 and Schedule 2.	We will ensure that the recruitment requirements in both the policy and documentation held comply with independent healthcare regulations.	Kate Edwards and Wendy Hutchinson	29/08/2026
13.	There was currently no formalised system to routinely confirm that all staff remained suitable to work within the service. It is recommended that an annual declaration or certification process is introduced to address this gap.	The registered manager must ensure an annual declaration or certification process is introduced to confirm that all staff remain suitable to work within the service.	NMS Workforce recruitment and employment practices IHC, regulatio16 and 21 (2)	A new system has been put in place to ensure an annual declaration to confirm that all staff remain suitable to work.	Kate Edwards and Wendy Hutchinson	Already Completed

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): Kate Edwards (Current Practice Manager) and Wendy Hutchinson (Replacement Practice Manager)

Job role: Practice Manager **Date: 7/7/2026**