Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report (Announced)

The City Surgery, Cardiff and Vale University Health Board

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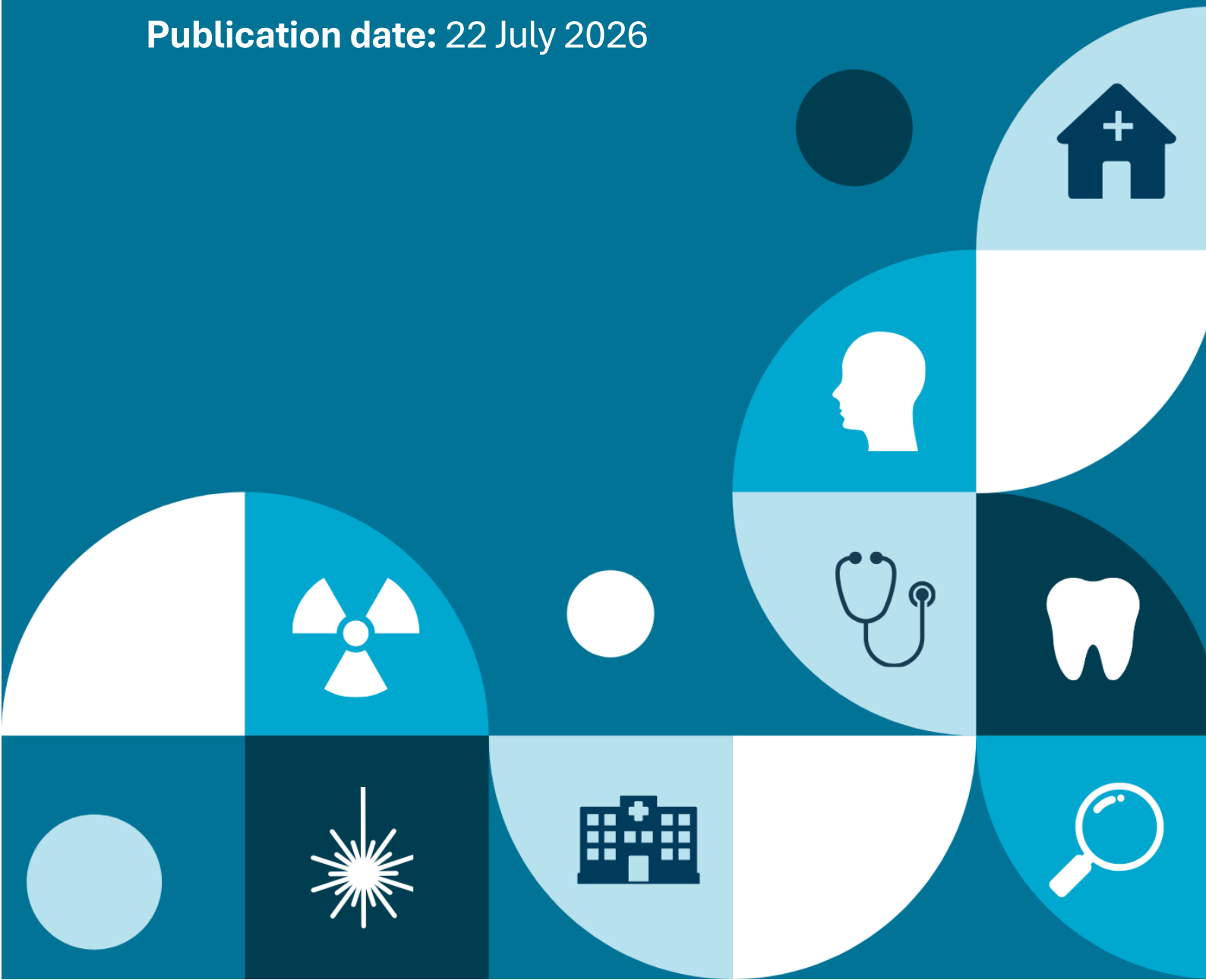

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Healthcare Inspectorate Wales (HIW) is the independent regulator and inspectorate of healthcare in Wales

Our Purpose

We check the safety and quality of healthcare across Wales.

Our 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 Vision

A future where healthcare in Wales is safe, effective, and high-quality for everyone.

Our Priorities

Putting People First - We will focus on the biggest risks facing people and communities as they access healthcare services now and in the future.

Learning and Working Together - We will collaborate with partners to share learning and drive lasting improvements.

Investing in Our People - We will ensure our people feel supported, valued, and empowered.

Taking Action That Matters - We will take action to improve the quality and safety of healthcare for the future of Wales.

Contents

1. What we did

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

Healthcare Inspectorate Wales (HIW) completed an announced inspection of The City Surgery, Cardiff and Vale University Health Board on 21 April 2026.

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

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of 13 questionnaires were completed by patients and 12 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:

Patients generally reported a positive experience of using the service, with high levels of satisfaction relating to dignity, respect and communication. Most patients found the practice accessible, clean and welcoming, and felt listened to and involved in decisions about their care.

The practice demonstrated strengths in patient-centred communication and maintaining a clean, well-maintained environment. However, there were some areas where improvement is required, including privacy at reception, and strengthening systems to capture and act on feedback.

This is what we recommend the service can improve:

- Strengthen arrangements to ensure patient confidentiality at reception areas
- Improve visibility of patient feedback mechanisms, such as “you said, we did” approaches

This is what the service did well:

- Patients reported being treated with dignity and respect and feeling listened to during consultations
- The practice environment was consistently described as clean, accessible and well maintained
- A range of health promotion information and services, including mental health support and cluster services, were available.

Delivery of Safe and Effective Care

Overall summary:

The practice had several effective systems in place for delivering safe care, including good arrangements for medicines management, well-maintained clinical environments and strong patient record keeping.

However, there were areas requiring improvement, particularly around governance of infection prevention and control (IPC), documentation and policy development, auditing processes, and ensuring training and records relating to staff immunisation and competencies were up to date.

There was evidence of good clinical practice within patient records, which were comprehensive, contemporaneous and supported continuity of care.

This is what we recommend the service can improve:

- Strengthen IPC governance, including embedding audit processes, completing action plans from identified risks and staff training
- Improve oversight and documentation of staff training, immunisation status and competency records
- Ensure policies are practice-specific, up to date and reflect current practice.

This is what the service did well:

- Medicines were generally stored safely, and appropriate systems were in place for emergency drugs and equipment checks
- Patient records were of a high standard, with clear documentation and appropriate coding
- Effective collaboration with cluster services supported patient care pathways.

Quality of Management and Leadership

Overall summary:

The practice demonstrated a positive and supportive culture, with staff describing good teamwork and approachable leadership.

However, governance arrangements required strengthening. This included the need for more robust oversight of audits, clearer documentation of meetings and actions, and improved formalisation of workforce planning and training systems.

Whilst policies were generally in place, several required updating to ensure they were practice-specific and aligned with current frameworks and guidance.

This is what we recommend the service can improve:

- Strengthen governance systems, including recording of meetings, audits and action plans
- Develop a formal workforce and training matrix to ensure oversight of staff competencies and training
- Improve systems for learning from complaints, incidents and feedback, including formal trend analysis

This is what the service did well:

- Staff reported a supportive working environment with strong teamwork and open communication
- Leaders were visible and accessible to staff.

3. What we found

Quality of Patient Experience

Patient feedback

HIW issued a questionnaire to obtain patient views on the care at The City Surgery for the inspection in April 2026. In total, we received 13 responses from patients at this service.

Patients reported good access to services, with most satisfied with opening hours and ease of contacting the practice. While the majority were able to obtain routine appointments when needed, access to same-day urgent appointments was more variable. Most respondents also demonstrated awareness of how to access out-of-hours services.

In relation to appointments, patients were broadly satisfied, with many offered a choice of consultation type and all respondents content with the format provided. All reported appointments were conducted in person.

The practice environment was viewed positively. Most patients considered the premises accessible, clean, and appropriately equipped, with adequate seating and suitable toilet and handwashing facilities. The environment was generally regarded as child-friendly, and health promotion information was visible.

Infection prevention and control measures were largely reported as appropriate. Most respondents observed the availability of hand hygiene facilities and signage and reported that staff adhered to hand hygiene practices. Where invasive procedures had been undertaken, all respondents confirmed appropriate use of personal protective equipment and hygienic practices.

Feedback regarding privacy and dignity was mostly positive. While many patients felt able to speak to reception staff without being overheard, this was not universal. However, most respondents agreed that the practice took appropriate steps to protect privacy, and over half reported being offered a chaperone where relevant.

The quality of care was rated highly. Most patients reported timely appointments and confirmed that staff checked relevant clinical information. Patients consistently felt listened to, treated with dignity and respect, and involved in decisions about their care.

With regard to equality and diversity, most respondents felt able to access appropriate care regardless of protected characteristics.

Patient comments included:

> "All staff are great, only have had positive interactions at the surgery. Very helpful”

Person-Centred

Health promotion

The practice demonstrated a broad range of health promotion and access to preventative services. Seasonal immunisation programmes were in place, including influenza and shingles vaccinations, supported by effective communication through a text messaging service to invite eligible patients. Respiratory syncytial virus (RSV) and COVID-19 vaccinations were not delivered at the practice, with patients directed to local mass vaccination centres.

Smoking cessation support was available via a neighbouring practice, with patients able to self-refer or be referred by the practice. Community connectors were also accessible through the neighbouring practice, enabling social prescribing and onward referral to voluntary sector organisations.

Mental health support was promoted through a combination of services. The practice employed a mental health practitioner who delivered two sessions per month, accessible via GP referral. In addition, patients were able to self-refer to external services, including Mind, and access a range of mental health self-help resources via the practice website.

Cluster-based services were in place, including access to a frailty and chronic conditions practitioner and a cluster pharmacist. Physiotherapy services were available through self-referral, supported by information displayed in the waiting area and on the practice website. A self-help hub on the website provided signposting to a wide range of health and wellbeing services.

Most services were accessed through the practice triage system, with GPs directing patients to appropriate services following assessment. The practice ensured information was accessible to patients who may not use digital services, including through in-person reception support, the triage system, and clear information displayed in the waiting area.

The practice had a ‘Was Not Brought’ policy in place, which was up to date. Processes were in place to follow up children who did not attend appointments, with escalation to the safeguarding lead where there were concerns.

While the practice demonstrated a strong range of health promotion activity, we identified that the ‘Did Not Attend’ policy referred to the practice manager by name. We advise this is amended to refer to the role rather than an individual to ensure the policy remains current.

Dignified and respectful care

The practice promoted person-centred care through respectful interactions, involvement in decision-making and provision of lifestyle advice during consultations. Patients confirmed they felt listened to and treated with respect.

The practice demonstrated appropriate arrangements to support patients' privacy and dignity during consultations and examinations.

Chaperone services were available and promoted through notices displayed in both clinical rooms and the waiting area. However, these notices were only available in English and not in Welsh. Patients were able to request a chaperone at the time of booking, and this was recorded on the appointment system.

Chaperones were primarily female members of staff; however, male GPs were available to act as chaperones where required. All chaperones had received appropriate training, which was completed via an online learning package. Evidence of training, including certificates, was seen in staff files. Chaperone training also formed part of the induction programme for new staff.

A chaperone policy was in place, was up to date, and had been reviewed. We were informed that clinicians are expected to record verbal consent for intimate examinations and document whether a chaperone was offered or present in the patient's medical record. This requires ongoing review to ensure consistent recording.

The practice should ensure the offer of a chaperone is recorded in the patient's medical record in line with GMC standards.

The practice had arrangements in place to support confidential conversations. Both clinical and non-clinical staff were able to speak with patients and discuss sensitive information away from the reception area, using a private room located behind reception. However, as previously noted, patient questionnaire responses indicated that although many patients felt able to speak to reception staff without being overheard, this was not the experience for all patients, suggesting some inconsistency in privacy at reception.

The practice must take steps to ensure patient confidentiality is consistently upheld at reception. This should include implementing measures to reduce the risk of conversations being overheard and ensuring staff proactively offer patients the opportunity to discuss sensitive matters in a private space.

Timely

Timely care

The practice operated a total triage model to manage patient access. All patients contacting the surgery were either signposted at the initial point of contact, where appropriate, or added to a GP triage list for further assessment. The GP reviewed all

patients on the triage list and directed them to the most appropriate service, including arranging face-to-face or telephone consultations, or signposting to other services such as the mental health practitioner.

Care navigators were able to signpost patients to a range of services, including community pharmacy and the Common Ailments Scheme. Staff had completed care navigation training through Health Education and Improvement Wales (HEIW), and evidence of training was seen. Where staff were unsure, they could seek advice from a GP to ensure patients were directed appropriately. Vulnerable patients or those requiring urgent care were discussed directly with a GP and prioritised, with same-day appointments arranged where necessary.

Information regarding access arrangements was available on the practice website and displayed in the waiting area. However, we noted that additional services, such as the mental health practitioner and frailty and chronic conditions practitioner, were not clearly included within the access policy and were located separately within the website. We recommend that this information is incorporated into the main access section to improve clarity for patients.

The practice should update its access policy and patient information to clearly include all services in one place, ensuring patients can easily understand how to access appropriate care.

The practice monitored access through GP activity data, which indicated that most calls were answered within the expected two-minute access standard. The practice reported a high student population, who were more likely to access services through digital means. The practice also ensured that patients who may not use digital pathways, including older people, could access services through alternative options such as telephone contact, paper information, and support from reception staff.

While the practice demonstrated effective systems to manage timely access, we did not see a formal care navigation or signposting policy. Although there was evidence of referral pathways, including information on the Common Ailments Scheme displayed in the reception area, we recommend the development of a clear, documented care navigation pathway and policy to support consistency in patient signposting.

The practice should develop and implement a clear, documented care navigation pathway and policy to support consistent and effective patient signposting

Equitable

Communicating and language

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

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

The practice used a range of communication methods including telephone, text messaging and online systems. Translation services were available where required.

However, limited provision of Welsh language services was evident, with no Welsh-speaking staff and limited 'Active Offer' arrangements in place.

The practice should take steps to strengthen the provision and visibility of Welsh language services, including promoting the Active Offer and ensuring patients are supported to access care through the medium of Welsh where desired.

Rights and equality

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

All patients responding to our questionnaire thought the building was easily accessible.

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

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

Delivery of Safe and Effective Care

Safe

Risk management

The practice demonstrated a range of systems to support effective risk management.

Home visits were rarely required due to the demographics of the local patient population, which largely comprised of students, and the absence of care homes or nursing facilities within the practice area. While a formal home visit risk assessment process was not in place, staff advised that any risks would be discussed in advance where a visit was required, reflecting the low demand for this service.

A comprehensive Business Continuity Plan (BCP) was in place and was accessible to all staff via email, the shared drive, and a hard copy in the reception office. The plan included detailed arrangements to manage risks associated with partnership changes, including contingency plans should a GP partner be unable to continue in their role. However, we noted that the supplier information within the BCP was incomplete and required updating.

The practice should ensure that the Business Continuity Plan is regularly reviewed and updated, including maintaining complete and accurate supplier information.

The practice utilised locum GPs to ensure service continuity, including a regular locum working two days per week, with additional locum support arranged as required during periods of leave.

Risk escalation processes were in place, with monthly escalation levels submitted via the primary care portal and an annual sustainability assurance document completed for the health board.

Patient safety alerts were received via a dedicated email account, with access currently shared between the senior partner, practice manager, and senior receptionist.

The practice had a significant event policy and reporting system in place. Significant events were discussed during practice meetings involving clinical and managerial staff, and shared learning was disseminated through meetings and internal communication. The policy was reviewed; however, it required updating to remove references to the Quality and Outcomes Framework (QOF) and consider inclusion of the Quality Assurance and Improvement Framework (QIF).

Emergency drugs and equipment were stored in the reception area, with clear signage indicating their location, supporting staff awareness and timely access in the event of an emergency. However, signage indicating the presence of oxygen was not displayed on the reception doors. This was rectified on the day of inspection, with appropriate signage put in place.

The practice environment, including clinical areas, was observed to be clean, tidy, and free from clutter, and maintained in a good state of repair.

Infection prevention and control (IPC) and decontamination

The practice had arrangements in place to support infection prevention and control. A GP acted as the IPC lead, reflecting the structure of the practice team, with the practice nurse working on a limited basis. We were informed that the practice nurse undertook hand hygiene audits.

IPC training was mandatory for staff, and we found that the majority had completed training appropriate to their roles; however, GPs had only completed Level 1 IPC training.

The practice should ensure all GP's complete IPC training appropriate to their role, in line with current guidance, to support effective infection prevention and control practices.

The practice engaged with wider IPC networks, including attendance at bi-monthly Cardiff and Vale GP and nurse meetings. Cluster level IPC leadership was provided by a designated lead, who shared regular updates and guidance with practices. Weekly primary care update emails were also received to support awareness of current IPC requirements.

An IPC policy was in place. Waste management arrangements were observed, including the use of locked clinical waste bins located within the sluice area, with external contractors responsible for collection and disposal. Waste audits were seen and were undertaken regularly. A waste management policy was also in place. However, we noted that actions identified within an external waste audit had not been fully addressed. We recommend that the practice develops a clear action plan to respond to audit findings and ensures ongoing monitoring of progress.

The practice should develop and implement a clear action plan to address findings from waste audits, ensuring identified actions are completed and progress is routinely monitored.

The practice environment supported effective IPC arrangements. Clinical areas were equipped with appropriate hand hygiene facilities, including clinical hand wash basins, suitable flooring, and wipeable examination couches. Cleaning schedules were in place and evidenced. Signage was displayed throughout the practice to indicate the location of emergency equipment. We also saw needlestick injury pathway posters displayed in all clinical rooms, supported by a relevant policy.

Arrangements were in place to isolate patients where necessary, using available GP rooms; however, there was no dedicated isolation room.

We identified that IPC audits were not yet fully embedded into routine practice, which limited the effectiveness of assurance processes. Separately, the system for recording staff hepatitis B immunisation status required improvement to ensure records were accurate, complete and easily accessible.

The practice should strengthen IPC assurance processes by embedding routine IPC audits into day-to-day practice.

The practice should improve systems for recording and maintaining accurate, complete and accessible staff hepatitis B immunisation records.

Medicines management

The practice demonstrated appropriate systems for managing medicines safely and effectively.

Prescription pads were stored securely in a locked cupboard within the reception area. A robust process was in place to monitor the issue of prescriptions, with a log maintained to record when prescriptions were collected. Prescriptions were signed for by patients or community pharmacies, which reflects good practice. Arrangements were also in place to return unused prescription pads when a GP leaves the practice.

Patients were able to request repeat prescriptions through a range of methods, including the NHS App and email. Administrative staff were trained to process prescription requests, with any queries or reauthorisation requests directed to a GP or the cluster pharmacist. Medication reviews were predominantly undertaken by the cluster pharmacist, supported by GPs where required. A defined scope of practice for the cluster pharmacist was in place, demonstrating good governance arrangements.

The practice had an up-to-date prescribing policy and prescribing related training needs were identified through appraisals, incident reviews, and general queries, with support provided by the medicines management team. Processes were in place to identify potential overuse of medication, with concerns escalated to a GP and prescriptions withheld where appropriate.

Arrangements were in place to maintain the cold chain for vaccines. Dedicated clinical refrigerators were in use, with temperatures monitored daily using data loggers. Temperature records were maintained, and signage was displayed to prevent accidental disconnection. Vaccines were observed to be stored appropriately, with sufficient airflow, within recommended capacity limits, and within expiry dates. A cold chain policy was in place and provided clear guidance; however, the associated audit tool was not currently in use. We advise that this tool is implemented to strengthen ongoing assurance.

We identified that the practice policy stated that no medicines were held on site; however, vitamin B12 and emergency resuscitation medicines were stored within the practice. We recommend that the policy is updated to accurately reflect current

practice. In addition, we suggest implementing ambient room temperature monitoring where medicines are stored.

The practice should update its medicines management policy to accurately reflect current practice and implement ambient room temperature monitoring where medicines are stored.

Emergency equipment and medicines were available, and oxygen training was included as part of cardiopulmonary resuscitation (CPR) training. However, we noted that specific training relating to the use of oxygen cylinders (BOC training) had not been completed.

The practice should ensure that all staff complete appropriate training in the safe use of oxygen cylinders, in line with patient safety notice 041, to support the safe management of emergency equipment.

Safeguarding of children and adults

The practice demonstrated reasonable arrangements in place to safeguard children and adults at risk.

A safeguarding policy was in place, accessible to staff, and aligned with All Wales Child Protection Procedures, which were available via the shared drive. A GP was identified as the safeguarding lead. Staff were able to access relevant safeguarding guidance and were aware of escalation processes.

The practice population largely consisted of students, with relatively few families and children registered. At the time of inspection, staff reported that there were no children on the child protection register. However, following discussion, it was identified that two foster children were registered with the practice and should be recognised as Looked After Children (LAC) and appropriately coded within the clinical system. This requires prompt review to ensure accurate identification and monitoring.

The practice should review and update coding and systems to ensure all Looked After Children are accurately identified and monitored within the clinical system

The practice monitored emergency department attendances and received information regarding frequent attenders, which was reviewed by the GP to identify any safeguarding concerns.

We noted that regular safeguarding meetings were not in place. While the number of safeguarding cases was low, it is important that the practice establishes routine safeguarding discussions, including liaison with external professionals such as health visitors, to ensure any emerging risks are identified and managed appropriately.

The practice should establish regular safeguarding meetings, including liaison with relevant external professionals, to support the identification, discussion and effective management of safeguarding concerns

The practice participated in a well-established multidisciplinary team (MDT) cluster meeting, held twice monthly. These meetings provided an opportunity to discuss patient care and wider concerns, including those related to vulnerability.

Referrals to external services, including local referral pathways, were in place to support patients where safeguarding or additional needs were identified.

Management of medical devices and equipment

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

Effective

Effective care

The practice population largely comprised students, which influenced service delivery and demand. Clinical summarising of patient records was supported by medical students, with appropriate oversight in place.

The practice utilised disease registers to identify and monitor patients with chronic conditions, supporting ongoing management and review of care.

Clinical communication was managed effectively through the use of electronic tasking within the clinical system. Messages remained within inboxes until actioned, supporting continuity where staff may be absent due to leave or sickness. Non-clinical communication was also managed through internal tasking systems and NHS email, with read receipts utilised to confirm that important messages had been received and acknowledged.

Incoming correspondence was managed in a consistent and timely manner. Letters received via post or electronic transfer were scanned, coded, and forwarded to a GP for review. Hospital correspondence was also systematically processed and reviewed by clinicians. Alerts were in place within the clinical system to identify patients who were housebound.

Home visit requests were incorporated into the triage system, with staff notifying the GP when a visit was added to ensure timely review and prioritisation.

The practice had effective processes in place to manage follow-up for test results, including the use of a diary system to track ongoing actions and ensure patients

received appropriate follow-up. This approach demonstrated good practice. However, we suggested that consideration be given to utilising the clinical system diary functionality to further enhance oversight and enable routine monitoring of outstanding actions.

The practice should consider utilising the clinical system's diary functionality to enhance oversight and support routine monitoring of outstanding follow-up actions.

Patient records

We reviewed 10 electronic patient records, which were stored securely and were password protected from unauthorised access. Records were of a high standard, being clear, comprehensive and contemporaneous. There was good use of coding, although language preference was not consistently recorded. They were contemporaneous and information was easy to understand for other clinicians reviewing the records.

The practice should ensure that patients' language preferences are consistently recorded within clinical records to support personalised and accessible care

As highlighted earlier, the practice has a chaperone policy which states that the practice should document when a chaperone is offered, who is present and if a chaperone was offered and declined. During the review of the patients records we did not always see evidence of this being recorded.

Quality of Management and Leadership

Staff Feedback

Staff described the practice as supportive, with strong teamwork and approachable leaders. They reported feeling able to raise concerns and having sufficient time to perform their roles.

Feedback was received from 12 staff members working at The City Surgery. Respondents included a mix of permanent staff, regular visiting clinicians and locum staff, providing a broad representation of the workforce.

Overall, staff feedback was consistently positive. All respondents who answered the relevant questions reported effective collaboration with the practice, highlighting good communication, timely involvement in patient care, and access to appropriate training and resources to support their roles. No respondents indicated that they had needed to raise concerns with senior management.

Responses relating to training and professional development were also positive. All staff who answered confirmed they had received appropriate training for their role and had undertaken a recent appraisal or development review.

Most respondents agreed or strongly agreed that they were able to meet the demands of their role, supported by adequate staffing levels, appropriate skill mix, sufficient supplies and access to ICT systems. Staff also reported that they were involved in service changes and felt able to suggest improvements.

Staff confirmed that patient dignity and confidentiality were maintained, with appropriate use of chaperones and systems in place to identify and respond to patients with communication difficulties. Respondents also indicated that patients were generally able to access services in a timely manner.

All respondents who answered questions relating to carers reported that the practice maintained a carers register, provides access to a carers champion, offers appropriate assessments, and signposts carers to relevant support services.

Workplace culture was described positively, with all respondents reporting that they had not experienced discrimination and that the practice promotes equality, diversity and inclusion, with fair access to opportunities for all staff.

Staff comments included:

> "The surgery have identified a need for extra support for people with mental health issues hence my role I think this is an excellent idea”
>
> “Very welcoming, work well together as a team to ensure patients are seen in a timely manner by the appropriate healthcare professional, or signposted to other local service”

"Good patient's care & well organised practice"

Leadership

Governance and leadership

The practice demonstrated defined leadership arrangements, with the senior partner holding overall responsibility for clinical oversight and delivery of the Quality Assurance and Improvement Framework (QAIF). Evidence of GP activity and performance was visible on both the practice website and within the waiting area.

Clinical meetings were reported to take place on a bi-monthly basis and included GP's and the Advanced Nurse Practitioner (ANP). Whilst a number of meetings were described, we were unable to review supporting minutes and actions for all meetings. It is important that formal records are maintained, securely stored, and shared with all relevant staff, including those not in attendance, to ensure effective communication and governance.

The practice should ensure that formal records of all meetings are maintained, securely stored, and shared with relevant staff to support effective communication and governance.

The practice shared learning from incidents and service developments through staff discussions and meetings. However, we did not see a formalised practice development plan outlining clear objectives, responsibilities, and timescales for any identified service improvement. Although the practice appeared to be operating effectively, we recommend the development of a structured plan to support ongoing improvement and to provide clarity of roles and accountability, particularly in light of changes within the practice management team.

The practice should develop and implement a formal practice development plan with clear objectives, defined responsibilities and timescales to support structured service improvement, governance and accountability

Arrangements were in place for engagement with cluster initiatives and projects. The practice manager and a GP represented the practice at cluster level and were able to present and discuss project proposals. A cluster agreement was in place, including data-sharing arrangements. Whilst the practice reported involvement in regular meetings, limited documentary evidence of meeting minutes was available, with the exception of palliative care meetings.

Workforce

Skilled and enabled workforce

We were provided with evidence that most staff had completed mandatory training and were told that plans were in place for staff to renew their training where applicable. However, during our inspection we identified some training gaps which identified the need for development of a training matrix.

The practice should develop and maintain a training matrix to identify, monitor and address mandatory training requirements and any gaps.

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

The practice did not have a formal workforce plan in place. However, due to the small team size, staff were multi-skilled and able to undertake a range of roles, which supported continuity of service and provided resilience during periods of absence. Non-clinical rotas were in place to ensure adequate staffing levels, with staff providing internal cover where required. The practice should consider the development of a formal workforce plan to support future planning, to clarify staffing needs, and to strengthen resilience as the practice develops.

Clinical workforce arrangements were managed effectively. GPs notified the practice manager in advance of leave, and locum cover was arranged to maintain service provision. Skill mix was reviewed on an ongoing basis, including through appraisals and changes in staffing.

Clinical staff held appropriate additional indemnity cover. Training and development needs were identified through appraisal processes and day-to-day practice requirements.

We identified that occupational health checks were not routinely completed at the point of recruitment. This is a requirement under the GMS contract and supports the identification of any health needs of new staff, enabling appropriate risk assessments to be undertaken. We recommend that the practice implements occupational health screening as part of its recruitment processes.

The practice should ensure occupational health screening is completed as part of the recruitment process, and on-going where necessary, to support any identified workplace adjustments.

An induction policy and checklist were in place to support new staff. However, inconsistencies were identified, including the presence of two different checklists and references to the Care Quality Commission (CQC), which are not applicable in Wales. Additionally, some template documents within the policy annex were incomplete and required updating to reflect practice-specific information.

The practice should review and update its induction policy and materials to ensure they are consistent, relevant to Wales, and fully completed with practice-specific information.

Culture

People engagement, feedback and learning

The practice had limited arrangements in place to capture and use patient feedback to inform service improvement. A suggestions box was available within the waiting area; however, there was no clear information displayed to advise patients how they could provide feedback on their experience. In addition, the practice website did not include accessible information on how patients could share feedback.

As previously highlighted in this report, we were not provided with evidence to demonstrate that patient feedback was routinely reviewed, analysed, or used to inform service improvements. To strengthen governance and support a patient-centred approach, the practice must ensure that clear information is available to patients on how to provide feedback, and that feedback is actively used to drive service development.

The practice had a complaints policy and tracking system in place. However, complaints were not routinely analysed to identify themes or trends. We also noted that the complaints process remained aligned to the NHS Wales Putting Things Right guidance, which was superseded by Listening and Learning from Feedback (Listening to People) on 1 April 2026. The practice must update its policies and procedures to reflect current guidance.

The practice must ensure its complaints policy and processes are updated to reflect current guidance, including the Listening and Learning from Feedback (Listening to People) framework, and should implement routine analysis of complaints to identify themes, trends and learning opportunities.

Staff reported that they felt confident to raise concerns within the practice. A whistleblowing policy was in place, and staff advised they felt supported to speak up and share suggestions for service improvement with management.

The practice had a Duty of Candour policy in place. However, records reviewed indicated that staff had not completed formal training in relation to Duty of Candour. While staff who completed questionnaires reported that they understood their responsibilities, the practice must ensure that all staff complete appropriate training to support consistent understanding and application of Duty of Candour requirements.

The practice must ensure that all staff complete appropriate Duty of Candour training to support consistent understanding and application of requirements

Arrangements were in place to gather patient feedback, including an annual survey distributed via paper copies, QR codes, text messaging, and the practice website. A suggestions box was also available in the waiting area. However, the practice website primarily promoted complaints information. We recommend the introduction of a dedicated feedback mechanism on the website, alongside a 'You said, we did' approach to demonstrate how patient feedback has informed improvements.

The practice should introduce a dedicated feedback mechanism on its website and demonstrate how patient feedback is used to inform improvements through a 'You said, we did' approach

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, and we saw evidence that all staff had completed training on this topic.

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

Learning, improvement and research

Quality improvement activities

Internal audit and quality improvement activity was undertaken but lacked consistency and formalisation. We were told learning was shared across the practice via regular staff meetings to make improvements, however, as highlighted earlier, there were no formal minutes or actions recorded.

The practice should formalise its audit and quality improvement processes within a coherent annual plan. Activities should be completed consistently and supported by clear documentation, including recorded actions and follow-up to demonstrate learning and improvement.

4. Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions, they are taking to address these areas.

The improvement plans should:

- Clearly state how the findings identified will be addressed
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

Appendix A – Summary of concerns resolved during the inspection

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

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

Appendix B – Immediate improvement plan

Service: The City Surgery

Date of inspection: 21 April 2026

The table below includes any immediate non-compliance concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	No Immediate non-compliance issues were identified on this inspection				
Findings:					

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

Service representative:

Name (print):

Job role: **Date:**

Appendix C – Improvement plan

Service: **The City Surgery**

Date of inspection: **21 April 2026**

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

	Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	We were informed that clinicians are expected to record verbal consent for intimate examinations and document whether a chaperone was offered or present in the patient's medical record. This requires ongoing review to ensure consistent recording.	**The practice should ensure the offer of a chaperone is recorded in the patient's medical record in line with GMC standards.**	Health and Care Quality Standards – Information	All staff has been reminded that coding needs to be accurate and completed each time a chaperone is used for a consultation. PM will audit one a monthly basis.	PM	15/06/2026

2.	HIW's patient questionnaire responses indicated that although many patients felt able to speak to reception staff without being overheard, this was not the experience for all patients, suggesting some inconsistency in privacy at reception.	**The practice must take steps to ensure patient confidentiality is consistently upheld at reception. This should include implementing measures to reduce the risk of conversations being overheard and ensuring staff proactively offer patients the opportunity to discuss sensitive matters in a private space.**	Health and Care Quality Standards – Equitable	Reception staff has been advised to offer to take a patient to a side room where possible to ensure a confidential conversation can take place without other overhearing this.	All staff	01/06/2026

3.	Information regarding access arrangements was available on the practice website and displayed in the waiting area. However, we noted that additional services, such as the mental health practitioner and frailty and chronic conditions practitioner, were not clearly included within the access policy and were located separately within the website. We recommend that this information is incorporated into the main access section to improve clarity for patients.	**The practice should update its access policy and patient information to clearly include all services in one place, ensuring patients can easily understand how to access appropriate care.**	Health and Care Quality Standards – Information	Policy has now been updated	PM	01/06/2026

4.	While the practice demonstrated effective systems to manage timely access, we did not see a formal care navigation or signposting policy. Although there was evidence of referral pathways, including information on the Common Ailments Scheme displayed in the reception area, we recommend the development of a clear, documented care navigation pathway and policy to support consistency in patient signposting.	**The practice should develop and implement a clear, documented care navigation pathway and policy to support consistent and effective patient signposting**	Health and Care Quality Standards – Information	This has now been created	PM	01/06/2026

5.	Limited provision of Welsh language services was evident, with no Welsh-speaking staff and limited 'Active Offer' arrangements in place.	**The practice should take steps to strengthen the provision and visibility of Welsh language services, including promoting the Active Offer and ensuring patients are supported to access care through the medium of Welsh where desired.**	Health and Care Quality Standards – Information	Posters have now been created and displayed to offer services to the Welsh medium where/ when possible	All staff	01/06/2026

6.	A comprehensive Business Continuity Plan (BCP) was in place and was accessible to all staff via email, the shared drive, and a hard copy in the reception office. The plan included detailed arrangements to manage risks associated with partnership changes, including contingency plans should a GP partner be unable to continue in their role. However, we noted that the supplier information within the BCP was incomplete and required updating.	**The practice should ensure that the Business Continuity Plan is regularly reviewed and updated, including maintaining complete and accurate supplier information.**	Health and Care Quality Standards – Information	BC updated and now accurate	PM	01/06/2026
7.	IPC training was mandatory for staff, and we found that the majority had completed training appropriate to their roles; however, GPs had only completed Level 1 IPC training.	**The practice should ensure all GP's complete IPC training appropriate to their role, in line with current guidance, to support effective infection prevention and control practices.**	Health and Care Quality Standards – workforce	GPs to complete the appropriate IPC training	PM	01/09/2026

8.	A waste management policy was also in place. However, we noted that actions identified within an external waste audit had not been fully addressed. We recommend that the practice develops a clear action plan to respond to audit findings and ensures ongoing monitoring of progress.	**The practice should develop and implement a clear action plan to address findings from waste audits, ensuring identified actions are completed and progress is routinely monitored.**	Health and Care Quality Standards – Safe, Information	A plan is in the process of being created.	PM	01/09/2026
9.	We identified that IPC audits were not yet fully embedded into routine practice, which limited the effectiveness of assurance processes.	**The practice should strengthen IPC assurance processes by embedding routine IPC audits into day-to-day practice.**	Health and Care Quality Standards – Safe, Information	An audit schedule has now been created and completed.	PM/ Nurse	01/06/2026
10.	The system for recording staff hepatitis B immunisation status required improvement to ensure records were accurate, complete and easily accessible.	**The practice should improve systems for recording and maintaining accurate, complete and accessible staff hepatitis B immunisation records.**	Health and Care Quality Standards – Safe, Information	A system is in place to record Hep B status in form, spreadsheet with all staff statuses is recorded in the staff files on the g-drive and easily accessible	PM	01/06/2026

11.	We identified that the practice policy stated that no medicines were held on site; however, vitamin B12 and emergency resuscitation medicines were stored within the practice. We recommend that the policy is updated to accurately reflect current practice. In addition, we suggest implementing ambient room temperature monitoring where medicines are stored.	**The practice should update its medicines management policy to accurately reflect current practice and implement ambient room temperature monitoring where medicines are stored.**	Health and Care Quality Standards – Information	Policies updated and thermometer now is place	PM	01/06/2026

12.	Emergency equipment and medicines were available, and oxygen training was included as part of cardiopulmonary resuscitation (CPR) training. However, we noted that specific training relating to the use of oxygen cylinders (BOC training) had not been completed.	**The practice should ensure that all staff complete appropriate training in the safe use of oxygen cylinders, in line with patient safety notice 041, to support the safe management of emergency equipment.**	Health and Care Quality Standards – Safe, Workforce	Staff training is being looked at.	PM	01/09/2026

13.	At the time of inspection, staff reported that there were no children on the child protection register. However, following discussion, it was identified that two foster children were registered with the practice and should be recognised as Looked After Children (LAC) and appropriately coded within the clinical system. This requires prompt review to ensure accurate identification and monitoring.	**The practice should review and update coding and systems to ensure all Looked After Children are accurately identified and monitored within the clinical system**	Health and Care Quality Standards – Safe, Information	Coding system reviewed and coding now in place	Dr Raj Aggarwal	01/06/2026

14.	We noted that regular safeguarding meetings were not in place. While the number of safeguarding cases was low, it is important that the practice establishes routine safeguarding discussions, including liaison with external professionals such as health visitors, to ensure any emerging risks are identified and managed appropriately.	**The practice should establish regular safeguarding meetings, including liaison with relevant external professionals, to support the identification, discussion and effective management of safeguarding concerns**	Health and Care Quality Standards – Safe, Information	Meetings are now in place and scheduled on regular intervals.	PM	01/06/2026

15.	The practice had effective processes in place to manage follow-up for test results, including the use of a diary system to track ongoing actions and ensure patients received appropriate follow-up. This approach demonstrated good practice. However, we suggested that consideration be given to utilising the clinical system diary functionality to further enhance oversight and enable routine monitoring of outstanding actions.	**The practice should consider utilising the clinical system's diary functionality to enhance oversight and support routine monitoring of outstanding follow-up actions.**	Health and Care Quality Standards – Information	The diary system is currently in the process of being set up.	PM	01/09/2026

16.	Clinical meetings were reported to take place on a bi-monthly basis and included GP's and the Advanced Nurse Practitioner (ANP). Whilst a number of meetings were described, we were unable to review supporting minutes and actions for all meetings. It is important that formal records are maintained, securely stored, and shared with all relevant staff, including those not in attendance, to ensure effective communication and governance.	**The practice should ensure that formal records of all meetings are maintained, securely stored, and shared with relevant staff to support effective communication and governance.**	Health and Care Quality Standards – Information	A folder has been created on the g-drive and meeting minutes are now recorded and saved in the appropriate folder		01/05/2026

17.	The practice shared learning from incidents and service developments through staff discussions and meetings. However, we did not see a formalised practice development plan outlining clear objectives, responsibilities, and timescales for any identified service improvement. Although the practice appeared to be operating effectively, we recommend the development of a structured plan to support ongoing improvement and to provide clarity of roles and accountability, particularly in light of changes within the practice management team.	**The practice should develop and implement a formal practice development plan with clear objectives, defined responsibilities and timescales to support structured service improvement, governance and accountability**	Health and Care Quality Standards – Information	Practice Development plan is in the process of being created and will be completed by the end of July 2026	PM	30/09/2026

18.	We were provided with evidence that most staff had completed mandatory training and were told that plans were in place for staff to renew their training where applicable. However, during our inspection we identified some training gaps which identified the need for development of a training matrix.	**The practice should develop and maintain a training matrix to identify, monitor and address mandatory training requirements and any gaps.**	Health and Care Quality Standards – Information, Workforce	Training matrix now in place.	PM	01/06/2026

19.	We identified that occupational health checks were not routinely completed at the point of recruitment. This is a requirement under the GMS contract and supports the identification of any health needs of new staff, enabling appropriate risk assessments to be undertaken. We recommend that the practice implements occupational health screening as part of its recruitment processes.	**The practice should ensure occupational health screening is completed as part of the recruitment process, and on-going where necessary, to support any identified workplace adjustments.**	Health and Care Quality Standards – Information, Workforce	Occupational health paperwork has been created. Current staff have completed the paperwork and this will also be used for new staff.	PM	01/06/2026

20.	An induction policy and checklist were in place to support new staff. However, inconsistencies were identified, including the presence of two different checklists and references to the Care Quality Commission (CQC), which are not applicable in Wales. Additionally, some template documents within the policy annex were incomplete and required updating to reflect practice-specific information.	**The practice should review and update its induction policy and materials to ensure they are consistent, relevant to Wales, and fully completed with practice-specific information.**	Health and Care Quality Standards – Information	This has now been updated	PM	01/06/2026

21.	The practice had a complaints policy and tracking system in place. However, complaints were not routinely analysed to identify themes or trends. We also noted that the complaints process remained aligned to the NHS Wales Putting Things Right guidance, which was superseded by Listening and Learning from Feedback (Listening to People) on 1 April 2026. The practice must update its policies and procedures to reflect current guidance.	**The practice must ensure its complaints policy and processes are updated to reflect current guidance, including the Listening and Learning from Feedback (Listening to People) framework, and should implement routine analysis of complaints to identify themes, trends and learning opportunities.**	Health and Care Quality Standards – Information, Learning, Improvement and Research	This was updated on the day of inspection. An agenda item has been added to practice meetings every quarter to discuss complaints and learning opportunities arising from the same.	PM	01/06/2026

22.	The practice had a Duty of Candour policy in place. However, records reviewed indicated that staff had not completed formal training in relation to Duty of Candour. While staff who completed questionnaires reported that they understood their responsibilities, the practice must ensure that all staff complete appropriate training to support consistent understanding and application of Duty of Candour requirements.	**The practice must ensure that all staff complete appropriate Duty of Candour training to support consistent understanding and application of requirements**	Health and Care Quality Standards – Information, Workforce	Training to be scheduled	PM	30/09/2026

23.	Arrangements were in place to gather patient feedback, including an annual survey distributed via paper copies, QR codes, text messaging, and the practice website. A suggestions box was also available in the waiting area. However, the practice website primarily promoted complaints information. We recommend the introduction of a dedicated feedback mechanism on the website, alongside a 'You said, we did' approach to demonstrate how patient feedback has informed improvements.	**The practice should introduce a dedicated feedback mechanism on its website and demonstrate how patient feedback is used to inform improvements through a 'You said, we did' approach**	Health and Care Quality Standards – Information, Learning, Improvement and Research	Website updated and feedback option now available. A feedback board has been created in the waiting room.	PM	01/06/2026

24.	Internal audit and quality improvement activity was undertaken but lacked consistency and formalisation. We were told learning was shared across the practice via regular staff meetings to make improvements, however, as highlighted earlier, there were no formal minutes or actions recorded.	**The practice should formalise its audit and quality improvement processes within a coherent annual plan. Activities should be completed consistently and supported by clear documentation, including recorded actions and follow-up to demonstrate learning and improvement.**	Health and Care Quality Standards – Information, Learning, Improvement and Research	As mentioned above this is now in place	PM	01/06/2026

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: Danielle Plowright

Name (print): Danielle Plowright

Job role: Practice Manager **Date: 01/07/2026**