Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report (Announced)

Bradley's Practice, Mold.

Betsi Cadwaladr University Health Board

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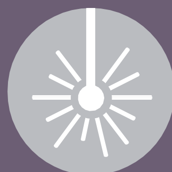

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

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:

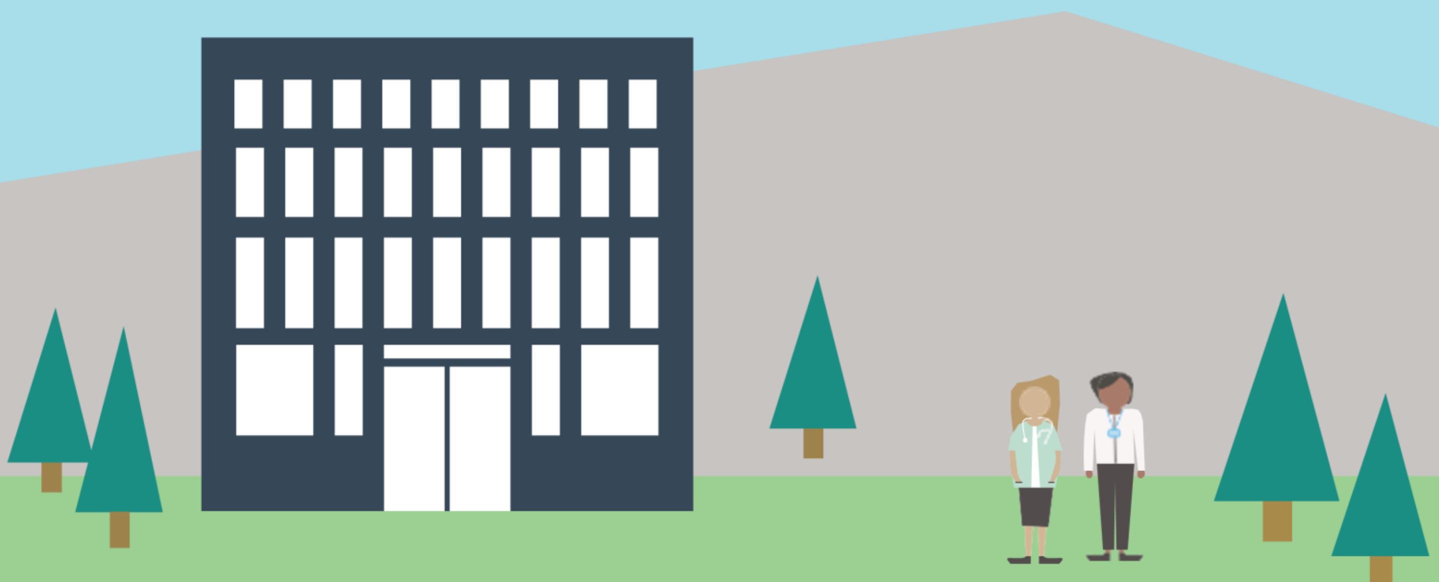
- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and 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 Bradley's Practice, Mold, Betsi Cadwaladr University Health Board on 17 March 2026.

Our team for the inspection comprised of two HIW healthcare inspectors, two clinical peer reviewers and one practice manager 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 11 questionnaires were completed by patients or their carers and 28 were completed by staff. Feedback and some of the comments we received appear throughout the report.

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

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

2. Summary of inspection

Quality of Patient Experience

Overall summary:
The premises provided convenient access for all patients including those with impaired mobility and wheelchair users ensuring step free ease of entry to the facilities and consulting rooms. The patient waiting area was maintained to a high standard, both being clean, tidy and spacious. There was good seating facility and a quiet area for those who preferred.

There was a dual level reception desk which enabled direct face to face conversation with all those attending the surgery.

The spacious reception area included a fully stocked pharmacy, enabling patients to obtain their prescriptions without delay.

Patient questionnaires were positive with the majority rating the service as 'good' or 'very good'. Individuals utilising the service had access to health promotion resources, wellbeing and healthy lifestyle choices. Comprehensive patient information was accessible online through the practice website, as well as via printed information leaflets provided at the practice for individuals without digital access. Some patients reported some difficulty in navigating access to information on the practice website. This did not include the digital appointment booking platform.

The environment was conducive to patient privacy and dignity with staff respectful during conversations on the telephone and at the reception desk. Conversations could not be overheard, and we noted that staff refrained from discussing patient identifiable details.

Effective processes were established to facilitate timely access to care via the appropriate channels and personnel, including a new digital self-help access portal

for patient bookings. This was reported by patients as very useful and easy to use. Those who had difficulty using the online e-consult were supported to complete by reception and administration staff.

Communication with patients was clear, accessible and tailored to individual needs enabling informed decision-making regarding care. The use of Welsh language was at the forefront of care with many staff conversing openly in Welsh with patients. There were additionally several staff learning to speak Welsh and wore appropriate identification so that patients were aware of their abilities.
The practice fostered a culture of supportive equality and diversity, embedding these values into their policies and staff training initiatives.

It was observed and discussed with staff that concerns on occasion are raised by patients at the reception desk. Such concerns were not formally documented but verbally communicated to the senior team.

This is what we recommend the service can improve:

- Simplify the website to enable ease of search
- Enable the reception staff to log concerns from patients on arrival.

This is what the service did well:

- Access arrangements for patients including the new digital access platform which facilitated same day appointments
- Enable prescription collection post consultation for those who may have difficulty in accessing such services.

Delivery of Safe and Effective Care

Overall summary:
The processes in place at the practice protected health, safety and wellbeing of all service users. All areas of the practice were clean, tidy, free of clutter and in a good state of repair.

The practice environment, policies and procedures staff training and governance arrangements upheld the required standards of IPC and maintained safety of staff and patients. Appropriate handwashing facilities were available including handwashing technique notices present in each room. We also saw good audit on all aspects of IPC to include water temperature and clinical relevance IPC techniques.

We saw that all clinical staff were protected against Hepatitis B and that appropriate monitoring of all staff was undertaken for their own protection and that of their patients.

Disposable privacy curtains were in place with appropriate measures for safe use and disposal.

There was appropriate resuscitation equipment and emergency drugs in place to manage an acute patient emergency. These met the primary care equipment standards as outlined by the Resuscitation Council UK Guidance. All staff had completed appropriate training to care for the acutely unwell and cardiac arrest. The practice had identified that the position of the emergency equipment was unsuitable and was not always accessible therefore they had taken the decision to relocate the equipment and were going through the relocation process during our visit of notifying all staff and changing signage.

There were processes in place to support safe and effective care to the wider primary care services. The practice ensured that patients requiring mental health support were appropriately signposted and supported. The practice policies, procedures and culture ensured that people and staff were able to report and manage safeguarding concerns.

Patient records were clear, written to a very good standard and complete with appropriate information. They were contemporaneous and were easy to

understand by other clinicians reviewing the records. These were stored securely and were password protected from unauthorised access.

This is what we recommend the service can improve:

- Relocate the emergency equipment when safe to do so.

This is what the service did well:

- Good compliance with emergency equipment and training
- Good quality medical notes.

Quality of Management and Leadership

Overall summary:
Established processes supported effective governance, leadership, and accountability, facilitating the sustainable delivery of safe and high-quality care. Staff and management demonstrated clarity regarding their roles, responsibilities, reporting relationships and the necessity to operate within their defined scope of practice.

The team consists of professionals from various disciplines. Interdisciplinary meetings were held regularly to promote information exchange among senior staff and to ensure that updates were disseminated to those not present. Nevertheless, it was observed that limited information sharing occurred regarding the discussions at each multi-professional meeting.

The practice maintained a strong team of staff members who possessed the necessary knowledge and skills to meet current demand. Staff were actively supported in completing training relevant to their roles and encouraged to pursue personal professional development. Mandatory training records indicated that staff were up to date with the relevant training.

Staff understood their responsibilities under the duty of candour policy and had received appropriate training.

The practice understood its responsibilities when processing information and demonstrated that personal data was managed in a safe and secure way. An information governance policy was in place.

This is what we recommend the service can improve:

- Create a clinical meeting log to enable all staff to keep abreast of all relevant meetings and information.

This is what the service did well:

- The practice has made substantial investments in its information technology (IT) infrastructure
- The implemented systems facilitated efficient access to staff contracts, training records, workforce information and all other workforce-related documentation at-a-glance.

3. What we found

Quality of Patient Experience

Patient feedback

HIW issued a questionnaire to gather patients' views on the care provided at Bradley's Practice as part of the inspection undertaken in March 2026. In total, HIW received 11 responses from patients at this service. Some respondents did not answer all questions.

In general, respondents expressed satisfaction with the practice's opening hours and confirmed their ability to contact the GP practice as needed. The majority indicated that urgent, same-day, and routine appointments were typically accessible, although some noted challenges in securing appointments. Among those living with ongoing conditions, most reported they could obtain regular support when required. Additionally, most respondents demonstrated awareness of how to access out-of-hours services.

Person-centred

Health promotion
Patients who used the service were able to access information to support their health and wellbeing and to help them maintain a healthy lifestyle.

We saw a range of information to promote healthy lifestyle, including smoking cessation and healthy eating. We also noted an information board in both waiting areas which promoted a variety of campaigns, including influenza, respiratory virus and shingles. Further information was available on the practice website, including advice on asthma, domestic abuse and mental health support.

We found a number of initiatives had been introduced including physiotherapy referrals and the provision of a podiatry clinic within the practice.

Staff told us they provided the immunisation service to all patients who were deemed eligible and would invite those patients either by email, letter or telephone, depending upon preferred communications style or needs.

Dignified and respectful care

The environment supported the patients right to be treated with dignity and respect. Clinical rooms provided appropriate levels of privacy, with lockable doors. Disposable privacy curtains were also available within examination rooms. We noted that all telephone conversations with patients were held in a room which was adjacent to the reception area and could not be overheard. Most respondents stated they were able to speak to reception staff in private when required and reported that appropriate privacy measures were in place during consultations.

The practice offered male and female chaperones as appropriate and a chaperone policy was in place. However, in the patient questionnaire some patients told us they were not always offered a chaperone for intimate examinations or procedures.

The practice must ensure that a notice advising patients of chaperone availability is displayed in each consultation room and documented within clinical notes.

Timely

Timely care

Around a third of patients who responded to our questionnaire reported being offered a choice of appointment type for example, face-to-face, telephone or virtual. All respondents who answered this question stated they were satisfied with the appointment type offered. Most respondents reported their most recent appointment was face-to-face, with a small number reporting a telephone appointment.

There were processes in place to support patients to access care via an appropriate channel, in a timely manner, and from the most suitable member of the team.

Arrangements to support patients to access services were described, and we found that different access models were in use. The practice access policy was available on the practice website. Most appointments were arranged by telephone. Trained reception staff used an agreed list of conditions to support signposting to other appropriate service providers where relevant, for example directing patients to an optician for eye problems and a dentist for dental problems.

Patients assessed as less urgent were booked for an initial telephone assessment and were then managed either by telephone or through a face-to-face appointment, as appropriate. Staff told us that children and vulnerable patients were always seen face-to-face.

Staff described the arrangements in place for patients requiring urgent mental health support. Where a patient was in crisis and required an urgent mental health assessment, staff told us they would be assessed by the duty doctor, who could contact NHS 111 Wales, option 2 (mental health support line), as required. Staff stated that this service could also be accessed directly by patients who required urgent support, or by people seeking advice on behalf of someone else. Staff told us that children with mental health issues would be referred urgently to Child and Adolescent Mental Health Services (CAMHS) and could also contact NHS 111 Wales, option 2.

Equitable

Communication and language

The practice provided information to patients and communicated in a clear accessible manner using language appropriate to individual need. This supported patients to make informed decisions about their care.

All patients who completed our questionnaire reported that staff checked their identity and that they were given sufficient time during their appointment. Respondents stated that the GP explained matters clearly, listened to them and treated them with dignity and respect. Most respondents reported being involved in decisions about their care.

A hearing loop was available at main reception. We saw signage and information available in Braille.

Staff told us that if appointments were running late, patients waiting would be informed by reception staff. This was confirmed in our patient survey feedback, however most said their appointments were on time.

Staff told us there was several Welsh speaking staff at the practice and several members of staff who were learning to speak Welsh. When asked, staff were aware of the 'Active Offer' and we noted that all signage was in Welsh and English. We were told a small proportion of staff were Welsh speakers and reported using Welsh in their daily work, with some displaying the 'Iaith Gwaith' badge. However, on the day of the inspection a large number of Welsh speakers were on duty and the use of Welsh language with patients and each other was notable.

Rights and equality

Respondents reported that the premises were accessible, with sufficient seating and appropriate toilet facilities. Respondents also considered the practice to be child-friendly and stated that health promotion information was displayed.

Accessible parking was provided at the practice and entry to the main entrance was straightforward. All facilities, including the reception desk, waiting area, patient restroom and consultation rooms, were situated on the ground floor. Some clinics were held on the first-floor suite of consultation rooms and these were accessed by a lift or staircase.

Delivery of Safe and Effective Care

Safe

Risk management

The building was in a very good state of repair and there were no outstanding maintenance issues. A current Business Continuity Plan (BCP) was established, effectively outlining procedures for addressing major health emergencies as well as managing long-term GP absences.

We found effective processes in place for the receipt, distribution and management of patient correspondence and documents. Information received from secondary care was recorded and acted upon appropriately, including all discharge information and test results.

There was clear workflow for clinicians to review incoming correspondence supported by an up-to-date policy. Administration staff had been trained to process documents, and we reviewed an audit trail which found these were appropriately managed.

Staff communicated internally using EMIS tasks within the electronic patient record system. Outstanding actions were monitored by the practice manager for assurance. Any paper documentation received is scanned into the EMIS system.

Where a child did not attend an appointment at the practice or other healthcare practice the case would be followed up appropriately. There were clear channels of responsibility, policy and protocol in place.

A designated staff member was assigned to receive and distribute patient safety alerts, with the senior partnership team stepping in as needed during their absence.

It was reported that significant events, including those impacting patient safety, were discussed at meetings across all organisational levels. There was a clear understanding that such events would be examined to identify any required changes. Documentation was provided demonstrating discussion, escalation, and learning resulting from these meetings.

The emergency equipment required in the event of a serious cardiac event was housed in one of the clinical rooms. Although well-equipped and regularly checked because of its location, it would not always be readily accessible. This had been previously identified by the senior team and a risk-assessed process was underway to relocate the equipment once all staff members had been notified.

The practice must relocate the emergency equipment trolley to improve the response in an emergency.

Infection, prevention and control (IPC) and decontamination

Respondents to our questionnaire reported seeing information displayed regarding infectious conditions and stated that hand sanitiser was available within the practice. Respondents generally stated that staff washed their hands before and after providing care or treatment. The few respondents who reported undergoing invasive procedures stated that staff used gloves, sterile equipment and cleaned the skin prior to treatment.

There was an infection control policy in place which was reviewed annually and the Lead Practice Nurse was named as IPC Lead. We saw evidence that all staff had read the policy and its updates as appropriate.

All areas of the practice appeared visibly clean and staff had access to personal protective equipment, such as gloves and disposable plastic aprons to reduce cross infection.

Hand sanitizers were readily available around the practice and hand washing and drying facilities were provided in clinical areas and toilets. We saw evidence that water temperature was monitored and was consistent, as were the cleaning schedules for the building.

IPC was part of the practice mandatory training programme. We saw that all clinical and non-clinical staff had completed training, at a level appropriate to their role.

There was a system in place to manage waste appropriately and safely. Contract documentation was in place for the disposal of hazardous (clinical) and non-hazardous (household) waste. We saw that all waste had been segregated into the designated bags / containers in accordance with the correct method of disposal.

Medicines management

There were policies and procedures in place for the storage and administration of medication and documented evidence of excellent linkage of medication and repeat prescribing to diagnosis.

We looked at the Patient Group Directives in use at the practice and found that all were in date and had been appropriately signed and authorised.

We found that medication for use in an emergency was stored in a tamper evident container. The medication storage refrigerator temperature was monitored on a regular basis by electronic means and records maintained as required. Medications and associated equipment were otherwise stored securely by the practice.

There were portable oxygen cylinders available and ready to use and were appropriately stored within a cannister holder. All staff had been educated on oxygen therapy and safe delivery and administration in accordance with the Betsi Cadwaladr University Health Board policy through British Oxygen Company (BOC) online training.

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 are vulnerable or at risk. There was a named safeguarding GP lead for the practice and we saw that they regularly engaged with multi professional external agencies to address any concerns.

We saw that staff had undertaken safeguarding training at a level appropriate to their roles. Children and family members who were subject to safeguarding concerns were easily identified on the electronic record system.

Management of medical devices and equipment

We found that portable electrical appliances were safety tested on a regular basis.

It was confirmed that disposable single use clinical equipment was used where appropriate. The annual check and calibration on all items of medical equipment was in date and subject to regular annual checks. We saw that there was a system in place to address any breakdown issues and all equipment and servicing would be undertaken quickly.

We found that there was an oxygen saturation monitor (SaO2) missing from the resuscitation trolley and being used within the consultation room where additional monitors were available. This was discussed with senior team members at the time and an agreement reached on the permanent location of 3 available SaO2 monitors. **This was actioned during our inspection under Appendix A.**

Effective

Effective care

From our discussions with staff and examination of patient records, we found that patients were receiving safe and clinically effective care. Patient records were found to be of a very good standard of detail and follow up. We saw evidence of holistic- person centred approach to the provision of care.

A range of written policies and procedures were available to support the operation of the practice. These were reviewed and updated on a regular basis.

We also saw that staff had recently completed comprehensive training in the management and recognition of Sepsis. Posters were being prepared for public viewing explaining the recognition of sepsis and were to be positioned in the waiting areas and consultation rooms.

Patient records

A robust information governance framework was in place and staff demonstrated an understanding of their responsibilities in relation to accurate record-keeping and the maintenance of confidentiality.

We reviewed the records of ten patients and found an effective records management system in place, with appropriate security arrangements to prevent unauthorised access. This also confirmed that clinicians consistently documented instances when patients gave verbal consent for examinations or treatments.

Record entries were contemporaneous, clear, legible, and of good quality. Records contained a clear narrative of the patient presentation and clinical assessment, the rationale for decisions made, and any advice provided. We saw appropriate documentation of actions taken, including investigations requested, referrals made, medicines prescribed and any required safety-netting, with evidence of follow-up arrangements recorded where relevant. Where patient consent was required, this was consistently documented in the clinical record, providing assurance that consent had been obtained and recorded in line with expected practice. The level of detail within the records was of a high standard and supported continuity of care by enabling other clinicians to readily understand the patient’s history and management.

Efficient

Efficient
Arrangements were in place to support the delivery of safe and effective care. We identified good practice in the management of both acute and long-term conditions, with a clear narrative and evidence of person-centred decision-making.

Staff described appropriate arrangements for the reporting of, and organisational learning from, significant events.

Clinical staff confirmed that robust processes were in place for the receipt and dissemination of new evidence-based practice, together with updated or newly issued NICE guidance.

Quality of Management and Leadership

Staff feedback

HIW issued a questionnaire to obtain staff views on the care at Bradley's Practice for the inspection in March 2026. In total, we received 28 responses from staff at this service. Staff comments included:

> *"I feel the improvement in the morale and running of the practice has been excellent over the past 12 months. I feel proud to be part of such a hard working & dedicated work force".*

> *"Lovely place to work and they care about the staff and patients."*

> *"This is the first job I've had working in general practice and the NHS and it was a massive learning curve, but I can honestly say this has been by far the best job I have had."*

> *"I'm very pleased to share how positive my experience has been working at the practice. The team is supportive, professional, and genuinely committed to delivering high-quality care, which makes it a rewarding environment to be part of. From a management perspective, there is a clear sense of direction, strong communication, and a culture that values both staff development and patient outcomes. Overall, it's a great place to work, and I feel confident in the future of the business."*

Equally some comments included room for improvement for communication within the team.

The practice must ensure all staff members are included in future communications.

Leadership

Governance and leadership

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

The practice had a process in place for sharing information with staff, such as changes in policies or procedures. All policies and procedures were stored on the shared drive and all staff would be told about any changes via bespoke team meetings. There was a comprehensive suite of policies and procedures, with controls in place. All policies were in date and had been read by staff members to whom they applied.

Management confirmed that there was an open-door policy for staff to share concerns and ideas for the practice.

We saw that clinical meetings, such as multidisciplinary team meetings, were formally recorded. However, we noted that due to the size of the workforce, when team meetings of specific disciplines met not all relevant staff were present. We understand from staff feedback that this can sometimes be a problem to those who were part time and felt they were missing out on vital staff communications.

Staff told us they felt involved in decisions that affected their work and able to suggest improvements.

Workforce

Skilled and enabled workforce

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

Most staff reported having appropriate training for their roles and all had received an appraisal or development review within the past 12 months. We also saw an induction programme for new starters.

There were appropriate recruitment policies and procedures in place, and the practice manager described suitable 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.

It was evident that management maintained effective oversight of mandatory training compliance to ensure all staff continued to demonstrate competency in safely and appropriately performing their duties. We saw a notable exemplary system of a training matrix which would identify good and poor compliance with mandatory training across all staff groups. It also alerted a month prior to when an individual was due to renew a specific topic.

Staff told us they generally felt they had sufficient resources, including equipment and information communication technology (ICT) systems.

Overall, staff described a positive work-life balance and awareness of occupational health support, while noting some stress and workload pressures.

We saw staff shared the benefits of the staff wellbeing app which they all had access to, this was felt to be notable good practice and workforce support.

Culture

People engagement, feedback and learning

We saw evidence displayed in the waiting area indicating how patients could submit feedback. We also found evidence to demonstrate that patient feedback was routinely used by the practice to learn and inform service improvement.

The practice had a patient complaints policy; this was aligned to the NHS Wales Putting Things Right process. The practice manager was responsible for managing all complaints and this was clear within the complaints policy.

We spoke to staff about the arrangements to ensure compliance with the Duty of Candour. A Duty of Candour policy was in place and the records we reviewed showed that staff had completed training on this topic and when spoken to were knowledgeable on the subject.

Staff felt that appropriate measures were in place to protect patient confidentiality, privacy and dignity and that chaperones were offered when required. Most staff reported no experience of discrimination and felt the practice supported equality, diversity and inclusion.

Information

Information governance and digital technology

The practice understood its responsibility when processing information and demonstrated that data was 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 and on the website.
Our review of training records confirmed that staff had received information governance training.

Learning, improvement and research

Quality improvement activities

We were told learning was shared across the practice via regular group staff meetings to make improvements. We saw evidence of regular clinical audit on

several topics which were undertaken by more than one member of staff. We saw sharing of data from a number of clinical threads, infection control and immunisation data.

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
Missing paediatric oxygen saturation monitor (SaO2)	Unable to undertake an accurate assessment	Staff were aware of the saturation monitor being shared by staff, however there was more than one SaO2 monitor.	All monitors were re located to specific locations and staff informed immediately of their new location. One on the emergency trolley, another in the room always used by the paediatric GP and one in the clinical treatment room.

Appendix B - Immediate improvement plan

Service: Bradleys Practice Mold

Date of inspection: 17 March 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.

	Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	No immediate non-compliance issues.					
2.						
3.						
4.						

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: Bradleys Practice Mold

Date of inspection: 17 March 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.	Emergency trolley was in a treatment room which was often occupied. Trolley needs to be located in an area which is always accessible. Staff need to be aware of relocation in a safe and timely manner.	The practice must relocate the emergency equipment trolley to improve the response in an emergency.	Health and Care Quality Standard (2023) Safe; Timely; Information.	The practice has now identified a safe and suitable place for the Emergency Trolley	Catrin Williams	This has been completed

2.	We found that non-medical prescribing training was inconsistent.	Training schedule and improvements were noted to be part of a plan	Health and Care Quality Standard (2023) Safe; Workforce: Information.	All of our non-medical prescribers are adequately trained and governance and training checks have taken place. The practice accepts however that more structured monitoring of their practice was needed and this has been put in place.	Tomos Williams	6 monthly audits of their prescribing practices have been implemented.

3.	Staff had no means of recording concerns at the front reception desk from patients as they arrive.	A concerns log was discussed to be introduced.	Health and Care Quality Standard (2023) Effective; Person Centred; Safe.	Although there is no log in place at front desk reception, we have a complaints procedure, and a log of complaints are held with Senior Management. Our staff now have access to a function button to record the enquiry directly into the patient notes and staff are able to task this action to the relevant member of staff via Emis or email. We currently follow health board guidance "Listening to People" that has recently replaced "Putting Things Right"	Clare Gill	This has been set up and is running effectively. This avoids a manual log being misplaced with patient identifiable information and concerns.

4.	The practice offered male and female chaperones as appropriate, and a chaperone policy was in place. In the patient questionnaire some patients told us they were not always offered a chaperone for intimate examinations or procedures.	The practice must ensure that a notice advising patients of chaperone availability is displayed in each consultation room and documented within clinical notes.	Health and Care Quality Standard (2023) Dignified Care.	Patients should always be offered a chaperone when appropriate. This has been reiterated to clinical staff.	Clare Gill / Tomos Williams	This will again be raised in the next Clinical meeting and has been communicated via an email to all clinicians.
5.	Some comments were made by staff stated in the questionnaire about poor communication.	The service must ensure all staff members are included in future communications.	Health and Care Quality Standard (2023) Communication and Language.	As well as the current weekly communications to the reception team in the form of a newsletter, our Teams channels and daily emails / alerts we will provide the staff with a quarterly drop in staff meeting	Clare Gill	First meeting planned and invites have been sent out.

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): Clare Gill

Job role: Operations Manager **Date:01.05.2026**