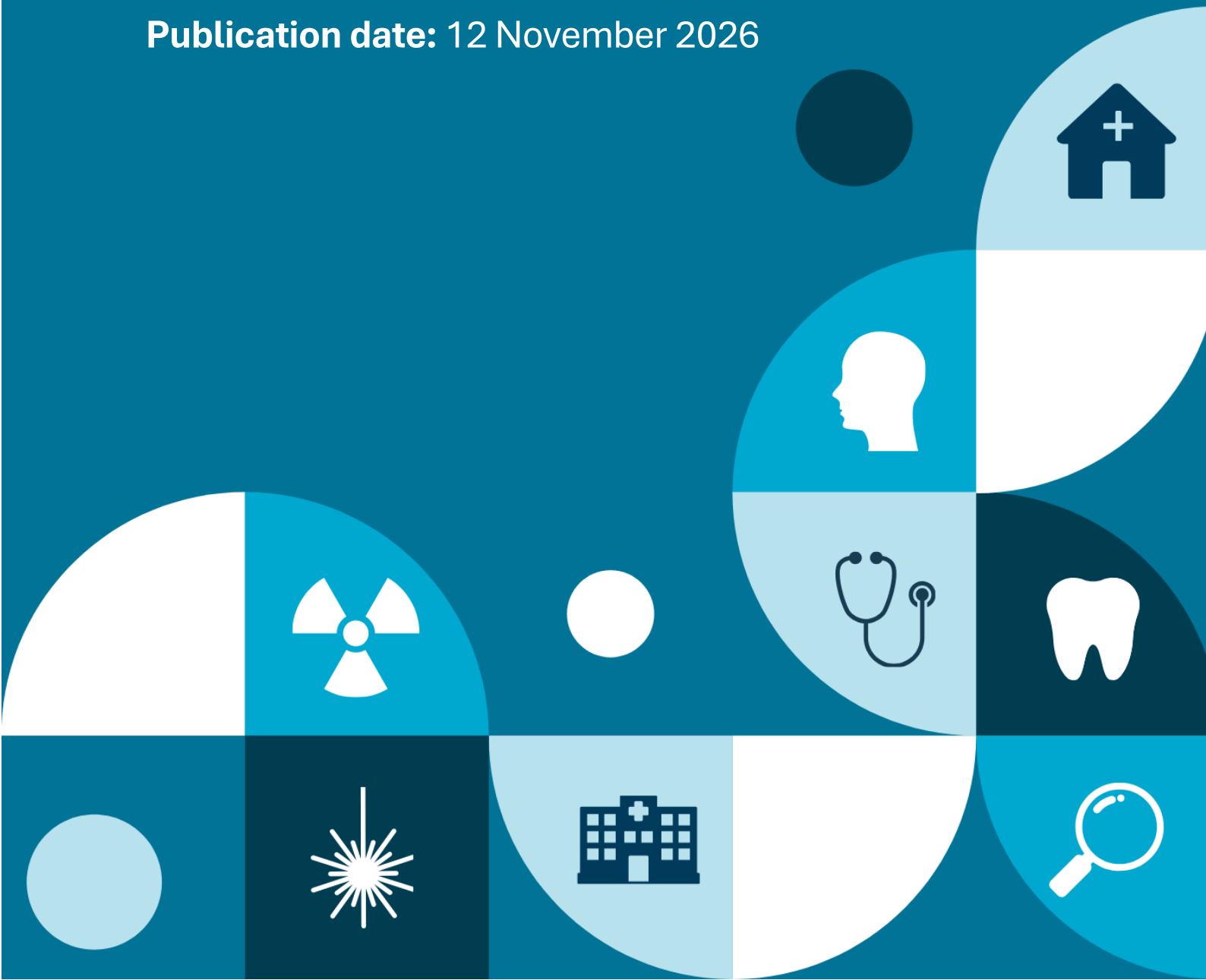
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Healthcare Inspectorate Wales

General Practice Inspection Report (Announced)

Abercynon Medical Centre, Cwm Taf Morgannwg University Health Board

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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.



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1. What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an announced inspection of Abercynon Medical Centre, Cwm Taf Morgannwg University Health Board on 12 August 2026.

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

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

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

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

2. Summary of inspection

Quality of Patient Experience

Overall summary:

Overall, patients who responded to the HIW questionnaire were generally positive about the service and all rated the service good or very good. We found most areas of the practice were accessible for people of various needs. However, we saw that the position of the self-service blood pressure machine could prevent safe access to some clinical areas by wheelchair or walking aid users. It was positive to see signs informing patients that a hearing loop was available and the practice patient information leaflet was also readily available in a large print format to assist communication with patients with sensory impairments. However, several improvements were identified to further develop the quality of patient experience.

Immediate assurances:

The emergency pull cord within the disabled toilet was not functioning.

This is what we recommend the service can improve:

- Ensure health promotion information is relevant to the local population, reviewed regularly, and displayed accessibly
- Consider the arrangements at reception and for the interview room to ensure that these promote confidentiality and accessibility for all patients
- Ensure patients' language preferences are consistently recorded within clinical records to allow arrangements for interpreters or other language support to be made for consultations
- Strengthen implementation of the Welsh Language Active Offer.

This is what the service did well:

- Staff were observed interacting with patients in a caring, dignified and respectful manner
- Patients contacting the practice by email would receive an automatic reply acknowledging the incoming message and providing the standard timescales for response.
- Access to services for veterans was particularly promoted and a dedicated area of the website signposted to LGBTQ+ health advice and resources.

Delivery of Safe and Effective Care

Overall summary:

The size and overall facilities available at the practice were appropriate to meet practice need. However, the practice environment looked generally tired. We were told that painting had been arranged for the following week. However, we noted several areas requiring further maintenance, including clinical and staff areas.

There were processes in place for the ordering and disposal of vaccinations and other medication. However, the placement of refrigerated stocks within clinical fridges required improvement. Clinical staff were aware of notifiable diseases and reporting via the Yellow Card scheme should a patient experience an adverse drug reaction.

Satisfactory procedures were in place for the management of out-going referrals and in-coming correspondence. Separate email addresses for patient and practitioner queries assisted with prioritisation and receptionists worked together to ensure all administrative tasks were allocated and completion reviewed at the start and end of each working day.

In general, patient records were of sufficient clinical quality to ensure safe practice. Narrative provided the context of the patient's clinical presentation and there was evidence that condition and treatment specific information was given to patients to help them understand more about their care and treatment. Appropriate consent was obtained and recorded in relation to invasive procedures including vaccinations, wound care and minor surgery.

Immediate assurances:

- We were not assured regarding aspects of Infection Prevention and Control (IPC), safeguarding, fire safety and emergency preparedness procedures within the practice.

This is what we recommend the service can improve:

- Review and update the business continuity plan to ensure it is practice specific, comprehensive and subject to clear version control
- Ensure all relevant staff complete training on the safe use of oxygen cylinders in line with Patient Safety Notice 041
- Develop formal workflow procedures and guidance to support consistent and risk-based patient follow-up
- Improve aspects of patient record keeping by ensuring consistent recording of allergies and use of clinical coding. Additional training may support consistent and effective use of the new electronic patient record system.

This is what the service did well:

- Staff were able to access assistance in emergencies and appropriate support arrangements were in place for patients awaiting emergency transport. Effective systems were in place to support staff safety during home visits
- Appropriate training and support was available to ensure all staff involved in the review and prescribing of medications were working safely
- Arrangements were in place for annual calibration of medical devices.

Quality of Management and Leadership

Overall summary:

All respondents to our staff questionnaire indicated they believed patient care was the practice's top priority and that they would recommend the practice as a good place to work. Practice management was well-established and staff told us they were clear regarding their roles and responsibilities.

We were told that staff could access a range of policies and procedures within their staff handbook and shared computer drive. However, during our inspection staff and inspectors found it difficult to navigate the document storage system. Policies that were available did not always provide information specific to the practice or relevant to the delivery of healthcare services in Wales. Some required review and lacked version control.

Most staff files we reviewed contained evidence of appropriate checks both on recruitment and an on-going basis. However, some improvements in arrangements to further support staff health, safety and wellbeing were identified.

This is what we recommend the service can improve:

- Ensure staff induction is clearly documented to demonstrate competence by the end of the induction process
- Update the complaints policy to align with the Listening to People: the NHS Wales concerns, complaints and redress framework (2026) and strengthen organisational learning from recurring themes
- Ensure that information governance policies are consistently implemented to protect patient information.

This is what the service did well:

- Effective communication systems were in place, including auditable messaging systems and regular minuted practice meetings
- The practice actively participated in national quality improvement work and local cluster initiatives to improve patient care.

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

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, we note that overall, all respondents to the HIW patient questionnaire rated the service as either 'good' or 'very good'.

Patient comments included:

> "It's a good service...but I find because I work it's hard to get a appointment and I struggle to book it on a day that I want"
>
> "The staff are extremely friendly"

Person-Centred

Health promotion

The practice provided a range of services to patients, including minor surgery and vaccination programmes. Practice services were delivered by General Practitioners (GPs), practice nurses and phlebotomists. Cluster pharmacists, mental health practitioners and physiotherapists also regularly worked from the practice which was positive for patient care. However, the patient information leaflet and practice website needed reviewing to ensure these provided consistent and accurate information regarding practice services, the in house and attached teams.

We saw that health promotion information was displayed within the practice premises, in their patient information leaflet and on their website. Information covered a range of topics including common illnesses, screening campaigns and local support services. However, not all information available through the practice website was applicable to the practice location and it was unclear how frequently health promotion materials in the practice waiting area were reviewed to ensure they were displayed in a clear and accessible manner. The self-service blood pressure machine available for patient use also did not display any instructions for use or information to support patients in discussing their results with clinicians.

The practice should review practice information and the presentation of health promotion materials to ensure information is clear, relevant and easy for patients to access.

Dignified and respectful care

We observed staff interacting with patients in a caring manner throughout our

inspection.

Reception and waiting areas were completely separate. Reception and administrative staff were located behind a glass partition to prevent their interactions with patients at reception or on the phone from being overheard. However, as the patient reception area was small we observed patients having to stand close together, compromising confidentiality. Two respondents to the HIW patient questionnaire disagreed that they could talk to reception staff without being overheard. An interview room was available should patients request to have a confidential conversation away from reception and it was positive that one respondent to the HIW patient questionnaire was aware of this facility. However, no signage was seen informing patients of this option and the room provided limited space or comfort due to the storage of practice photocopier and other items of stationery.

There was no lowered reception desk to enable communication with wheelchair users and the self-check-in screen was also out of use due to incompatible software since the practice had undergone an information technology upgrade.

The practice should:

- **Consider the layout of reception and the interview room to ensure that these promote confidentiality and accessibility for all patients**
- **Ensure that the offer of a separate room for private conversations is advertised to patients**
- **Arrange for the self-check-in-screen software to be updated, where possible, so that this option can be reinstated within a reasonable timescale.**

All consultation rooms had lockable doors and window coverings. However, not all clinical rooms had curtains or a screen available to fully maintain patient dignity and privacy before and after intimate examinations.

The practice should ensure that privacy curtains or screens are available around couches within all clinical rooms.

Suitable arrangements were in place for patients to be offered a chaperone for intimate examinations. We discussed enlarging the font on posters informing patients of their right to be accompanied during examinations and placing these more prominently within clinical rooms in addition to where these were already displayed at reception.

Timely

Timely care

Staff we spoke with felt that care navigation underpinned by suitable resources and training and the appointment system enabled timely patient access to appropriate care

based on clinical need.

Patients could request appointments in person or by phone. A phone line dashboard enabled monitoring of incoming call volume and timely call answering. The call answering message was provided in both Welsh and English and notified patients that calls were recorded.

Patients contacting the practice by email would receive an automatic reply acknowledging the incoming message and providing the standard timescales for response.

Non-urgent appointments could be pre-booked. However, we were told that most patients requested to be seen on the same day and this would be accommodated, where possible and appropriate, following clinical triage. Face-to-face appointments were offered as a default unless a patient had specifically requested a telephone consultation and this was considered clinically appropriate. Home visits could be arranged to ensure that patients unable to leave their home to attend appointments continued to have access to the care they required.

Patients contacting with mental health concerns would be offered an appointment, directed to the NHS 111 press 2 service or referred on to primary or secondary mental health services according to clinical need. Practice staff told us that communication with mental health services generally worked well. There was concern expressed that communication was more challenging with respect to accessing children's mental health services sometimes resulting in multiple referrals to different agencies. However, the practice told us they were able to escalate service access concerns to the health board.

However, patients who responded to the HIW questionnaire provided mixed opinions regarding whether they could access either urgent or routine appointments when needed.

Equitable

Communicating and language

It was positive to see signs informing patients that a hearing loop was available and the practice patient information leaflet was also readily available in a large print format to assist communication with patients with sensory impairments.

Staff confirmed there was access to an interpreter service should this be needed to assist patient communication. However, from our review of eight patient records we could not see that patient's language preference was routinely recorded to inform forward planning for communication assistance required during appointments.

The practice should ensure that language preference is routinely recorded within patient records to ensure staff are aware of any communication needs in advance

of appointments.

The implementation of the Welsh Language Active Offer was very minimal. The practice website could be translated into Welsh as well as a range of other languages. However, no Welsh language signage was seen within the practice premises and other provision was found to be limited.

The practice should strengthen its implementation of the Welsh Language Active Offer.

All respondents to the HIW patient questionnaire agreed that during appointments the clinician explained things well to them, that they felt listened to, and that they were treated with dignity and respect.

Rights and equality

We found most areas of the practice were accessible for people of various needs. Access to the building was via a ramp through an automated door and we were told that ensuring access to the building was free of ice, debris or other hazards was completed as part of the daily practice opening procedure. Inside the practice, all thresholds were level and flooring secure. All patients who completed a questionnaire and attended the practice for their appointment said that the building is easily accessible, and that there were enough seats in the waiting area. However, we saw that the position of the self-service blood pressure machine could prevent safe access to some clinical areas by wheelchair or walking aid users.

The practice should consider the position of self-service blood pressure machine and ensure that this does not obstruct access to any clinical areas for any patients.

Separate patient and staff toilet facilities were available. However, we found that the emergency pull cord within the disabled toilet did not work. Our concerns regarding this issue was dealt with as part of a wider concern regarding patient safety under our immediate assurance process. More details can be found in Appendix B.

The practice had given some consideration to the needs of children attending the premises. However, no baby-changing facility was available.

The practice should consider installing baby changing facilities, where feasible, to better meet the needs of its patient population, particularly families with young children.

An equality, diversity and inclusion policy was in place at the practice and a range of training to raise staff awareness of different patient needs, including anti-racism, had been undertaken. Access to services for veterans was particularly promoted and a dedicated area of the website signposted to LGBTQ+ health advice and resources. We were told the practice would assist patients to access digital health resources or complete online healthcare forms if required.

Delivery of Safe and Effective Care

Safe

Risk management

The size and overall facilities available at the practice were appropriate to meet practice need. However, the practice environment looked generally tired. We were told that painting had been arranged for the following week. However, we noted several areas requiring maintenance, including of clinical and staff areas, that painting would not address. Our concerns regarding these issues were dealt with as part of wider concerns regarding IPC and fire safety under our immediate assurance process. More details can be found in Appendix B.

A business continuity plan was in place and suitably accessible to practice management. However, this required updating to include accurate practice specific information, fully assign roles and responsibilities for implementing actions and display comprehensive version control.

The practice should review their Business Continuity Plan to ensure this is up-to-date, sufficiently detailed and fully personalised to the practice and displays clear version control.

We were told that staff were able to summon assistance from appropriate colleagues in an emergency and that patients would be provided with appropriate support while awaiting emergency transport.

A system was in place to support staff safety in relation to home visits.

Infection prevention and control (IPC) and decontamination

Staff told us that an IPC lead had been appointed and that IPC policies were in place. Procedures for segregating patients suspected to have an infectious illness and a staff seasonal flu vaccination programme were described. However, formal policies and evidence of cleaning completed or IPC audit were not available during our inspection. Our concerns regarding these issues were dealt with as part of wider concerns regarding IPC under our immediate assurance process. More details can be found in Appendix B.

Suitable foot operated bins were available within clinical areas. However, we noted that no waste management policy or audits were available.

The practice should ensure that a waste management policy is implemented and audits completed at suitable regular intervals.

Medicines management

There were processes in place for the ordering and disposal of vaccinations and other medication.

Temperature monitoring of the clinical fridges was completed on a daily basis. We suggested that room temperature monitoring in all areas where drugs were kept was also completed, notably in the warmer months, to ensure medication does not exceed upper temperature limits.

We saw that clinical fridges were not overstocked. However, items stored at the top, bottom and close to the sides of the fridge needed to be moved to allow more air flow around the fridge from the fan.

The practice should ensure that clinical fridges are suitably stocked to enable air flow for temperature control.

Staff were aware of the location of drugs and equipment available for use within a medical emergency within the practice and wall-mounted signs also informed staff and visitors. However, our review of the emergency equipment and drugs identified a number of concerns which were dealt with under our immediate assurance process. More details can be found in Appendix B.

Training specific to the oxygen cylinders used at the practice was also required following Patient Safety Notice 041.

The practice should ensure that all relevant staff have completed training regarding the safe use of the oxygen cylinders available at the practice.

Clinical staff were aware of notifiable diseases and reporting via the Yellow Card scheme should a patient experience an adverse drug reaction.

Appropriate training and support was available to ensure all staff involved in the review and prescribing of medications were working within their competence. Patients could request repeat prescriptions digitally, via a handwritten form, or by phone if known to the practice as housebound. Suitable measures were in place for the safe storage of prescriptions awaiting collection. Patients could nominate a pharmacy to collect their prescriptions for preparation of the medicines prescribed. However, there was no log of prescriptions collected. This is particularly important for high-risk medication prescriptions.

The practice should introduce a system to log the collection of high-risk medication prescriptions.

Safeguarding of children and adults

A practice safeguarding lead was in place for staff to escalate any safeguarding

concerns they identified. However, discussions with practice staff and our review of patient records identified a number of concerns regarding the safeguarding arrangements within the practice. These concerns were dealt with under our immediate assurance process. More details can be found in Appendix B.

Management of medical devices and equipment

Arrangements were in place for the annual calibration of medical devices.

Effective

Effective care

Satisfactory procedures were in place for the management of out-going referrals and in-coming correspondence. A locum induction pack provided information regarding referral mechanisms to temporary staff. Separate email addresses for patient and practitioner queries assisted with prioritisation and receptionists worked together to ensure all administrative tasks were allocated and completion reviewed at the start and end of each working day.

We were told that any revised clinical guidance received would be discussed within practice meetings to raise awareness and to decide on implementation. Significant events would also be discussed.

Patient records

We reviewed a sample of eight electronic patient records within the secure IT system. In general these were of sufficient clinical quality to ensure safe practice. Narrative provided the context of the patient's clinical presentation and there was evidence that condition and treatment specific information was given to patients to help them understand more about their care and treatment.. Appropriate consent was obtained and recorded in relation to invasive procedures including vaccinations, wound care and minor surgery. However, inconsistencies were noted in the recording of allergies and medications were linked to conditions in only some of the notes seen. Coding was also not consistently completed to enable audit or review of patient care in relation to specific conditions. As a new patient records system had recently been implemented we suggested that further training may help to address some of the issues identified.

The practice should:

- **Ensure that patient records consistently record sufficient narrative**
- **Ensure that appropriate codes are used throughout patient records**
- **Consider further training or other support to consistent and effective use of the new electronic patient record system, thereby supporting high quality record keeping.**

Our review of patient records identified some instances where follow-up regarding a range of health concerns would have been appropriate but had not been completed. These cases were discussed with the practice team during the inspection to enable appropriate clinical action to be taken and to support consideration of whether governance arrangements are sufficiently robust to ensure appropriate patient follow-up. More information regarding the actions taken to resolve our concerns are provided in Appendix A.

Quality of Management and Leadership

Staff Feedback

All staff we spoke with appeared committed to patient care.

All respondents to our staff questionnaire indicated they believed patient care was the practice's top priority and that patients had access to a range of health promotion materials and timely care through practice services.

Most respondents felt they had received training relevant to their role and felt involved in decisions regarding their work. All respondents indicated they would recommend the practice as a good place to work. Thank you cards and gifts received from patients were placed in an area accessed by all staff to ensure these tokens of appreciation were shared throughout the team.

Staff comments included:

> "Nice practice to work for, GPs very approachable and helpful"

Leadership

Governance and leadership

Practice management was well-established and many members of the team had also worked at the practice for a number of years. Staff told us they were clear regarding their roles and responsibilities.

The practice had effective leadership and governance arrangements and had taken steps to plan for future staffing changes. However, arrangements to maintain continuity of practice management during short-term absences could be strengthened.

Auditable messaging systems and frequent, minuted practice meetings provided forums for communication. All staff were encouraged to attend and this was facilitated by rotating the day meetings would occur on.

Practitioners told us they routinely supported one another through informal case discussions and by seeking second opinions. While these arrangements appeared effective, we discussed how regular formal clinical meetings could provide further opportunities for shared learning, reflective practice and discussion of clinical issues, supporting professional development and consistency of practice across the team.

We observed the practice manager was visible to the staff and we saw emails displaying a compassionate and supportive communication style.

We were told that staff could access a range of policies and procedures within their staff handbook and shared computer drive. However, during our inspection staff and inspectors found it difficult to navigate the document storage system and only some

policies were available for inspection. Policies that were available did not always provide information specific to the practice or relevant to the delivery of healthcare services in Wales. Some required review and lacked version control. .

The practice should ensure that policies and procedures are:

- **Personalised to the practice and provide information relevant to the delivery of healthcare services in Wales**
- **Stored in a manner that ensures they are readily available to staff**
- **Reviewed at regular, timely intervals to ensure they reflect current guidance**
- **Display comprehensive version control.**

Workforce

Skilled and enabled workforce

We reviewed a sample of five staff files and found that in most cases these contained job descriptions and contracts, pre-employment checks included reference requests and responses, employment history, evidence of professional qualifications and, where applicable, professional registration. Disclosure and Barring Service checks were completed on initial employment and self-declarations were used to confirm that staff continued to meet the suitability requirements for working in healthcare.

Systems for induction and appraisals were in place. However, the induction programme was not clearly documented to demonstrate competence by the end of the induction process. A systematic programme of core training requirements and evidence of completion on initial recruitment and an on-going basis were also missing.

The practice should ensure that systematic induction, appraisal and training programmes are defined and evidence of completion maintained for all staff.

We saw that staff could request flexible working options and that these were accommodated where possible. We were told that well-being services were also available to staff and all respondents to the HIW staff questionnaire indicated they were aware of these. However, staff we spoke with were not. We also saw that items were stored within cupboards in a way that placed staff at risk of moving and handling injuries.

The practice should ensure that:

- **Health and safety is fully considered in relation to all staff activities**
- **Information regarding staff well-being services is shared with all staff.**

Culture

People engagement, feedback and learning

We saw that patients were invited to provide feedback or raise concerns or complaints through the practice website, directly with the practice manager, via a suggestion box on the practice premises or through engaging with the annual patient survey. A complaints policy was available. However, this required updating to align with the Listening to People: the NHS Wales concerns, complaints and redress framework (2026).

The practice should update their complaints policy to align with the Listening to People: the NHS Wales concerns, complaints and redress framework (2026).

Our review of six practice complaints recorded since 2026 indicated that responses and investigations were completed within appropriate timescales. However, as we saw that a number of complaints were regarding communication we questioned how effectively complaints were learnt from within the practice.

The practice should reflect on this feedback and consider how their approach to learning from complaints could be strengthened.

Information

Information governance and digital technology

We saw that a suitable data protection officer had been appointed and that a range of data protection and information governance policies were in place to protect confidential information. The practice privacy notice was available to patients to inform them of how data was processed, used and stored, and the right to access their individual patient record. Staff had signed confidentiality agreements.

Learning, improvement and research

Quality improvement activities

We saw that the practice participated in national quality improvement projects including regarding Chronic Kidney Disease, Cardiovascular Disease and Continuity of Care. We were also told that the practice was active within their cluster and had been involved in setting up a ‘back to work’ initiative in collaboration with a government agency. Palliative care meetings with District Nurses were due to restart following a pause due to service cover constraints. We suggested an audit of practice Urgent Suspected Cancer referrals and mortality reviews also be completed as part of its ongoing audit and quality improvement schedule.

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
Our review of patient records revealed instances where follow-up with patients regarding a variety of health concerns would have been appropriate but was not completed.	Patients potentially left at risk of harm due to lack of follow-up.	These patients were discussed with practice management and GP partners during our inspection for appropriate clinical action and longer-term consideration of governance arrangements with respect to ensuring appropriate follow-up. This may include a formal workflow policy and guidance for staff regarding what type of follow-up would be appropriate in a variety of scenarios.	GP partners added patients identified to their afternoon list for follow-up contact. Practice management to consider longer-term governance arrangements.

Appendix B – Immediate improvement plan

Service: **Abercynon Medical Centre**

Date of inspection: **12 August 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	We were not assured regarding Infection Prevention and Control (IPC) procedures within the practice. Our findings regarding this matter included: • No IPC policy was available during the inspection. Practice management and staff unaware of the location or content and were also unable to produce IPC and related audits (e.g. hang hygiene, aseptic touch etc). • The clinical waste bin required locking while awaiting weekly collection within a shared storage area. • Limited bins available within clinical areas. • Not all sharps bins were signed and dated as required or kept closed when not in use. • A needlestick procedure was available but this needed updating to reflect current guidance and accurate contact details for local teams signposted to within the policy. • No protocol for the cleaning of fabric curtains and screens used in nurses rooms was available. • Cleaning completed was not documented on cleaning schedules or any other record. • Build-up of dust was seen on fans within the waiting rooms. This presents a risk to patients and staff from debris and microbes being circulated within the practice environment. • Rust was seen within clinical rooms and on radiators. This would prevent effective decontamination. • Chairs and toys provided for children's use while in the waiting room were not wipeable and no evidence that other decontamination methods may be used was available. • Hand sanitiser was observed to be available to patients at reception only. However, this did not display an expiry date and stored stocks of hand sanitiser had expired in 2025. Stocks of hand wash had also expired in 2025. • Items were observed stored on the floor within walk-in cupboards, preventing effective cleaning of the cupboard environment and assurance that stored items were not contaminated. • Food items were seen stored in the same cupboard as clinical items within clinical areas. • Mops were stored head down within buckets. Mop head colours also did not correspond to mop bucket colour for consistent identification and appropriate use to prevent cross-contamination.

	• Hot water had been turned off for the summer months resulting in hot water running at temperatures too low to effectively prevent the risk of legionella contamination and to enable effective hand washing. Cold water was also at a temperature too high to prevent the risk of legionella contamination. • There were several gaps within the Hepatitis B register of clinical staff. • Staff toilets required maintenance to enable effective cleaning and the table in the staff room was sticky. Overall, the practice did not look or feel clean in patient or staff areas to a standard expected of a healthcare environment. • Infection Prevention and Control training amongst all staff groups was missing or inconsistent, hindering their understanding of IPC and implementation or IPC measures.

Improvement needed		**Standard / Regulation**
1.	Comprehensive IPC policies, including appropriate needlestick and decontamination protocols, to be in place. These must be personalised to the practice, accessible to staff for guidance, and reviewed at timely intervals or to reflect changes in best practice. Formal, documented IPC and related audits (e.g. hand hygiene, aseptic touch etc) to be completed at suitable intervals and any actions identified implemented.	Health and Care Quality Standards (2023) - Safe
2.	Clinical waste bin to be kept locked within the shared storage area. An appropriate range of bins to be available for use within all clinical areas. All sharps bins to be signed and dated as required and kept closed when not in use.	
3.	Cleaning to be completed to a consistently high standard throughout the practice and documented on auditable cleaning schedules. All fixtures and furnishings to be maintained to enable effective decontamination.	
4.	In date hand sanitiser and handwash to be available to patients and staff throughout the practice.	
5.	Items stored within walk-in cupboards to be suitably arranged to enable effective cleaning of the cupboard environment and assurance that stored items are not contaminated. All non-clinical items, including food, to be kept away from clinical areas. Mops to be stored head up and out of buckets. Mop head colours to be available in line with mop bucket colours to aid consistent identification and appropriate use.	

6.	Hot water to be available throughout the year to enable effective handwashing. Hot and cold water temperatures to be checked on a regular basis and suitable action taken should they be out of range to effectively prevent the risk of legionella contamination.		
7.	A comprehensive Hepatitis B register of clinical staff to be maintained.		
8.	All staff to complete Infection Prevention and Control training to a level suitable to their role. This includes IPC level 2 for clinical staff and level 1 for non-clinical staff. Any appointed IPC lead should consider a higher level, applicable to role and responsibilities.		

Service Action:	**Responsible Officer**	**Timescale**
1. IPC policies located on G drive within Infection Control file now moved to a sub-title folder under Practice Policies within the G drive. All policies have been reviewed and revisited annually. Audit to be completed and re-audited at least 6 monthly. Posters for needlestick injuries to be displayed in all treatment rooms. IPC and waste management audits to be undertaken at suitable intervals and improvements identified and implemented.	Practice Manager	Within 2 weeks
2. Cleaning staff have been informed to ensure the clinical waste container located in our outer storage building is locked at all times. The key is kept within the cleaner's storage cupboard. A notice outlining this procedure to be placed on the inside of the cupboard door. This outer building is kept securely locked at all times. Clinical staff reminded of the importance of signing and dating sharp bins when opening and closing. Monthly checks to continue to be carried out to ensure compliance.	Cleaners/ Nurses/HCAs	Within 1 week

3. Comprehensive cleaning schedules to be created for each room and held on the back of each door throughout the practice. This is to assure cleaners have undertaken cleaning of all practice areas with an emphasis on clinical areas and equipment. Discussions already taken place with cleaning staff however a meeting is to be held with cleaning staff to go through the cleaning schedules to ensure understanding and compliance. The fans in the waiting room have now been cleaned. Fabric curtains will be replaced with horizontal vinyl (PVC) blinds. These blinds allow for them to be easily wiped down and disinfected to support infection control standards. A protocol will be created to ensure regular cleaning of all screens following the National standards of healthcare cleanliness 2025. Children's chairs and toys have been removed from the waiting room. Practice fixtures and fittings to be repaired/replaced to aid with cleaning process. We have arranged and are awaiting on a painting contractor to undertake decorating the practice.	Cleaners/Oversight by Practice Manager	Within 2 weeks for schedules 8 weeks for curtain replacement
4. Handwash is available at every basin within sealed dispensing units on the walls. Hand sanitiser has been ordered and will be placed at each room throughout the practice.	Cleaners	Within 1 week
5. Mops and buckets to be stored separately with mop heads up and buckets inverted or on shelving. Correct mop head colours to be used with matching-coloured buckets to ensure no risk of cross contamination. Mop handles and mop buckets to be labelled accordingly. Storage cupboards to be cleared of any items stored on the floor to ensure adequate cleaning can be undertaken.	Cleaners	Immediate effect
6. Hot water has been switched back on. Hot and cold-water temperatures to be checked on a regular basis at least monthly and suitable action to be taken if not within safe range. Record to be kept in the Water Management Legionella Logbook.	Admin Assistant/overseen by Practice Manager	Immediate effect
7. The Staff Hepatitis B register has been updated. There are a few gaps where clinicians claim they are immune, but evidence has not been seen. These members have been asked to either provide evidence or arrange a blood test at the practice to check and prove their immunity.	Clinical Staff/Practice Manager	Within 6 weeks
8. A review of training requirements is to be undertaken. IPC training suitable to their role to be undertaken by all staff that have not completed this. We have a centralised training register which is available on the G drive. This will be updated to include all required staff training for each member of staff. It will include the level of training required alongside the most recent training completed date and a record of when the next update is due. Any outstanding training to be completed. All store cupboards have been cleared of any out of date materials. These materials have been disposed of. Monthly checks to be made and stock rotated upon receipt.	All Staff/ Oversighted by Practice Manager	Within 6 weeks

Findings	We were not assured that suitable arrangements were in place to ensure patient safety. Our findings regarding this matter included: • A range of expired cleaning and clinical materials were found in store cupboards and clinical rooms. • Some substances hazardous to health were visible within clinical areas and not locked away. • The emergency alarm in the disabled toilet did not work when tested by inspectors. • Patient Group Directions for Combined Hepatitis A and Typhoid, Shingles, Herpes Zoster and Haemophilus Type B and Meningococcal C vaccinations were out of date by between 1-6 years. This meant that the delegation of vaccination within the practice was not legally compliant. • One patient record reviewed as part of the selected sample revealed that follow-up had not been actioned as required on receipt of blood test results. • Our review of practice complaints records also indicated that Duty of Candour should have been considered in relation to at least one incident within the last four months to identify whether practice actions had contributed to patient harm and to underpin a robust response, and any practice learning. • The cold chain procedure was not well understood by clinical staff and required updating to provide effective instruction on the action to take should a cold chain breach occur. This compromised the effectiveness of vaccinations provided at the practice.

Improvement needed		**Standard / Regulation**
9.	All items stored within the practice to be in date and ready for use.	Health and Care Quality Standards (2023) - Safe
10.	All substances hazardous to health to be locked away	
11.	The emergency alarm within the disabled toilet to be maintained, including regular testing.	
12.	All patient group directions to be in date, appropriately delegated and signed	

13.	Patient follow up to be completed as required in all cases and in relation to Duty of Candour when indicated. Duty of Candour training and / or refresher to be complete by all members of the practice team involved in delivering care and reviewing patient incidents / complaints.		
14.	Cold chain procedure to be reviewed and made available to all relevant staff.		
Service Action:		**Responsible officer**	**Timescale**
9.	All store cupboards have been cleared of any out of date materials. These materials have been disposed of. No food items will be kept in clinical areas. Monthly checks to be made and stock rotated upon receipt.	Practice Nurses/Cleaners	Immediate effect
10.	Checks made to ensure that no items hazardous to health were visible within clinical areas. One item found which had been brought to the surgery by a patient that he was using and inadvertently left behind has been destroyed and disposed of. All substances hazardous to health to be securely locked away at all times	Practice nurses/Cleaners	Immediate effect
11.	A new Pull switch system has been purchased for the disabled toilet emergency alarm system. An electrician has been sought to fix the problem. The alarm is to be tested on a weekly basis alongside the weekly testing of the fire alarm call points. This will ensure it is maintained and in good working order.	Admin Assistant/ oversighted Practice Manager	Within 2 weeks
12.	All patient group directions have been checked to make sure they are the latest versions. Those that were found to be out of date have not been updated by the Health Board. These are to be reviewed by one of the Practice GP Partners and signed off until a further update version is available.	Practice Nurse	Immediate effect
13.	Duty of candour training to be undertaken by all members of the practice. Duty of candour to be considered on each occasion when reviewing patient incidents/complaints. Training register to be updated once completed.	All staff	Within 6 weeks
14.	The practice cold chain procedure has been relayed to all practice staff. The policy is available within the G drive of our computer system available to all staff. Hard copies have been given to each member of the relevant team and signatures obtained to acknowledge receipt and understanding of this procedure. Relevant staff have received training via their immunisation training updates.	All Staff/Oversighted by Practice Manager	Immediate effect

Findings	We were not assured regarding the safeguarding arrangements within the practice. Our findings regarding this matter included: • Safeguarding policies did not align with the Wales Safeguarding Procedures and did not contain contact numbers or flow charts to support staff to report safeguarding concerns. • No regular safeguarding reports were produced or reviewed and no safeguarding meetings took place either internally to the practice or with other members of the wider multidisciplinary team, e.g. health visitors. • Records indicating patients at risk could not be confirmed as accurate. Patient records did not display the effective use of digital flags, linking of family members or coding to identify patients at risk. • Two patient records reviewed provided narrative which could indicate a child at risk. However, there was no evidence of the formulation of risk or follow-up. • Safeguarding training had not been completed by all staff. Where training had been completed this was not always to the appropriate level for role.

Improvement needed		**Standard / Regulation**
15.	Practice safeguarding policies and clinical oversight to reflect the Wales Safeguarding Procedures.	Health and Care Quality Standards (2023) - Safe
16.	Patient records to be appropriately maintained and safeguarding concerns actioned, in collaboration with the multidisciplinary team where appropriate.	
17.	All staff to complete safeguarding training for children and adults to a level appropriate to their role. Guidance can be sought from the RCGP Safeguarding Standards resource.	

Service Action:	**Responsible officer**	**Timescale**
15. The practice safeguarding policies have been reviewed and updated in line with current guidance and best practice. These policies contain local contact information. Those staff who haven't already are to undertake safeguarding training appropriate to their roles and responsibilities. All staff have access to the updated policies and are aware of the designated safeguarding lead and the process for raising safeguarding concerns. These are to be included in the practice locum pack. Information is also readily available online for Cwm Taf residents.	Safeguarding lead	Immediate

16. All safeguarding concerns to be coded within subject's records. Records are to be appropriately flagged. Adult and child safeguarding authorities have been approached to see if they can supply us with a list of all active safeguarding of any patients registered at our practice. In the meantime, we are combing through our register to ascertain the current status of needs. We have noted that some adults remain on our register that are no longer in need of safeguarding and this need to be reflected on the records. Good progress has already been made. We will allocate time in our regular practice meetings for any safeguarding concerns to be raise.	Safeguarding Lead	Within 12 weeks
17. Staff to complete safeguarding training at level suitable to their role. This will be updated in the practice register. All staff have access to the updated policies and are aware of the designated safeguarding lead and the process for raising safeguarding concerns.	All Staff/Oversighted by Practice Manager	Within 6 weeks

Findings	We were not assured regarding the fire safety arrangements within the practice. Our findings regarding this matter included: • Inconsistent procedures regarding the actions to take in a fire and muster points. • Outside fire escape routes very close to the building. Steps providing a rapid exit from the site were not able to be used due to a locked gate. There were no external signs informing patients or staff of the routes available to the muster point. This meant there could be a delay in patients or staff reaching the muster point in the event of a fire. • A formal fire risk assessment had been completed in 2025 and reviewed by the practice manager in 2026. However, not all recommendations had been fully implemented and staff had not received formal fire training. Additional risks from the use of multiple extension leads and electrical devices that did not display evidence that they had been subject to portable appliance testing within the last 10 years were also identified on our inspection.

Improvement needed		**Standard / Regulation**
18.	Additional PAT to be completed for any devices not recently tested. All staff to undertake formal fire training. Fire escape routes and instructions to be appropriate and suitably communicated to patients and staff.	Health and Care Quality Standards (2023) - Safe

Service Action:	**Responsible officer**	**Timescale**
The devices noted and mentioned to practice manager on the day of inspection in the staff room were the power leads to the computer. An explanation was offered that they had been included in the check and the possibility of the sticker had dropped off as they often require pushing back to secure as in time they work loose. Having		Within 6 weeks

checked our PAT test report, they are listed as being checked and passing the test, this test was carried out on 3/12/25. We will check for any new additions purchased however that have been added since this inspection and a Pat test arranged. The last formal Fire Risk Assessment was undertaken in 2025 we will arrange to have a new formal fire assessment undertaken. Staff members to undertake fire training and the training register to be updated accordingly. All staff have been informed of the fire safety arrangements within the practice. New signage to be purchased to ensure awareness of fire assembly point and are to be placed appropriately around the practice.	Practice Manager	

Findings	We were not assured regarding the suitability of emergency drugs and equipment within the practice. Our findings regarding this matter included: • Emergency drugs checked on a monthly basis, not weekly in line with Resuscitation Council UK guidance. Checklists did not confirm expiry dates. Emergency equipment was not checked and a nebuliser machine for use with nebuliser vials kept within the emergency drugs could not be located. • Several items had expired, some by over 10 years. • Algorithms were not all up to date or in place. These also needed securing to emergency drugs and equipment storage unit to ensure they remained accessible for use when required. • Emergency drugs and equipment available according to comprehensive risk assessment. • Emergency drugs and equipment stored within a clinical area which could be locked during a consultation, preventing rapid access in an emergency.

Improvement needed		**Standard / Regulation**	
20.	Emergency drugs and equipment to be maintained and located in line with Resuscitation Council UK guidelines and a comprehensive local risk assessment.	Health and Care Quality Standards (2023) - Safe	
Service Action:		**Responsible officer**	**Timescale**

Comprehensive list of Emergency Drugs and equipment to be checked and updated weekly. Emergency drugs, nebuliser, oxygen & AED equipment moved to a safe place in reception to allow better access in an emergency. Weekly checks to be carried out by practice nurse to ensure drugs and equipment are present, in date and stored correctly, and that all equipment is functionality. The practice Manager is to review the completed logs monthly to ensure all records are complete and any issues have been recorded and addressed. A detailed drug and equipment check is completed separately in a dedicated document which records full inventory, expiry dates, batch numbers (for drugs) and detailed equipment functionality. This log is to be kept at the site of the emergency trolley within reception.	Practice Nurses/Practice Manager	Immediate effect

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): Ann Brown

Job role: Practice Manager **Date:** 21/08/2026

Appendix C – Improvement plan

Service: **Abercynon Medical Centre**

Date of inspection: **12 August 2026**

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions, they are taking to address these areas.

	Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	Not all information available through the practice website was applicable to the practice location and it was unclear how frequently health promotion materials in the practice waiting area were reviewed to ensure they were displayed in a clear and accessible manner. The self-service blood pressure machine available for patient use also did not display any instructions for use or information to	The practice should review practice information and the presentation of health promotion materials to ensure information is clear, relevant and easy for patients to access.	Health and Care Quality Standards (2023) - Effective	The practice website and waiting-room displays have been reviewed to remove outdated, irrelevant or duplicate information. We have introduced a monthly review policy of displayed materials. The self-service blood pressure machine has clear instructions on the machine on how to use it. Patients are instructed on what to do with the machine readings when	Practice Manager	Completed

	support patients in discussing their results with clinicians.			directed to the machine. Patients are instructed to give the BP reading to reception with their name and date-of-birth. These are then processed as per the practice's blood pressure protocol. Additional instructions for the patient on what to do with the BP reading print out has been placed on the wall next to the machine.		
2.	The patient information leaflet and practice website needed reviewing to ensure these provided consistent and accurate information regarding practice services, the in house and attached teams.	Patient information to be reviewed at regular intervals to ensure this provides accurate information regarding practice and other health board services.	Health and Care Quality Standards (2023) - Effective	The patient information leaflet that was attached to the website has been removed as the website contains all the information regarding the current practice service provision including in-house clinicians, attached staff and	Practice Manager	Completed

				relevant Health Board services within it and was therefore regarded as superfluous. The practice leaflet is reviewed and updated regularly. Update both sources together in accordance with the Practice Leaflet/Notices Displays and Practice Monthly review Policy.		
3.	The patient reception area was small, compromising confidentiality. Two respondents to the HIW patient questionnaire disagreed that they could talk to reception staff without being overheard. An interview room was available. However, no signage was seen informing patients of this option and	The practice should: • Consider the layout of reception and the interview room to ensure that these promote confidentiality and accessibility for all patients • Ensure that the offer of a separate room for private conversations is	Health and Care Quality Standards (2023) – Person centred / Safe	Assess reception layout and review accessibility and confidentiality. Clear signage has been placed at reception offering the comms room for private conversations. The practice will ensure staff proactively offer it. Self-check-in-screen will be removed as no longer	Practice Manager	8 weeks

	the room provided limited space or comfort due. There was no lowered reception desk to enable communication with wheelchair users and the self-check-in screen was also out of use due to incompatible software since the practice had undergone an information technology upgrade.	advertised to patients • Arrange for the self-check-in-screen software to be updated, where possible, so that this option can be reinstated within a reasonable timescale.		compatible. Clear signage has been placed on the check in screen to inform patients that is out of order until it is removed.		
4.	Not all clinical rooms had curtains or a screen available to fully maintain patient dignity and privacy before and after intimate examinations.	Privacy curtains or screens to be available around couches within all clinical rooms.	Health and Care Quality Standards (2023) – Person centred	Install privacy curtains/ screens in all clinical rooms. Curtains will all be replaced with disposable medical curtains.	Practice Manger	8 weeks.
5.	From our review of eight patient records we could not see that patient's language preference was routinely recorded to inform forward planning for communication assistance	The practice should ensure that language preference is routinely recorded within patient records to ensure staff are aware of any communication needs in advance of appointments.	Health and Care Quality Standards (2023) – Person centred	Practice staff to ensure new registrations all have a language preference recorded and we will aim to engage the practice team in opportunistically collecting and recording	Practice Manager	8 weeks with a re- audit in the first 12 weeks of implementation.

	required during appointments.			this information on patients already registered with us with the aim to improve. Audit this to assess compliance		
6.	The implementation of the Welsh Language Active Offer was very minimal, with no Welsh language signage seen within the practice premises and other provision found to be limited.	The practice should strengthen its implementation of the Welsh Language Active Offer.	Health and Care Quality Standards (2023) – Person centred	Introduce appropriate bilingual signage at reception, entrances and patient-facing areas. Provide Welsh-language versions of documents and forms upon request. The practice currently has no Welsh speakers. Encourage future staff who speak or are learning Welsh to wear badges or lanyards to identify this.	Practice Manager	12 weeks
7.	The position of the self-service blood pressure machine could prevent safe access to some clinical	The practice should consider the position of self-service blood pressure machine and ensure that this does not obstruct	Health and Care Quality Standards (2023) – Person centred / Safe	The self-service blood pressure machine has been re-positioned so that wheelchair/ walking aid users have ease of	Practice Manager	Completed

	areas by wheelchair or walking aid users.	access to any clinical areas for any patients.		access to the clinical areas. Practice Nurses to monitor this position is maintained and clear access continues.		
8.	Some consideration of children's needs when attending the practice. However, no baby changing facility was available.	The practice should consider installing baby changing facilities, where feasible, to better meet the needs of its patient population, particularly families with young children.	Health and Care Quality Standards (2023) – Person centred	Install a wall-mounted baby changing table in the patient toilet.	Practice Manager	12 weeks
9.	A business continuity plan was in place and suitably accessible to practice management. However, this required updating to include accurate practice specific information, fully assign roles and responsibilities for implementing actions and	The practice should review their Business Continuity Plan to ensure this is up-to-date, sufficiently detailed and fully personalised to the practice and displays clear version control.	Health and Care Quality Standards (2023) – Safe / Effective	Review and update the Business Continuity Plan to reflect current practice-specific arrangements, staffing, contact details, IT systems, premises and essential services. Assign named leads and deputies for each contingency, including IT failure, loss of premises,	Practice Manager Partners	6 weeks

	display comprehensive version control.			staffing shortages and utility disruption. Add a document owner, approval date, review date, version number and change history.		
10.	No waste management policy or audits were available for inspection.	The practice should ensure that a waste management policy is implemented and audits completed at suitable regular intervals.	Health and Care Quality Standards (2023) – Safe	Renew and make available the practice waste management policy covering clinical, domestic, offensive and pharmaceutical waste, segregation, labelling, storage, collection and spill management, as applicable. Ensure staff receive appropriate instruction. Complete regular audits.	Practice Manager	8 weeks
11.	Items stored at the top, bottom and close to the sides of the fridge needed to be moved to allow more air flow around the fridge from the fan.	The practice should ensure that clinical fridges are suitably stocked to enable air flow for temperature control.	Health and Care Quality Standards (2023) – Safe	Items stored against the sides, top and bottom were rearranged to aid ventilation of the clinical refrigerator.	Practice Nurse	Completed

12.	Training specific to the oxygen cylinders used at the practice was also required following Patient Safety Notice 041.	The practice should ensure that all relevant staff have completed training regarding the safe use of the oxygen cylinders available at the practice.	Health and Care Quality Standards (2023) – Safe	Identify all staff who may need to access or use the practice's oxygen cylinders. Arrange training specific to the cylinders and equipment held at the practice,	GP Partner	6 weeks
13.	There was no log of prescriptions collected. This is particularly important for high-risk medication prescriptions.	The practice should introduce a system to log the collection of high-risk medication prescriptions.	Health and Care Quality Standards (2023) – Safe	Introduce a prescription collection register for high-risk prescriptions. Record the patient name, date issued, medication, date collected, identity verification, the name/signature of the person collecting and staff member handing over.	Practice Manager	6 weeks
14.	No formal workflow policy or guidance was available to guide staff on what type of follow-up would be appropriate. This meant that follow-up was based	The practice should review its workflow procedures and provide clear guidance for administrative and clinical staff on appropriate follow-up action.	Health and Care Quality Standards (2023) – Safe	Develop a written workflow policy defining responsibilities for administrative and clinical staff when managing incoming	GP Partner lead	Immediate review of the outstanding follow-up. 8 weeks to develop policy

	on discretion rather than robust risk assessment. Our review of patient records revealed instances where follow-up with patients regarding a variety of health concerns would have been appropriate but was not completed.			results, hospital correspondence, and referrals. Establish clear escalation criteria for urgent, abnormal or potentially significant findings; specify timeframes, task ownership, tracking of outstanding work and actions when patients cannot be contacted. Review the patient records highlighted during inspection and complete any outstanding clinically indicated follow-up.		
15.	Inconsistencies noted in the content and coding of patient records.	• The practice should: • Ensure that patient records consistently record sufficient narrative • Ensure that appropriate codes	Health and Care Quality Standards (2023) – Safe / Effective	Develop a clinical record-keeping standard covering sufficient consultation narrative, relevant examination findings, assessment, management plan,	GP Partner Lead	6 weeks

		are used throughout patient records • Consider further training or other support to consistent and effective use of the new electronic patient record system, thereby supporting high quality record keeping.		safety-netting and appropriate clinical coding. Provide targeted training on the new electronic patient record system		
16.	During our inspection staff and inspectors found it difficult to navigate the document storage system and only some policies were available for inspection. Policies that were available did not always provide information specific to the practice or relevant to the delivery of healthcare services in Wales. Some required	The practice should ensure that policies and procedures are: • Personalised to the practice and provide information relevant to the delivery of healthcare services in Wales • Stored in a manner that ensures they are readily available to staff	Health and Care Quality Standards (2023) – Safe / Effective	All practice policies to be stored in a single folder on the practice shared drive which is accessible to all staff. Ensure policies are specific to the practice and relevant to Cwm Taf Morgannwg University health board and NHS Wales.	GP Partner lead	8 weeks

	review and lacked version control.	• Reviewed at regular, timely intervals to ensure they reflect current guidance • Display comprehensive version control.		Assign a version number and review date for each policy. Review policies regularly to ensure that they are up-to-date.		
17.	The staff induction programme was not clearly documented to demonstrate competence by the end of the induction process. A systematic programme of core training requirements and evidence of completion on initial recruitment and an on-going basis were also missing.	Systematic induction, appraisal and training programmes to be defined and evidence of completion maintained for all staff.	Health and Care Quality Standards (2023) – Safe / Effective	Introduce a structured induction programme for all new staff, including role-specific duties, safeguarding, information governance, confidentiality, infection control, health and safety, emergency procedures and relevant clinical competencies. Use a checklist signed by the employee and supervisor, with competency assessment where appropriate.	Practice Manager	8 weeks

18.	We saw items stored within cupboards in a way that placed staff at risk of moving and handling injuries. Not all staff were aware of well-being services available to them.	• Health and safety to be fully considered in relation to all staff activities • Information regarding staff well-being services is shared with all staff.	Health and Care Quality Standards (2023) – Safe / Effective	Remove any unsafe storage, relocate heavy or frequently used items to suitable heights. Communicate to staff what wellbeing services are available to them.	Practice Manager	Storage moved Immediately 2 weeks.
19.	The practice complaints policy required updating to align with the Listening to People: the NHS Wales concerns, complaints and redress framework (2026).	Complaints policy to be reviewed to align with the Listening to People: the NHS Wales concerns, complaints and redress framework (2026).	Health and Care Quality Standards (2023) – Person-centred / Effective	Review and update the complaints policy to align with Listening to People: the NHS Wales concerns, complaints and redress framework (2026). Confirm the current requirements for receiving, acknowledging, investigating and responding to concerns; responsibilities and escalation arrangements; communication with patients; and recording, monitoring and learning.	Practice Manager Complaints Lead	4 weeks

				Ensure staff know where the policy is held and how to escalate a concern.		
20.	Repeated themes identified within complaints causing us to question how effectively complaints were learnt from within the practice.	The practice should reflect on this feedback and consider how their approach to learning from complaints could be strengthened.	Health and Care Quality Standards (2023) – Safe / Effective	Review complaints from the previous 12 months, or a longer period if needed to identify trends. Categorise recurring themes, identify contributory factors and assess whether previous actions were effective. Discuss findings at a practice meeting and agree specific corrective actions. Continue to discuss complaints in practice meetings to try and identify trends and reflect on how to prevent them in future.	Practice Manager, Partner, Complaints Lead	6 weeks

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative:

Name (print): Ann Brown

Job role: Practice Manager **Date: 14/10/2026**