Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report
(Announced)
Ferndale Medical Centre, Cwm Taf Morgannwg University Health Board

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

Our purpose

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

Our values

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

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

Our goal

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

Our priorities

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

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 Ferndale Medical Centre, Cwm Taf Morgannwg University Health Board on 25 February 2026.

Our team for the inspection comprised of two HIW healthcare inspectors, two clinical peer reviewers and a 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 7 questionnaires were completed by patients or their carers and 4 were completed by staff. Feedback and some of the comments we received appear throughout the report.

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

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

2. Summary of inspection

Quality of Patient Experience

Overall summary:
We found that patients experienced care in a friendly, respectful and supportive environment. Feedback described positive interactions with staff, with respondents stating they felt listened to, treated with dignity, and involved in decisions about their care. Patients expressed confidence in contacting the practice and satisfaction with opening hours, appointment options and the helpfulness of reception staff. The premises were clean, accessible and easy to navigate.

A range of accessible information supported people to manage their health. Materials were available in Welsh and Easy Read formats, and staff routinely provided lifestyle advice during consultations. The practice demonstrated noteworthy person-centred support for veterans through a structured and proactive fortnightly group, offering peer support, wellbeing monitoring and early signposting where needed.

Interactions observed during the inspection were courteous and professional. Measures were in place to promote privacy and dignity, including a clearly signposted private room near reception for confidential discussions, separated reception and waiting areas, and appropriate privacy measures within clinical rooms. All respondents agreed that privacy was maintained during appointments and that chaperone arrangements were well communicated.

Systems supported timely access to care. A range of appointment types was available, with staff adapting communication for people who were digitally excluded or had additional needs. Home-visiting arrangements were supported by an up-to-date risk assessment. Patients reported positive experiences when accessing both urgent and routine appointments, although the Access policy required updating to reflect services available in Wales.

Communication methods were varied and inclusive, including digital screens, leaflets, text messaging and email. Staff demonstrated a person-centred approach by offering information in alternative formats, using British Sign Language (BSL) where available, and arranging longer appointments when required. Language needs were considered, with interpretation support accessible through Language Line.

Staff had completed equality and diversity training, and reasonable adjustments were in place to support patients with sensory, communication or neurodiversity-related needs. The building was accessible, with disabled parking, appropriate toilet facilities and ground-floor clinical rooms. However, the practice did not have an Equality and Diversity policy at the time of inspection, and bariatric weighing scales required calibration.

This is what we recommend the service can improve:

- Update the Access policy so it accurately reflects services available in Wales
- Implement an Equality and Diversity policy
- Ensure bariatric weighing scales are calibrated so they remain fit for purpose.

This is what the service did well:

- Delivered notable person-centred support for veterans, including structured peer-support groups and proactive wellbeing monitoring
- Demonstrated strong communication accessibility, including staff able to use British Sign Language to support deaf patients
- Provided clear arrangements to promote privacy and dignity, including a dedicated private room and well-designed reception and waiting areas.

Delivery of Safe and Effective Care

Overall summary:
We found that the practice was generally well organised to support the delivery of safe and effective care. The environment was clean, hazards were clearly signposted, and essential governance arrangements were in place. Staff described some challenges linked to health-board-managed recruitment processes, but safe cover arrangements were maintained, including access to locum GP support. Patient-safety alerts and significant events were disseminated appropriately and used to promote shared learning.

Infection prevention and control (IPC) arrangements were satisfactory overall. Cleaning schedules were in place and all patient respondents rated the environment as clean. PPE and waste management procedures were appropriate. However, the practice did not have a designated IPC lead, some IPC audits had not been completed, and repairs to the automatic doors and lift button were outstanding. Needle-stick injury posters were not displayed in treatment rooms.

Medicines management processes were mostly well established. Repeat prescribing and medicines requiring monitoring were overseen by the clinical team, and cold-chain arrangements were supported by twice-daily temperature checks. Improvements were required to prescription security, as printed prescription pads were not stored securely and there was no system to track their collection. Emergency drugs and equipment were in good order, though checks were completed monthly rather than weekly. Issues relating to the location of emergency drugs and equipment were addressed during the inspection.

Safeguarding arrangements were sound. Staff knew how to escalate concerns, and clear markers were visible on relevant patient records. Read-coding for children at risk and looked-after children was consistently applied. Regular safeguarding meetings with co-located health visitors supported timely information-sharing. The lead GP had completed IRIS domestic-abuse training and provided support to other professionals, which is noteworthy practice.

Medical equipment was well maintained and appropriately serviced, with clear oversight of device checks. Staff had access to training and protected learning time, and systems for learning from incidents were embedded. Referral pathways were effectively managed, with urgent referrals actioned promptly and oversight supported through participation in the OWLS (Outpatients Waiting List) initiative. Improvements were required to the telephone message for emergencies and to strengthen red-flag signs and symptoms awareness among non-clinical staff.

Patient records were consistently high quality: clear, contemporaneous and person-centred. Entries captured clinical reasoning, language preferences and follow-up arrangements. Read-coding was used consistently, and chronic disease summaries were complete. Administrative summarising was undertaken appropriately, although routine data-quality audits were not in place.

This is what we recommend the service can improve:

- Appoint an IPC lead and ensure routine IPC audits, including hand hygiene audits, are undertaken
- Strengthen prescription security and introduce a system for tracking prescription collection
- Improve emergency arrangements, including weekly checks of equipment and telephone signposting for urgent care.

This is what the service did well:

- Maintained consistently high-quality, person-centred clinical records
- Showed notable safeguarding leadership through the lead GP's 'IRIS' domestic abuse training and support to others
- Provided notable palliative care co-ordination, using a structured palliative care board to support oversight and timely follow up.

Quality of Management and Leadership

Overall summary:
Leadership and governance arrangements were visible within the practice, supported by oversight from the health board. Staff understood their roles and reporting lines and described approachable, supportive leaders who were available on a day-to-day basis. Regular meetings were held for clinical and non-clinical teams, with information shared to ensure all staff remained informed. The lead GP and deputy practice manager were accessible and engaged, contributing to a positive working culture.

Workforce arrangements demonstrated strengths as well as some areas requiring development. Recruitment processes were managed by the health board, and delays in filling posts had contributed to ongoing workload pressures. However, staff's continued commitment to providing high quality care ensured that patients remained safe, and service delivery continued, during a challenging period. Appraisal arrangements were in place across staff groups, mandatory training compliance was monitored, and nurses had access to continued professional development opportunities. Formal clinical supervision, including for the non-medical prescriber, required strengthening to ensure consistent oversight.

Systems for managing complaints, concerns and feedback were established. Quarterly reporting to the health board supported oversight, and staff described an open culture where they felt able to raise issues and contribute ideas. While feedback was collected proactively, the practice did not always demonstrate how patient views influenced changes. The whistleblowing policy required the inclusion of relevant contact details.

Information governance arrangements were in place, with clear processes for managing data, subject-access requests and information quality. Policies were up-to-date but some were not titled accurately, and key governance documents were stored across several folders, which could make access less efficient.

The practice participated in a range of improvement activity, including internal audits and collaborative work with external partners. Learning from incidents, complaints, significant events and mortality reviews was shared through regular meetings and email communication, supporting ongoing quality improvement.

This is what we recommend the service can improve:

- Update key governance documents, including the complaints and whistleblowing policies, and ensure policy titles are correct
- Formalise clinical supervision arrangements

This is what the service did well:

- Demonstrated clear governance structures, proactive leadership and effective communication processes
- Fostered an open and supportive culture where staff felt able to raise concerns and contribute ideas
- Maintained service delivery despite longstanding staff pressures.

3. What we found

Quality of Patient Experience

Patient feedback

HIW issued a questionnaire to gather patient views on care at Ferndale Medical Centre, and seven responses were received. All respondents agreed that their comments could be published anonymously. Due to the low number of responses, findings may not fully represent the practice patient population.

Overall, feedback was positive, with patients expressing satisfaction with opening hours, ease of contacting the practice, and the accessibility and cleanliness of the premises.

Patients reported positive experiences of appointment access and care. Most said they could obtain same-day appointments when urgent, were able to book routine appointments when needed, and were satisfied with the type of appointment offered. Respondents described feeling listened to and treated with dignity, and said clinical staff explained information clearly.

The environment and infection prevention measures were viewed positively, with patients reporting accessible facilities, sufficient seating, and visible health information. Some variation was noted around the availability of hand sanitiser, but overall respondents felt the practice was clean and that appropriate hygiene measures were followed during care.

All respondents stated they would know how to make a complaint if needed, and all felt they could access the right care regardless of protected characteristics. All rated the service as “very good” and “good”. Free-text feedback was limited but included positive comments about reception staff, with one respondent noting:

“The girls on the desk are amazing”.

Person-centred

Health promotion

We found that the practice demonstrated a clear commitment to promoting healthy lifestyles through accessible information, routine clinical conversations, and visible resources within the building. Health-promotion materials covering diabetes, smoking cessation, healthy eating, alcohol reduction and physical activity were displayed throughout the practice, alongside breastfeeding support

posters and an abundance of printed leaflets, available in both English and Welsh. We found all information to be relevant, up-to-date, and of high quality.

Staff told us that healthcare assistants routinely explored lifestyle factors such as alcohol use, weight, diet and exercise during assessments, and provided printed materials, including easy-read versions, to support patients who may require information in different formats. All respondents that completed the patient survey saw health information on display, and most respondents (6/7) recalled being offered healthy lifestyle advice during their appointment.

A dedicated 'Carers' Information' board was present in the reception area, signposting support available for individuals in unpaid caring roles. A prominent 'Veteran Noticeboard' was also on display, highlighting services available for veterans and their families. In the waiting area, the practice had a blood pressure machine, which patients could utilise independently. Readings were printed and could be reviewed by the appropriate healthcare professional.

Patients were able to access a range of healthcare professionals at the practice to encourage and improve healthy lifestyles across the Rhondda cluster. This included a physiotherapist, who attended the practice weekly, as well as a wellbeing officer who provided a remote service but would proactively meet patients at the practice if patients struggled with digital access. The practice also benefited from engagement with the 'IRIS' domestic abuse team. Patients could self-refer to these services.

Staff described additional collaborative activity with Public Health, including work on medication change communication pathways, and the OWLS (Outpatient Waiting List) process, which checks that patients on the waiting list still require their appointment. Information about these services was made available through posters, the practice website and direct conversations with reception staff, who were described as proactive in signposting patients to relevant support.

The practice had recently completed their winter vaccination programme. Dedicated clinics were arranged, and patients were invited by clinical priority. The practice used a combination of text messages, letters, and opportunistic promotion during appointments to inform eligible groups about the vaccination programme, ensuring equitable access for all.

We found that the practice had arrangements in place to manage patients who did not attend their appointments. Clinicians would ask reception staff to reschedule missed appointments where appropriate. An up-to-date 'Was Not Brought' policy was seen, and we were told that children who did not attend appointments were routinely followed up. The practice also monitored instances where patients did

not attend hospital appointments: letters received from secondary care triggered a template letter being sent to the patient, advising them to contact the hospital.

To support older people and those without digital access, staff used telephone calls, postal letters and direct conversations at reception, with the reception team described as being proactive in verbally promoting services offered by the practice and wider agencies.

Dignified and respectful care
We found that the practice was committed to delivering dignified and respectful care. During the inspection, staff were observed to be interacting with patients in a professional and courteous manner. A private room was available adjacent to reception for confidential discussions, and this was clearly signposted for patients. Notably, the reception and waiting areas were separated, providing patients with appropriate levels of privacy when checking in for appointments and seeking assistance. Of those that responded to the HIW questionnaire, all respondents agreed that they were able to talk to reception staff without being overheard.

Observations during the inspection confirmed that clinical rooms supported privacy and dignity. Doors were closed during consultations, external windows were appropriately covered, and disposable privacy curtains were available in every room. All respondents agreed that measures were taken to protect their privacy during consultations.

Chaperone information was clearly displayed throughout the practice. Staff had access to training, and newer team members were required to read the chaperone policy and complete a quiz to demonstrate understanding of the roles and responsibilities of a chaperone. We reviewed an up-to-date, comprehensive chaperoning policy. All respondents to the HIW questionnaire agreed that they were offered a chaperone where appropriate.

Timely

Timely care
We found that the practice had arrangements in place to help patients access care in a timely manner. Information about appointment options was available on the practice website and displayed on notice boards, and staff told us they explained these options to patients when needed. The practice used an annual survey to gather feedback on access. We reviewed the practice's Access policy and noted references to services in England.

The practice must ensure the Access policy is updated to reflect services available within Wales.

Reception staff were able to signpost patients to appropriate local services, such as opticians, dentists and pharmacies. Reception staff did not undertake clinical triage, and any concerns requiring clinical input were added to the GP list for assessment. Where reception staff were unsure about the most suitable option for a patient, they could seek advice from clinical staff through email or by adding queries to clinician lists.

A range of appointment types was available, including pre-bookable, face-to-face and telephone consultations. E-consults were also available, although staff told us they were reviewing their use due to low levels of digital literacy within the patient population. We were told that the new practice manager intends to promote digital education to support patients in accessing online services.

Staff described challenges at the Maerdy branch site, where transport difficulties required additional consideration to ensure that patients were seen appropriately. We noted occasions where patients registered at the branch surgery were routinely asked to attend the Ferndale practice due to staffing challenges. Given the patient demographics and accessibility to transport, the practice must ensure that sustained measures are taken to minimise disruption to patient access.

The practice should ensure that patients registered at the Maerdy branch can access care without unnecessary delays or additional travel arising from staffing arrangements.

We found arrangements in place to support people requiring alternative communication or access routes. For example, deaf patients routinely used email to request appointments, and older people or those who were digitally excluded could arrange appointments in person or by telephone. Patients could request home visits, and the need of this provision would be accessed by the GP. We reviewed a Home Visiting risk assessment, which was up-to-date and relevant. Patient respondents reported positive experiences of access, stating they were satisfied with opening hours, could contact the practice when needed, were able to obtain same-day appointments when required, and could access routine appointments as appropriate.

Processes were also in place to support patients with urgent mental health needs. Staff told us that patients requiring urgent support were added to the duty-doctor list for timely review, with additional signposting to NHS 111 option 2 and the mental health liaison worker based at the practice. Patients could also be referred to MIND when appropriate. Staff reported long waiting lists for secondary mental health services. The practice continued to review patients during this period and offered alternative support options where referrals were not accepted, such as signposting to Silvercloud and WISE.

Equitable

Communication and language

We found that information about the services offered by the practice was communicated to patients through a range of methods, including the practice website, written information leaflets, social media channels and noticeboards within the practice. Staff told us that Easy-read materials could be provided if required, and older people or those without digital access were kept informed through letters and verbal updates during appointments. Digital screens in the reception area displayed health information and details of local services.

Staff described a person-centred approach to communication, with examples of individualised support for patients with specific needs. This included a member of the reception team who was able to use British Sign Language (BSL) and another receptionist who proactively contacted patients by text message or alternative means to ensure they received important information in a format that suited them.

Staff were aware of the importance of communicating with patients in their preferred language. We were told that language preferences were documented in patient records, and staff could arrange longer appointments or interpretation support when needed, including the use of Language Line. Welsh language training was available through the health board, and language requirements formed part of the recruitment process. Bilingual posters were visible in the waiting area, and staff confirmed that basic Welsh greetings were used when answering the telephone.

Appropriate information workflows were in place to ensure that clinical communications were reviewed, actioned and recorded promptly. Incoming paper mail was scanned into patient notes and routed to the most appropriate clinician, and medication changes were flagged to the prescribing team. Discharge letters were allocated to relevant clinicians (and the pharmacist for medication updates), with urgent actions telephoned through to patients where necessary. Interactions from Out-of-Hours services were received electronically, checked by administrative staff and escalated to a GP if action was required. We also saw a structured approach for patients receiving end-of-life care, including a palliative care board to support oversight and a named receptionist as a point of contact for the patient and family.

Of those who responded to the HIW questionnaire, all reported that information was explained clearly, their questions were answered, they felt listened to, treated with dignity and respect, and involved in decisions about their healthcare to the extent they wished.

Rights and equality

We found that the practice took a proactive approach to recognising the diversity and rights of individuals. Staff had completed equality and diversity training, and the deputy practice manager told us this was actively promoted and encouraged. However, there was no Equality and Diversity policy in place.

The practice must implement an Equality and Diversity policy.

Overall, the premises were accessible to people with additional mobility needs. The automatic front doors were out-of-order and had been escalated to the health board for repair. An accessible toilet with handrails and an emergency cord was available, treatment rooms were located on the ground floor, and a designated disabled parking bay was available at the rear of the practice. A hearing loop was in place at reception. One treatment room contained a bariatric examination couch, and bariatric weighing scales were available. However, the scales had not been calibrated recently.

The practice must ensure the bariatric weighing scales are calibrated so they remain fit for purpose.

All respondents to the HIW questionnaire agreed that the building was easily accessible, toilet and hand-washing facilities suited their needs, and there were enough seats in the waiting area.

We found notable, person-centred support for veterans coordinated by the practice secretary. A fortnightly veterans' group provided refreshments and structured peer support, enabling regular contact and early recognition of any deterioration in wellbeing. The secretary used these touchpoints to encourage timely help-seeking, including arranging GP input or referral to other services where appropriate. Staff described the group as integral to sustaining members' mental health, with practical initiatives, such as a community garden at the branch surgery, supporting social connection, routine and purpose. Staff told us that the secretary's trusted relationships with group members, alongside her sustained dedication and commitment to the group, were instrumental to the positive outcomes it delivers.

Reasonable adjustments were in place to support patients with specific communication or sensory needs. Staff provided examples including access to a healthcare professional able to use British Sign Language, proactive text messaging or alternative contact methods for deaf and older patients, and access to a quiet, low-stimulus room for autistic patients or those with severe mental health needs. We were told that appointment times were adapted where necessary (for example,

offering later appointments), and that individuals known to find waiting difficult were prioritised to be seen promptly on arrival.

The practice also had processes to uphold the rights of transgender patients. Preferred name, title and pronouns were recorded in medical records, and the lead GP had undertaken relevant transgender healthcare training.

Delivery of Safe and Effective Care

Safe

Risk management
We found that the practice environment was clean, clutter-free and in a good state of repair. Appropriate signage was used to highlight hazards, including a wobbly step at the entrance which had been clearly marked with cones and warning notices to reduce risk.

The practice had an up-to-date and relevant Business Continuity Plan, which included arrangements for managing significant health emergencies. Staff told us that the branch surgery would be used if the main building became unavailable. As a managed practice, the service described challenges with recruitment and retention, including delays in obtaining approval to advertise vacancies, which had affected staff morale. Locum GP cover was arranged directly by the practice when required.

Systems were in place for managing patient safety alerts, with a designated member of staff responsible for receiving and disseminating them to clinicians. The practice held meetings to discuss significant events, including patient safety incidents, and we reviewed minutes confirming that learning was shared among the team.

Infection, prevention and control (IPC) and decontamination
We found that overall, the practice had appropriate arrangements in place for infection prevention and control. The environment was clean and generally well maintained. All respondents to the HIW questionnaire rated the environment as clean. Two estates requests were outstanding at the time of inspection – repairs to the automatic front doors, and to a lift button utilised by staff. These had been escalated to the health board in May but remained unresolved at the time of our inspection.

A cleaning contract was in place, and cleaning schedules were available for all areas of the premises. Staff were aware of their roles and responsibilities in upholding IPC standards, with the nursing team restocking clinical rooms with personal protective equipment, and healthcare assistants managing GP rooms and clinical waste. An up-to-date IPC policy was available. However, the practice did not have an appointed IPC lead. The practice informed us that they intend to identify and train a nurse to take on this role.

The practice must implement an IPC lead who can promote and monitor IPC practices.

We reviewed the practice's Waste Management policy, which hadn't been updated since 2018. The practice may benefit from reviewing and updating the policy to ensure it remains current. Waste was observed to be managed appropriately, with locked bins in the courtyard. An appropriate contract with a waste carrier was in place, though we did not see evidence that a waste audit had been completed.

All treatment rooms were equipped with appropriate PPE and hand hygiene facilities, with elbow operated taps in each room. Suitable arrangements were in place to segregate patients if required to reduce the risk of healthcare associated infections. However, we did not see evidence that hand-hygiene audits had been carried out.

The practice should ensure that an annual IPC audit is completed, with routine supplementary audits, including hand-hygiene, bare below the elbow and ANTT, as relevant to the practice.

We found appropriate arrangements for blood-borne virus management, including an up-to-date policy and evidence of Hepatitis B vaccination status for almost all staff. Needlestick and sharps policies were current, and sharps containers were correctly assembled, secured and not overfilled. However, needle-stick injury posters were not displayed in treatment rooms.

The practice must ensure that needle-stick injury posters are displayed in all treatment rooms.

Medicines management

We found arrangements in place for the storage and oversight of prescription stationery. Hand-written prescription pads were stored securely and signed out for home visits. However, printed prescription pads were not locked away and there was no system to sign these in or out.

The practice must ensure that all prescription scripts are stored securely.

The practice did not maintain an audit trail of prescriptions collected by patients or third parties, particularly for high-risk medications such as opioids.

The practice must implement a system to track the collection of high-risk prescriptions, particularly when collected by a third party.

We found that the practice had a structured approach to repeat prescribing and medication reviews. Patients could request repeat medicines through several routes, with prescriptions processed by the prescribing clerk and reviewed by a

pharmacy technician where monitoring or blood tests were due. Medication changes from secondary care were electronically assigned directly to the practice pharmacist for reconciliation, ensuring repeat medication lists remained accurate.

Clinicians re-authorised medicines following appropriate review, with specialist nurse input for long-term conditions such as respiratory disease, diabetes and contraception. Staff described clear escalation pathways for queries or overdue monitoring, and prescribing clerks had received on-the-job training supported by the health board, including quality-improvement training relevant to prescribing. Whilst staffing pressures within the prescribing team were noted, we found that appropriate oversight was being maintained through the sustained efforts of the current team.

We found that vaccines were stored in a locked clinical fridge, with temperatures monitored twice daily. The practice were in the process of embedding a health board data logger to strengthen assurance over cold chain compliance. An up-to-date cold chain policy was reviewed. The fridge was appropriate for vaccine storage, and we saw evidence of annual maintenance checks. However, vaccines were stored in boxes that did not allow sufficient airflow around the products.

The practice must use appropriate boxes for vaccine storage to ensure adequate airflow.

We found systems in place for the safe management and checking of medication. The nursing team were responsible for stock checks, and records were maintained electronically, including expiry dates. A spot check of vaccines confirmed that all items were in date. Expired drugs and sharps were disposed of in sharps boxes taken to pharmacy. Adverse effects to drugs were reported via the 'Yellow Card' System.

Emergency drugs and equipment were checked monthly by the nursing team, and all items were present and in-date at the time of inspection. However, national guidance from Resuscitation Council UK recommends weekly checks.

The practice should ensure that emergency drugs and equipment are checked on a weekly basis, in line with Resuscitation Council UK guidance.

Appropriate signage was in place to indicate the location of emergency equipment. The practice held multiple oxygen cylinders due to the potential delays in emergency services. The defibrillator was checked daily, with both adult and paediatric pads available and in date. Some staff had expired basic life support training due to issues with training cancellations, however we saw evidence that training sessions had been re-booked to take place imminently.

During the inspection, we noted that the emergency drugs and equipment were stored within a treatment room. This could have restricted immediate access if intimate examinations were taking place in the treatment room, or if the treatment room doors were locked. This was raised with the team, and the equipment was relocated to a central, easily accessible area during the inspection. Further detail is included in Appendix A.

Safeguarding of children and adults

We found that the practice had an appropriate safeguarding policy in place, which included guidance for vulnerable adults and children. The policy identified the Safeguarding Lead at the practice and provided local contact details to support staff when making a referral. Staff told us they were aware of who to contact in the event of a safeguarding concern.

We saw evidence that all staff had completed safeguarding training appropriate to their roles. The Safeguarding Lead had also completed specialist training to be the 'IRIS' Domestic Violence Lead for Cwm Taf and Cardiff and Vale Health Boards, which is noteworthy practice.

There were effective systems for identifying children at risk. Alerts were visible on patient records, including linked family members, and we saw that children on the child protection register, as well as looked-after children, were consistently Read coded. We also found structured processes in place for monitoring A&E attendances, and for reviewing cases where patients did not attend or were not brought for appointments. Relevant correspondence, including out-of-hours crisis notifications, were forwarded to GPs for timely review.

We saw evidence of effective multi-agency and multi-professional evidence. Safeguarding meetings were held regularly and included health visitors, who were co-located within the building. Staff told us that this significantly improved communication, timely information-sharing and joint decision-making. Concerns about both children and vulnerable adults were discussed within these meetings, with a named GP leading on care-home safeguarding and escalating concerns when required.

Management of medical devices and equipment

We found that medical devices and equipment at the practice were clean, well maintained and fit for purpose. Single-use equipment was utilised wherever possible, and items were stored appropriately across clinical and treatment rooms.

There was a named member of staff responsible for overseeing equipment checks, and we saw evidence that these checks were completed and recorded, providing

assurance that devices remained safe and suitable for use. Contracts were in place for the servicing and maintenance of medical equipment, and we saw evidence that portable appliance testing (PAT) had been undertaken recently. Staff told us that any urgent repair or replacement needs would be escalated to the practice manager.

Doctors were responsible for checking clinical bags used during off-site patient visits, and staff confirmed that these checks were completed regularly.

Effective

Effective care

We found that the practice had systems in place to remain up to date with best practice, national guidance and developments in clinical care. Staff told us they had access to regular training, with protected learning time available for clinical and non-clinical teams. Health care assistants attended dedicated training days each year, and administrative staff were encouraged to undertake further qualifications such as NVQs. Clinical meetings were held to discuss updates to NICE guidance and other relevant clinical information, and information from meetings was circulated to staff unable to attend.

There were effective processes for reporting and learning from incidents. Staff told us that incidents were reported to the deputy practice manager and reviewed by the lead GP, who determined whether they required escalation through systems such as DATIX. Reflective reports were encouraged, and learning was shared at monthly clinical meetings. Duty of Candour processes were followed where required.

We found that referral pathways were well managed. Urgent referrals were completed the same day, with GPs tasking secretaries to send the necessary correspondence and copying the deputy practice manager for safety netting. Routine referrals were sent the following working day. Staff described a tracking process for urgent referrals, with secretaries maintaining a spreadsheet to ensure referrals had been received by secondary care. The practice participated in the OWLS service, which helped monitor referral patterns and ensure appropriateness. Mortality reviews were conducted as part of palliative care meetings, including reviews of community and hospital deaths where primary care input was relevant.

On the day of inspection, we noted that the practice's telephone system did not provide signposting information for patients experiencing a medical emergency.

The practice must implement a message on the telephone system to direct patients to the appropriate urgent or emergency care services.

We did not see evidence that non-clinical staff had received any training or awareness to help them recognise potential red-flag symptoms or sudden deterioration while patients were in the waiting area.

The practice should consider introducing a red-flag poster or providing red-flag awareness training for non-clinical staff to strengthen their ability to respond appropriately in an emergency.

There were appropriate arrangements for requesting, reviewing and communicating blood test results. Nurses reviewed results for tests they had initiated, and GPs reviewed all results requiring action. Patients were informed of results by telephone or at the practice as needed, and staff told us that blood result audits were undertaken.

We found arrangements in place to support patients with mental health needs. Staff were confident in signposting to relevant mental health services and in identifying when patients required urgent or crisis support. Patients in crisis were added to the triage list for timely assessment, and the practice received notifications from out-of-hours or crisis services, enabling follow-up care where required.

Patient records

We reviewed a sample of patient records and found them to be of consistently high quality. Records were clear, legible and contemporaneous, with all consultations, including face-to-face, telephone and home visits, entered within one working day. Each entry identified who had made the record, the type of contact, clinical findings and the plan of care. Medication prescribed was linked to the relevant condition, and investigations and referrals were clearly documented.

We found evidence of person-centred narrative within consultation entries, providing context to coded information. Language preference had been recorded in all cases, and where required, appropriate actions such as arranging interpretation were documented. Records also demonstrated that information had been provided to patients about their condition and treatment options, supported by the use of patient information leaflets. Where appropriate, the offer or use of a chaperone was recorded.

Read coding was used appropriately across the records reviewed. All new problems, morbidity, and risk factors were coded, and chronic disease summaries contained full details of long-term conditions, medication, allergies and past medical history. We noted that some problem lists would benefit from future tidying, although this was expected to be resolved as part of the migration from Vision to EMIS.

Clinical entries demonstrated good adherence to General Medical Council (GMC) expectations for clarity, reasoning and decision-making, with several examples

meeting the CARAT principles (complete, accurate, relevant, accessible and timely). Overall, record-keeping was excellent, and no significant concerns were identified.

We found that non-clinical staff supported administrative summarising of new records (for example, applying initial Read codes), while any clinical input or changes were referred to and completed by clinicians. We did not see evidence of routine audits to check the quality and consistency of summaries or problem lists.

The practice should introduce periodic data quality reviews (for example, scheduled audit/tidy-up searches) of summaries, coding and problem lists to provide ongoing assurance.

Quality of Management and Leadership

Staff feedback

In total, we received 4 responses from staff at this setting. Some questions were skipped by some respondents, meaning not all questions had 4 responses. Due to the low response rate, it is not possible to fully interpret the results however the feedback received provided helpful insight into staff experience.

Overall, staff provided positive feedback about working at the practice. Respondents told us they had received appropriate training for their roles and had access to the resources they needed to undertake their duties. Staff reported good awareness of safeguarding and Duty of Candour responsibilities, and all felt confident that the organisation encouraged the reporting of incidents and took appropriate action in response.

Some areas for improvement were highlighted. One respondent noted that staffing shortages had contributed to work-related stress, although recruitment was underway. Staff views were mixed regarding involvement in decisions that affect their work, with some feeling included and others less so. Despite this, staff told us they felt able to make suggestions to improve services, and all reported that the workplace promoted equality, diversity and inclusion. No concerns about discrimination were raised.

All respondents told us that patient care was the practice's foremost priority and that the practice took appropriate steps to ensure a safe environment. Staff said they would recommend the practice as a place to work and would be confident receiving care here themselves or directing their friends and family to the service.

Leadership

Governance and leadership

Ferndale Medical Centre has been managed by the health board since 2017. We were told that the health board had explored returning the practice to partnership in recent years but had not yet identified a suitable arrangement, preferring to ensure long-term sustainability before progressing further. Clinical staffing arrangements were overseen directly by the health board, with Primary Care Support Unit GPs now working solely at this practice. The health board maintained day-to-day oversight through regular meetings between the directorate manager and the deputy practice manager, alongside established governance structures,

including GMS meetings and reporting through directorate quality and safety forums.

We found that staff and managers were clear about their roles, responsibilities and reporting lines, and understood the importance of working within their scope of practice. The lead GP took a proactive approach in making herself visible within the practice by speaking with staff daily and encouraging colleagues to have lunch together as a team. The deputy practice manager also routinely checked in with staff throughout the day.

The lead GP held responsibility for clinical oversight and management of the Quality Assurance and Improvement Framework (QAIF), with three protected non-clinical sessions each week to support leadership duties. The practice contributed to cluster-based initiatives related to continuity of care, chronic kidney disease, hypertension and frailty.

Structured governance meetings were in place. Whole-team meetings had recently been introduced, and separate monthly meetings were held for clinical staff and for reception and administrative teams, ensuring that information could be targeted appropriately to each group. Staff were encouraged to contribute during meetings, and minutes were recorded and stored electronically for all staff to access. The practice may benefit from actively distributing meeting minutes to ensure all staff are kept informed. Lessons learned were shared through meetings and email communication.

Processes were in place to share updates to policies and safety notices. The deputy practice manager received information from MHRA and Welsh Government and forwarded this to clinical staff, while the lead GP received these updates separately to ensure continuity. Other members of staff could access the generic practice manager inbox in periods of absence to ensure information was not missed. Policies and procedures were stored electronically and available to all staff, although they were located across several folders. Some policies required review or updating, and several titles were inaccurate. Reviewing and centralising these documents would support timely access for staff when required.

The practice must ensure that its policies and procedures are reviewed to ensure they are complete, accurate, and fully accessible to staff.

Staff were able to access wellbeing programmes. Wellbeing was discussed at return-to-work meetings, and staff could be signposted to Canopi or referred to the Occupational Health service provided through the health board.

The practice identified staffing and recruitment as the main pressures at the time of inspection. Posts were being actively advertised through the health board, and the practice hoped that upcoming recruitment rounds would be successful.

Designated leads were in place for safeguarding and complaints, and staff were aware of these roles. The practice did not currently have an infection prevention and control lead but was seeking to identify and train a nurse to take on this responsibility.

Workforce

Skilled and enabled workforce

Recruitment processes were managed centrally by the health board, with vacancies advertised and progressed through the Trac system, and all pre-employment checks completed by the health board. Staff were required to provide annual evidence to the deputy practice manager that their professional registration with the relevant regulatory body remained current.

Processes were in place to ensure that staff remained suitable for their roles. The health board was responsible for GP appraisal arrangements, while the lead GP carried out appraisals for nurses and healthcare assistants. The deputy practice manager undertook appraisals for reception and administrative staff, and pharmacy staff received their appraisals through the pharmacy lead at the health board. All staff received annual appraisals. Mandatory training was provided through the health board to ensure staff were appropriately trained and qualified to carry out their duties. Practice management were able to oversee this through ESR.

As recruitment was overseen by the health board, the practice did not have its own recruitment policy. Nurses completed their induction programme via the health board, while reception and locum staff received induction directly from the practice. We were told by the health board that some recruitment responsibilities may be devolved back to the practice manager over time.

Nurses had access to continued professional development meetings to discuss training needs. We found there was no formal clinical supervision structure in place beyond discussions with doctors as required. Nurses told us they had open access to senior clinicians for clinical advice.

The practice should consider formalising clinical supervision sessions.

Advanced nurse practitioners reported working within their scope of practice. One non-medical prescriber had a defined scope, and the lead GP had agreed to provide supervision. We were told that there was always a prescriber on site.

The practice should formalise this supervision arrangement to support governance for non-medical prescribing.

Culture

People engagement, feedback and learning

We found that the practice had systems in place to manage and monitor complaints and concerns. A dedicated complaints folder was maintained to track the number and types of issues raised, and the practice provided quarterly metrics to the health board. The lead GP monitored complaints relating to clinical matters and encouraged reflection and learning. The deputy practice manager oversaw compliance with response timelines in line with the NHS Wales Putting Things Right process, and information about the procedure was displayed in an area accessible to patients. A named staff member was responsible for handling complaints; however, this was not reflected in the complaints policy.

We were told that serious complaints with potential legal implications were managed by the health board, and cover arrangements were in place to ensure oversight when the designated lead was unavailable. We saw evidence that the setting proactively collected patient feedback, through a QR code displayed in reception. However, there was no feedback loop to demonstrate how suggestions were considered or acted upon.

The practice should introduce a system to inform patients of changes made as a result of feedback.

Processes were in place for learning from incidents, complaints and concerns. Staff involved were encouraged to complete reflective accounts, and significant events were discussed at monthly meetings, which were minuted. Management told us they aimed to foster an open learning culture in which staff were encouraged to share concerns, ideas and learning.

We were told that staff were encouraged to raise issues and contribute to service improvement. The deputy practice manager operated an open-door approach, and the lead GP made efforts to speak with staff daily. Staff could bring suggestions to meetings, via email or through informal discussion. A whistleblowing policy was in place; however, the contact details for the “Speak Up Safely Champion” and “Speak Up Safely Executive Lead” were not completed.

The practice had an up-to-date Duty of Candour policy, and all staff had completed the required training. We were told that Duty of Candour had been applied previously and that communication with the affected patient and family had been

delivered verbally, with an apology and explanation provided in line with national expectations. Support had been offered to those involved, and the practice described a robust internal process for notifying senior staff when Duty of Candour is triggered.

The practice must ensure that Duty of Candour guidance is followed when formally communicating with patients and / or families.

Information

Information governance and digital technology

The practice had an up-to-date and comprehensive information governance policy for all information processed by the practice. However, it was incorrectly titled as a "Home Visiting Policy".

Digital Health and Care Wales (DHCW) provided the Data Protection Officer (DPO) function for the practice. The practice had a clear process for handling data, supported by the subject-access-request (SAR) flow chart issued by the DPO. Requests were documented in patient records when received, with records retrieved, organised and returned in line with defined procedures. A designated member of staff was responsible for checking the quality of data within records to support safe and effective care.

We were told that the health board carried out quarterly audits of subject-access requests, providing external assurance. The practice also maintained a log of information requests, and consent to release information was checked on receipt of each request. We found that arrangements were in place to ensure data and notifications were submitted to external bodies as required.

Learning, improvement and research

Quality improvement activities

We found that the practice engaged in a range of activities to support quality improvement. The practice used concerns and complaints as an opportunity for learning. These were discussed at clinical meetings alongside significant event analyses. More challenging complaints were escalated to the health board.

The practice engaged in a range of improvement-focused activities, including participation in collaborative initiatives and a Public Health Wales population project. Staff also told us about additional work such as the veterans' group established by the practice and the presence of mental health workers on site.

A programme of clinical and internal audit was in place. These included audits relating to chronic kidney disease and chronic obstructive pulmonary disease, and monitoring of safeguarding compliance. We were told that all GPs met annually with the health board's clinical director as part of ongoing quality oversight.

The practice was not currently involved in research projects or accreditation schemes. Learning from incidents, complaints and other reviews — including mortality reviews — were discussed during clinical meetings, and learning was shared across the team through meetings and email communication.

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
Emergency drugs and equipment were stored in a treatment room.	This could have restricted immediate access if intimate examinations were taking place in the treatment room, or if the treatment room doors were locked.	Raised with deputy practice manager and lead GP.	Equipment relocated to central, easily accessible location during the inspection.

Appendix B - Immediate improvement plan

Service: Ferndale Medical Centre

Date of inspection: 25 February 2026

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

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	No immediate assurances identified on this inspection.					
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):

Appendix C - Improvement plan

Service: Ferndale Medical Centre

Date of inspection: 25 February 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.	Information in the Access Policy referenced services in England.	The practice must ensure the policy is updated to reflect services available within Wales.	Health and Care Quality Standards (2023) – Information, Timely, Effective	The document has been updated; all references to English legislation have been removed. Document uploaded.	N Read	Implemented
2.	Patients registered at the Maerdy branch surgery were, at times, required to attend the main Ferndale practice due to staffing pressures.	The practice should ensure that patients registered at the Maerdy branch can access care without unnecessary delays or additional travel arising from staffing arrangements.	Health and Care Quality Standards (2023) – Timely	Maerdy surgery was unfortunately closed following several long-term sickness absences among our clinical and reception teams. Fortunately, we are midway through a recruitment	N Read	Implemented

drive, and we have three new addition members to our team with interviews in place for the 14-15, May 26 where we hope to appoint an additional receptionist. We also reopened the branch on 16.04.2026, Monday-Tuesday, with a practice nurse, HCA, and GP working moving forward, following our EMIS migration, and with new starters who are competent in their roles. We have reopened with minimal contact hours of 20 per week over 4 days. Our aim is to establish Monday afternoons as a diabetes specialist clinic.

3.	The practice did not have an Equality and Diversity policy in place.	The practice must implement an Equality and Diversity policy.	Health and Care Quality Standards (2023) – Equitable, Culture, Leadership	Updated document provided	N Read	Implemented
4.	Bariatric weighing scales had not been recently calibrated.	The practice must ensure the bariatric weighing scales are calibrated so they remain fit for purpose.	Health and Care Quality Standards (2023) – Safe, Effective	Calibration of the bariatric scales was completed on 18.05.2026.	N Read	Implemented
5.	The practice did not have a designated IPC lead.	The practice must implement an IPC lead who can promote and monitor IPC practices.	Health and Care Quality Standards (2023) – Safe, Effective	Training is being sourced. Our practice manager had a meeting with the lead for primary care nurses on 8.05.2026, where we will link all training expectations.	N Read	July 2026
6.	Routine IPC audits, including hand hygiene audits, were not consistently undertaken.	The practice should ensure that an annual IPC audit is completed, with routine supplementary audits, including hand-hygiene, bare below the elbow and ANTT, as relevant to the practice.	Health and Care Quality Standards (2023) – Safe	Training is being sourced for both practice nurses. Our practice manager had a meeting with the lead for primary care nurses on 8.05.2026, during which training was arranged. Once completed, we plan	Dr L Wass/Nursing team	July 2026

				to implement a lead to over see		
7.	Needle-stick injury posters were not displayed in treatment rooms.	The practice must ensure that needle-stick injury posters are displayed in all treatment rooms.	Health and Care Quality Standards (2023) – Safe	We have placed a poster in all clinical rooms	N Read	Implemented
8.	Printed prescription pads were not stored securely.	The practice must ensure that all prescription pads are stored securely.	Health and Care Quality Standards (2023) – Safe, Information	A lockable cupboard has been ordered via Oracle. Once delivered, it will be securely fixed to the wall in the reception area. All sensitive documents, including signed prescriptions, will be stored safely within the cupboard.	N Read	Awaiting Delivery
9.	There was no audit trail for prescriptions collected by patients or third parties, particularly for high-risk medications such as opioids.	The practice must implement a system to track the collection of high-risk prescriptions, particularly when collected by a third party.	Health and Care Quality Standards (2023) – Safe, Information	Please see the new procedure provided, which is also to be discussed upon our clinical leads' return	N Read	Implemented
10.	Vaccines were stored in boxes that did not	The practice must use appropriate boxes for	Health and Care Quality Standards	Our Practice nurse, now does as we were initially advised,	Nursing Team	Implemented

	allow adequate airflow.	vaccine storage to ensure adequate airflow.	(2023) – Safe, Effective	piecing the boxes to allow air flow		
11.	Emergency drugs and equipment were checked monthly.	The practice should ensure that emergency drugs and equipment are checked on a weekly basis, in line with Resuscitation Council UK guidance.	Health and Care Quality Standards (2023) – Safe, Timely	This has now been implemented.	Nursing/HCA Team	Implemented
12.	The telephone system did not provide clear signposting for patients experiencing a medical emergency.	The practice must implement a message on the telephone system to direct patients to the appropriate urgent or emergency care services.	Health and Care Quality Standards (2023) – Safe, Information	The practice now has a bilingual (Welsh and English) welcome message. This includes information advising patients that they may be asked the reason for their call and directed to the most appropriate clinician, who may not necessarily be a GP. The message also provides clear guidance on when to seek urgent help, including calling 999 for severe bleeding, as well as general	B Spear	Implemented

				advice on managing common ailments.		
13.	Non-clinical staff had not received training to support recognition of red-flag symptoms.	The practice should consider introducing a red-flag poster or providing red-flag awareness training for non-clinical staff to strengthen their ability to respond appropriately in an emergency.	Health and Care Quality Standards (2023) – Safe, Learning	Following recent changes in leadership, the practice has experienced managerial instability, alongside the appointment of a new clinical lead and practice manager. During the past three months, we have been without a clinical lead following emergency spinal surgery Formal arrangements for supervision of non-clinical staff are therefore being developed and will be implemented upon her return. When all new staff will have in the training as part of	N Read /L Wass	AUG 2026

				the induction process moving forward.		
14.	Routine data quality reviews of summaries, coding and problem lists were not undertaken.	The practice should introduce periodic data quality reviews (for example, scheduled audit/tidy-up searches) of summaries, coding and problem lists to provide ongoing assurance.	Health and Care Quality Standards (2023) – Information, Safe	The relevant protocol is being reviewed Follow the migration of our IT system. This will support the implementation of routine data quality reviews, including the auditing of clinical summaries, coding accuracy, and problem lists. This process will help ensure ongoing consistency and improvement in data quality within the practice.	Dr L Wass /T Faulkner / N Read	Sept 2026
15.	Policies and procedures were stored electronically and available to all staff, although they were located across several folders. Some	The practice must ensure that its policies and procedures are reviewed to ensure they are complete, accurate, and fully accessible to staff.	Health and Care Quality Standards (2023) – Information, Workforce, Effective	All policies and procedures are stored electronically and are accessible to all staff. Following a recent review, folders previously titled	N Read	Sept/Oct 2026

	policies required review or updating, and several titles were inaccurate.			"Policies / Procedures" and "Protocols" have been removed to improve document organisation and reduce duplication. These documents are now centrally managed by the administration team. Following the planned clinical system migration on 29.04.2026, all policies and processes will be reviewed and updated to ensure they are fully aligned with the new system and current practice requirements		
16.	There was no formalised clinical supervision framework in place.	The practice should consider formalising clinical supervision sessions.	Health and Care Quality Standards (2023) – Workforce, Effective	Following recent leadership changes, the practice has experienced	Dr L Wass / T Faulkner/N Read	Sept/Oct 2026

				managerial instability, alongside the appointment of a new clinical lead and practice manager. In the meantime, a meeting is scheduled with the Nursing Lead for Cwm Taf Morgannwg to develop a structured approach to regular, planned supervision for the nursing team.		
17.	Supervision arrangements for the non-medical prescriber were not formalised.	The practice should formalise this supervision arrangement to support governance for non-medical prescribing.	Health and Care Quality Standards (2023) – Safe, Effective	Following recent leadership changes, the practice has experienced managerial instability, alongside the appointment of a new clinical lead and practice manager. In the interim, a meeting will take place with the to	Dr L Wass / T Faulker /N Read	Sept/Oct 2026

				establish a structured plan for regular, planned supervision of non-medical prescribers.		
18.	There was no feedback loop to demonstrate how patient views were acted upon.	The practice should introduce a system to inform patients of changes made as a result of feedback.	Health and Care Quality Standards (2023) – Person-centred, Leadership	There is no formal feedback loop in place to demonstrate how patients' views are being acted upon. To address this, a notice board has been ordered and will be installed in the patient-facing reception area. This will be used to provide clear feedback to patients on comments received and the actions taken in response.	N Read	Aug 2026
19.	Duty of Candour communication had not been routinely	The practice must ensure that Duty of Candour guidance is followed when formally communicating	Health and Care Quality Standards (2023) – Safe, Effective, Learning	We have implemented a Duty of Candour audit process, which includes an Excel	N Read	Implemented

	provided in written format.	with patients and / or families.		document that we expect to be completed accordingly. Duty of Candour has also been added as a standing round-robin item within clinical meetings.		

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): Nancy Read

Job role: Deputy Practice Manager

Date: 26.05.2026