Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report

(Announced)

Sully Surgery practice, Cardiff and Vale University Health Board

Inspection date: 28 January 2025
Publication date: 30 April 2025

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager
Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

Or via

Phone: 0300 062 8163
Email: hiw@gov.wales
Website: www.hiw.org.uk

Digital ISBN 978-1-83715-649-8

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

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our values

We place people at the heart of what we do.
We are:

- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

Our goal

To be a trusted voice which influences and drives improvement in healthcare

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.

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 Sully Surgery, Cardiff and Vale University Health Board on 28 January 2025.

Our team for the inspection comprised of one HIW healthcare inspectors and three clinical peer reviewers.

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 19 questionnaires were completed by patients or their carers and three 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:
The findings in our patient questionnaires were positive. All but one respondent felt they were treated with dignity and respect and rated the service as 'good' or 'very good,'. We witnessed staff speaking to patients in a polite and respectful manner.

The practice emphasised health promotion and wellbeing to patients with a wide range of information displayed in the waiting area, which included screening services, dementia and carers information. In addition, a separate area was available next to the waiting area where patients were able to use the weighing scales and blood pressure machine, their results are automatically recorded in their patient record which could be reviewed by the nurse.

There were processes in place to ensure patients could access care in a timely manner, and with the most appropriate person. The practice has also implemented a telephone 'call back' system, which gives patients the option to receive a call back when they are at the front of the telephone queue. Appointments were made mostly by telephone, but online booking and in-person appointments could also be made.

The practice offered chaperones in all appropriate circumstances. A chaperone information notice was displayed in the waiting area, however, not all clinical treatment rooms had notices indicating that this service was available.

There are no Welsh speaking staff within the practice, however as part of the "active offer" for Welsh patients, all practice information and signs should be bilingual.

Delivery of Safe and Effective Care

Overall summary:
The practice was clean and tidy, free of clutter and in a good state of repair. There were also processes in place to help protect the health, safety and wellbeing of all who used the practice services.

Overall, the IPC arrangements in place were acceptable, but some arrangements needed strengthening to ensure the practice always upholds the required standards of IPC to maintain the safety of staff and patients. Although we were told IPC

audits took place, we recommended that a more thorough IPC audit programme is implemented to monitor against standards.

There was a cold chain process in place for medications or vaccines that required refrigeration. There were two dedicated clinical refrigerators for certain items, such as vaccines. Daily checks were completed and the documentation we reviewed confirmed this. Conversations with staff confirmed that they were aware of the upper and lower temperature and what to do in the event of a breach to the cold chain.

The patient records we reviewed were clear, written to a good standard and completed with appropriate information. Record entries were contemporaneous and were easy to understand by other clinicians. Continuity of care was overall good, with close oversight and supervision of patients and patients records by all the GPs. All the records that were reviewed identified whether the patient had an allergy or not. Whilst the records seen evidenced good quality patient consultations, these could be improved by the regular use of Read Codes to maintain summaries and link consultations for the same clinical problem.

There was one portable oxygen cylinder stored at the practice. Whilst a notice was attached to the door where oxygen was stored, this was not a statutory hazard notice, neither did the fire safety plan identify where the oxygen was stored.

Immediate assurances:
We identified several areas which needed to be address through our immediate assurance process, where we wrote to the practice within two working days of our inspection requesting an immediate improvement plan. The issues included:

- Timely checks of emergency drugs and equipment
- The location and accessibility of emergency drugs
- Completion of mandatory training

The practice submitted an immediate improvement plan to us which we reviewed and accepted. Details of the immediate improvements are highlighted in Appendix B.

Quality of Management and Leadership

Overall summary:
There were processes in place to support effective governance, leadership and accountability. Staff were clear about their roles, responsibilities and reporting lines, and the importance of working within their scope of practice.

Most staff we spoke with felt supported and able to approach leaders with any concerns and felt these would be addressed appropriately. Leaders confirmed that an open-door policy was in place to enable staff to share concerns and ideas for the practice.

We reviewed a comprehensive suite of policies and procedures, although four key policies were not in place. There was also a limited document control process in place, and some policies had not been implemented to align with the specific needs of the practice.

The practice sought patient feedback. Information was displayed in the waiting area detailing how people could feedback on their experiences. However, there was no evidence to demonstrate that patient feedback is routinely used by the practice to learn and inform service improvement.

We found evidence of partnership working with the practice's collaboration within a GP cluster. Medical staff attended cluster meetings and provided services on a cluster wide basis.
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 a questionnaire to obtain patient views on the care at Sully Surgery prior to the inspection undertaken in January 2025. In total, we received 19 responses. Responses were overall positive, all but one respondent who answered, rated the service as 'very good' or 'good.'

Some of the comments included the following:

> ***"The surgery is such a warm and welcoming place, everyone wants to help and provides good care. The GPs have up to date training and have supported me and my family in so many ways. I am informed about my health. I am so impressed with this surgery, especially as I have experience very poor care from other surgeries. We moved to this GP and have been so happy with our care!"***
>
> ***"This surgery seems very well organised, happy and extremely polite and willing to help with any question."***
>
> ***"My experience is of a practice that is very well run by competent, caring staff."***
>
> ***"First class in all respects."***
>
> ***" …is a very rude Dr who didn't listen to my daughter's concerns. She was dismissed and spoken to awfully… there is no compassion from many of the Drs, this with the exception of [Doctor]. The number of missed diagnosis's that have occurred in Sully Surgery is of a huge concern. My husband which was one… We have tried to leave this surgery but due to areas of where [we] live, no other GP surgery's will take on myself and my family."***

Person-centred

Health promotion

The practice had a range of health promotion information available for patients. We saw health promotion information on a variety of topics, including screening services, dementia and carers information.

Responses to our patient questionnaire confirmed that health promotion and patient information material was on display at the practice. Additionally,

respondents to our staff questionnaire said the practice offered health promotion advice and information about chronic conditions to patients.

We were told the practice engages with several agencies to improve access to various healthcare professionals via their cluster group. This included access to physiotherapy, mental health services, the primary care liaison service, and the safe at home team which enables patients to access help and support from other agencies in a timely manner.

A separate area was available next to the waiting area where patients were able to use the weighing scales and blood pressure machine, their results are automatically recorded in their patient record. This is an area of noteworthy practice, since patients can access this anytime the surgery is open. However, **patients would benefit from increased awareness of this service and a notice with clear instructions.**

Preparations by the practice to manage the annual winter vaccination programme were suitable and included arrangements for vulnerable patients and those without digital access.

Dignified and respectful care
We found patients were treated with dignity and respect throughout their GP journey. Clinical rooms provided patients with an appropriate level of privacy, with doors kept closed during consultations. Privacy curtains were also available.

All but one respondent to the patient questionnaire felt they were treated with dignity and respect, and that measures were taken to protect their privacy.

Reception staff were observed welcoming patients in a professional and friendly manner. The reception desk was partitioned by glass, which offered some level of privacy from the waiting area. To protect confidentiality, telephone calls could also be taken in two private rooms, away from the reception desk if needed. For those responding to our patient questionnaire, the majority felt they could talk to reception staff without being overheard.

The practice offered chaperones in all appropriate circumstances, and there was a chaperone policy in place. A chaperone information notice was displayed in the waiting area, however, not all clinical treatment rooms had notices indicating that this service was available.

The practice must ensure that information is available to patients regarding the option of a chaperone in all clinical treatment rooms

Timely

Timely care
There were processes in place to ensure patients could access care and with the most appropriate person in a timely manner.

Appointments were made mostly by telephone, but some appointments could also be made online and in-person. Appointments comprised of urgent on the day appointments, or routine bookable appointments. We were told that the practice offers bookable appointments 13 weeks in advance, **this is an area of noteworthy practice**.

All but one respondent to our patient survey said they were able to get a same-day appointment when they needed to see a GP urgently, and all but two said they could get routine appointments when they needed them.

The practice has implemented a telephone 'call back' system, which allows patients to request the practice to call them back when they are at the front of the queue, instead of waiting on hold. On the day of our inspection, we saw the GP call log activity data that showed the practice had received no drop out phone calls that morning.

Some patients commented on access to appointments, which included:

> ***"I was previously at another surgery and having issues getting appointments, even for a young baby, leading to me writing a complaint letter. In complete contrast, Sully Surgery has been a breath of fresh air! The staff are always so accommodating and friendly and really take the time to help you. Waiting times on the phone are low and I have always felt satisfied with the speed in which I get an appointment. I only wish that all GP practices could be like Sully!"***

There were processes in place to support patients in mental health crisis. Where appropriate, patients are referred to the mental health crisis team/ child and adolescent mental health service for urgent crisis support. Alternative support and signposting were also available for patients needing mental health support.

Equitable

Communication and language
We found that staff communicated in a clear manner and in language appropriate to patient needs. They also provided information in a way that enabled patients to

make informed decisions about their care. The surgery had a hearing loop to support those with hearing difficulties.

Patients were usually informed about the services offered at the practice through the website and by sharing information and updates via a text messaging service. Where patients were known not to have a mobile phone, letters would be sent to individuals, and communication through telephone calls.

We were told there were no Welsh speaking staff at the practice. As part of the "active offer" for Welsh patients, all practice information and signs should be bilingual. We saw that some signs and posters were available in Welsh, however, most were available in English only.

The practice should ensure that the active offer of Welsh language is promoted to patients.

There were appropriate processes in place for the recording and action of information from secondary care. Letters and documents are directed to the correct health care practitioner to action as required and are sent to be scanned onto patient records. From the records we observed, we saw healthcare staff had provided information to patients in a way that met their individual needs.

Rights and equality
The practice offered good access for patients. We noted that patient areas, including treatment rooms and an accessible toilet were all located on the ground floor.

Access to the premises was good, providing patients with impaired mobility and wheelchair users with easy access while inside the building. The practice also has its own wheelchair that patients can use if necessary.

All patients responding to our questionnaire thought the building was easily accessible, however one respondent commented:

> *'…the surgery is on a hill which can be difficult for a mobility scooter or a wheelchair. Also, the toilet available is big but not quite accessible for someone on a mobility scooter or has no mobility.'*

An equality and diversity policy was in place, however this was not practice specific. Most respondents to the patient questionnaire felt they had not faced discrimination when accessing or using the service.

We were told that mandatory Equality and Diversity training was not in place for all staff at the time of inspection, and staff were not able to confirm who, if any had attended this training. This was addressed under our immediate assurance process at Appendix B.

The practice was proactive in upholding the rights of transgender patients. We were told transgender patients were treated with sensitivity and it was confirmed that their preferred names and pronouns would always be used.

Delivery of Safe and Effective Care

Safe

Risk management
The practice was clean and tidy, free of clutter and in a good state of repair. There were also processes in place to protect the health, safety and wellbeing of all who used the practice services.

We reviewed the practice business continuity plan which covered the business partnership risk, pandemic risk and appropriately detailed contingencies for long-term sickness absence.

The practice demonstrated cluster collaboration to ensure patient care could continue in the event of an extreme situation.

The process in place for managing patient safety alerts and significant incidents was robust. The practice manager was responsible for receiving patient safety alerts who disseminated to staff.

Infection, prevention and control (IPC) and decontamination
Overall, the IPC arrangements in place were acceptable, but some arrangements need strengthening to ensure the practice always upholds the required standards of IPC to maintain the safety of staff and patients.

There was no record maintained of staff who had completed IPC training or when it required updating. This was addressed under our immediate assurance process at Appendix B.

On review of human resource files and documentation, we found a system in place to check that all staff have immunity and/or are protected against the transmission of Hepatitis B. Although there was a register of all staff, we found this was undated.

The practice should ensure that the register for Hepatitis B is dated.

Although we were told IPC audits took place, we recommended that a more thorough IPC audit programme is implemented to monitor against standards.

This would help ensure that areas for improvement are identified promptly. For example, we noted carpet was used throughout the practice and in some clinical areas. Daily carpet cleaning was undertaken by the cleaning contractor and added to the cleaning schedules. However, carpet in clinical rooms pose an IPC risk, due to their inability to be cleaned as effectively as hard floors. It is recommended not to have carpet in clinical places.

The practice must update its IPC audit to ensure it is comprehensive and aligned with current, recognised IPC standards.

We were told that the practice had employed a contractor to provide the cleaning. During the inspection there were no records of weekly cleaning schedules available, however, cleaning schedules were found on the back of every door in each clinical room. We found that the public areas, treatment rooms/consulting rooms and reception were all clean and tidy.

The practice must ensure weekly cleaning schedules are implemented and a record kept, to maintain an audit trail.

Most patients responding to the questionnaire felt there were hand sanitizers available, and that healthcare staff washed their hands before and after being treated. All but one respondent described the practice as ‘very clean’ or ‘clean’.

There was an arrangement in place to segregate people with transmissible infections to reduce the risk of cross infection. We were told that a side door at the back of the building is available, which could be utilized for reducing contact with other patients. There was also an undercover seating area for patients to wait if necessary. Most patients responding to the questionnaire agreed there were signs at the entrance explaining what to do if they had a contagious infection.

Notices were displayed in the treatment rooms with information regarding sharps and waste disposal. However, a needle stick injury and blood borne virus policy were not in place, nor did we see a needle stick injury flow chart displayed in the clinical rooms to support staff if necessary. We suggested the practice displays a needlestick injury poster clearly within treatment areas.

The practice should display a needlestick injury management notice within treatment rooms to support staff following any sharps injuries.

The patients who indicated they had received an invasive procedure at the practice, said that staff used PPE, such as gloves during the procedure. They also said the equipment used was individually packaged or sanitised, and that antibacterial wipes were used to clean the skin prior to a procedure.

Suitable procedures were in place for the management and disposal of all waste, and a policy was in place to support this. We noted that the waste was secure, with no public access.

There was no record maintained to identify any staff who had completed IPC training, or when refresher training was needed. This was addressed under our immediate assurance process, with details in appendix B.

Medicines management
Processes were in place to ensure the safe prescribing of medication. The process for patients to request repeat medication was clear.

Most prescriptions were directed to the patient's pharmacy of choice. Prescriptions can also be collected at the reception desk, where a check of name, address and date of birth is conducted, and a record is kept.

The practice had a member of staff trained in repeat prescribing. The GPs authorise any actions or reauthorisations.

We saw that prescription pads were securely stored in a locked cupboard. We were told there was a process in place to securely dispose of prescription pads when a GP leaves the practice.

There was a cold chain process in place for medications or vaccines that required refrigeration. There were two dedicated clinical refrigerators for certain items, such as vaccines. Daily temperature checks were completed and the documentation we reviewed confirmed this. Conversations with staff confirmed that they were aware of the upper and lower temperature and what to do in the event of a breach to the cold chain.

The GPs complete medication reviews, which we were told was tied in with re-authorising. The practice has a repeat prescribing policy in place, but no general prescribing policy at present.

No controlled drugs were kept at the practice.

There was one portable oxygen cylinder stored in the practice. Whilst a notice was attached to the door housing the oxygen cylinder, this must be a statutory hazard notice and must be in place for areas where oxygen is stored or used. In addition, the location of the oxygen store was not highlighted in the fire safety plan.

The practice should ensure the oxygen storage room displays an appropriate statutory hazard notice on the door, and ensure the fire safety plan highlights the location of the oxygen store.

We also found that staff had not completed appropriate training for Portable Oxygen Cylinder. This was addressed under our immediate assurance process at Appendix B. We also found that the practice did not have a medicine management policy in place.

Safeguarding of children and adults
The practice had a named safeguarding lead for adults and children. Staff had access to practice safeguarding policies and procedures, which were ratified, current, and included contact details of designated leads. However, not all staff had completed safeguarding training at the required level. This was addressed under our immediate assurance process at Appendix B.

On review of patient records, we saw examples where people were appropriately flagged subject to any safeguarding concerns and followed a suitable safeguarding pathway. A computer desktop icon for child protection was present on every desktop, which was a good resource for all staff regarding Child protection. This contained the practice child protection policy and other support resources for staff.

Management of medical devices and equipment
Processes were in place to safely maintain equipment. We found all equipment was in a good condition, well maintained with appropriate electrical checks had been carried out. There were contracts in place for maintenance and calibration of equipment as appropriate, and for any emergency repairs and replacement.

There were appropriate resuscitation equipment and emergency drugs in place to manage a patient emergency, such as cardiac arrest. However, we were not assured that appropriate checks were undertaken on the emergency drugs and equipment. The records we reviewed showed checks were only completed monthly, but should be completed weekly, in line with the Resuscitation Council UK; Quality Standards: Primary care equipment and drug list. This should include checking the oxygen cylinder, Automated External Defibrillator (AED), and resuscitation equipment and drugs. This was addressed under our immediate assurance process at Appendix B.

We also found that the practice did not have a backup battery for the defibrillator, nor was there a sign indicating where the AED equipment was being stored. When asked, staff however, confirmed correctly where the emergency equipment and drugs were kept.

The practice must:

- **Consider stocking a back-up battery for the defibrillator**
- **Implement a notice clearly indicating where the AED equipment is being kept.**

During our inspection, we found that the emergency drugs located in the Practice Nurses room were kept in a locked cupboard. All resuscitation drugs must be stored in tamper-evident container and are easily accessible in the event of a patient emergency, in line with the Resuscitation Council UK. The practice must ensure that the emergency drugs are easily accessible to staff and are stored in a secure location, in a tamper- evident container. This was addressed under our immediate assurance process at Appendix B.

We did not see evidence that staff had completed appropriate training for medical emergencies, and basic life support training. This was addressed under our immediate assurance process at Appendix B. We also found that the practice did not have a Resuscitation policy in place.

Effective

Effective care

Processes were in place to support safe and effective care, and this included the process for receiving treatment or care across the GP cluster and wider primary care services. We found examples of acute and chronic illness management, and clear narrative with evidence of patient centred decision making.

There was an appropriate system in place for reporting incidents, and any shared learning was completed within team meetings.

We were told that any safety notices, changes or new guidance is shared with staff via email and discussed with staff as appropriate, and the information is stored on the shared drive for all staff to access.

Patient referrals were managed to a good standard, including those which are urgent. Patient records contained investigation/ test results and had narrative as to why investigations were requested.

Patient records

We reviewed a sample of ten electronic patient records. These were stored securely and were password protected from unauthorised access. The records were clear, written to a good standard and completed with appropriate information. Record entries were contemporaneous and were easy to understand by other clinicians. All the records that were reviewed had recorded whether the patient had an allergy or no allergy. **This is an area of noteworthy practice.**

We found the continuity of care was overall good, with close oversight and supervision of patients and their records by all the GPs. The records seen evidenced good quality patient consultations. However, these could be improved

by the regular use of Read Codes to maintain summaries and link consultations for the same clinical problem. There was no formal training process in place or documents to support staff with coding, nor is there a formal audit of summarising accuracy.

The practice must

- **Audit patient records and Read coding use, to ensure a consistent approach in recording information**
- **implement formal training for summarising and coding, and audits should be completed on the accuracy of that summarised and coded.**

Efficient

Efficient

We found that services were arranged in an efficient manner and are person centred, to ensure people feel empowered in their healthcare journey.

The practice can refer to physiotherapy, mental health services, drug and alcohol support and sexual health services via the cluster group. However, the counselling service was no longer available within the cluster.

Overall, we found that services were arranged in an efficient manner and were person centred to ensure people feel empowered in their healthcare journey.

Quality of Management and Leadership

Staff feedback

We engaged with staff throughout our inspection and sought feedback through a staff questionnaire. All respondents agreed that they had received the appropriate training to undertake their role. Two of the three respondents stated that they had not had their appraisal, development review or annual review.

All respondents 'strongly agreed' or 'agreed' that they were able to meet the conflicting demands on their time at work and had adequate materials, supplies and equipment to do their work. However, one felt there were not enough staff to allow them to do their job properly, and another felt they were not able to make suggestions to improve GP services.

All respondents 'strongly agreed' or 'agreed' that the care of the patient is the practice's top priority

All respondents felt:

- Content with the efforts of the practice to keep staff and patients safe
- They would recommend the practice as a good place to work
- They would be happy with the standard of care provided by the practice for myself or friends and family

Leadership

Governance and leadership

There were processes in place to support effective governance, leadership and accountability. Staff were clear about their roles, responsibilities and reporting lines, and the importance of working within their scope of practice.

Most staff we spoke with felt supported and able to approach leaders with any concerns and felt these would be addressed appropriately. Leaders confirmed that an open-door policy was in place to enable staff to share concerns and ideas for the practice.

We were told staff meetings were routine, and these were formally recorded. The meeting minutes we reviewed did not however, include a record of actions, where applicable, to enable action owners to understand what was required of them.

The practice should consider including an action log on meeting minutes to effectively allocate and monitor actions appropriately.

We reviewed a comprehensive suite of policies and procedures, with five not being in place (Medicine Management, General Prescribing, Summarising, Resuscitation and Blood Borne Virus Policies). There was a limited document control process in place, and some policies had not been implemented to align with the specific needs of the practice.

The practice must strengthen governance arrangements to include robust document control and review process, to ensure all relevant policies and procedures are in date, reviewed regularly, are available to staff and relevant to the practice.

Workforce

Skilled and enabled workforce

During our inspection we were only provided the training records of administrative staff. We were informed that a record is not held at the practice, such as a training matrix, to monitor whether all staff had completed the required training and were up to date with refresher training, to maintain the safety of patients, staff and visitors to the surgery. Implementing a training matrix for all staff roles would clearly identify training compliance and those due to complete update training. As a result, we were not assured that the management and oversight of mandatory training compliance is robust to ensure all staff remain competent to perform their roles safely and appropriately. This was addressed under our immediate assurance process at Appendix B.

There were appropriate recruitment policies and procedures in place, and the practice manager described the required pre-employment checks for any new members of staff before they joined the practice. This included checking of references and undertaking Disclosure and Barring Service (DBS) checks appropriate to their role.

Culture

People engagement, feedback and learning

The practice sought patient feedback, and information was displayed in the waiting area detailing how people could feedback on their experiences. However, there was no evidence to demonstrate that patient feedback is routinely used by the practice to learn and inform service improvement.

The practice must ensure that any patient experience feedback is used to help inform service improvement and enhance the patient experience.

An effective complaints process and tracking system was in place to monitor, review and resolve complaints and feedback. This was aligned to the NHS Wales Putting Things Right process.

Staff felt comfortable to speak up regarding any concerns they may have, and a whistleblowing policy was in place to support this. In addition, staff felt comfortable to share any suggestions they might have and could provide these to their manager for consideration. However, one respondent to the staff questionnaire disagreed they could make suggestions to improve services at the practice.

We spoke to staff about the arrangements in place regarding compliance with the Duty of Candour. A Duty of Candour policy was in place, however the records we reviewed showed not all staff had completed training on this topic. This was addressed under our immediate assurance process at Appendix B.

The members of staff who completed a questionnaire agreed that they knew and understood their role in line with Duty of Candour.

Information

Information governance and digital technology

The practice understood its responsibility when processing information and demonstrated that data is managed in a safe and secure way. A current information governance policy was in place to support this; however, we didn't see evidence that all staff had completed training on this topic. This was addressed under our immediate assurance process at Appendix B.

The practice's process for handling patient data was available for review on the website.

Learning, improvement and research

Quality improvement activities

The practice engaged in learning from internal and external reviews, including incidents and complaints. We were told learning was shared across the practice via regular staff meetings to make improvements, however, as highlighted earlier, there was no evidence of any actions taken.

Whole-systems approach

Partnership working and development

We found evidence of partnership working with the practice's collaboration within a GP cluster. Medical staff attended cluster meetings and provided services on a cluster wide basis.

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 resolved during this inspection			

Appendix B – Immediate improvement plan

Service: Sully Surgery

Date of inspection: 28 January 2025

Findings

HIW is not assured that appropriate checks are undertaken on the emergency drugs and equipment. The records we reviewed showed checks were only being recorded monthly. Checks should be carried out weekly, in line with the Resuscitation Council UK; Quality Standards: Primary care equipment and drug list. This should include checks of the oxygen cylinder, the defibrillator and resuscitation equipment and drugs.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
1.	The practice must: • ensure all emergency drugs and equipment are checked and recorded on a weekly basis	Health & Care Quality Standards (2023) – Safe; Timely; Information	We have amended our schedule so that our lead nurse makes these checks weekly now, which is documented each time for assurance.	SK (Sian Kelly, lead nurse), overseen by KS (Kathy Stanton, practice manager)	Immediate effect

Findings

HIW found that the emergency drugs located in the Practice Nurses room were kept in a locked cupboard. All resuscitation drugs must be stored in tamper-evident containers, and are easily accessible in the event of a patient emergency, in line with the Resuscitation Council UK

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale

2.	The practice must ensure that the emergency drugs are easily accessible to staff and are stored in a secure location, in a tamper-evident container	Health & Care Quality Standards (2023) – Safe	We will be purchasing a tamper evident seal/container for the emergency drugs, and no longer use the lock on the cupboard.	SK/KS	4 weeks

Findings

HIW is not assured that the management and oversight of mandatory training compliance is sufficiently robust to ensure all staff remain competent to perform their roles safely and appropriately.

During our inspection we were only able to review the training records of administrative staff. We were informed that a record is not held at the practice, such as a training matrix, to monitor whether all staff had completed the required training and were up to date with refresher training, to maintain the safety of patients, staff and visitors to the surgery.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
3.	The practice must: • Ensure all staff complete all aspects of mandatory training, and provide evidence of completion • Implement a robust system to monitoring staff compliance with mandatory training and any update training.	Health and Care Quality Standards – Safe; workforce; information	We have established a central training matrix for mandatory training for all staff, including administrative staff. This matrix will be reviewed and kept up to date annually, as well as individual staff having this monitored via their annual appraisal as currently takes place.	KS	4 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): Dr Calum Forrester-Paton

Job role: GP Partner

Date: 30/01/2025

Appendix C - Improvement plan

Service: Sully Surgery

Date of inspection: 28 January 2025

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.	A chaperone information notice was displayed in the waiting area, however, not all clinical treatment rooms had notices indicating that this service was available.	**The practice must ensure that information is available to patients regarding the option of a chaperone in all clinical treatment rooms**	Health & Care Quality Standards - Information	Chaperone notices are now displayed in all clinical treatment rooms	K Stanton PM	Implemented
2.	There are no Welsh speaking staff within the practice, however as part of the	**The practice should ensure that the active offer of Welsh language is promoted to patients.**	Health & Care Quality Standards - Information	We are a small practice with 14 mostly part-time staff members. Although the ability to speak Welsh has been	K Stanton PM	3 months

	“active offer” for Welsh patients, all practice information and signs should be bilingual. We saw that some signs and posters were available in Welsh, however, most were available in English only.			considered desirable criteria for all job advertisements for many years, we unfortunately don’t have a Welsh speaker amongst our staff. The Welsh language is not spoken widely in this area, however, we appreciate the importance of patients being able to consult in their 1st language if they wish to. We therefore feel Language Line would be the best option should the need arise. Staff have been asked to complete the Welsh Language Awareness (More than just words) training on Learning@NHSWales. This will be incorporated into their routine training programme. Once this is completed they will		

				be encouraged to consider the Cymraeg Gwaith Work Welsh short online taster courses for the healthcare sector. We are hopeful tis will highlight small changes that can be made by everyone to increase the use of Welsh in everyday life at the practice. Patients joining the practice list are asked their language preference as part of the New Patient Questionnaire. A record of any preferred language is made in the electronic clinical system. Where Welsh is expressed as the preferred language this information would also be added as a pop-up 'message' when the record is		

				opened to remind/encourage staff to use well-known Welsh phrases such as shwmae, da iawn, hwyl fawr etc. This approach is also taken by clinicians if they become aware of Welsh being spoken during a consultation, for example by a parent to a child. We will ensure that practice information and posters are bilingual.		
3.	On review of human resource files and documentation, we found a system in place to check that all staff have immunity and/or are protected against the transmission of	**The practice should ensure that the register for Hepatitis B is dated.**	Health & Care Quality Standards – Information; Safe	Hepatitis B register is dated	K Stanton PM	Implemented

	Hepatitis B. Although there was a register of all staff, we found this was undated.					
4.	Although we were told IPC audits took place, we recommended that a more thorough IPC audit programme is implemented to monitor against standards.	**The practice must update its IPC audit to ensure it is comprehensive and aligned with current, recognised IPC standards.**	Health & Care Quality Standards – Information; Safe	Our lead IPC nurse will review our audit process and ensure this is comprehensive and aligned with current IPC standards. We have an updated IPC policy which includes an IPC audit programme. We are planning to change carpets to hard flooring compliant with IPC standards	S Kelly Practice Nurse	3 months
5.	We were told that the practice had employed a contractor to provide the	**The practice must ensure weekly cleaning schedules are implemented and a**	Health & Care Quality Standards – Information; Safe	The cleaning contractor has been instructed to supply and maintain weekly cleaning schedules	K Stanton PM	1 month

	cleaning. During the inspection there were no records of weekly cleaning schedules available, however, cleaning schedules were found on the back of every door in each clinical room. We found that the public areas, treatment rooms/consulting rooms and reception were all clean and tidy.	**record kept, to maintain an audit trail.**		and records will be kept. Response is awaited		
6.	Notices were displayed in the treatment rooms with information regarding sharps and waste disposal. However, a needle stick injury and blood	**The practice should display a needlestick injury management notice within treatment rooms to support staff following any sharps injuries.**	Health & Care Quality Standards – Information; Safe	Needlestick Injury management notices have been displayed in all treatment rooms. Our IPC policy has been updated to include Blood Borne	K Stanton PM S Kelly Practice Nurse	Implemented

	borne virus policy were not in place, nor did we see a needle stick injury flow chart displayed in the clinical rooms to support staff if necessary. We suggested the practice displays a needlestick injury poster clearly within treatment areas.			Virus and Needlestick injury sections.		
7.	Whilst a notice was attached to the door housing the oxygen cylinder, this must be a statutory hazard notice and must be in place for areas where oxygen is stored or	**The practice should ensure the oxygen storage room displays an appropriate statutory hazard notice on the door, and ensure the fire safety plan highlights the location of the oxygen store.**	Health & Care Quality Standards – Information; Safe	We have amended the fire safety plan to incorporate the oxygen cylinder location. We have changed the signage on the treatment room door to ensure it complies with statutory signage.	K Stanton PM	Implemented

	used. In addition, the location of the oxygen store was not highlighted in the fire safety plan.					
8.	We found that the practice did not have a backup battery for the defibrillator, nor was there a sign indicating where the AED equipment was being stored. When asked, staff however, confirmed correctly where the emergency equipment and drugs were kept.	**The practice must:** • **Consider stocking a back-up battery for the defibrillator** • **Implement a notice clearly indicating where the AED equipment is being kept.**	Health & Care Quality Standards – Information; Safe	We have added the battery for the AED to the emergency drug list, so that it is monitored on a weekly basis. We have added an AED sign to the treatment room door. We have training for all staff on where emergency equipment is kept and posters are not considered an appropriate way of managing clinical staff or critical situations.	K Stanton PM	Implemented
9.	We found the continuity of care was overall good,	**The practice must** • **Audit patient records and Read**	Health & Care Quality Standards – Information; Safe	Read coding policy to be agreed and implemented. This	C Forrester-Paton GP Partner	6 months

	with close oversight and supervision of patients and their records by all the GPs. The records seen evidenced good quality patient consultations. However, these could be improved by the regular use of Read Codes to maintain summaries and link consultations for the same clinical problem. There was no formal training process in place or documents to support staff with coding, nor is there a formal audit of summarising accuracy.	**coding use, to ensure a consistent approach in recording information** • **implement formal training for summarising and coding, and audits should be completed on the accuracy of that summarised and coded.**		will be discussed and explained at practice meetings. Summarising policy to be agreed and implemented, with audit of notes to ensure consistency with the policy	K Stanton PM	

10.	We were told staff meetings were routine, and these were formally recorded. The meeting minutes we reviewed did not however, include a record of actions, where applicable, to enable action owners to understand what was required of them.	**The practice should consider including an action log on meeting minutes to effectively allocate and monitor actions appropriately.**	Health & Care Quality Standards – Information	A template document has been created to ensure that all meetings have a clear log of agenda items, actions, who is completing and timelines associated	A Rayani GP Partner K Stanton PM	Commenced and ongoing
11.	We reviewed a comprehensive suite of policies and procedures, with five not being in place (Medicine Management, General	**The practice must strengthen governance arrangements to include robust document control and review process, to ensure all relevant policies and procedures are in date, reviewed**	Health & Care Quality Standards – Information	We have a resuscitation policy which is in the electronic Policies, Procedure & Protocols folder. If it was not available during the visit this was an	K Stanton PM	2 months

	Prescribing, Summarising, Resuscitation and Blood Borne Virus Policies). There was a limited document control process in place, and some policies had not been implemented to align with the specific needs of the practice.	**regularly, are available to staff and relevant to the practice.**		oversight. We have plans above to implement a BBV policy and summarising policy. We have also added a Medicines Management policy to the prescribing policy. We will improve our document control and review process to ensure all policies are review at appropriate intervals.		
12.	The practice sought patient feedback, and information was displayed in the waiting area detailing how people could feedback on their experiences. However, there	**The practice must ensure that any patient experience feedback is used to help inform service improvement and enhance the patient experience.**	Health & Care Quality Standards – Information	We will include patient feedback as a section in our regular practice meetings to ensure we consider this as a method for improvement. We have created a suggestions/feedback box for informal feedback, which will	K Stanton PM	3 months

	was no evidence to demonstrate that patient feedback is routinely used by the practice to learn and inform service improvement.			be included for discussion alongside more formal avenue such as annual survey and orbit 360 as part of appraisal.		

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): **K Stanton**

Job role: **Practice Manager**

Date: **26.3.25**