Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report

(Announced)

Presteigne Medical Centre, Powys Teaching 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 Presteigne Medical Centre, Powys Teaching Health Board on 12 February 2026.

Our team for the inspection comprised of one HIW healthcare inspector, one clinical peer reviewer and a 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 9 questionnaires were completed by patients and 13 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:
Patient feedback was largely positive. The majority of respondents to our patient questionnaire reported that the practice environment was clean and felt treated with dignity and respect. However, some patients felt that privacy at reception and some elements of communication during consultations could be improved. There were also mixed responses regarding the availability of timely appointments.

A range of services were provided from the practice premises and health promotion information was available. All appropriate staff had completed care navigation training. However, written information to support non-clinical staff within this role was limited.

This is what we recommend the service can improve:

- Improve support for non-clinical staff undertaking the care navigation role through the provision of standard pathway documents and mental health awareness training.

This is what the service did well:

- Appropriate implementation of the practice chaperone policy
- Welsh language signage and information proportionate to the Welsh language use within the local population and practice team.

Delivery of Safe and Effective Care

Overall summary:
We saw that the practice was free of clutter and generally well maintained. Suitable arrangements for the regular checking and servicing of medical devices were in place and comprehensive maintenance records kept.

Patient records were considered to be very good overall. However, paper patient consent forms needed incorporating into the electronic patient record. Processes were in place to promote the safe prescription and management of medicines. However, formal supervision arrangements for non-medical prescribers, more robust prescription pad audits and some updates to the checks and location of emergency equipment and drugs were required.

Suitable systems were in place to support communication into, out of and internally within the practice. Close working with cluster and other services aimed

to support efficiency. However, waiting lists and different reporting systems used by organisations were reported as barriers to continuity of care within the local context.

This is what we recommend the service can improve:

- Review infection prevention and control, cleaning, waste management and handwashing policies, procedures and facilities
- Comprehensively review their safeguarding arrangements in line with national standards, including Royal College of GP Safeguarding Standards (2024) and Wales Safeguarding Procedures
- Better support staff through provision of Oxygen cylinder training, clearer needlestick and blood borne virus policies and occupational health information and displaying cold chain flow charts for easy implementation.

This is what the service did well:

- Clear signage was displayed to inform patients and staff of hazards and protective equipment
- Suitable procedures and training were in place to support any patients who were becoming acutely unwell including a red flag document to help identify emergency patient medical needs and ensure escalation to appropriate clinicians
- A comprehensive lone working policy and home visit risk assessment also provided clear instructions to support staff safety while working within the community.

Quality of Management and Leadership

Overall summary:
Staff we spoke with were positive about working at the practice. Practice leadership was visible and we observed good working relationships between team members. Respondents to our staff questionnaire reported to be satisfied with the quality of care and support given to patients and most agreed that patient care was the practice's top priority. However, some respondents felt that the practice could do more to promote staff well-being and we found there were differing views regarding the approach taken to reviewing skill mix and supporting sustainable staffing and practice development.

Key safety training was kept up to date and protected Practice Learning Time enabled the whole team to meet, learn and reflect together several times a year. Documentation regarding the responses to any concerns or complaints raised by patients needed to be more detailed to assist the practice in identifying and addressing any recurring themes and sharing an overview of practice learning and development with patients.

This is what we recommend the service can improve:

- Review and update practice policies and procedures to ensure these reflect relevant standards and provide comprehensive information to guide staff
- Ensure that comprehensive records of Hepatitis B vaccination and immunity or appropriate risk assessments are in place for all clinical staff
- Strengthen audit and performance monitoring activity in collaboration with relevant partners.

This is what the service did well:

- Staff employed at the practice had current and comprehensive job descriptions to work to and lines of reporting and accountability were clear
- A whistleblowing policy and zero tolerance policy for violence towards staff were in place to support and protect staff.

3. What we found

Quality of Patient Experience

Patient feedback

Due to the relatively low number of patient responses, it is not possible to provide a full analysis within this report. However, responses given by patients to the HIW questionnaire were generally positive with all rating the service provided as 'very good' or 'good' overall. Most considered the premises to be clean and that practitioners adhered to Infection Prevention and Control measures.

In general respondents to our questionnaire felt treated with dignity and respect. However, three of the nine respondents indicated that privacy could be improved at reception and that communication with practitioners could be improved so that they felt better listened to, informed about their health and involved in decisions regarding their healthcare.

All respondents reported they were satisfied with the practice opening hours. However, there were more mixed responses regarding the availability of timely appointments.

Patient comments included:

> *"The delay in getting appointments is frustrating…There do not appear to be enough doctors at the practice…I don't think telephone appointments really work for patients they are just a way of filtering things out for the practice."*
>
> *"Receptionists are very helpful and do their best to ensure they give the best care to their patients."*
>
> *"Occasionally feel not listened to about concerns or other symptoms which feel may be linked to reason your there."*

Person-centred

Health promotion

We saw a range of health promotion materials and information regarding support services available to patients and their carers both within the practice premises and on the website. This included living well resources, signposting to smoking

cessation and mental health services, symptom checking tools, information regarding screening programmes, and support available through other health care services and charities.

All appropriate staff had completed care navigation training and demonstrated understanding of their role and processes in assisting patients to receive the right care at the right time. Non-clinical staff could seek advice from available GPs or Urgent Care Practitioners. However, we found limitations in the written information provided to support non-clinical staff in their care navigation role.

The practice should ensure that care navigation is supported via provision of standard pathway documents as a resource for non-clinical staff.

The practice employed a community pharmacist for two days each week. Health board physiotherapy and drug and alcohol services were also delivered from the practice premises on a sessional basis in addition to the core GP and nursing functions the practice provided. Minor injuries interventions and cluster initiatives were in place to support patients remain within their local community and avoid admissions to hospital. The annual flu vaccination programme had also been completed to support people vulnerable to winter illnesses to stay well.

Patients were kept informed about the practice and their healthcare via letters, telephone contacts, in person and digital means. However, we noted that the practice information leaflet, access policy and website all required updating to provide consistent information regarding staff working at the practice, all services delivered on the practice premises and the role of the practice manager in responding to patient concerns or complaints.

The practice should review their patient information leaflet, access policy and website to provide consistent information.

Processes were in place to follow-up with children or other vulnerable patients who had not attended practice or hospital appointments.

Dignified and respectful care
We observed patients being treated with dignity and respect by all staff and that effective measures were in place to preserve patient confidentiality at reception and within consultation rooms. A quiet room away from the main waiting area was available for patients who required this.

Posters promoting the offer of a chaperone for examinations were clearly visible within the waiting area and clinical rooms. Staff records indicated that staff who undertook the chaperone role had been suitably trained and patient records

evidenced that patient consent and the offer or request of a chaperone for intimate examinations was clearly recorded. Respondents to our questionnaires also indicated staff and patients felt chaperones were appropriately offered when required. However, we noted that the chaperone policy required updating to provide full details of staff training requirements so that this could be easily accessed on an on-going basis as required.

Timely

Timely care

All appointment requests were triaged by Urgent Care Practitioners who would then arrange any follow-up appointment required with the most suitable practitioner or external service within an appropriate timescale. Same day consultations would be offered to all patients assessed as requiring this. Non-urgent appointments were generally available within a week.

We were told that where appropriate patients would be seen within their preferred setting and the practice website indicated that home visits could be provided by practitioners as required.

Patients could contact the practice in person, by telephone, letter, or via the practice website if non-urgent. Patients were informed that all calls were recorded at the beginning of the answering message and via signage within the practice. No call-back service was available on the phone but the practice identified an opportunity to improve this situation in the near future as their phone contract was coming to end.

Respondents to our patient questionnaire expressed mixed satisfaction with the availability of timely appointments at the practice. However, all reported they were satisfied with the practice opening hours and most were aware of how to access healthcare outside of the practice opening hours should they need to. The practice told us that the availability of NHS App services and online hospital waiting list information varied for patients according to whether they were resident in Wales or England.

We were told that patients presenting in mental health crisis were signposted to 111 press 2, referred to the relevant locality team, or directed to the nearest emergency department if required to maintain patient safety. Patients presenting with non-urgent psychological symptoms were signposted to third sector services. However, non-clinical staff had not undertaken mental health awareness training which could hinder the timely care navigation of patients to suitable mental health services.

The practice should ensure that all relevant staff have completed mental health awareness training to underpin timely and appropriate response, signposting and onward referral for patients presenting with mental health symptoms.

Communication between the practice and mental health services ensured relevant clinicians remained informed of patient needs and treatments to provide clinical oversight and continuity of care.

Equitable

Communication and language
Patient records indicated appropriate communication with patients. We were told that practitioners knew their patients well and that reasonable adjustments were implemented to assist communication. This included the provision of information in the patient's preferred format or setting or use of a hearing loop. A language line and a self-check-in screen which had a range of language selections were also available.

We observed Welsh language signage and information proportionate to the Welsh language use within the local population and practice team.

Rights and equality
We saw that equality and diversity and consent policies were in place to uphold patient rights. Information was also available regarding external support and involvement for specific population groups, for example, carers of people with dementia and LGBTQ+ people.

An automatic door, level access to the practice premises and all consultation rooms and a range of seating would accommodate people of varying mobility. Both reception and the self-check-in screen were suitable for patients to access from either standing or sitting heights. An accessible toilet and suitable baby changing facilities were available should patients require these.

We were informed the practice provided a regular ward round and other services to a nearby residential home, supporting these patients to receive the healthcare they required without them needing to be able to attend the practice.

Delivery of Safe and Effective Care

Safe

Risk management
We observed that the practice was clean, tidy, free of clutter and generally well maintained. Signage was in place to indicate the locations of medical gases, hand hygiene facilities and personal protective equipment available, fire escape routes, the presence of first aiders and water either suitable or unsuitable for drinking. Sharps disposal boxes were appropriately secured for staff and patient safety.

A Business Continuity Plan (BCP) was available to all staff to refer to should major service disruption occur. However, although arrangements to access locum GPs and other staff cover were informally in place the BCP also needed to provide details of actions to be taken in response to staff absence.

The practice should review their BCP to ensure it provides enough detail regarding actions to be taken to mitigate for staff absence.

Patient safety alerts were received by the practice manager who would forward onto relevant members of the practice team. A comprehensive log of all alerts received was also kept within the practice shared drive for staff to refer back to as required. Detailed Significant Adverse Event (SAE) records were maintained. SAE responses were managed by the practice manager and clinical lead and meetings with the wider practice team were held to discuss incidents and learning.

We saw that staff and patients were protected within the practice premises through the use of emergency alarms and suitable procedures to support any patients who were becoming acutely unwell. A comprehensive lone working policy and home visit risk assessment also provided clear instructions to support staff safety while working within the community.

Infection, prevention and control (IPC) and decontamination
An IPC policy was in place at the practice. However, this needed reviewing to ensure clarity regarding the roles and responsibilities of the IPC lead and management structure.

The practice should review their IPC policy and ensure it is clear regarding the expectations of leaders.

Cleaning was provided by an external company who provided comprehensive records indicated what cleaning had been completed in different areas of the

practice. However, these were not signed reducing the accountability of any cleaning which did not meet expected standards.

The practice should request that cleaning records are signed by the cleaner completing the tasks or person responsible for providing oversight.

A sterilising machine was on site but we were told that the practice was looking into its suitable disposal as it was no longer used. Single use items ensured that clinical equipment was sterile.

A separate waiting area was available for use by patients if required to limit the spread of infections. Hand hygiene facilities and personal protective equipment were also available for patients and staff. However, we noted that the sink in at least one clinical area did not have suitable non-touch or elbow controlled taps and one sink had a plug.

The practice should ensure that all hand washing facilities within clinical areas adhere to the latest IPC guidance within a reasonable timeframe.

Spill kits were available for cleaning up bodily fluids. However, we found that some of these needed replacing as they had either no expiry date or had expired. These were removed and reordering agreed during the inspection.

The practice should ensure that all equipment expiry dates are routinely checked and items replaced ahead of expiry to ensure availability.

We saw evidence of monthly waste management audits. However, we noted that the waste management policy was aligned with guidelines for healthcare settings and workplaces in England and so needed checking against the relevant standards for Wales. We also saw that the waste disposal contractor had been on the day of the inspection but had not removed all items and had left bins unlocked.

The practice should ensure that:

- **The waste management policy aligns with the latest guidance and standards for healthcare and workplace settings within Wales**
- **Waste disposal is completed by contractors in line with agreed standards and any discrepancy is raised with the company.**

Staff training records indicated that suitable IPC training was completed on an annual basis. We were also told that all staff were offered appropriate vaccinations to maintain and promote their own and patients' health. Needlestick flow charts were displayed detailing the action for staff to take in the event of a needlestick injury. However, not all staff were aware of how to contact the

Occupational Health support available. Procedures within the needlestick and blood borne virus policies also required reviewing to ensure these provided staff with clear instructions regarding the sequence of steps to take to reduce risk should they sustain a needlestick injury.

The practice should review their needlestick and blood borne virus policies to ensure these are appropriate and made clear to all staff.

Medicines management
Processes were in place to promote the safe prescription and management of medicines.

GPs and pharmacists completed all medication reviews and oversaw all other professionals involved in medication prescribing. Positively, Urgent Care Practitioners were undertaking non-medical prescriber training. Patients could request repeat prescriptions in electronic or written formats and prescribing clerks were clear on their role with processing these and when they would request clinical input.

An appropriate prescribing policy was in place and audits of prescribing by all clinicians were being introduced. Escalation processes were also clearly defined. However, evidence of formal supervision provided to non-medical prescribers was not available at the time of inspection.

The practice should ensure that evidence of formal supervision is maintained for all non-medical prescribers working from the practice to support competence, quality improvement and on-going safe practice.

Prescription pads were stored in a locked cupboard. A log of pads arriving at and leaving the premises was maintained. However, no records of prescription pad movement internally within the practice were kept.

The practice should ensure that prescription pad logs provide a comprehensive audit trail of all prescription pad movement into, out of and internally within the practice.

We reviewed the equipment and drugs used to manage medical emergencies. Medications approaching their expiry dates were labelled to prompt timely reordering and all medications and equipment we checked were in date. Charts were seen demonstrating regular checks of emergency items were completed. However, not all checks were completed on a weekly basis in line with Resuscitation Council UK guidelines.

The practice should ensure that all checks of emergency drugs and equipment are completed on a weekly basis.

The location of emergency items was clearly indicated through appropriate signage. However, emergency items were stored within a clinical area that would be locked for privacy if in use for patient consultations.

The practice should ensure that emergency equipment and drugs are kept in a readily accessible location.

Oxygen cylinders were available for use at the practice and were suitably maintained. However, no evidence of staff training in the safe use of oxygen was available, in line with patient safety notice 041

The practice should ensure that all relevant staff complete training to ensure the safe use of oxygen cylinders.

We found that all staff at the practice had completed relevant resuscitation training or had this booked for completion within a few weeks. A red flag document was available to help identify emergency patient medical needs either over the phone or within the premises. Non-clinical staff confirmed that if they were unsure, they would escalate to a GP or Urgent Care Practitioner.

No controlled drugs were kept within the practice. However, we found no risk assessments providing reasoning regarding what drugs were and were not kept on the premises, in line with services offered, the local patient population, and national guidelines

The practice should complete risk assessments to ensure robust justification is available regarding what drugs are kept on the premises.

Non-controlled, non-emergency drugs were kept within a suitable cupboard of dedicated drugs fridge as required. Fridge temperatures were checked on a daily basis and any temperatures noted outside of the acceptable range were escalated to the health board medicines management team for advice. Cold chain procedures were in place and we were told these had been effective following a recent cold chain breach. However, flow charts were not displayed which would better support staff in implementing cold chain breach procedures in response to any future incidents.

The practice should ensure that cold chain flow charts are readily available for staff to follow in the event of a cold chain breach.

Ambient room temperature monitoring of areas where non-refrigerated drugs were kept was not being completed.

The practice should make arrangements for monitoring and recording ambient room temperatures for areas where non-refrigerated drugs are kept.

Suitable arrangements were in place for the safe disposal of drugs.

We were told that the Yellow Card scheme was used for the reporting of any adverse effects of medications prescribed or administered from the practice. An entry would also be made within the individual patient record to inform future safe prescribing.

Safeguarding of children and adults
We considered the safeguarding procedures in place at the practice. We found that an appointed safeguarding lead within the practice and strong interagency joint working and documented multidisciplinary meeting discussions aimed to ensure patient safety and staff learning from events. Processes were also in place to ensure that all staff were up to date with safeguarding training.

A safeguarding policy and list of contact details for relevant agencies were available to all staff and included within locum packs. However, we found there were inconsistencies in procedures specified within the safeguarding and Was Not Brought policies. Policies did not instruct staff to contact the police if the threat of immediate harm was detected and flow charts and posters to inform staff at a glance of who to report safeguarding concerns to require more detail and the inclusion of relevant contact numbers.

The practice must comprehensively review their safeguarding policies in line with national standards, including Royal College of GP Safeguarding Standards (2024) and Wales Safeguarding Procedures.

We found that that digital flags were appropriately used within patient records to alert practitioners to vulnerable patients, children on the child protection register and relevant contacts of patients with identified safeguarding concerns.

Management of medical devices and equipment
We found responsibility for the checking of medical devices and equipment was appropriately delegated and that suitable maintenance contracts were in place. Comprehensive records of all checks and servicing were available and devices were seen to be in good condition.

Effective

Effective care

We saw that suitable systems were in place for receiving clinical information into the practice, sharing relevant information within the practice and wider multidisciplinary team and communicating with patients regarding their care.

Electronic systems were used for internal communication requiring an audit trail and would also be followed up verbally when able. Meetings with attached teams supported continuity of person-centred care and shared practice development.

Letters received from secondary care and other services were appropriately summarised into patient records and the practice would initiate any follow-up tests and appointments required. GPs would prioritise onward referrals as urgent or routine so that they were completed within the appropriate timescale. Urgent cancer referrals would also be followed up to confirm these had been acted upon within two weeks.

Most referrals were completed via an electronic portal with letters also being typed and sent by medical secretaries as required. The practice had developed a database of information to aid effective onward referrals and reduce administration time associated with supporting patients to access a large number of care service providers across health boards in England and Wales due to its border location. From this database and a shared folder containing leaflets about different services, all team members were supported by clear information on how and where to raise referrals.

Patients were informed of the timescale they could expect test results in. GPs would review all results to ensure appropriate communication and any further follow-up required was provided to patients.

Mortality review processes were undertaken by the practice clinical lead. Practice management were aware of incident reporting procedures. However, we were told that as these mechanisms were not shared by all health boards with which the practice interacted this provided a barrier to escalating issues.

Patient records

We examined a random sample of ten recent electronic patient records which were kept within a secure IT system. Records reviewed were considered to be very good overall, adhering to professional standards and clearly reporting clinical processes, findings and pathways and the reasoning underpinning clinical decisions. We saw that comprehensive patient summaries and problem lists were appropriately READ coded and that the recording of adverse drug reactions and

repeat medications was robust. Formal consent forms were used for certain procedures. However, we found that these paper forms were not always scanned into the electronic patient record.

The practice should ensure that paper consent forms signed by patients are scanned onto the electronic patient record.

Efficient

Efficient

We found that signposting and referral pathways aimed to support patients with timely access to the services they required. Where efficiency was compromised this was identified and addressed through the cluster, for example, a meeting to discuss strengthening admission avoidance had been arranged in response to a number of patients having recently been admitted to secondary care. We were told that communication was strong with other services that worked from the practice on a sessional basis, including first contact physiotherapy and counsellors, but that patient access to these services was hindered when waiting lists occurred.

Quality of Management and Leadership

Staff feedback

All respondents to the HIW staff questionnaire told us that they were satisfied with the quality of care and support given to patients and the majority agreed that patient care was the practice's top priority. However, some respondents felt that the practice could do more to promote staff well-being and that there were not enough staff or the correct skill mix available to enable conflicting workplace demands to be met.

Staff comments included:

> *"I feel the patient's get a good service, specifically relating to urgent care."*
>
> *"Overall, the surgery is professional and runs well. Day to day running appears effective but the overall direction of service development, staff training / clinical support and operational direction seems lacking."*
>
> *"A lovely place to work, we have a great team with a wealth of experience…Patients that need to be seen on the day will be seen, however with only one GP working each day, patients can wait 3-4 weeks for a routine appt…More than one GP working here each day would be beneficial to our practice."*

Leadership

Governance and leadership
We were told that practice leadership was visible and supportive and observed good working relationships at the practice. Practice leaders reported that they in turn were supported through regular meetings with ShropDoc who held the contract for out of hours and for the management of the practice. This arrangement provided the practice with practice development and governance, finance and performance reporting, occupational health and human resources support.

Staff could access practice policies and procedures. However, we noted that several policies needed refinement to ensure they reflected relevant standards and provided the detailed information staff required. We were told that practice management were considering purchasing new software to assist with the tracking and dissemination of policies and procedures.

The practice should review and update practice policies and procedures to ensure these reflect relevant standards and provide comprehensive information to guide staff.

Workforce

Skilled and enabled workforce

Staff we spoke with told us they felt positive regarding their work and that strong communication between practice colleagues enabled the delivery of quality service to patients.

We found that training was kept up to date and that made available to staff in line with job roles and responsibilities. Cover arrangements were also in place to protect half day Practice Learning Time (PLT) several times each year. These events enabled the whole practice team to meet together, receive updates and engage in reflection and other continuous professional development activities. Practice leads would also meet more regularly to ensure the timely implementation of clinical and operational changes and team support on an ongoing basis.

We were told that appraisals allowed for individual development needs to be identified. However, some respondents to our staff questionnaire reported they had not had an appraisal or other work review opportunity within the last 12 months. We also noted a difference in opinions between practice management and staff regarding the regular review of practice development needs and skill mix. The practice had one GP vacancy but hoped to recruit in the near future. Locum cover and connections with other local practices were used to sustained staffing levels on a temporary basis.

Comprehensive recruitment policies were available outlining clear expectations for pre-employment checks. Staff employed at the practice had current and comprehensive job descriptions to work to and lines of reporting and accountability were clear. Suitable arrangements were also in place for maintaining relevant professional obligations on an on-going basis. The Practice Manager was in the process of updating their central register to formally evidence the Hepatitis B immunity records of some clinical staff.

The practice should ensure that comprehensive records of Hepatitis B vaccination and immunity or appropriate risk assessments are in place for all clinical staff.

Culture

People engagement, feedback and learning
We saw that a suitable complaints policy aligned with Putting Things Right was made available to patients on the practice premises and via the website. A Duty of Candour policy was also in place accompanied by suitable flow charts to support policy implementation if required. A spreadsheet held collated details of patients who had raised concerns or complaints and the date the final response had been provided following investigation. However, the initial response timescale was not recorded and there was no information regarding the broad reason for the complaint to assist the practice in identifying and addressing any recurring themes. Staff had the opportunity to reflect on concerns and complaints at meetings or PLT. However, no information was provided to patients regarding how the practice had addressed concerns, complaints or other patient feedback, including national survey results.

The practice should:

- **maintain detailed records regarding complaints handling to support practice learning**
- **inform patients of concerns, complaints and other feedback received and how this has effected change when applicable.**

Staff we spoke with reported they felt able to speak up with any ideas or concerns. A whistleblowing policy and zero tolerance policy for violence towards staff were in place to support and protect staff.

Information

Information governance and digital technology
A suitable data protection officer was in place. However, website and practice copies of information governance and privacy policies needed reviewing for consistency and ensure they were in date.

The practice should review their information governance and privacy policies and ensure website and practice copies are the same.

Learning, improvement and research

Quality improvement activities
We found that the practice engaged in required audit activities internally and in collaboration with partners. However, audit and performance monitoring were identified as requiring further development as clinical audits had been completed in 2025 but none were planned for the coming year at the time of inspection.

The practice should strengthen their audit and performance monitoring activity in collaboration with relevant partners.

Whole-systems approach

Partnership working and development
We were told that the practice worked collaboratively with other services for the delivery of robust clinical care and governance. The practice manager met quarterly with ShropDoc managers and the practice informed us they were active contributors to cluster meetings and involved in cluster project design and delivery when appropriate.

4. Next steps

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

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

The improvement plans should:

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

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

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

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

Appendix A – Summary of concerns resolved during the inspection

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

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

Appendix B - Immediate improvement plan

Service: Presteigne Medical Centre

Date of inspection: 12 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 assurance issues were found on this inspection.					

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: Presteigne Medical Centre

Date of inspection: 12 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.	Limited written information to support non-clinical staff with care navigation.	Suitable pathways to be available to support staff.	Health and Care Quality Standard (2023) – Timely	Existing processes already support care navigation, including triage guidance, red flag prompts and staff training. These are available to staff and continue to be used in day-to-day practice. Staff have been reminded of how to access this information with further discussion at next practice meeting.	Natalie McLaughlin	Completed – March 2026

2.	Practice leaflet, access policy and website did not provide consistent information regarding practice staff, services provided on the practice premises, or the role of the practice manager in dealing with concerns or complaints.	Patient information leaflet, access policy and website to be reviewed to ensure they contain consistent information.	Health and Care Quality Standard (2023) – Effective	Practice information (leaflet, website and access policy) has been reviewed and now align to ensure consistency. This reflects current roles, services and contact point for concerns and complaints	Natalie McLaughlin	Completed – March 2026
3.	No mental health awareness training had been completed to support care navigation.	All relevant staff to undertake mental health awareness training.	Health and Care Quality Standard (2023) – Safe / Timely.	Mental health awareness training has been incorporated into ongoing staff development, with sessions being arranged to support and refresh staff knowledge where appropriate.	Natalie McLaughlin	Completed – March 2026

4.	Cleaning records not signed reducing accountability for any episodes of cleaning not meeting expected standards.	Practice to request that cleaning records are signed by the cleaner undertaking tasks or the person responsible for providing oversight.	Health and Care Quality Standard (2023) – Effective	The existing recording process has been amended to ensure a signature/initial rather than a tick is used to identify a clearer audit trail.	Natalie McLaughlin/NIC Cleaning Company	Completed – March 2026
5.	At least one sink within a clinical area did not have suitable taps and had a plug.	All hand washing facilities within clinical areas to adhere to the latest IPC guidance.	Health and Care Quality Standard (2023) – Safe	The identified sink is being reviewed in line with IPC guidance, and adjustments planned as part of our routine maintenance programme of work In the meantime, the plug has been removed and the room and clear guidance posted with regards to usage,	Health & Safety/Natalie McLaughlin	Interim solution addressed March 2026 – replacement planned for April 2026.
6.	Spill kits found that had expired or had no expiry date on them.	All equipment expiry dates to be routinely checked and items replaced ahead of expiry to ensure availability.	Health and Care Quality Standard (2023) – Safe	Routine checks are undertaken, however a single out-of-date item was identified during the visit and	Nursing Team	Completed on date of visit – February 2026

				replaced immediately. Routine checks will continue ensure dates for upcoming expiry dates are complied with.		
7.	Waste disposal not completed by contractors in line with expectations.	Any discrepancy between the completion of waste disposal to the agreed standards to be raised with the contracted company.	Health and Care Quality Standard (2023) – Safe	This was raised with the waste contractor at the time of the visit, and no ongoing concerns have been identified.	Natalie McLaughlin	Completed on date of visit – February 2026
8.	Needlestick and blood borne virus policies required reviewing and resharing with staff to ensure clarity.	Needlestick and blood borne virus policies to be reviewed and staff awareness to be raised regarding the actions to take in the event of a needlestick injury.	Health and Care Quality Standard (2023) – Safe	Policies are being refreshed and shared with staff to ensure clarity. Key guidance will be reiterated as part of routine updates.	Natalie McLaughlin	April 2026
9.	No evidence available regarding the formal supervision for non-medical prescribers working from the practice.	Evidence of formal supervision to be maintained for all non-medical prescribers working from the practice to support competence,	Health and Care Quality Standard (2023) – Safe	Appropriate supervision arrangements are in place together with a non-medical prescriber policy. Recording of these	Natalie McLaughlin/Dr Linda Duffin	Completed – March 2026

		quality improvement and on-going safe practice.		arrangements are being formalised to ensure clear evidence is available.		
10.	Prescription pad movement within the practice premises not recorded.	Prescription pad logs to provide a comprehensive audit trail of all prescription pad movement into, out of and internally within the practice.	Health and Care Quality Standard (2023) – Safe	A logging process has been introduced to provide a clear record of prescription pad movement within the practice. Electronic prescribing is in place at the practice therefore there is limited use of prescription pads.	Natalie McLaughlin	Completed – March 2026
11.	Some checks of emergency drugs and equipment only completed twice a month.	All checks of emergency drugs and equipment to be completed on a weekly basis in line with Resuscitation Council UK guidelines.	Health and Care Quality Standard (2023) – Safe	The frequency of checks has been adjusted to weekly in line with guidance and incorporated into routine processes.	Natalie McLaughlin/Nursing Team	Completed – March 2026
12.	Emergency equipment and drugs kept in a location that may be locked during patient consultations.	Emergency equipment and drugs to be kept in a readily accessible location.	Health and Care Quality Standard (2023) – Safe	The location of emergency equipment has been reviewed to ensure it remains accessible at all times.	Natalie McLaughlin/Dr Linda Duffin	Completed March 2026

13.	No evidence that practice staff had completed training in line with patient safety notice 041 to ensure the safe use of oxygen cylinders.	All relevant staff to complete oxygen cylinder training.	Health and Care Quality Standard (2023) – Safe	Relevant staff training is being scheduled.	Natalie McLaughlin	April 2026
14.	No risk assessments in place regarding what drugs are and are not kept on the premises in line with services offered, the local patient population, and national guidelines.	Risk assessments to be completed to ensure robust justification regarding what drugs are kept on the premises.	Health and Care Quality Standard (2023) – Safe	A review of medicines held on site is being undertaken, with risk assessments being documented to reflect current practice and patient need.	Natalie McLaughlin/Dr Linda Duffin	April 2026
15.	Cold chain flow charts not displayed to support staff in the event of a future cold chain breach.	Cold chain flow charts to be displayed.	Health and Care Quality Standard (2023) – Effective	Cold chain flow charts are in place and are now displayed to support staff in the event of a breach.	Natalie McLaughlin	Completed March 2026
16.	No ambient room temperature monitoring completed for areas where non-	Ambient room temperature monitoring and recording to be undertaken in areas where non-refrigerated drugs are kept.	Health and Care Quality Standard (2023) – Safe	Temperature monitoring has been introduced in relevant areas as part	Natalie McLaughlin	Completed 2026

	refrigerated drugs were kept.			of routine medicines management.		
17.	Paper consent forms signed by patients not routinely scanned onto the electronic patient record.	All paper consent forms signed by patients to be scanned onto the electronic patient record.	Health and Care Quality Standard (2023) – Person-centred	The practice routinely scans patient consent forms, however those found during the visit have now been updated.	Dr Linda Duffin	Completed on date of visit – February 2026
18.	Several policies required refinement to ensure they reflected relevant standards and provided the detailed information staff required.	The practice should review and update practice policies and procedures to ensure they are sufficiently detailed and fully aligned with standards, including: • Business Continuity Plan – to ensure it provides enough detail regarding actions to be taken to mitigate for staff absence • Infection Prevention and Control policy – to ensure clarity regarding leaders	Health and Care Quality Standard (2023) – Effective	All practice policies are in the process of being updated with scheduled completion date of April 2026. The review will specifically ensure adherence with these recommendations.	Natalie McLaughlin	April 2026

		roles and responsibilities • Waste management policy – to align with the latest guidance and standards for healthcare and workplace settings within Wales • Safeguarding and Was Not Brought policies – to ensure these are consistent and in line with national standards including Royal College of GP Safeguarding Standards (2024) and Wales Safeguarding Procedures.				
19.	Some gaps in the formal evidence available of Hepatitis B vaccination and	Comprehensive records of Hepatitis B vaccination and immunity or appropriate risk assessments to be in place for all clinical staff.	Health and Care Quality Standard (2023) – Safe	Staff records are being reviewed and updated where needed to ensure completeness. We	Natalie McLaughlin/Dr Linda Duffin	April 2026

	immunity status for clinical staff.			discussed the two outstanding clinical records on the day of the visit, and I provided assurances this would be updated as soon as possible.		
20.	Processes for recording complaints handling and providing feedback to patients regarding practice learning needed development.	• More detailed records regarding complaints handling to be maintained to support practice learning • Mechanisms to inform patients of concerns, complaints and other feedback received and how this has effected change when applicable to be implemented.	Health and Care Quality Standard (2023) – Person-centred	Feedback process has now been implemented.	Natalie McLaughlin	Completed March 2026
21.	Different versions of information governance and	• information governance and privacy policies to	Health and Care Quality Standard (2023) – Effective	Policies have been aligned across the website and practice	Natalie McLaughlin	Completed on date of visit –

	privacy policies on the website and within the practice.	be reviewed to ensure website and practice copies are the same and in date.		to ensure consistency and accuracy.		February 2026
22.	Audit and performance monitoring activity required strengthening.	Audit and performance monitoring activity to be developed in collaboration with relevant partners.	Health and Care Quality Standard (2023) – Effective	Audit and performance monitoring activity is routinely undertaken with relevant partners. Due to the timing of the visit, the schedule for 2026/27 had not yet been finalised at that point. The programme is now in development.	Natalie McLaughlin/Dr Linda Duffin	May 2026

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

Service representative

Name (print): Natalie McLaughlin

Job role: Practice Manager

Date: 26/03/2026