Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report
(Announced)
Shotton Lane Surgery, Betsi Cadwaladr University Health Board

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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.

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1. What we did

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

Healthcare Inspectorate Wales (HIW) completed an announced inspection of Shotton Lane Surgery, Betsi Cadwaladr University Health Board on 1 May 2025.

Our team for the inspection comprised of two HIW Healthcare Inspectors, a general practitioner, and a practice manager peer reviewer. The inspection was led by a HIW Healthcare Inspector. We were unable to secure a practice nurse reviewer as part of the inspection team and therefore some elements of infection prevention and control were not reviewed.

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 15 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:
We found staff at Shotton Lane Surgery were committed to providing a positive experience for patients and were treating them with kindness and professionalism. Measures to ensure privacy included closed consulting room doors and privacy curtains. Despite these efforts, more than half the survey respondents felt they could not talk to reception staff without being overheard.

The patient feedback in our survey was mixed across various areas, with most respondents rating the service as very good or good. Patients expressed satisfaction with the helpfulness and responsiveness of staff, while noting challenges in booking some appointments. Staff's helpfulness and friendliness were also highlighted.

Health promotion was evident to some extent, with patients being encouraged to manage their own health through advice provided both verbally, via leaflets and on the practice website. However, there was a lack of health promotion materials in the waiting area. The practice provided various services and clinics, and patients with internet access could find information on health conditions and practice details online.

Timely care was addressed, with policies in place for accessing services and information available through various channels. Patients could make appointments by phone or in person, and housebound patients could request home visits. Most respondents were satisfied with the practice's opening hours and knew how to access out-of-hours services. However, fewer than half were offered options for appointment types.

Equitable communication and language services were highlighted, with bilingual practice information leaflets available. Although Welsh language promotion was limited due to few Welsh-speaking patients, the practice is advised to promote bilingual signage and patient information. Translation services and a hearing loop were available to assist patients with communication needs.

Limited parking was available, and access to the main entrance was good. All facilities were located on the ground floor.

This is what we recommend the service can improve:

- Offer more health promotion materials

- Consider installing closed circuit television (CCTV) in the waiting area
- Promote the active offer of Welsh language and install bilingual signs.

This is what the service did well:

- Staff at the practice treated patients with dignity and respect, and we saw measures were taken to protect their privacy
- There was good disabled access to the building. Wheelchair users could access all consulting rooms, the reception, waiting area and toilet facilities
- Most patients who provided feedback told us they were given enough time to explain their healthcare needs, and the GP had explained things clearly.

Delivery of Safe and Effective Care

Overall summary:
We found a staff team who were very patient centred and committed to delivering a quality service.

Measures were in place to ensure the safety and wellbeing of staff and visitors. The premises were well-maintained, free from hazards, and equipped with serviced equipment. Current risk assessments included fire, environment, and health and safety.

Infection prevention and control (IPC) measures were in place, including an IPC policy, but there was no designated IPC lead. Cleaning schedules were followed, and personal protective equipment and hand sanitisers were readily available. Measures were in place to prevent and address sharps injuries, and clinical staff were immunised against Hepatitis B. Staff had completed mandatory IPC training.

Safeguarding policies and procedures were present but lacked a detailed flowchart to support staff. We saw evidence that all staff had completed safeguarding training, and they knew how to recognise safeguarding concerns.

Medical devices and equipment were regularly tested, and single-use medical equipment was used as appropriate.

Basic life support training was provided to staff, and emergency drugs and equipment were securely stored and regularly checked. An expired oxygen cylinder was found and addressed, but a more robust logging system is needed.

The sample of patient records we reviewed were of good standard, secure, clear, and legible, reflecting contemporary documentation and valid consent.

Processes were in place to promote safe and effective care, with good examples of illness management and patient-centred decision-making. Systems for reporting and learning from significant events were appropriate, and clinical staff stay updated with new evidence-based practices and NICE guidance.

This is what we recommend the service can improve:

- Nominate an IPC lead
- Develop a safeguarding flowchart
- Review the child protection register
- Implement a more robust log for checking the emergency drugs and equipment.

This is what the service did well:

- The practice premises was visibly well maintained, clean and free from obvious hazards
- Effective arrangements were described and demonstrated in relation to safeguarding
- We saw an effective records management system and the patient records we reviewed were clear, legible and of good quality.

Quality of Management and Leadership

Overall summary:
We found staff provided good leadership, and there were clear lines of accountability. A strong ethos and positive culture were present, and staff aimed to provide a high standard of patient care.

Our online staff survey received 15 responses, and the feedback was generally positive, with staff expressing satisfaction with patient care quality and safety. Most staff felt involved in decision-making processes and were comfortable suggesting improvements.

The practice appeared to be well-managed by a committed and dedicated practice manager. Staff found the management team approachable and thorough in addressing issues. However, certain policies needed implementation, such as those for home visits and patient waiting times. Formal team meetings for all staff were recommended to improve communication.

Whilst training opportunities were available, annual appraisals were noted as missing and needed completing regularly. Recruitment policies were in place with mandatory and role-specific training completed, evidenced in a staff training matrix.

Patient feedback was actively sought through questionnaires, and feedback was used to improve services. However, there was no system for sharing feedback results with patients. The practice had a Duty of Candour policy, with all staff trained and aware of their responsibilities.

Information governance and digital technology arrangements were adequate, ensuring patient confidentiality and compliance with General Data Protection Regulations (GDPR) 2018.

No DBS details were available to indicate that the nurses or administrative staff had a suitable DBS certificate in place. Our concerns regarding staff DBS details were dealt with as an immediate assurance.

Staff engaged in quality improvement activities, developing innovative care delivery methods and participating in cluster-wide projects. The practice collaborated well within the GP cluster, with strong engagement and effective joint efforts. The clinical team were knowledgeable, professional and demonstrated their understanding of where and how to access advice and guidance.

Immediate assurances:

- No evidence was available to indicate that the nurses or administrative staff had a suitable Disclosure Barring Service (DBS) certificate in place.

This is what we recommend the service can improve:

- Introduce formal team meetings
- All staff to receive a staff appraisal.

This is what the service did well:

- We witnessed all staff, clinical and non-clinical, working very well together as part of a team
- Good staff induction process in place
- Practice managed by a committed and dedicated practice manager.

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

The 19 responses to the patient survey were mixed across all areas. Most respondents rated the service as very good or good.

We received several patient comments through the survey, and these are reflected throughout the report. Some comments included:

> ***"Always helpful and try to sort out problems. Doctors and nurses always listen. Medication always on time. A great service."***
>
> ***"Appointments with the nurse always booked easily and they are friendly, professional and knowledgeable. Getting a doctor's appointment is more challenging."***
>
> ***"Given the pressures on GP services, the staff are always so helpful and friendly. My only problem is trying to get through in the morning if you need a routine appointment, you sometimes need to phone over a couple of days. However, staff are really helpful and will always make sure your request for an appointment can wait."***
>
> ***"Nurse appointment always good. Doctor also good, can be a challenge to get a pre-booked appointment."***

Person-centred

Health promotion
We found that patients were encouraged to take responsibility for managing their own health, through the provision of health promotion advice. This was available on the practice website and verbally by the doctors and nurses during consultations.

No Smoking signs were displayed confirming that the practice adhered to the smoke free premises legislation.

Written information was displayed in the practice building advising patients of the other services they could access for health advice or treatment, such as their local pharmacy and NHS 111.

In our survey, most patients said they had been offered advice on healthy lifestyle, and health promotion and patient information material was displayed. However, we found little evidence of any health promotion materials around the waiting area for patients to read and take home.

The practice should offer more health promotion materials in the form of posters and leaflets in the waiting area.

The practice offered a range of services and clinics, such as those for vaccinations and chronic disease management.

We found patients with internet access could find information about a range of health conditions on the practice's website. Additionally, information relating to practice opening times and out of hours service was available on the practice website and in the practice information leaflet.

Dignified and respectful care
We found staff at the practice treated patients and their representatives with respect and kindness, and we saw staff greeting patients in a professional manner, both face to face and over the telephone.

We saw doors to consulting rooms were closed when patients were being seen by GPs or other healthcare staff, promoting their privacy and dignity. Consulting rooms had privacy curtains that could be used to provide additional privacy when patients were being examined.

All respondents who answered the survey question (and who felt it was applicable to them) told us they had been treated with dignity and respect, and all patients who answered felt that measures were taken to protect their privacy. However, more than half felt they were unable to talk to reception staff without being overheard.

A self-service, touch screen facility was available so that patients could check-in for their appointment along with a patients' privacy counter.

Consulting rooms and the reception were located away from the waiting area, which helped ensure conversations were not overheard by people in the waiting area. However, as the waiting area was not within the receptionists' view, this

meant that staff could not monitor patients' wellbeing while waiting to be seen by clinicians.

The practice should consider options, such as installing a closed-circuit television (CCTV) for the reception desk to monitor patients in the waiting area.

An up-to-date written policy was in place in relation to the use of chaperones and staff had received the relevant training. The right to request a chaperone was clearly displayed in the waiting room and in each consulting room. We found that chaperone request had been offered and recorded within the sample of patient records we viewed. Most respondents who answered the survey question about chaperones said they had been offered one (for intimate examinations or procedures).

Timely

Timely care

The practice had a current policy on how patients could access the services provided. Information for patients on how they could access appointments with the GP, or another suitable healthcare professional was available on the practice website, telephone message and in the practice information leaflet.

We were told that patients could make an appointment either by phone or in person at the practice. Housebound patients could request a home visit by a GP. We were also told that the practice provided services to a local care home, and regular care home visits took place.

Most respondents who answered the relevant survey question felt satisfied with the opening hours of the practice. In addition, all said they knew how to access out of hours services if needed. In addition, most said they were able to contact the practice when they needed a same day appointment if urgent and could get routine appointments when they needed one. However, less than half said they were offered the option to choose the type of appointment they preferred. Overall, most felt able to access the right healthcare at the right time, and when asked whether their appointment was on time, most said it was.

We were told that all reception staff had undertaken Care Navigation training to help them do their job.

Referrals to other specialists were made in a timely fashion by the practice.

Equitable

Communication and language

A practice information leaflet, which was available bilingually and in hard copy, provided useful information for patients. This included practice contact details and opening times, the services provided, how patients could register, appointment options, how patients could order repeat prescriptions and an overview of the practice team. A range of information was also available on the practice website.

We were told that very few Welsh speaking patients attended the practice, and there was only one staff member who spoke Welsh. All patients who completed the questionnaire told us their preferred language was English. This subsequently meant that the active offer of Welsh was not actively promoted within the practice. We also noted that the signage throughout the practice was in English only.

The practice must ensure that the active offer of Welsh language is promoted to patients and bilingual signs are displayed throughout the practice.

Staff told us they could access a translation service to help communicate with patients whose first language was not English or Welsh. The practice had a hearing loop to help staff communicate with patients who were hard of hearing and wore hearing aids.

Rights and equality

The practice had an up-to-date written policy relating to equality and diversity and we saw that all staff had completed this training.

Most patients in our survey felt they were given enough time to explain their healthcare needs, and that the GP had explained things well, had answered their questions, they felt listened to, and were involved in decisions about their healthcare as much as they wanted to be.

There was limited parking available at the practice, but access to the main entrance was good. All facilities, including the reception desk, waiting room, patients' toilet and consulting rooms were all located on the ground floor.

Where applicable, all respondents in the patient survey said the premises was accessible. All but one said there were enough seats in the waiting area, and the toilets and handwashing facilities suited their needs.

There was an up-to-date written policy on obtaining valid patient consent. Our examination of a sample of patient records confirmed that clinicians were recording when patients gave verbal consent to examination or treatment.

Delivery of Safe and Effective Care

Safe

Risk management
Arrangements were in place to protect the safety and wellbeing of staff and people visiting the practice.

We saw the premises were visibly well maintained both internally and externally. All areas were free from obvious hazards.

Fire safety equipment was available at various locations around the practice, and we saw these had been serviced within the last 12 months. Emergency exits were clearly displayed and a Health and Safety poster was displayed.

We saw a general risk assessment was in place, covering fire, environment and health and safety, which was current and regularly reviewed.

A review of a range of documentation confirmed that all risks, both internally and externally, to staff, visitors and patients had been considered. We were therefore assured that the premises were fit for purpose.

Infection, prevention and control (IPC) and decontamination
There was a detailed infection control policy in place. However, we found there was no IPC lead identified. The practice must nominate an IPC lead and ensure appropriate training for this role is undertaken.

The practice is required to nominate an IPC lead and ensure appropriate training is completed.

Where applicable, all respondents to our patient survey said, in their opinion the premises were 'very clean' or 'clean'. Most respondents said that when they received an invasive procedure that staff wore gloves and that the equipment used was individually packaged or sanitised.

Staff had access to personal protective equipment, such as gloves and disposable plastic aprons to reduce cross infection. The areas of the practice that we viewed were visibly clean.

The designated cupboard for cleaning equipment was well-organised and maintained efficiently. Cleaning schedules and checklists were in place and completed daily. However, it was noted there were no caution notices displayed

on the door alerting individuals to potential hazards, and to ensure proper handling of cleaning chemicals.

The practice should arrange for a relevant notice to be placed on the cleaning equipment cupboard alerting individuals to potential hazards.

We found that all consulting rooms had disposable curtains, which could easily be replaced should they become contaminated or dirty. However, we found the date label on one of the disposable curtains had not been completed. The curtains should be replaced six-monthly unless soiled sooner. This issue was dealt with immediately during the inspection and is referred to in Appendix A of this report.

Hand sanitizers were readily available around the practice. Hand washing and drying facilities were provided in clinical areas and toilet facilities.

Appropriate arrangements were in place to deal with sharps injuries. We saw records relating to Hepatitis B immunisation status for all clinical staff, which highlighted appropriate measures were taken to ensure that patients and staff were protected from blood borne viruses.

Medicines management
The medication storage refrigerator temperature for all three refrigerators were monitored twice daily. The temperature checks were carried out by the nurses and reception staff would also check as part of their evening close-down. Staff were able to describe what they would do in the event of any discrepancies. However, we found some influenza vaccines that had passed their expiry date in the treatment room refrigerator. The issue around the expired influenza vaccines was dealt with immediately during the inspection and is referred to in Appendix A of this report.

Repeat prescriptions could be requested in person via the repeat prescription box in the practice, by post, NHS Wales App, drop off at patients nearest chemist, and by emailing the practice using their secure online form. It was noted that the practice endeavoured to dispense prescriptions within 72 hours. No telephone repeat prescriptions requests were accepted by the practice for safety reasons.

Safeguarding of children and adults
There were policies and procedures in place to promote and protect the welfare and safety of children and adults who were vulnerable or at risk. The policies contained the contact details for the local safeguarding team. However, there was no flowchart to accompany the policy to further support staff. We recommend that the practice develops a detailed flowchart to accompany the policy so that it provides clear guidance to staff on the steps to take in a safeguarding situation.

The practice is required to develop a safeguarding flowchart to support staff.

Staff clearly explained to us how to recognise signs of abuse in vulnerable adults and children. Staff were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies.

We saw evidence that all clinical and non-clinical staff had completed training in the safeguarding of children and vulnerable adults.

We saw there was a system in place to ensure children on the child protection register could be identified from their family records. The practice receives notification from the local safeguarding team when a child was added to the register. However, we were informed that the practice did not receive any notification from the safeguarding team when a child was removed from the register.

The practice must ensure the child protection register is regularly reviewed and checked with the local safeguarding team to ensure clinical records are accurate.

The practice manager described the pre-employment checks that are undertaken for any new members of staff. This included checking of references and undertaking Disclosure and Barring Service (DBS) checks on staff appropriate to the work they undertake. However, no DBS details were available to indicate that the nurses or administrative staff had a suitable DBS certificate in place. We were also told that regular checks were not being completed to ensure DBS certificates for staff members remained accurate throughout their employment at the practice.

Our concerns regarding staff DBS details were dealt with as an immediate assurance. This meant that we wrote to the practice immediately following the inspection requiring that urgent remedial actions were taken. Details of the immediate assurances we identified are provided in Appendix B.

Management of medical devices and equipment
We found that portable electrical appliances were being tested on a regular basis, and only single use medical equipment was used where applicable.

There were procedures in place showing how to respond to patient medical emergencies. All clinical staff had received basic life support (BLS) training.
The emergency drugs were stored securely. There was a system in place to check the emergency drugs and equipment to ensure they remained in date and ready for

use, in accordance with standards set out by the Resuscitation Council (UK). However, we found that one of the two oxygen cylinders had passed its expiry date. The practice manager must ensure a more robust log is maintained by staff. The issue around the expired oxygen cylinder was dealt with immediately during the inspection and is referred to in Appendix A of this report.

The practice manager must ensure a more robust log is maintained for oxygen cylinders.

Effective

Effective care

There were suitable arrangements in place to report patient safety incidents and significant events. The practice made use of the electronic Datix system for reporting incidents.

Patient records

We reviewed the care records of 10 patients and saw that an effective records management system was in place. Records were securely stored to prevent unauthorised access.

The records we reviewed were clear, legible and of good quality. From the records, it was clear who was documenting in the records, the date and details of consultation or treatment. Records were completed contemporaneously. They also evidenced that valid consent is obtained, where appropriate.

The records also reflected known patient allergies, and adverse reactions to medications were also highlighted.

Efficient

Efficient

Processes were in place to promote safe and effective care. We found good examples of acute and chronic illness management, and a clear narrative with evidence of patient centred decision making.

Staff described appropriate systems for reporting and learning from significant events.

Clinical staff confirmed that a comprehensive process was in place to receive and share new evidence-based practice and updated or new National Institute for Health and Care Excellence (NICE) guidance.

Quality of Management and Leadership

Staff feedback

We invited the practice staff to complete an online survey to obtain their views of working for the practice. In total, we received 15 responses, however, some questions were skipped by some respondents.

The response to the staff survey was generally positive. Staff felt satisfied with the quality of care provided to patients and would be happy with the standard of care if provided to their own friends and family. All agreed that care of patients was the practice's top priority, and that they were content with the practice's efforts to keep staff and patients safe.

Most staff felt that they could make suggestions to improve GP services at the setting, and felt they were involved in any decision-making surrounding changes that may affect their work.

Staff comments included:

> *"Shotton Lane is a lovely practice & a very inclusive & supportive place to work - it is in a different league to other places that I have worked."*
>
> *"The increased patient demand for appointments is I feel the leading issue the surgery faces. The supply is not able to meet the demand and often signposting to other often more appropriate services meets resistance. This leads to dissatisfaction for both patients and clinicians, and this is a difficult problem to resolve."*
>
> *"The day to day running of the practice is very professional."*
>
> *"I have always found that support and advice if needed is always given by Doctors, Nurse and our Practice Manager. I can always approach them at any time. I have been given an opportunity to train and expand my role in the practice. I enjoy meeting and interacting with our patients. I feel that we are all a good team, and I enjoy working at our Surgery."*

Leadership

Governance and leadership

We found the practice manager demonstrated strong leadership, was highly motivated and very dedicated to the role. In addition, staff told us the practice manager and GP partners were approachable and supportive. They also felt able to raise any issues with the practice manager, and that issues would be addressed in a comprehensive and thorough manner.

We found a patient-centred staff team who were very committed to providing the best services they could. Staff members were respectful and courteous and were positive about the working environment and said they felt well respected and supported by their colleagues.

Whilst staff had access to policies and procedures to guide them in their day-to-day work, we found that the following polices required implementation:

- Did not attend / Was not brought
- Home visit policy and risk assessments
- Lone working
- Access and triage policy
- Patient waiting time for ambulance.

The practice must develop and implement the absent polices highlighted in the report and ensure these are shared with staff.

We saw that the GP partners attended daily huddle meetings where any issues or concerns could be discussed. We were told that the management team and clinical staff attended monthly clinical management meetings, and we reviewed a sample of minutes from these meetings. However, it was confirmed that a formal all staff team meeting did not regularly take place; and therefore, no records maintained.

The practice is required to introduce formal team meetings for all staff to attend, producing minutes for those who cannot attend.

We found staff to be proactive, knowledgeable and professional. Staff also demonstrated their understanding on how they would access advice and guidance if necessary.

Workforce

Skilled and enabled workforce
The practice had an established reception and administration team in place. Staff we spoke with said they were very proud and happy to work at the practice. In addition, our discussions indicated that staff had the right skills and knowledge to fulfil their identified roles within the practice. Staff also felt they had

opportunities to attend relevant training. However, we found that staff had not received an annual appraisal.

The practice must ensure all staff working at the practice receive an annual appraisal.

We found formal recruitment policies and procedures in place, and information we saw within staff files demonstrated that staff had completed mandatory training and other training relevant to their roles.

Culture

People engagement, feedback and learning

There was a written complaints procedure in place. We also found that the NHS Wales Putting Things Right process was displayed and available to all patients in the waiting area. Details were also included within the practice information leaflet and practice website.

We discussed the mechanism for actively seeking patient feedback, which was done by issuing questionnaires to patients. Patients were also able to give feedback via social media. However, we found that the results of patient feedback was not displayed or shared with people.

The practice must implement a suitable system to feedback to patients following their response to surveys or comments on social media.

We saw the practice had a Duty of Candour policy in place, which contained details of staff roles and responsibilities as recommended by The Duty of Candour Statutory Guidance (2023). All staff we spoke with said they knew and understood their responsibilities under the Duty of Candour. We saw that all staff had received Duty of Candour training.

Information

Information governance and digital technology

Suitable communication systems were in place to support the operation of the practice.

Adequate arrangements were in place for maintaining patient confidentiality, and adherence to Information Governance and the General Data Protection Regulations (GDPR) 2018.

Learning, improvement and research

Quality improvement activities

We found that staff engaged with quality improvement by developing and implementing innovative ways of delivering care. This included the involvement in cluster wide projects.

Whole-systems approach

Partnership working and development

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

We were informed that the engagement with the cluster group was very good, and practices worked well together.

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
We found the date label on one of the disposable curtains had not been completed.	Date labels on disposable curtains serve to track when the curtains were last changed and to help reduce the risk of infection.	We escalated the concern to the practice manager during our visit.	The practice manager immediately arranged for a new disposable curtain to be installed during our visit.
We found that one of the practices oxygen cylinders had expired.	An expired oxygen cylinder poses serious risks to patient care, particularly in an emergency where delayed or ineffective treatment is given. In addition, degraded oxygen due to expiry could pose health risks, especially for vulnerable patients requiring precise oxygen therapy.	We escalated the concern to the practice manager during our visit.	The practice manager immediately arranged for the expired oxygen cylinder to be removed, and a replacement was purchased and delivered the next day.

We found some influenza vaccines that had passed their expiry date stored in the treatment room refrigerator.	Expired influenza vaccines may have reduced potency, meaning they might not provide effective protection against the flu. Additionally, because flu vaccines are updated annually to match circulating strains, an expired vaccine may not target the current season's viruses.	We escalated the concern to the practice manager during our visit.	The practice manager immediately arranged for the expired influenza vaccines to be disposed of during our visit.

Appendix B – Immediate improvement plan

Service: Shotton Lane Surgery

Date of inspection: 01 May 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	Service action	Responsible officer	Timescale
1.	HIW was not assured that the processes in place to maintain safe recruitment of staff is robust. This is because there was no evidence available to indicate that the nurses or administrative staff had a suitable Disclosure Barring Service (DBS) certificate in place. We were also told that regular checks were not being completed to ensure DBS certificates for staff members remained accurate	The practice must ensure: • All staff complete a DBS check relevant to their role • Staff confirm annually whether any new information has been added to their DBS certificate since previously issued • Staff are reminded that they should report any	Workforce	DBS checks have been requested via Avon LMC for all staff as at 06.05.2025 – some staff have completed the forms & ID checks are in progress. Going forward as part of annual appraisals all staff will be asked to indicate and sign to confirm any changes to their DBS certificate.	Carol Martin – Practice Manager	Asap for all updated DBS checks to be carried out before the end of May 2025 Annually as part of annual appraisal to indicate any changes

	throughout their employment at the practice.	changes to their DBS certificate to their employer as they occur.		DBS has been added to the training log document with certificate numbers and issue dates.		

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): **Carol Martin**

Job role: **Practice Manager**

Date: **06.05.2025**

Appendix C - Improvement plan

Service: Shotton Lane Surgery

Date of inspection: 01 May 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	Service action	Responsible officer	Timescale
1.	We found little evidence of any health promotion materials around the waiting area for patients to read and take home.	The practice should offer more health promotion materials in the form of posters and leaflets in the waiting area.	Person Centred	We have increased the availability of health promotion materials around reception & in nurses rooms but are looking to get a designated display area set up	Practice Manager	ongoing
2.	We saw that the waiting area was not within the receptionist's view and therefore staff were unable to monitor patients' wellbeing while	The practice should consider options, such as installing a closed-circuit television (CCTV) for the reception desk to monitor patients in the waiting area.	Safe	We will look into the feasibility of CCTV in the waiting area - the waiting rooms although not in view of the reception area are frequently monitored as all	Practice Manage & GP Partners	Review asap

	waiting to be seen by clinicians.			clinicians come to waiting area to call patients & staff walk through from admin areas		
3.	We found that the active offer of Welsh was not actively promoted within the practice.	The practice must ensure that the active offer of Welsh language is promoted to patients and bilingual signs are displayed throughout the practice.	Equitable	We have no Welsh speaking patients or staff – we do use bilingual health promotion materials & will look to amend all signage to bilingual in the near future – we do have bilingual phone messages	All staff	ongoing
4.	We found there was no IPC lead identified.	The practice is required to nominate an IPC lead and ensure appropriate training is completed.	Safe	One of the practice Nurses has taken this responsibility & will be the named lead for IPC	Practice Manager/Practice Nurse	completed
5.	We found that the cleaners' cupboard did not have a caution sign.	The practice should arrange for a relevant notice to be placed on the cleaning equipment cupboard alerting	Safe	Caution - Hazardous substances sign has been ordered & will be put onto the door –	Practice Manager	completed

		individuals to potential hazards.		this door is always locked		
6.	We found that there was no safeguarding flowchart in place to accompany the safeguarding policy.	The practice is required to develop a safeguarding flowchart to support staff.	Safe	This is in draft & waiting for review and approval from all relevant staff	Practice Manager & Safeguarding Lead	August 2025
7.	We found that the practice does not receive any notification from the safeguarding team when a child is removed from the register.	The practice must ensure the child protection register is regularly reviewed and checked with the local safeguarding team to ensure clinical records are accurate.	Safe	We will ensure that the register is enhanced to include review dates and ensure that it is review regularly (at least bi-annually) – we will also liaise with the safeguarding Team and other PM's to discuss best practice	Practice Manager & Safeguarding Lead	asap
8.	We found that one of the oxygen cylinders had expired.	The practice manager must ensure a more robust log is maintained for oxygen cylinders.	Safe	This was ordered & replaced the day after the inspection	Practice Manager/Practice Nurse	Actioned May 25
9.	We found that the practice needed to	The practice must develop and implement	Workforce	We did have a was not brought protocol	Practice Manager & GP Partners	

	develop the following polices: • Did not attend (DNS) / Was not brought (WNB) • Home visit policy and risk assessments • Lone working • Access and triage policy • Patient waiting time for ambulance.	the absent polices highlighted in the report and ensure these are shared with staff.		which is on the shared drive & we are writing/adopting policies for the remaining outstanding We have implemented a new home visiting policy so that we know when clinicians have left & returned to the surgery – this also includes a risk assessment for all HV properties		ongoing
10.	We found that all staff team meetings were not being held.	The practice is required to introduce formal team meetings for all staff to attend, producing minutes for those who cannot attend.	Workforce	We do have 6 PET sessions per year 2 of which are practice run – we will schedule all staff meetings on these sessions & try to get as many staff involved – we do have lots of informal staff meetings but these	Practice Manager & GP Partners	ongoing

				are not documented – we will document going forward		
11.	We found that staff had not received an annual appraisal.	The practice must ensure all staff working at the practice receive an annual appraisal.	Workforce	Appraisals have been booked in & are progressing – this will be done annually going forward	Practice Manager	In progress
12.	We found the results of patients' feedback was not published or available for the public to view.	The practice must implement a suitable system to feedback to patients following their response to surveys or comments on social media.	Learning, improving and research	We will be looking to do the next survey through August & September & will publish the results on our website	Practice Manager	In progress

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): **Carol Martin**

Job role: **Practice Manager**

Date: **10.07.2025**