Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report

(Announced)

Willowbrook Surgery, Cardiff & Vale Health Board

Inspection date: 03 February 2025
Publication date: 06 May 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 978-1-83715-654-2

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 Willowbrook Surgery, Cardiff & Vale Health Board on 03 February 2025.

Our team for the inspection comprised of one HIW healthcare inspectors, 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 two questionnaires were completed by patients or their carers and four 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 practice had a range of health promotion information available for patients, which was displayed in the patient waiting areas and promoted through the practice website. The waiting area also had a blood pressure monitor that patients could use without the need for an appointment.

Patients were treated with dignity and respect and clinical rooms provided an appropriate level of privacy during consultations. Reception staff were observed welcoming patients in a professional and friendly manner, with measures in place to protect confidentiality during phone calls and at the reception desk.

Patient could access various healthcare professionals through the GP cluster group, including physiotherapists, mental health services, and pharmacists. Staff at the practice worked closely with their patient group to ensure they received the right care from the right services, especially vulnerable patients who were contacted directly to ensure they had access to services specific to their needs.

There was good access into the premises allowing patients with impaired mobility and wheelchair users to easily access the facilities. The practice also had access to translation services to support their community with specific language needs.

This is what we recommend the service can improve:

- The practice must update their workflow list within the policy to ensure all correspondence is being managed by the most appropriate person

This is what the service did well:

- Good patient access
- Provided a blood pressure monitor, enabling patients to access this without the need for an appointment
- Access to translation services to support patients with specific language requirements.

Delivery of Safe and Effective Care

Overall summary:
Our findings demonstrated a dedicated and enthusiastic team who worked hard to provide patients with safe and effective care.

There were processes in place to protect the health, safety and wellbeing of all who used the service, including within clinical rooms. The practice was clean and tidy, free of clutter. At the time of the visit, the practice was in the process of making improvements to the environment.

The Infection Prevention and Control (IPC) arrangements were generally acceptable, but certain areas require improvement to consistently meet the required standards and ensure the safety of both staff and patients.

Daily temperature checks of the fridges were completed and recorded. The fridges we checked had good air circulation due to the appropriate storage of the medicines as per the manufacturer's guidelines.

There was an appropriate mechanism in place should help be urgently required within the practice. The emergency drugs and equipment were stored within the nurse's room. Access to the emergency kit could be restricted if the room was occupied by a patient and therefore, we recommended the emergency drugs and equipment are re-located to an area with easy access.

The safeguarding procedures in place were satisfactory supported by a policy, which also highlighted the named safeguard leads. However, we found that the level of safeguarding training relevant to staff roles, and as listed in the policy, did not correlate with staff records.

Overall, the patient medical records were of good quality. They were clear, written to a good standard and complete with appropriate information. Entries were contemporaneous, and information was easy to understand for other clinicians reviewing the records.

Responses from staff who completed the questionnaire were positive. All staff felt that the care of patients was this practice's top priority, and they all were content with the efforts of the practice to keep staff and patients safe.

Immediate assurances:

- A controlled drug was stored in an unsecured cupboard
- Some equipment and medication were passed their expiry dates
- The IPC procedures were not robust to uphold the required standards of IPC and maintain the safety of staff and patients.

The details of the immediate improvements required, and remedial action is highlighted in Appendix B.

This is what we recommend the service can improve:

- Reconsider relocating the emergency drugs and equipment to an area that would enable easy access
- Ensure staff have the required level of safeguarding training as listed in the policy
- Expand their process to be able to audit when and who collects prescriptions for controlled drugs.

This is what the service did well:

- Patient records were clear, written to a good standard and complete with appropriate information. They were contemporaneous and information was easy to understand for other clinicians reviewing the records
- The practice demonstrated good cluster cooperation to ensure patient care could continue in the event of an extreme situation
- Medical devices and equipment were in good condition, safe to use and had been appropriately checked.

Quality of Management and Leadership

Overall summary:
There were processes in place to support effective governance, leadership and accountability, to ensure a sustainable delivery of safe and effective care. This was supported by a suite of relevant policies and procedures, and there were suitable processes in place to share any information updates with staff.

Staff had access to an online training platform and were given time to complete training. However, whilst most staff had completed their mandatory training, some needed refresher training which needs completing promptly to ensure their skills and knowledge remain up to date. A training matrix was being developed, which will provide an overview of training compliance for all the staff at the practice.

Staff were clear about their roles, responsibilities, and reporting lines, and the importance of working within their scope of practice. Information sharing with staff was facilitated through a shared drive and email notifications about changes in policies or procedures. Policies were detailed, specific to the practice, and accessible to all staff both digitally and in paper format.

The practice had a comprehensive complaints process aligned with the NHS Wales Putting Things Right process, with identified staff responsible for managing complaints. Compliance with the Duty of Candour is supported by a policy, although training is recommended to ensure staff are aware of their responsibilities. Staff felt able to raise concerns and make suggestions for improvement.

This is what we recommend the service can improve:

- All staff must complete their mandatory training at a level specific to their role
- The practice must implement a system which ensures a person remains suitable to work at the practice

This is what the service did well:

- Well managed complaints process with systems to identify any themes
- The practice understood their responsibility when processing information and demonstrated that data is managed in a safe and secure way
- Staff were friendly and engaging
- The re-starting of the patient participation group.

3. What we found

Quality of Patient Experience

Person-centred

Health promotion
During our inspection we saw that the practice had a wide range of written health promotion information available for patients. The information was displayed in the patient waiting areas, on the display screen and promoted through the practice website. We saw health promotion information on a variety of topics including various support groups and carers information.

The waiting area had a blood pressure monitor that patients can use without the need for an appointment. Print out results from the blood pressure monitor can be taken to reception for the information to be added to the patients record.

We were told the practice engaged with several agencies to improve access to various healthcare professionals via their cluster group. These included access to physiotherapy, mental health services and pharmacists. This enables patients to access help and support from other agencies in a timely manner.

Staff at the practice work closely with their patient group to ensure they receive the right care from the right services. To ensure vulnerable patients receive timely care, the practice has lists of patients that they call to make certain they have access to services specific to their needs.

The ‘was not brought’ procedure was included within the ‘did not attend’ policy. Staff confirmed that any person who misses their appointments receives a letter, including any children who do not attend their appointments, at the practice or at hospital. The policy and system in place to manage these patients was appropriate.

The process and preparations in place to manage the annual winter vaccination programme were suitable and included arrangements for those without digital access.

From the patient questionnaires, one patient told us there was health promotion information on display at the practice and another respondent disagreed with this statement. Both respondents disagreed they were offered healthy lifestyle advice and strongly disagreed that their GP explained things well to them and answered

their questions. One patient said they felt listened to and they were involved as much as they wanted to be in decisions about their healthcare, another patient strongly disagreed with this.

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

One out of two respondents 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. To protect confidentiality, telephone calls could be taken in the administration office, away from the reception desk. The reception desk was located opposite the waiting area, which offered some level of privacy from the waiting area.

Both patients responded negatively regarding their ability to talk to reception staff without being overheard.

We saw notices displayed offering a chaperone service at the reception desk and within the clinical rooms. Both male and female chaperones were offered, and this included clinical and non-clinical staff. The policy reflected the process in place, and we saw that patient notes recorded whether chaperones were accepted or declined by the patient.

For patients who responded to the question about chaperones, one said they were offered a chaperone, and one said this option was not applicable to them.

Timely

Timely care
There were processes in place to ensure patients could access the right service at the right time and in a timely manner. Patients are informed of the different options available to them in terms of accessing appointments via the practice website, notices in the waiting room, social media platforms and staff also provide information on the appointments system.

Appointments are mostly made via telephone, and we were told that reception staff will explain to patients what options they have regarding the type of appointment. Most patients are offered face to face appointments, however, if a telephone call is requested this can be provided.

Both respondents to the survey told us they had made an appointment in person at the practice.

A practice access policy was in place and the website is informative regarding appointment systems.

We found the care navigators had a good pathway in place, assigning patients to the most appropriate person or service. The pathway was available to all staff and the care navigators had access to the on-call doctor who was available to provide guidance as necessary. Staff signpost to appropriate services using their pathway and made good use of cluster-based support services.

We were told that patients could self-refer to the mental health service.

In response to our questionnaire, all patients agreed they were satisfied with the opening hours of the practice. Both patients disagreed that they were able to contact the practice when they need to by phone/online booking system, and one patient agreed they were able to have a same-day appointment when they need to see a GP urgently.

Equitable

Communication and language
We found staff communicating in a clear manner and in a language appropriate to patient needs. They provided information in a way that enabled patients to make informed decisions about their care.

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

We were told there were no Welsh speaking staff at the practice and that there were no patients who had requested services in Welsh. However, the practice has access to and has used translation services to support patients who required services in a different language.

The practice ensured messages were communicated internally to the appropriate people, by using the practices communication and technology (ICT) systems. Staff told us emails were the preferred option because the read receipt ensured communications were read and where applicable, acted upon.

A workflow policy was in place, but we recommended the workflow list is updated to ensure correspondence is being managed by the most appropriate person in the team.

The practice must update the workflow list within the policy to ensure all correspondence is being managed by the most appropriate person.

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

All patients who answered the HIW questionnaire thought the building was easily accessible.

We saw evidence of an equality and diversity policy in place. Staff had access to and had completed equality and diversity training. All respondents who answered the question confirmed they had not faced discrimination when accessing or using this health service.

The rights of transgender patients were also upheld, staff confirmed that preferred pronouns and names were used from the outset of transition.

Delivery of Safe and Effective Care

Safe

Risk management
There were processes in place to protect the health, safety and wellbeing of all who used the service, including within clinical rooms. The practice was clean and tidy, free of clutter. At the time of the visit, the practice was in the process of making improvements to the environment.

A business continuity plan (BCP) was in place and readily available for all staff. We found the BCP did not include information on how the sole practitioner GP will continue to provide essential healthcare services to patients if faced with their sudden departure.

The practice must update their business continuity plan to include the strategy for the incapacity of the sole practitioner GP.

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

We saw how patient safety alerts were received and disseminated to the practice and told that these were communicated in meetings. The process in place for managing patient safety alerts and significant incidents was good, but we recommended that meetings are recorded, and significant events are reviewed regularly to determine the impact of any lessons learnt.

The practice must record meetings for any significant events and ensure any lessons learnt are followed up.

There was an appropriate mechanism in place should help be urgently required within the practice. The emergency drugs and equipment were stored within the nurse's room. Access to the emergency kit could be restricted if the room was occupied by a patient and therefore recommended the emergency drugs and equipment are re-located to an area with easy access.

The practice must consider re-locating the emergency drugs and equipment to an area that would always enable easy access.

We were told the number of home visits the surgery carries out has significantly declined due to the loss of a local care home. However, the processes in place for undertaking home visits remain the same and include routine assessments as to the

risks posed by the individual patient circumstances, including the need for PPE where air borne infections are suspected.

Infection, prevention and control (IPC) and decontamination
Overall, the IPC arrangements in place were appropriate. However, we did find areas that required improvement to ensure the practice upholds the required standards of IPC to maintain the safety of staff and patients.

An IPC policy was in place and all staff had access to this. The policy identified a named person as the IPC lead. However, discussions with staff confirmed that there was no clinical related IPC advice and oversight being provided, and this was evident in our findings on the day. Therefore, we recommended that the practice ensures their IPC lead has the authority to lead and implement change in both clinical and non-clinical areas.

The practice must ensure the IPC lead has the skills and experience to lead and implement change in both clinical and non-clinical areas.

We noted that the practice had made improvements to some areas of the surgery, which included new flooring in the waiting areas. Staff described the plans to continue with upgrading the surgery which will improve IPC standards. However, we identified areas that required immediate improvements.

There was no IPC audit available, which we recommended is completed urgently. This will ensure compliance with established guidelines, including the practices' IPC policy. The details of this immediate improvement and the remedial actions is highlighted in Appendix B.

Records confirmed all relevant clinical staff had Hepatitis B immunity. An up-to-date blood borne virus policy was also in place.

A needlestick injury policy was in place and staff had access to this. The process staff follow should they sustain a needlestick injury was described to us and reflected what the policy included.

Appropriate procedures were in place for the management and disposal of all waste, and a policy was in place to support this. Waste was stored appropriately in a locked room. During the inspection, there were no female hygiene bins available. A change in contract had resulted in the delay of bins being delivered. This was raised at the time and confirmation has since been provided to confirm these are now in place.

The practice had a cleaning contract in place and cleaning schedules were visible.

Suitable arrangements were in place to segregate people with transmissible infections to reduce the risk of cross infection. One out of two patients responding to the questionnaire agreed there were signs at the entrance explaining what to do if they had a contagious infection.

The patients responding to the questionnaire felt there were hand sanitizers available, and those that answered the question said in their opinion the practice was clean.

Medicines management
Processes were in place to ensure the safe prescribing of medication. We saw prescriptions were kept in a cupboard; a lock was to be installed shortly. Prescriptions are taken out of computers at night and kept in a locked cupboard. We were told a new log process for this is being introduced shortly.

Staff described the process in place for when and who collects weekly prescriptions, which can be audited. We recommended this is expanded to include the collection of controlled drugs prescriptions.

The practice must expand their process and be able to audit when and who collects prescriptions for controlled drugs.

The process followed by the practice for repeat prescriptions was clear. Prescriptions were processed in a timely manner by suitably trained clerks and authorised by a doctor.

A prescribing policy was in place and prescribing clerks had access to regular training to ensure their skills and knowledge remains up to date.

A medication cold chain policy was in place for medicines and vaccines that require refrigeration, and clinical refrigerators were used to store them as appropriate. Daily temperature checks were completed and recorded. The fridges we checked had good air circulation due to the appropriate storage of the medicines as per the manufacturer's guidelines.

The practice had a nominated person responsible for checking the drugs on a weekly and monthly basis and the nursing staff were aware of who this is. Records were kept evidencing the drugs check. However, we noted some drugs and equipment were out of date. Further details of the actions taken by HIW in respect of this matter are recorded in Appendix B of this report.

All the emergency drugs and equipment were in place and met the standards of the UK resuscitation council guidelines. The nursing team are responsible for checking these on a weekly basis and the checks are documented. We discussed with staff the potential for a designated emergency bag that can store all the emergency kit. This would allow staff to obtain this quickly when needed rather than collect multiple bags and boxes.

An automated external defibrillator (AED) was in place and was fully charged. We found the AED had pads for both adults and children. All staff knew the location of the AED, and there was a sign at the reception to specify its location.

We saw the oxygen cylinder was in date, with appropriate stock levels and was checked on a weekly basis.

Safeguarding of children and adults
We considered the safeguarding procedures in place and found a which included a policy for both adults and children. The policy referenced the national Wales safeguarding procedures and was available for all staff on the shared drive. The practice had named safeguarding leads which were recorded in the policy.

We found that the required safeguarding training levels for staff, as listed in the policy did not match the evidence we found on certificates.

The practice must ensure all staff undertake the required level of safeguarding training (both children and adults) appropriate to their role, and a record should be kept to evidence this.

On review of patient records, we saw examples where people were appropriately flagged with any safeguarding concerns and followed a suitable safeguarding pathway.

We found evidence of multi-agency safeguarding meetings taking place, including the attendance of health visitors. Meetings are recorded. These measures help to ensure that people and staff can report safeguarding concerns, and necessary actions can be taken to protect the welfare of vulnerable patients.

Management of medical devices and equipment
We found medical devices and equipment were in good condition, safe to use and had been appropriately checked. Suitable contracts were in place for the repair or replacement of relevant equipment. Single use items were used where appropriate and disposed of correctly.

Effective

Effective care

Suitable processes were in place to support the safe, effective treatment and care for patients. We were told that any changes or new guidance is emailed and discussed with staff in meetings.

Appropriate processes were in place for reporting incidents, including discussions at internal meetings and Datix reporting where appropriate. We noted minutes of meetings are not formally captured and recommend they are.

The practice must ensure a record is kept of meeting minutes, which can be shared with staff as appropriate.

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.

Patients in need of urgent medical help or those in a mental health crisis were provided with suitable support and information. The practice has access to the local mental health crisis team, which we were told has provided prompt support to patients.

The practice had a suitable process in place to deal with the changes in legislation for person death certification.

Patient records

We reviewed ten electronic patient records, which were stored securely and were password protected from unauthorised access. Overall, the records were clear, written to a good standard and complete with appropriate information. They were contemporaneous and information was easy to understand for other clinicians reviewing the records.

We found the use of clinical Read codes were not being used consistently, which makes analysis and audit difficult. The practice is scheduled to migrate their records to a new system which will help mitigate this issue.

The patient records where chronic disease was recorded contained a full summary of the condition/s, including all past and continuing problems as well as the medication being taken.

From the notes reviewed, we found that the patient's language choice was not always recorded.

The practice must ensure that patient language preference is recorded and easily identified in their clinical records.

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 and mental health services and most patients are able to self-refer for certain services.

There are close working relationships with the cluster group, and we were told of the projects the practice is involved in via the cluster, including Fit for 50 and Teen Talk.

Quality of Management and Leadership

Leadership

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

The practice had a process in place for sharing information with staff, such as changes in policies or procedures. All policies and procedures were on the shared drive and all staff would be told about any changes via email.

The document control on the polices we saw included a review date and signed by. Overall, the policies we reviewed were detailed and specific to the practice. Policies are saved on a shared drive which allows all staff access to them. Paper copies were also available.

We found appropriate measures were in place to share any safety notices with staff.

We were told staff meetings do take place, but the practice would like to make them more frequent. Some minutes of meetings were seen, but we recommended minutes and actions are captured at all meetings. Any lessons to be learned are shared with staff to ensure the practice retains good service standards and improvements, where applicable. This was also highlighted earlier in the report.

The practice worked closely within the Health Board cluster group and worked collaboratively to lead projects, share learning and jointly manage initiatives.

Workforce

Skilled and enabled workforce
We spoke with staff across a range of roles. They all had sound knowledge of their roles and responsibilities, and each appeared committed to providing a quality service to patients.

Staff told us the process the practice uses for recruitment and conducting pre-employment checks, which included written references, evidence of registration with professional bodies and disclosure and barring (DBS) checks.

We found the system being used to check a healthcare's professional registration involved staff submitting a copy of their professional certificate for their staff file.

We were told the practice were considering asking staff to provide a self-declaration to confirm they remain suitable to work for the service and no changes have occurred since their last DBS check. Informal appraisals have been taking place for staff, but we were told these will now be documented.

The practice must confirm the system implemented to ensure a person remains suitable to work at the practice.

An induction process was available for new staff and a recruitment policy was in place. The contents of which included what we had been told.

There was no workforce plan in place but there were rotas for each area of work. Staff leave is planned, so cover can be arranged. We were told there were no issues with the skill mix across the teams and this is reviewed regularly by the practice manager, ensuring staff numbers and clinical staff levels are maintained.

Generally, we found staff had completed their mandatory training, however some areas had expired and these need to be completed as soon as possible to ensure staff skills and knowledge remain up to date. The administration staff all need to complete safeguarding and CPR training, and one nurse requires updating their safeguarding training.

The practice must ensure all staff are up to date with their mandatory training and complete the levels applicable to their role.

A training matrix was being developed which will provide an overview of training compliance for all the staff at the practice. All staff had access to an online training platform and staff are given time to complete training.

The practice must update the training matrix with all clinical staff and ensure it is monitored regularly to ensure staff skills and knowledge remain current.

A review of staff records showed their files contained employment information specific to the requirements in the recruitment policy. This information included DBS checks, contracts of employment and Hepatitis B immunity.

We were assured that staff would be supported to raise a concern should the need arise, and we were provided with the practice whistleblowing policy.

Staff results from the HIW questionnaire confirmed:

- Three out of four staff agreed they were able to meet all the conflicting demands on my time at work
- All agreed they had adequate materials, supplies and equipment to do their job
- Half agreed there is an appropriate skill mix at the setting.

Culture

People engagement, feedback and learning
The practice had a comprehensive complaints process in place. A complaints procedure and policy were aligned to the NHS Wales Putting Things Right process. There were identified staff at the practice responsible for managing all complaints. This was clear within the complaints policy. Complaints/concerns are monitored to identify any themes and trends, and any actions for improvement are communicated to staff.

We found evidence that patient suggestions are welcomed and acted upon. A suggestion box was available next to the reception. It was positive to hear that the practices' patient participation group had restarted after Covid-19. We proposed that any suggestions the practice implement because of patient feedback could be displayed to show how they used this for service improvement.

We were told staff felt able to speak to the practice manager regarding any concerns they may have. In addition, they felt comfortable to share any suggestions they might have with the practice manager for their consideration. Three out of four staff members who completed the HIW survey agreed they could make suggestions to improve services. Three out of four members of staff disagreed that they are involved in deciding on changes introduced that affect their work.

We spoke to staff about the arrangements in place regarding compliance with the Duty of Candour. A Duty of Candour policy was in place, but we were unable to find evidence that staff had completed Duty of Candour training. We recommended training is undertaken to ensure staff are aware of their responsibilities as set out in the Duty of Candour Statutory guidance 2023.

The practice must confirm staff have completed Duty of Candour training.

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.

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

Learning, improvement and research

Quality improvement activities
There was evidence of some clinical and internal audit in place to monitor quality. We were told learning was shared across the practice to make improvements.

Whole-systems approach

Partnership working and development
The practice provided examples of how it, as a stakeholder in patient care, impacts on other parts of the healthcare system. This included following health board clinical pathways. The practice also interacts and engages with system partners at various multidisciplinary meetings, such as cluster meetings and practice manager meetings.

There were good collaborative relationships in place with external partners and within the cluster. The practice worked within the local GP cluster to build a shared understanding of the challenges and the needs of the local population, and to help integrate healthcare services for the wider area.

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

Immediate concerns Identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns were identified on this inspection			

Appendix B – Immediate improvement plan

Service: Willowbrook Surgery

Date of inspection: 03 February 2025

The table below includes any immediate 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.

	Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	HIW is not assured that Schedule 4 drugs are being stored appropriately in line with the Misuse of Drugs Regulations 2001. During our inspection we observed Diazepam stored in an unsecured cupboard. The lock was broken and staff confirmed this had been reported and they were waiting for it to be fixed. This means the practice was not	The practice must: • Move the Diazepam to a secure, temporary storage location. This could be another locked cupboard. • The incident is formally recorded (e.g. via Datix). • Arrange for the lock to be repaired or replaced as soon as possible.	Health & Care Quality Standard - Safe	• Diazepam was immediately moved to the lockable cupboard in the Practice Managers Office • The incident was formally recorded on Datix on 10.02.2025 • The lock was fixed on 07.02.2025	• Rachel Robinson • Kate Evans • Kate Evans	• Immediately – now complete • Within one week – now complete • Within one week – now complete

	compliant with the secure storage of a Schedule 4 drug. Whilst it is not mandatory to store controlled drugs in Schedule 4 within the controlled drugs cupboard the practice must ensure they are stored securely. The practice must take immediate action to secure Diazepam to prevent unauthorised access.	• Conduct an immediate audit and inventory check to ensure that none of the drugs are missing. • Review the practice's standard operating procedures (SOPs) for managing Schedule 4 drugs to identify any improvements that can prevent similar incidents in the future. • Ensure that all relevant staff are aware of the incident and are reminded of the procedures for managing schedule 4 drugs, including what to do in case of a security breach.		• An immediate audit and inventory check was carried out on 03.02.2025 and no drugs were found to be missing. • The SOP was reviewed on 05.02.2025. The SOP was not identified as needing improvement as in this incident it was a failure to follow up on maintenance issue with the contractor. • Details of the incident were distributed to all relevant staff. All staff have been reminded of the procedures for managing schedule 4 drugs	• Littu Poulose • Kate Evans • Kate Evans	• Immediately – now complete • Within one week – now complete • Immediately – now complete

				and know what to do in case of a security breach.		
2.	During the inspection, HIW found expired drugs and equipment that had not been removed from use. This included vaccines and asthma spacers. Failure to remove expired items may result in their inadvertent use by a clinician, potentially impacting on patient safety.	The practice must ensure all expired drugs and clinical items are removed from the treatment rooms and are disposed of appropriately.	Health & Care Quality Standard - Safe	Drug checks are completed on a weekly basis. All staff are aware of the procedure for removal and safe disposal of expired drugs and clinical items.	All nurses	Immediately – now complete
3.	We were not assured that robust procedures were in place to ensure that infection prevention and control (IPC) was always maintained at the surgery. An IPC audit had not been completed, and from our observations of the environment, we identified areas that require immediate improvement. This included privacy	The practice must: • undertake an IPC audit and ensure this is conducted on at least an annual basis • ensure privacy curtains are replaced and include dates of when hung to highlight the date they need to be changed • repair or replace the rusted dressing trolley	Health & Care Quality Standard - Safe	• IPC Audit lead has been nominated as Nurse Rachel Robinson. Nurse Rachel will carry out an IPC audit on 14.02.2025. Nurse Rachel will carry out regular IPC audits after this date. • Privacy curtains have been ordered. A note	• Rachel Robinson • Kate Evans	• Within two weeks • Within two weeks

	curtains that did not show the date of when they need to be replaced; a dressing trolley had a rusted frame, and flooring and broken cupboards that need repairing or replacing.	• repair or replace the damaged flooring and cupboards.		will be made of when they are hung to highlight the date they need to be changed. • The rusted trolley has been disposed of and a new dressing trolley has been ordered. • Damaged flooring has been placed on the surgery action plan to be completed within a six-month timeframe. The cupboards have been repaired.	• Kate Evans • Kate Evans	• Immediately – now complete • Within six months

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

Service representative:

Name (print): Kate Evans

Job role: Practice Manager

Date: 10.02.2025

Appendix C - Improvement plan

Service: **Willowbrook Surgery**

Date of inspection: **03 February 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 workflow policy was in place, but we recommended the workflow list is updated to ensure correspondence is being managed by the most appropriate person in the team.	**The practice must update the workflow list within the policy to ensure all correspondence is being managed by the most appropriate person**	Health & Care Quality Standards - Information	Workflow list to be updated to ensure there are clear instructions on where correspondence is to be sent. Workflow list to be distributed to all staff to ensure correct workflow process followed.	Kate Evans	Workflow list to be updated within 3 weeks of date of report and distributed to all staff - action complete
2.	We found the BCP did not include information on how the sole practitioner GP will	**The practice must update their business continuity plan to include the strategy for the incapacity**	Health & Care Quality Standards - Information	Discussion to be held with Kate Evans and Dr Okosieme to ensure plan in place should	Kate Evans	Discussion to be held and plan to be made within

	continue to provide essential healthcare services to patients if faced with their sudden departure.	**of the sole practitioner GP.**		the practice be faced with Dr Okosieme's sudden departure. BCP to be updated once discussion held and plan made.		2 months of date of report
3.	We found that meetings were not being formally recorded and any actions captured.	**The practice must record meetings for any significant events and ensure any lessons learnt are followed up.**	Health & Care Quality Standards – Information	Regular meetings are to be booked in and formally recorded using the a spreadsheet which will be kept on the G Drive. Note taker to be assigned as Elizabeth Hobson to ensure all meetings are recorded and actions are captured.	Kate Evans	Within two weeks from date of report – action completed
4.	The emergency drugs and equipment were stored within the nurse's room. Access to the emergency kit could be restricted if the room was occupied by a patient and therefore recommended the	**The practice must consider re-locating the emergency drugs and equipment to an area that would always enable easy access.**	Health & Care Quality Standards – Safe	There is currently no other suitable place for the emergency drugs to be stored as they need to be safely secured and accessible; The practice is to look into	Kate Evans	3 months from date of report

	emergency drugs and equipment are re-located to an area with easy access.			suitable alternatives that will ensure the emergency drugs are always secure and easily accessible.		
5.	Discussions with staff confirmed that there was no clinical related IPC advice and oversight being provided, and this was evident in our findings on the day. Therefore, we recommended that the practice ensures their IPC lead has the authority to lead and implement change in both clinical and non-clinical areas.	**The practice must ensure the IPC lead has the skills and experience to lead and implement change in both clinical and non-clinical areas.**	Health & Care Quality Standards – Information; Safe; Workforce	The IPC lead has been named as Nurse Rachel Robinson. Nurse Rachel Robinson, Nurse Littu Poulose and Nurse Marcia Mundell have all completed their IPC Level 2 clinical training. Practice Manager Kate Evans has completed their IPC Level 1 non-clinical training. This training has been allocated to all other non-clinical members of staff and time has been allocated for all members of staff to	Rachel Robinson Kate Evans	Clinical staff to complete training immediately – action now completed Non-clinical staff to complete the training within 3 months from date of report IPC audit to be carried out immediately and will be completed

				complete this training. Nurse Rachel Robinson to complete an IPC audit. Nurse Rachel Robinson is to complete weekly handwashing audit Handwashing guidance posters to be placed in every clinical room. Weekly IPC checklist is to be completed by Theresa Evans		every six months going forward – IPC audit completed on 14.02.2025 by Nurse Rachel Robinson, action now complete Weekly handwashing audit is already in place – action complete Posters to be placed within 3 weeks of visit – posters now in all clinical

						rooms, action complete Weekly IPC checklist to be implemented within 3 weeks of visit date – weekly checklist now being completed, action complete
6.	We were told there was a process in place for when and who collects weekly prescriptions which can be audited. We recommended this is expanded to include	**The practice must expand their process and be able to audit when and who collects prescriptions for controlled drugs.**	Health & Care Quality Standards – Information; Safe	Controlled drugs books to be ordered and placed in reception. Books to used whenever a prescription is picked up for a controlled drug. This new	Kate Evans	Books to be ordered immediately – books have been ordered and have arrived,

	the collection of controlled drugs.			process to be distributed to all colleagues once new procedure in place.		action complete Staff to be briefed on new prescription collection policy once books have arrived – staff have been briefed on new procedure and books are now being used, action complete
7.	We found that the level of safeguarding training relevant to staff roles, and as listed in the policy, did not correlate with staff records.	**The practice must ensure all staff undertake the required level of safeguarding training (both children and adult) appropriate to their role,**	Health & Care Quality Standards – Information; Safe; Workforce	GPs are to ensure they have completed Safeguarding Adult Level 1,2 and 3 and Safeguarding Children Level 1,2 and 3	Kate Evans	GPs to have completed training within 4 weeks of report date – All GPs have

		and a record should be kept to evidence this.		Nurses are to ensure they have completed Safeguarding Adult Level 1,2 and 3 and Safeguarding Children Level 1,2 and 3 Admin staff are to ensure they have completed Safeguarding Adult Level 1 and Safeguarding Children Level 1 All courses are recorded on the staff matrix and a copy of all certificates are kept on the G Drive		now completed training, action complete Nurses to have completed training within 4 weeks of report date – All nurses have now completed training, action complete Admin staff to have completed training within 3 months of report date

						Matrix to be updated immediately and folder created on G drive - action completed
	We noted minutes of meetings are not formally captured and recommend they are.	**The practice must ensure a record is kept of meeting minutes, which can be shared with staff as appropriate.**	Health & Care Quality Standards – Information	Note taker has been assigned as Elizabeth Hobson. Elizabeth will sit it on all meetings and type up notes ASAP after a meeting and forward to Kate Evans. Kate Evans will then forward on any actions identified as required. In the event Elizabeth Hobson is not available Hayley Cowan will stand in as note taker.	Kate Evans	Immediate – action complete
8.	From the notes reviewed we found that the patient's	**The practice must ensure that patient language preference is recorded**	Health & Care Quality Standards – Information	Patients preferred language to be recorded upon	Kate Evans	Immediate – action complete

	language choice was not always recorded.	**and easily identified in their clinical records.**		registration. This is to be briefed to all staff members.		
9.	The practice did not have a formal process in place to ensure a person remains suitable to work at the practice.	**The practice must confirm the system implemented to ensure a person remains suitable to work at the practice.**	Health & Care Quality Standards – Information; Safe; Workforce	GP suitability to practice to be checked by Kate Evans every year. This to be done by checking GMC website to ensure suitability to practice. Nurses suitability to practice to be checked by Kate Evans every year. This to be done by checking NMC website to ensure suitability to practice. DBS checks to be completed when staff member starts at the practice. Yearly self-declaration form to be implemented and completed by every staff member each	Kate Evans	Immediate action. GP and Nurse suitability to practice added to skills matrix – action complete Immediate action. All staff have DBS check in place and declaration sheet has been created – action complete

				year to declare there have been no changes since their last DBS check was issued.		
10.	Generally, we found staff had completed their mandatory training, however some areas had expired and these need to be completed as soon as possible to ensure staff skills and knowledge are up to date. The administration staff all need to complete safeguarding and CPR and one nurse requires updating their safeguarding training.	**The practice must ensure all staff are up to date with their mandatory training and complete the levels applicable to their role.**	Health & Care Quality Standards – Information; Safe; Workforce	Safeguarding training to be completed by all admin staff CPR training to be booked in early to ensure all staff have up to date training Nurses to complete safeguarding training	Kate Evans	Admin staff to complete training within 3 months CPR training to be booked within 6 weeks of report date Nurse to complete safeguarding training within 3 weeks – action complete
11.	A training matrix was being developed which will provide an	**The practice must update the training matrix with all clinical staff and ensure it**	Health & Care Quality Standards – Workforce	Training matrix to be updated to include all members of staff	Kate Evans Abbi Harris	Training matrix to be updated

	overview of training compliance for all the staff at the practice. Only administration staff had been populated on the matrix at the time of the visit.	**is monitored regularly to ensure staff skills and knowledge remain current.**		working at the practice. Matrix to be monitored monthly by nominated colleague(s). Kate Evans to be nominated colleagues for clinicians and Abbi Harris to be nominated for admin staff.		within 3 weeks of report date to include all members of staff – action complete Matrix to be monitored immediately by nominated colleagues – action complete
12.	We were unable to find evidence that staff had completed Duty of Candour training	**The practice must confirm staff have completed Duty of Candour training**	Health & Care Quality Standards – Information; Workforce	Training to be allocated to all colleagues on Practice Index. Kate Evans to ensure clinical staff complete training and Abbi Harris to ensure admin staff complete training	Kate Evans Abbi Harris	Training to be completed by all members of staff within 3 months of report date

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

Service representative

Name (print): Kate Evans

Job role: Practice Manager

Date: 18/03/2025