The Weobley and Staunton-On-Wye Surgeries

Quality Report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Outstanding ☆
Are services responsive to people's needs?	Outstanding ☆
Are services well-led?	Outstanding ☆

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We inspected this service on 28 April 2015 as part of our new comprehensive inspection programme.

The overall rating for this service is outstanding. We found the practice to be good for providing safe and effective services and outstanding for providing caring, responsive and well led services.

The practice was outstanding at providing services for older patients and patients with long term conditions. The practice was good at providing services for families, children and young patients, the working age population and those recently retired and patients experiencing poor mental health.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from incidents were maximised.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure they met the needs of patients.
- Information about how to complain was available and easy to understand.
- The practice held regular multidisciplinary clinical team meetings to discuss the needs of complex patients, for example those with end of life care needs or children who were considered to be at risk of harm.
- The practice had an open culture that was effective and encouraged staff to share their views through staff meetings and significant event meetings.

Summary of findings

We saw several areas of outstanding practice including:

- Weobley Surgery had looked for innovative ways to develop services for patients in their area. They had been involved in a number of pilot schemes such as the provision of a specialist clinic to review all patients with Atrial Fibrillation (heart disease) who may be at additional risk of a stroke. These reviews resulted in positive outcomes for patients. The practice shared their learning from these and other pilots they engaged in with the CCG area.
- The practice had an equipment fund that was registered with the charities commissioners and managed by a committee of patient representatives. This fund enabled the purchase of additional equipment to be used for the benefit of patients. The practice told us that they contributed to this fund-raising by asking for donations rather than charge fees for some forms they were requested to complete. The fund had enabled them to purchase and loan equipment to patients such as syringe drivers (for pain management), heart monitoring recorder to aid diagnoses, blood pressure monitoring machines, an audiometer to assess hearing, and defibrillators in all GP cars for restarting a person's heart in an emergency. There was a community defibrillator attached to the outside of the building for the use of the village first responder.
- The practice showed a high level of commitment to the needs of patients receiving palliative care and recognised that many of them wanted to receive the highest quality of care and support to enable them to die with dignity in their own home or care home. Effective systems were in place to ensure they received their end of life care in line with their expressed preferences. The practice operated a direct one to one on-call rota to provide individual care and support to patients in their end of life.
- The practice was one of the highest performing practices in Herefordshire for the care for diabetic patients. The practice had 300 patients diagnosed with diabetes. A dedicated community dementia worker provided clinics at the practice. There was a high uptake of flu vaccines (100% which was higher than the national average of 93%) and foot examinations (96% which was higher than the national average of 88%) for diabetic patients.
- Weobley Surgery was leading on trials for a standardised approach to practice nurse appraisal documentation. This documentation was to be used in the completion of appraisals towards continued professional development, leading to revalidation for nurses. The outcome of the trial was to share the documentation with all practices within the county. One of the GPs also coordinated a monthly educational evening in conjunction with a neighbouring practice. The evening was open to all local practices and consultants, and other experts were invited according to the learning needs identified by the group.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were robust safeguarding measures in place to help protect children and vulnerable adults from the risk of abuse. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. Data showed that the practice was performing highly when compared with neighbouring practices in the Clinical Commissioning Group (CCG) and nationally.

Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles. Any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams internally and externally to deliver positive health outcomes for patients.

The practice had been involved in a number of pilot schemes and shared their learning from these within the Clinical Commissioning Group (CCG) area. This included the screening of patients with Atrial Fibrillation (heart disease) to identify those patients who may be at risk of a stroke. Positive outcomes were achieved for nine patients found to be at risk as a result of the specialist clinics.

Are services caring?

Outstanding

The practice is rated as outstanding for providing caring services. Data showed that patients rated the practice higher than others for almost all aspects of care. Data for the year 2014 showed that

Summary of findings

patients reported they had a positive experience of the practice at 93%, which was above the national average of 85%. Patients experience of making an appointment was reported as 91% which was also above the national average of 73%.

Feedback from patients about their care and treatment was consistently and strongly positive. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. We observed a patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care.

The practice supported patients to have a forum where they could learn and share ideas that promoted their health. There was an active patient participation group (PPG) at the practice that directed its own agenda and focused on topics that mattered to patients. PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

The practice had received consistent, continually positive and high scores for feedback and recognition of patients' needs by staff.

Are services responsive to people's needs?

Outstanding ☆

The practice is rated as outstanding for providing responsive services. The practice had initiated positive service improvements for its patients. It acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG) and patient surveys.

The practice had obtained a range of equipment which helped to reduce referrals to secondary care services. The equipment was available for use both by patients and staff. The practice was equipped with audioscopes (machines to perform screening for hearing) at both surgery sites. There was no local facility available so screening carried out at the practice reduced the number of patients referred to secondary care. Patients could be screened locally, promptly and this reduced waiting times and the need to travel some distance for the screening to be done.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to make a complaint was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff. The practice had a positive approach to using complaints and concerns to improve the quality of the service.

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Are services well-led?

Outstanding

The practice is rated as outstanding for being well-led. The aim of the practice was to provide an appropriate and rewarding healthcare experience for their patients whenever they needed their support. The practice considered their core values to be those of openness, fairness, respect and accountability. There was a clear leadership structure in place and staff felt supported by the management team.

There were positive examples of how the practice's vision and ethos were implemented by the staff team working together to maintain high standards, deliver positive health outcomes for patients and foster a supportive work environment. We saw examples of how the staff team worked together and supported each other throughout the inspection. Quality performance data showed the practice was performing exceptionally highly compared with local and national averages, achieving an overall score of 100% in 2014/2015.

The practice carried out proactive succession planning to ensure that the quality of service they provided and the continuity of care for patients were maintained, developed and improved. The practice gathered feedback from patients and it had an active patient participation group (PPG).

There were systems in place to monitor and improve quality and identify risk. Staff had received inductions, regular performance reviews and attended staff meetings and events. Staff told us they were supported to develop their skills to improve services for patients.

There was evidence of high levels of staff satisfaction, strong collaboration and support across all staff who worked at the practice. Staff had a common focus to improve quality, drive continuous improvement, with a proactive approach to seek out and embed new ways of providing care and treatment to patients.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Outstanding 

This practice is rated as outstanding for the care of older patients. The practice offered proactive, personalised care to meet the needs of older patients in its population and had a range of enhanced services for example, in dementia and end of life care. The percentage of patients diagnosed with dementia whose care has been reviewed for 2014 was 95% which compared with national rates of 83%.

The practice provided a responsive service to patients who lived in a local nursing home. The practice maintained a register of all patients in need of palliative care and offered home visits and rapid access appointments for those patients with complex healthcare needs. Other professionals and practice staff had access to clear information about patients receiving end of life care so they were able to respond in the event that medical assistance was needed. The practice held regular multidisciplinary integrated care meetings where all patients on the palliative care register were discussed.

Nationally reported data showed that the practice performed well against indicators relating to the care of older patients. Patients over the age of 75 had a named GP and GPs carried out visits to patients' homes if they were unable to travel to the practice for appointments. The practice had exceeded the national average for providing flu vaccinations to patients over the age of 65. Data for the year 2014/2015 showed that 100% of patients had been given their flu vaccination compared with the national rate of 73%.

The practice had taken part in a pilot for a treatment approach to stroke prevention for those patients with Atrial Fibrillation (AF) (heart disease). GPs told us this was particularly relevant to their practice as Herefordshire had a large number of elderly patients potentially at high risk of strokes. This project was successful for the practice patients. Nine patients were found to be at risk and treated to minimise that risk. The programme was implemented across the whole of the county by the CCG.

People with long term conditions

Outstanding 

This practice is rated as outstanding for the care of patients with long term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a

structured annual review to check that their health and medicine needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

The practice was one of the highest performing practices in Herefordshire for the care for diabetic patients. The practice had 300 patients diagnosed with diabetes. A dedicated community diabetes worker provided clinics at the practice. There was a high uptake of flu vaccines (100% which was higher than the national average of 93%) and foot examinations (96% which was higher than the national average of 88%) for diabetic patients. The quality monitoring data (QOF) for 2014/2015 showed that the practice was effective in supporting patients with diabetes to manage their health and had low accident and emergency admission rates.

Herefordshire had a high number of older patients many of whom had long term conditions. The practice had been involved in piloting specialist clinics to review patients with Atrial Fibrillation (heart disease) to identify those who may be at risk of a stroke. As a result of this pilot nine patients were identified to be at risk and preventative treatment was provided.

Families, children and young people

Good

This practice is rated as good for the care of families, children and young patients. Appointments were available outside of school hours and the premises were suitable for children and babies. The practice provided childhood immunisations and appointments for these could be booked throughout the week to provide flexibility for working families. Last year's performance was above average for the majority of immunisations where comparative data was available. For example, childhood immunisation rates for the vaccinations given to under twos ranged from 95.2% to 100% comparable to the CCG average of 90.9% to 97.5%.

The practice provided a family planning service and a range of options for contraception. The GPs and nurses worked with other professionals where this was necessary, particularly in respect of children living in vulnerable circumstances.

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk of harm, for example, children and young patients who had a high number of attendances at the accident and emergency (A&E) department of the local hospital.

Summary of findings

Working age people (including those recently retired and students)

Good

This practice is rated as good for the care of working age patients (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.

GPs in Herefordshire to provided additional medical services to patients. There were three primary care hubs open in the county that provide GP and practice nursing services to all Herefordshire patients during the evenings and weekends. Patients could therefore access GP and nurse appointments seven days a week from 8am and 8pm.

The practice offered a number of online services, including booking and cancelling appointments and requesting repeat medicines. They also provided a full range of health promotion and screening clinics that reflected the needs of this age group. The practice nurses had oversight for the management of a number of clinical areas, including immunisations, cervical cytology and some long term conditions.

People whose circumstances may make them vulnerable

Good

This practice is rated as good for the care of patients whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including patients with a learning disability. In 2014 there were nine patients on the learning disability register and an annual health check had been completed with all of them.

We saw the practice was proactive in responding to the needs of patients. They had put in place a system for patients needing support in an emergency. This was called the Message in a Bottle scheme which was a way for patients of keeping personal and medical information accessible quickly in an emergency.

Staff had received training and knew how to recognise signs of abuse in vulnerable adults and children who were considered to be at risk of harm. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Patients were provided with information about how to access various support groups and voluntary organisations. For example, through leaflets, on the information notice board in the waiting area and on the practice's website.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

This practice is rated as good for the care of patients experiencing poor mental health (including patients with dementia). The practice held a register of patients living in vulnerable circumstances including those patients with a learning disability and dementia.

The practice invited patients to attend for an annual health check. Longer appointments were arranged for these and patients were seen by the GP they preferred. The annual reviews took into account patients' circumstances and support networks in addition to their physical health. The percentage of patients diagnosed with dementia whose care has been reviewed for 2014/2015 was 95% which compared with national rates of 83%.

The practice had given patients experiencing poor mental health information about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for patients with mental health needs and dementia.

Summary of findings

What people who use the service say

We reviewed 11 patient comments cards from our Care Quality Commission (CQC) comments box that we had asked to be placed in the practice prior to our inspection. We saw that all of the comments recorded were extremely positive. Patients commented that they were given excellent care by everyone at the practice and that staff were helpful, friendly and listened to them. They also commented that they could always see a GP when they needed to.

We spoke with two patients during our inspection. These patients told us they were very satisfied with the treatment they received from all staff at the practice. They told us that they were treated with respect and that staff were friendly and courteous. We saw feedback from patients on the NHS Choices website which confirmed this. Comments related to all the staff at Weobley Surgery and indicated that receptionists, nurses and GPs were always helpful and courteous.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national GP Patient Survey 2014/ 2015 and a survey of patients undertaken by the practice during 2014. Results of the national survey showed the practice was higher than average for its satisfaction scores on consultations with GPs and nurses. Patients considered that the last GP they saw or spoke to was good at treating them with care and concern (92% compared with the national average of 85%); 91% described their experience of making an appointment as good compared with the national average of 73%; and 93% of the patients surveyed would recommend this practice to someone new to the area compared with national average of 81%.

We spoke with the manager of a local nursing home where some of the practice's patients lived. They told us the practice was excellent at responding to the needs of patients. They were very satisfied with the care and treatment patients received and felt able to contact the practice at any time should they have concerns about patients.

The evidence from all these sources showed patients were satisfied with the service they received, they felt that they were given enough time during their appointments and that they were treated with care and concern.

Outstanding practice

- Weobley Surgery had looked for innovative ways to develop services for patients in their area. They had been involved in a number of pilot schemes such as the provision of a specialist clinic to review all patients with Atrial Fibrillation (heart disease) who may be at additional risk of a stroke. These reviews resulted in positive outcomes for patients. The practice shared their learning from these and other pilots they engaged in with the CCG area.
- The practice had an equipment fund that was registered with the charities commissioners and managed by a committee of patient representatives. This fund enabled the purchase of additional equipment to be used for the benefit of patients. The practice told us that they contributed to this fund-raising by asking for donations rather than charge fees for some forms they were requested to complete. The fund had enabled them to purchase and loan equipment to patients such as syringe drivers (for pain management), heart monitoring recorder to aid diagnoses, blood pressure monitoring machines, an audiometer to assess hearing, and defibrillators in all GP cars for restarting a person's heart in an emergency. There was a community defibrillator attached to the outside of the building for the use of the village first responder.
- The practice showed a high level of commitment to the needs of patients receiving palliative care and recognised that many of them wanted to receive the highest quality of care and support to enable them to die with dignity in their own home or care home. Effective systems were in place to ensure they received

their end of life care in line with their expressed preferences. The practice operated a direct one to one on-call rota to provide individual care and support to patients in their end of life.

- The practice was one of the highest performing practices in Herefordshire for the care for diabetic patients. The practice had 300 patients diagnosed with diabetes. A dedicated community dementia worker provided clinics at the practice. There was a high uptake of flu vaccines (100% which was higher than the national average of 93%) and foot examinations (96% which was higher than the national average of 88%) for diabetic patients.
- Weobley Surgery was leading on trials for a standardised approach to practice nurse appraisal documentation. This documentation was to be used in the completion of appraisals towards continued professional development, leading to revalidation for nurses. The outcome of the trial was to share the documentation with all practices within the county. One of the GPs also coordinated a monthly educational evening in conjunction with a neighbouring practice. The evening was open to all local practices and consultants, and other experts were invited according to the learning needs identified by the group.

The Weobley and Staunton-On-Wye Surgeries

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP, a Practice Manager and Practice Nurse specialist advisors.

Background to The Weobley and Staunton-On-Wye Surgeries

Weobley and Staunton on Wye Surgeries are located near the town of Hereford and provide primary medical services to patients covering a large area of rural Herefordshire of approximately 200 square miles. This inspection focussed on the Weobley Surgery as we had no specific information about Staunton on Wye to lead us to inspect there on this occasion.

The practice building is purpose built, with good facilities and is well equipped to treat patients and meet their needs. Weobley Surgery is also a dispensing practice.

The practice has four GP partners including a female GP which provides a choice for patients. There is a management team which includes a practice manager, an assistant practice manager and a reception manager. The nursing staff team includes two practice nurses and two health care assistants. In addition there are dispensary, administrative and reception staff. There were 5647 patients registered with the practice at the time of the inspection.

The practice is open from 8.30am to 1pm and 2.45pm to 6pm Mondays, Thursdays and Fridays and from 8.30am to 1pm on Tuesdays and Wednesdays. The practice is closed at weekends. Home visits are available for patients who are too ill to attend the practice for appointments. There is also an online service which allows patients to book appointments and order repeat prescriptions. The practice does not provide an out-of-hours service but has alternative arrangements in place for patients to be seen when the practice is closed. Information on the out-of-hours service is provided to patients and is available on the practice's website. There is a GP Walk-In Access Centre in Hereford which is open from 8am until 8pm seven days a week and every day of the year. Patients could also telephone 111. NHS 111 enables patients to access local NHS healthcare services in England.

Additional appointments are made available, particularly for working patients. These are provided by a company that has been set up by the GPs in Herefordshire to provide additional medical services to patients. There are three primary care hubs open in the county that provides GP and practice nursing services to all Herefordshire patients during the evenings and weekends. Patients can therefore access GP and nurse appointments seven days a week from 8am and 8pm.

Weobley Surgery treats patients of all ages and provides a range of medical services. They provide clinics such as asthma, diabetes, heart disease, well woman, and child and travel immunisation clinics. Other clinics include wound dressings, removal of sutures, family planning, minor injuries and ear syringing. Community staff provide other services in the practice such as midwifery, health visitors, community mental health, and healthy lifestyle and memory clinics.

Detailed findings

Weobley Surgery has a General Medical Services (GMS) contract. The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities.

Weobley Surgery is an approved training practice for doctors who wish to be become GPs. A trainee GP is a qualified doctor who is training to become a GP through a period of working and training in a practice. Only approved training practices can employ trainee GPs and the practice must have at least one approved GP trainer. The practice is also a teaching practice and provides placements for medical students who have not yet qualified as doctors.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

Before our inspection of Weobley Surgery we reviewed a range of information we held about this practice and asked other organisations to share what they knew. We contacted Herefordshire Clinical Commissioning Group (CCG), NHS England area team and Healthwatch to consider any information they held about the practice. We also supplied the practice with comment cards for patients to share their views and experiences of the practice.

We carried out an announced inspection on 28 April 2015. During our inspection we spoke with a range of staff that included three GPs, the practice manager, the assistant practice manager, nursing, administration and reception staff. We spoke with a visiting member of the community nursing team. We also looked at procedures and systems used by the practice.

We observed how staff interacted with patients who visited the practice. We spoke with two patients who visited the practice during the inspection. We also spoke with the manager of a local nursing home who gave us information about the service provided by the practice to patients living in the home. We reviewed 11 comment cards where patients and members of the public shared their views and experiences of the practice.

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to patients' needs?
- Is it well-led?

We also looked at how well services are provided for specific groups of patients and what good care looks like for them. The population groups are:

- Older patients'
- Patients' with long-term conditions
- Mothers, babies, children and young patients'
- The working-age population and those recently retired
- Patients' whose circumstances may make them vulnerable
- Patients' experiencing poor mental health

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. We saw detailed records with comprehensive analyses completed by the practice in relation to reported incidents and complaints. These showed that all areas of reporting had been well managed and that the practice recognised the importance and the relevance in identifying risks and improving quality in relation to patient safety. Staff we spoke with understood the importance of recognising, reporting and recording significant events. They told us they would take issues of concern to their line manager or the practice manager should they have any. They gave us examples of situations they had reported and that the practice team had discussed during meetings.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. For example, we saw from meeting minutes that an incident recorded in December 2014 had been discussed at the next clinical meeting. Records showed the practice had managed these consistently over time and could show evidence of a safe track record.

Learning and improvement from safety incidents

The practice leadership shared a strong view that safety concerns were of significant value and integral to staff learning and improving the service for patients. There was a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were available to show significant events that had occurred over several years including those for the period January 2013 to April 2015. Staff used incident forms on the practice intranet and shared computer drive and sent completed forms to the practice manager. We tracked four such incidents recorded within the last 12 months and saw records had been completed in a comprehensive and timely manner.

We saw that significant events were a standing agenda item to be discussed at the weekly clinical meetings. There was evidence that the practice learned from these and that the findings were shared with relevant staff. For example, we saw that a clinical incident had been reported in 2014 regarding a patient diagnosis. Action had been taken and learning shared to minimise the likelihood of a recurrence. We saw evidence that showed the practice informed patients and gave them an apology when things went wrong.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with gave us examples of recent alerts that were relevant to the care they were responsible for. They also told us that alerts were discussed at clinical meetings to make sure that staff were aware of those relevant to the practice and any action that was needed. The practice manager showed us a log that was kept to track all the alerts received, with records of action taken and by whom.

Reliable safety systems and processes including safeguarding

Arrangements were in place to safeguard adults and children from the risk of abuse that reflected relevant legislation and local requirements. Staff told us that all policies were accessible to them. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GP and the practice nurse attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training relevant to their role and to the required level of their responsibility. Staff gave us examples where they had taken action to protect and safeguard patients they considered to be at risk of abuse. This had included both adults and children who were in need of protection.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments, for example any child known to be at risk of harm or who was in the care of the local authority.

There was a chaperone policy available to all staff on the practice computer. We saw that a poster was prominently displayed in the reception area informing patients about the chaperone facility. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. The practice manager told us that training was provided for non-clinical staff that may, in exceptional circumstances act as chaperones. This was confirmed by staff we spoke with and training records we looked at. Trained staff also

demonstrated an awareness of the role of chaperones including for example, knowing where to stand when intimate examinations took place. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. DBS checks identify whether a person has a criminal record or is on an official list of patients' barred from working in roles where they may have contact with children or adults who may be vulnerable.

Medicines management

There were suitable arrangements in place for managing medicines, including emergency medicines and vaccinations to ensure patients were kept safe. This included obtaining, prescribing, recording, handling, storing and security of medicines. Regular medicine audits were carried out with the support of the pharmacist employed by the practice to ensure prescribing was in line with best practice guidelines for safe prescribing. Prescription pads were securely stored and there were systems in place to monitor their use.

The practice offered a dispensary service in which they dispensed medicines to 96.5% of patients across both Weobley and Staunton Surgeries. They had appropriate written procedures in place for the production of prescriptions and dispensing of medicines that were regularly reviewed and accurately reflected current practice. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. Discussion with the dispensing staff at the practice showed that they were aware prescriptions should be signed before being dispensed.

The practice was signed up to the Dispensing Services quality scheme (DSQS) to help ensure processes were suitable and the quality of the service was maintained. Dispensing staff had all completed appropriate training and had their competency annually reviewed. We saw that three monthly audits of dispensary activities were being completed and arrangements were in place for incident reporting, reviewing of concerns and shared learning.

We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged efficiently and then reviewed promptly. For example, in March 2013 an incident occurred where a patient had returned their medicines as there were two labels attached to the bag, one for their medicines and another label for another patient. Action was taken which included an apology to the patient. We saw minutes of the meeting where this incident was discussed, learning identified and shared with all staff to minimise the risk of future occurrences.

We saw that no issues had been identified in the latest DSQS audit carried out in February 2015. The practice had performed highly in the area of drug review usage of medicines (DRUM) as part of the DSQS dispensing service quality monitoring. These reviews were an opportunity to check the patients' understanding of their medicines, and their ability to obtain and use them. The practice had completed 12% of the DRUM reviews which was above the 10% required under the scheme.

Cleanliness and infection control

Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be visibly clean and tidy. The practice nurse was the Infection Prevention and Control (IPC) clinical lead who liaised with the local infection prevention and control teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training.

The practice had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). The policy was due for review in December 2015. We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and we saw labels indicating the last testing date were displayed on equipment. We saw that a schedule of testing was in place with retests scheduled for January 2016. Records confirmed that measuring equipment used in the practice was checked and calibrated each year to ensure they were in good working order. For example, we saw that annual calibration (testing for accuracy) of relevant equipment such as weighing scales, ear syringes, nebulisers and blood pressure monitoring machines had been carried out during 2015.

Good

Are services safe?

Weobley Surgery had a range of equipment available for use, both by patients and staff. They told us they had fund raising projects in place to help with purchasing this additional equipment. For example, a number of blood pressure monitoring machines had been purchased and were available on loan to patients. There were external defibrillator machines (used to restart a person's heart) which were available in the GPs cars should they be needed in an emergency. There was a community defibrillator attached to the outside of the building for the use of the village first responder. There were audioscopes (machine to perform screening for hearing) held at both surgery sites. The use of these machines helped to reduce patient referrals to secondary care services.

Staffing and recruitment

The practice had a recruitment policy in place. Records we looked at contained evidence that the practice had followed their policy and appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). (DBS checks identify whether a person has a criminal record or is on an official list of patients' barred from working in roles where they may have contact with children or adults who may be vulnerable). The practice recruitment policy set out the standards it followed when recruiting clinical and non-clinical staff. The practice had completed risk assessments for staff where they had been required to apply for DBS checks. For example, those staff who never had unsupervised contact with patients. We spoke with staff who confirmed that all the checks had been carried out prior to their employment.

The practice had an experienced and skilled staff team with clear responsibilities and lines of accountability. The staff team were well established and many staff had worked at the practice for a number of years. Staff told us they were flexible and covered for each other and would work additional hours if required. There was a strong ethos of shared responsibility from the staff we spoke with, who recognised the difficulties that may arise as the practice covered such a large rural area. For example, staff explained the difficulties they encountered during winter weather and the strategies they had employed to ensure the practice remained staffed and that patients were cared for. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the environment, medicines management and dealing with emergencies and equipment. The practice had a health and safety policy which set out the arrangements in place to maintain a healthy and safe working environment. This included health and safety training and actions taken by the practice to control substances that are hazardous to the health of staff (COSHH). Health and safety information was also displayed for staff to see and there was an identified health and safety representative.

The practice risk log included hazards such as slips, trips and falls, work related stress and manual handling. Each identified hazard and associated risks were assessed and rated, and mitigating actions recorded to reduce and manage the risk. We saw that risks and risk assessments were reviewed and discussed at the practice team meetings.

The GPs and practice manager told us there were sufficient appointments available for high risk patients, such as patients with long term conditions, older patients and babies and young children. Patients were offered appointments that suited them, for example the same day, next day or pre-bookable appointments with their choice of GP. They told us there were registers in place for high risk patients including those with long term conditions, mental health needs, dementia and learning disabilities. The practices computer system was set up to alert staff to patients within these groups and to those adults or children who may be at risk of harm.

Staff told us they were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, staff explained how they would respond to patients who became unwell, including supporting them to access emergency care and treatment if necessary.

Good

Are services safe?

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that basic life support training had been completed by all staff including reception staff. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). There were external defibrillator machines (used to restart a person's heart) which were available in the GPs cars should they be needed in an emergency. There was a community defibrillator attached to the outside of the building for the use of the village first responder. Staff we spoke with all knew the location of this equipment and records confirmed that it was checked regularly so that it was suitable for use at all times.

There was an instant messaging system on the computers in all of the consultation and treatment rooms which alerted staff to any emergency. All staff received annual basic life support training and there were emergency medicines and equipment available in the treatment room. Emergency medicines and oxygen were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest (where the heart stops beating), a severe allergic reaction and low blood sugar. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Copies of the plan were kept in the reception area, on the practice's computer system and off site. Risks identified included power failure, loss of telephone system, loss of computer system, and loss of clinical supplies. The document also contained relevant contact details for staff to refer to which ensured the service would be maintained during any emergency or major incident.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to ensure all clinical staff were kept up to date. The practice had access to best practice guidance from NICE and used this information to develop how care and treatment was delivered to meet patients' needs. The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records. The practice nurse told us they accessed NICE guidance and actioned recommendations where these were applicable and gave us examples of changes they had made to their practice in response to this national guidance. This included for example, changes in treatment for asthma and heart conditions.

Clinicians told us and meeting minutes confirmed that patients with new cancer diagnosis were discussed at clinical meetings to ensure the appropriate care and referral pathways were followed. This ensured that there were no delays to their care and treatment.

GPs at the practice each led in specialist clinical areas such as diabetes, heart disease, chronic obstructive pulmonary disease (COPD) lung diseases and cancer. The practice nurses supported this work, which allowed the practice to focus on the specific conditions. The GPs attended educational meetings facilitated by the Clinical Commissioning Group (CCG) and engaged in annual appraisal and other educational support. For example, GPs told us they attend quarterly GP update forums and additional training opportunities at the local post graduate medical centre (PGMC).

The annual appraisal process required GPs to demonstrate that they had kept up to date with current practice, evaluated the quality of their work and gained feedback from their peers. Clinical staff told us they ensured best practice was implemented through regular training, networking with other clinical staff and regular discussions with the clinical staff team at the practice. Staff told us that GPs were very approachable and that they felt able to ask for support or advice if they felt they needed it.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that they encouraged a culture in the practice of patients cared for and treated based on need. The practice took account of patients' age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for patients

Information was routinely gathered about patients' care and treatment and monitored in order to improve patient care. Staff across the practice had key roles in monitoring and improving outcomes for patients such as data input, scheduling clinical reviews, managing child protection alerts, medicines management, prescriptions management and infection prevention and control.

There was a system in place for completing clinical audits. Clinical audits are quality improvement processes that seek to improve patient care and outcomes through systematic review of care and the implementation of change. We saw clinical audits that GPs had completed over a number of years, including four that had been completed more recently. This included audits on the prescribing of sedative medicines, a toenail surgery audit and a dementia audit. Following each clinical audit, changes to treatment or care had been made where needed to ensure outcomes for patients had improved. We saw that audit cycles had been completed following re-audits to ensure improvements were monitored and maintained.

Information collected for the Quality and Outcomes Framework (QOF), (a national performance monitoring tool) and performance against national screening programmes was used to monitor outcomes for patients. In most areas the practice had reached performance levels that were higher than the national average. For example, the number of patients with diabetes who had received their flu injection was 99% which compared with the national average of 93%. The practice had achieved 100% for their total QOF points compared with a national average of 94%.

The practice kept registers of patients identified as being at high risk of admission to hospital as well as registers of patients from vulnerable groups such as patients with a learning disability. Data showed 100% of annual reviews

Good

Are services effective?

(for example, treatment is effective)

had been carried out in the last year for these patients. The GP we spoke with told us that more time was given for review appointments to make sure there was enough time to speak with patients and explain things to them.

A palliative care register was maintained and the practice held regular multidisciplinary meetings to discuss the care and support needs of patients and their families. All patients had up to date care plans and these were shared with other providers such as the out-of-hours service. The practice provided a service for palliative care patients that was unique to Herefordshire. An on-call pager system was used by the GPs to provide individual care and support to patients in their end of life.

The practice had a proactive approach to the care of patients living with long term conditions. The practice carried out structured reviews either six monthly or annually, depending on the patient's condition. Where patients had multiple conditions they would attend the review clinics and all their conditions would be monitored at the same time to reduce the number of appointments and recalls needed.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit a year.

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also ensured that all routine health checks were completed for patients with long-term conditions, such as diabetes and that the latest prescribing guidance was being used. The computer system used at the practice flagged up relevant medicine alerts when the GP prescribed medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe these outlined the reason why they had decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

Effective staffing

Practice staffing included medical, nursing, dispensary, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with training such as annual basic life support. We noted an effective skill mix among the GPs who collectively had additional diplomas as medical education trainers, for minor surgery, diabetes and dermatology (skin). All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England). The dispensary team were responsible for the repeat prescribing service and dispensing medicines to patients who lived within the prescribing area of the practice.

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Staff confirmed that the practice was proactive in providing training and funding for relevant courses. Staff told us that they had protected time for learning and this occurred every three months when the practice was closed to facilitate this.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, on administration of vaccines, ear syringing, family planning and healthy lifestyle advice. Those with extended roles such as monitoring patients with long-term conditions which included asthma, diabetes and mental health were also able to demonstrate that they had appropriate training to fulfil these roles.

Weobley Surgery was an approved training practice for doctors who wished to be become GPs. A trainee GP is a qualified doctor who is training to become a GP through a period of working and training in a practice. Only approved training practices can employ trainee GPs and the practice must have at least one approved GP trainer. The practice was also a teaching practice and provided placements for medical students who had not yet qualified as doctors.

Working with colleagues and other services

We found the practice was exceptional in ensuring that services were tailored to meet the needs of individual

Good

Are services effective?

(for example, treatment is effective)

patients. In particular, staff were actively involved in multi-disciplinary working and delivery of care in a way that ensured flexibility, choice and continuity of care. Multidisciplinary team meetings were held monthly (or sooner if required) to discuss the needs of complex patients, for example those with end of life care needs or children who were considered to be at risk of harm. Staff also told us that these monthly meetings were attended by a district nurse, an occupational therapist, a physiotherapist and a social worker to share information or any concerns they had. Decisions about care planning were documented in patients' records. GPs told us that they worked closely with the team to make sure patients' needs were met and that important information was shared. There were also separate monthly meetings with the health visitor, and telephone conversations and discussions took place regularly in between these meetings to share information. We spoke with a member of the community team who told us they had a very good working relationship with the practice and that everyone worked very well together for the benefit of the patients.

The Herefordshire CCG locality data showed that positive outcomes were achieved for patients. For example, the practice had the lowest hospital admission rates and the second lowest attendance of accident and emergency (A&E) in the CCG area. The values were all better than the national average even though the practice had one of the highest older patient populations (aged over 65 years) at 31% compared with the national average of 16%. This practice told us this patient group may be more at risk of developing multiple health needs and the practice location was some distance from the nearest acute hospital. The practice staff felt this was a direct result of their effective systems to deliver integrated community care and case management. Feedback from patients and other health professionals we spoke with showed providing integrated care closer to the patients' homes ensured patients accessed care and treatment in a timely way and reduced the burden on hospital services.

The practice worked with other service providers to meet patients' needs and manage complex cases. It received blood test results, x-ray results and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

The practice used the Choose and Book service. This is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital. Patients were also able to book their appointments while at the practice. Staff reported that this system was easy to use.

Consent to care and treatment

We saw that the practice had a policy for documenting consent. We found that clinical staff we spoke with were aware of the Mental Capacity Act 2005 (MCA), the Children Acts 1989 and 2004 and their duties in fulfilling it. GPs told us they recorded decisions about consent and capacity in patient records and showed us an anonymised example to demonstrate this. The GPs we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance. They confirmed they accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures a patient's written consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure where applicable. We saw from the consent form used by the

Good

Are services effective?

(for example, treatment is effective)

practice that consent was obtained for permission to share information with family or carers and for student/trainee GP to sit in on sessions with patients. The clinical staff we spoke with understood the key parts of the legislation and they were able to describe to us how they implemented it in their practice. For example, staff told us that parental consent was sought prior to the administration of immunisations to children and was documented in the patient's record. We saw from training records that all clinical staff had completed training about consent.

Patients with a learning disability were supported to make decisions through the use of care plans, which they were involved in agreeing. Staff gave us examples of how a patient's best interests were taken into account if a patient did not have the capacity to make a decision. The GPs also demonstrated a clear understanding of Gillick competence. The 'Gillick Test' helps clinicians to identify children under 16 years of age who have the legal capacity to consent to medical examination and treatment. GPs confirmed that they always obtained written consent when they carried out minor surgery procedures. We saw an audit for consent for minor operations that had been carried out that confirmed that in all cases written consent had been obtained.

The manager of a local nursing home confirmed that the GPs understood the issues to be considered in respect of the MCA. They told us that GPs worked with the staff at the home to deal with issues such as consent and decisions about end of life care in a sensitive way.

Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice. GPs were informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, they promoted the benefits of childhood immunisations with parents, or carried out opportunistic medicine reviews.

A full range of immunisations were offered for children, travel vaccines (including yellow fever) and flu vaccinations in line with current national guidance. Last year's performance was above average for the majority of immunisations where comparative data was available. For example, childhood immunisation rates for the vaccinations given to under twos ranged from 95.2% to 100% comparable to the CCG average of 90.9% to 97.5%.

The practice told us they provided two Saturday morning clinics and a mop up clinic in October each year to carry out influenza vaccinations. Clinics to provide shingles vaccinations were held during February, although the vaccines were also provided for patients opportunistically.

Data showed that the practice was effective in supporting patients with diabetes to manage their health and they had low accident and emergency admission rates. For example, there was a high uptake of flu vaccines (100%) and foot examinations (96%) for diabetic patients, compared with the national averages of 93% and 88% respectively.

The practice kept a register of all patients with a learning disability and ensured that longer appointments were available for them when required. Annual health reviews were also carried out and we saw that health reviews had been completed for all nine patients with a learning disability registered with the practice.

The practice nurses carried out regular health checks of patients with range of long term conditions. They confirmed that meetings were held with the palliative care teams to ensure co-ordinated care was provided to patients that matched their needs and wishes. The practice offered a full range of immunisations for children and flu vaccinations in line with current national guidance. Clinical staff described the policy and procedure in place for following up patients who failed to attend these clinics. This was done by either the named practice nurse or the GP. The practice offered flu vaccinations to patients over the age of 65 and to patients with chronic diseases such as asthma, diabetes, heart disease, and kidney disease.

NHS Health Checks were offered to all patients aged 40-75 years of age. The NHS Health Check programme was designed to identify patients at risk of developing diseases including heart and kidney disease, stroke and diabetes over the next 10 years. GPs and clinical staff showed us how patients were followed up within two weeks if they had risk factors for disease identified at the health check and described how they scheduled further investigations. Up to date care plans were in place that were shared with other providers such as the out-of-hours provider and with multidisciplinary case management teams. Patients aged 75 years or over and patients with long term conditions were provided with a named GP.

Good

Are services effective?

(for example, treatment is effective)

Last year's performance for cervical smear uptake was 81%, which matched the national average. It was policy to offer telephone reminders for patients who had not attended for cervical smears and the practice carried out annual audits for patients who failed to attend.

We saw that a range of health promotion leaflets were available in the reception area, waiting room, treatment rooms and on the practice's website. Clinical staff we spoke with confirmed that health promotion information was available for all patients. They told us that they discussed healthy lifestyles with patients when they carried out their routine checks. Staff confirmed that patients were given information to access other services as was needed. This included clinics run by health professionals employed by other NHS organisations provided at the practice, such as mental health and dementia services, and smoking cessation advice. The practice had access to a range of support organisations that they were able to signpost patients to for further information.

Outstanding ☆

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We found there was a strong person-centred culture and staff were highly motivated to offer care that was kind and promoted patients' dignity. This was confirmed by feedback received from patients, interviews with practice staff, and health and social care professionals. We observed staff to be caring and understanding, while remaining respectful and professional.

We reviewed the most recent data available for the practice on patient satisfaction, taken from the national patient survey for 2014/2015 and complaints and compliments received by the practice. We also looked at the 11 Care Quality Commission (CQC) comment cards where patients were invited to provide us with feedback on the practice. We spoke with two patients who attended the practice during our inspection. The evidence from all these sources showed that patients were generally satisfied with how they were treated and confirmed that this was with respect, dignity and compassion.

The data available from the NHS England GP patient survey showed that the practice achieved higher than national average results generally; 94% of patients said the GP was good at listening to them which was higher than the national average of 89%; 97% said the GP they saw gave them enough time compared with the national average of 87%; and 98% said they had confidence and trust in the GP which compared with the national average of 95%.

We looked at each of the 11 comment cards completed by patients who told us what they thought about the practice. All comments were extremely positive about their experiences of the service. Comments included that the staff were very caring and always very helpful, the GPs were never in a hurry and they could not praise them highly enough, and everyone was friendly and helpful. Patients said they felt the practice offered an excellent service and that staff provided good care, were efficient and knowledgeable. Patients we spoke with were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Feedback received from two external health and social care professionals was also strongly positive in respect of the care provided to patients. For example, staff were described as treating older patients', patients' in vulnerable circumstances and those receiving end of life care in a sensitive and empathic manner.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. We saw the rooms had appropriate couches for examinations and curtains to maintain privacy and dignity during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. Staff told us that if patients wanted to speak to the receptionist or practice manager privately they would be taken to a private room. Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff.

There was information in the practice information leaflet and on the practice's website stating the practice's zero tolerance policy for abusive behaviour. Staff told us that there had been occasions when they had needed to share concerns when faced with difficult situations, but this had only been necessary on a small number of occasions. The practice manager confirmed that they or one of the GPs had responded to concerns raised by staff when difficulties arose, such as disrespectful and abusive behaviour. This had been resolved through face to face discussion with the individuals concerned.

Care planning and involvement in decisions about care and treatment

The national patient survey for 2014/2015 showed patients responded positively to questions about their involvement in planning and making decisions. For example, 90% of practice respondents said the GP involved them in decisions about their care which was higher than the national average (81%); 89% felt the GP was good at explaining treatment and results to them which was higher than the national average (81%). The proportion of

Are services caring?

respondents to the GP patient survey who stated that the nurses were good at involving them in decisions about their care was 97% which was higher than the national average (85%).

Patients we spoke with during our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff. Patient feedback on the comment cards we received was also positive and aligned with these views. Patients' commented that GPs and nurses took the time to give them the care and attention they needed, as well making sure they understood their treatment options.

The practice ensured personalised care, treatment and support was provided for patients. For example, the four care plans we reviewed showed evidence of patient involvement in agreeing these and included each patient's assessed needs, their preferences, how care would be delivered and consent about do not resuscitate decisions. We saw that care plans were in place for patients with a learning disability, and patients who were diagnosed with asthma, dementia and mental health concerns. Staff demonstrated knowledge regarding best interest decisions for patients who lacked capacity. Staff told us that they always encouraged patients to make their own decisions. They told us that they would always speak with the patient and obtain their agreement for any treatment or intervention even if they were with a carer or relative. The nurses told us that if they had concerns about a patient's ability to understand or consent to treatment, they would ask their GP to review them.

The practice was able to evidence joint working arrangements with other appropriate agencies and professionals. For example, palliative care was carried out in an integrated way. This was done using a multidisciplinary team (MDT) approach with district nurses, palliative care nurses and hospitals.

Patient/carer support to cope emotionally with care and treatment

Feedback from patients showed that they were positive about the emotional support provided by the practice. For example, one patient wrote in the comment cards that all staff were truly wonderful, they are always kind, pleasant and caring. Comments from patients we spoke with during our inspection and the comment cards we received were also consistent with this feedback. Patients told us that staff responded compassionately when they needed help and provided support when required.

From minutes of the practice's multi-disciplinary meetings we saw that all professionals were proactive in supporting population groups such as older patients', patients' experiencing poor mental health and families at risk of isolation to receive both practical and emotional support when needed. This was particularly important given the practice was located in the rural area of Herefordshire where some of its practice population lived in remote and dispersed locations. In addition, patients' aged 65 and over accounted for about 31% of the practice population, which was higher than the national average of 16%.

Notices in the patient waiting room told patients how to access a number of support groups and organisations including how to get benefits advice. This included details of various support groups and organisations for carers and families. Patients who were carers were encouraged to register so that the practice were aware of their role and could direct them to local carers' organisations for practical support and advice. The practice's computer system alerted GPs if a patient was also a carer. Information about local health and social care organisations and sources of support and guidance was available on the practice website and at the practice.

The practice also provided a carers information pack which included information on carers' assessments, where to get help and advice on carers allowance and other benefits. The pack also included contact details for Herefordshire Carers Support and an application form to register with them. A practice consent form for permission for patients' information to be shared with carers was also included in the pack. The practice told us they had 144 patients registered as carers which represented 2.5% of the practice population

Staff demonstrated an awareness of the support needs of young carers and the need to refer carers for respite through social services. One of the GPs at the practice had recently been awarded a Highly Commended in the County Carers Awards which underlined their caring approach to patients and their carers.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs of patients. The practice told us their patient population consisted of a higher number of older patients. National patient data from 2014 showed that the number of patients in the over 65 years of age population group registered with the practice was 31% compared with the national average of 16%. The population group of patients over 75 years of age registered with the practice was 13.5% compared with the national average of 8%.

The NHS area team and Clinical Commissioning Group (CCG) told us that the practice regularly engaged with them and other practices to discuss local needs and service improvements that needed to be prioritised. GPs told us they attended these quarterly meetings and shared information with practice staff where actions had been agreed to implement service improvements and manage delivery challenges to its population. The practice GPs were strongly involved and engaged with their local CCG and the Local Medical Council (LMC). They were keen to be involved in local initiatives and in sharing good practice. Two of the practices GPs were GP trainers and education leads, involved in recruiting and developing training opportunities for doctors and medical students.

We saw many examples to demonstrate that the practice engaged in promoting shared learning. For example, they were leading on trials for a standardised approach to practice nurse appraisal documentation. This documentation was to be used in the completion of appraisals towards continued professional development, leading to revalidation. The outcome of the trial was to share the documentation with all practices within the county. One of the GPs also coordinated a monthly educational evening in conjunction with a neighbouring practice. The evening was open to all local practices and consultants and other experts were invited according to learning needs identified by the group.

The practice had taken part in a pilot for a treatment approach to stroke prevention for those patients with Atrial Fibrillation (AF) (heart disease). GPs told us this was particularly relevant to their practice as Herefordshire had a large number of elderly patients potentially at high risk of strokes. This pilot offered those patients the opportunity to attend specialist clinics which were run at weekends. Each patient was given an educational package from cardiac specialist nurses and then saw a GP for an individual review to work out the best form of blood thinning prevention for them. This project was successful for the practice patients. Out of 200 patients seen by GPs, nine patients were found to be at risk and treated to minimise that risk. The programme was implemented across the whole of the county by the CCG. The practice told us the results of the programme were also published in the All Parliamentary AF group May 2015 as an example of good medical practice.

The practice had also started a heart failure pilot for those patients at increased risk (due to other diagnoses) of heart failure. This involved more intensive monitoring and treatment that included medicine optimisation to prevent deterioration and reduce the likelihood of hospitalisation for patients. At the time of the inspection outcomes of this trial were not available.

Weobley Surgery delivered core services to meet the needs of the patient population they treated. For example, screening services were in place to detect and monitor the symptoms of long term conditions such as asthma and lung disease. The practice explained they also used these sessions to give dietary advice and support for patients on how to manage their conditions. Standard appointments were scheduled for 15 minutes each but longer appointments were available for patients who needed them such as patients with mental health concerns, learning disabilities and long term conditions.

We saw that the practice had a palliative care register and regular multidisciplinary team meetings (MDTs) were held to discuss patient and their families care and support needs. We were told by staff that the MDTs worked very well as a team to provide care for all patients. The practice took a proactive approach to the needs of patients receiving palliative care and recognised that many of them wanted to receive the highest quality of care and support to enable them to die with dignity in their own home or care home. The practice operated a direct one to one on-call rota to provide individual care and support to patients in their end of life. The GPs told us they were the only practice to offer this service in Herefordshire. Records reviewed and feedback from staff and patients confirmed the positive impact of the GPs strategic role in prioritising the delivery

Are services responsive to people's needs?

(for example, to feedback?)

of high quality end of life care. They provided a positive experience for patients and their families in accessing health and social care services, as well promoting best practice within the practice and across the whole CCG area.

The practice offered proactive, personalised care to meet the needs of the older patients in its population and had a range of enhanced services. Practice nurses managed the care of patients with diabetes, asthma and lung diseases. Nationally reported data showed that the practice performed highly against indicators relating to the care of older patients. The percentage of patients diagnosed with dementia whose care has been reviewed for 2014 was 95% which compared with national rates of 83%.

The practice provided a range of services to meet the needs of patients with long term conditions. The practice was one of the highest performing practices in Herefordshire for the care for diabetic patients. The practice had 300 patients diagnosed with diabetes. A dedicated community dementia worker provided monthly clinics at the practice. There was a high uptake of flu vaccines (100% which was higher than the national average of 93%) and foot examinations (96% which was higher than the national average of 88%) for diabetic patients.

The practice operated an equipment fund that was registered with the charities commissioners and managed by a committee of patient representatives. This fund enabled the purchase of additional equipment to be used for the benefit of patients. The practice told us that they contributed to this fund-raising by asking for donations rather than charge fees for some forms they were requested to complete. The fund had enabled them to purchase and loan equipment to patients such as syringe drivers (for pain management), heart monitoring recorder to aid diagnoses, blood pressure monitoring machines, an audiometer to assess hearing, and defibrillators in all GPs cars for restarting a person's heart in an emergency. The practice explained that they covered a particularly wide rural area and patients were encouraged to contact GPs first in an emergency, as it was unlikely that a response time of less than 20 minutes by the emergency services would be attained.

Tackling inequity and promoting equality

The practice proactively removed any barriers that some patients faced in accessing or using the service. A female GP worked at the practice and was able to support patients who preferred to see a female GP. This also reduced any barriers to care and supported the equality and diversity needs of the patients.

There were arrangements in place to ensure that care and treatment was provided to patients with regard to their disability. For example, the practice building was on one level and provided easy access for patients. Doors were wide enough for patients in wheelchairs to gain access. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice.

The practice had recognised the needs of different groups in the planning of its services such as carers and vulnerable patients who were at risk of harm. The computer system used by the practice alerted GPs if patients had a learning disability, or if a patient was also a carer so that additional appointment time could be made available. Where patients were also identified as carers we saw that information was provided to ensure they understood the support that was available when needed. Staff told us that translation services were available for patients who did not have English as a first language. This service could be arranged to take place either by telephone or in person.

The practice was signed up to the learning disability direct enhanced service (DES) to provide annual health checks for their patients with a learning disability. The service looks to reduce the incidence of the presence of one or more additional disorders and premature deaths for patients' with learning disabilities. The DES is designed to encourage practices to identify patients aged 14 and over with the most complex needs and offer them an annual health check as well as a health action plan. As part of this service, the practice maintained a register of patients with learning disabilities. In 2014 there were nine patients on the register and an annual health check had been completed with all of them.

GPs also recognised they had a higher percentage of older patients registered with the practice. In order to ensure that patients' needs were being met, the practice worked in conjunction with district nurses to provide additional care and support. Weekly meetings were held with the district nursing team so they kept each other up to date with and shared information about patients registered with the

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practice. District nurses had direct access to GPs should they need support when visiting patients in the community. We were told by a member of the team that this worked exceptionally well and maintained continuity of care for patients.

The practice had a policy in place and provided equality and diversity training through e-learning. Clinical staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months. We saw records that confirmed this training had been completed. Staff were also aware that a patient may require an advocate to support them and information on advocacy services was available for patients.

Access to the service

Comprehensive information was available to patients about appointments on the practice website. This included details on how to arrange urgent appointments, home visits and how to book appointments through the practice website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. There was an answerphone message which gave the telephone number patients should ring depending on their circumstances. Information about the out-of-hours service was provided to patients in leaflets, through information displayed in the waiting room and on the practice website.

There was provision for patients with a hearing impairment at the practice. We saw signs within the waiting area to indicate a hearing loop was available; there was a screen which provided visual prompts for patients to be aware that they were being called for their appointment.

The practice was open from 8.30am to 1pm and 2.45pm to 6pm Mondays, Thursdays and Fridays and from 8.30am to 1pm on Tuesdays and Wednesdays. The practice was closed at weekends. Home visits were available for patients who were too ill to attend the practice for appointments.

Home visits were made to a local nursing home on a specific day each month by one of the GPs, with additional visits provided as requested. Longer appointments were also available for patients who needed them. This also included appointments with a named GP or nurse. There was also an online service which allowed patients to book appointments and order repeat prescriptions.

More appointments were made available, particularly for working patients. These were provided by a company that had been set up by the GPs in Herefordshire to provide additional medical services to patients. There were three primary care hubs open in the county that provided GP and practice nursing services to all Herefordshire patients during the evenings and weekends. Patients could therefore access GP and nurse appointments seven days a week from 8am and 8pm.

The 2014/2015 national patient survey results showed patients responded positively to questions about access to appointments and rated the practice highly in these areas. For example:

- 92% of respondents were able to get an appointment to see or speak to someone the last time they tried compared to the local CCG average of 89% and the national average of 85%.
- 95% of respondents find it easy to get through to this surgery by phone compared to the CCG average of 79% and the national average of 73%.
- 84% of respondents usually wait 15 minutes or less after their appointment time to be seen compared to the local CCG average of 68% and the national average of 65%.
- 91% described their experience of making an appointment as good compared to the CCG average of 79% and the national average of 73%.

Weobley Surgery treated patients of all ages and provided a range of medical services. They provided a number of clinics such as asthma, diabetes, heart disease, well woman, and child and travel immunisation clinics. Other clinics included wound dressings, removal of sutures, family planning, minor injuries and ear syringing. Other services provided by community staff within the practice included community midwifery, health visitors, community mental health, and healthy lifestyle and memory clinics.

Patients confirmed on the comment cards that they could see a GP on the same day if they needed to and they could see another GP if there was a wait to see the GP of their choice. Patients commented that they had always been able to make appointments when they were in urgent need of treatment on the same day of contacting the practice.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy and procedures

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were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We found that there was an open and transparent approach towards complaints. Accessible information was provided to help patients understand the complaints system on the practice's website and in a complaints leaflet available at the practice. The complaints leaflet included information about independent advocacy services to provide patients with support when they needed to make a complaint.

Patients told us on comment cards that they were aware of the process to follow should they wish to make a complaint. None of these patients had ever needed to make a complaint about the practice. Staff told us that they were aware of what action they would take if a patient complained. Staff confirmed that complaints were discussed at practice meetings and they were made aware of any outcomes and action plans in place to address changes needed. We saw minutes that confirmed these discussions had taken place.

We saw that the practice had recorded all complaints, including verbal and written complaints to provide a robust overview of patient concerns. All details were logged on a spreadsheet so that response progress for all complaints could be monitored. Annual audits of complaints had been carried out to identify themes or trends. The practice told us that all supervising staff had completed e-leaning training in the management of complaints. We saw records to confirm this.

We tracked three complaints and found these had been handled in accordance with the practice's policy, in a timely way with learning identified where appropriate. For example, we saw a verbal complaint had been recorded about the telephone answer machine message being incorrect on the afternoon of a practice training session. This had been investigated by the practice and the outcome recorded. We saw that a written complaint had been received in relation to a medicine reminder slip attached to the front of a prescription bag. This had been collected for the patient and personal medicine details had been visible to the collector. Written explanations had been sent to patients in response to their complaints. We saw evidence that the practice had responded to the patient's concerns appropriately and in line with their procedures, and where appropriate an apology had been made. We saw that where appropriate changes had been made to procedures to ensure the risk of further occurrences were reduced.

We saw that compliments received by the practice had been kept. Examples of some of the compliments received included a thank you for the treatment and care the practice had provided to families. Other comments included thanks to all staff for their friendly approach and willingness to listen to patients' concerns.

Are services well-led?

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(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Our findings

Vision and strategy

The practice sent us a copy of their statement of purpose prior to the inspection of the service. This told us that the aim of the practice was to provide an appropriate and rewarding healthcare experience for their patients whenever they needed their support. The practice considered their core values to be those of openness, fairness, respect and accountability. Information about their ethos was clearly explained on the practice's website.

The practice had a clear vision that had quality and safety as its top priority so as to promote good outcomes for patients. We saw positive examples of how the practice's vision and ethos were implemented by the staff team working together to maintain high standards, deliver positive health outcomes for patients and foster a supportive work environment. We saw examples of how the staff team worked together and supported each other throughout the inspection. Quality performance data showed the practice was performing exceptionally highly compared with local and national averages, achieving an overall score of 100% in 2014/2015 data year.

The practice had compiled their first business development plan in February 2015. The practice had consulted with staff and involved them in the production of the plan to focus on the developments of the practice for the next five years. This plan reviewed the current status of the practice and areas for consideration for development that they hoped to achieve by 2020. The action plan showed the steps that needed to be taken to fulfil the plan. For example, improvements in the use of information technology to enhance workflow processes, and recognition of the need to look at the way skills were utilised to achieve the best patient outcomes.

The practice acknowledged the benefit of compiling the plan and said they were pleased with the outcome. They commented that the plan gave all staff and others interested in the practice's progress a picture of what the practice was doing, and information about future changes to be made. Staff we spoke with confirmed they were aware of the business plan and that information had been shared with them.

Governance arrangements

There was clear evidence of effective and comprehensive oversight and governance of the practice. We saw a commitment to assessing and monitoring the quality of the service, taking account of the views of patients, the Clinical Commissioning Group (CCG), local and national guidance and priorities and staff feedback and ideas.

All clinical staff had lead roles and specific areas of interest and expertise. For example, there were leads for infection control, minor surgery, safeguarding, dementia and prescribing. They were engaged with the wider local medical community and attended CCG meetings and some were actively involved in the Local Medical Committee (LMC). We spoke with six members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns. Staff confirmed they had received inductions, regular performance reviews and attended staff meetings and events.

Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. The practice was proactive in identifying, recording and managing risks in a way that was consistent and robust. Records showed completed risk assessments which identified key risks, with action plans in place to manage and minimise these risks. Risks included those associated with fire, manual handling and lone workers.

The practice held regular governance meetings. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed and actions had been taken to address any required improvements.

The practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. This included using the Quality and Outcomes Framework (QOF) to measure its performance. QOF is a national performance measurement tool. The QOF data for this practice showed that in all relevant services it was performing above the national standards. We saw that QOF data was regularly discussed at weekly meetings and action taken to maintain or improve outcomes.

Policies and procedures were in place and well managed by the practice manager to govern activity and these were

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available to staff on any computer desktop within the practice. Hard copies of all policies and procedures were available to all staff at the practice and were accessible in well organised, efficiently labelled files within the practice manager's office. Staff told us they would be able to find any information easily as it was so well organised and accessible. We looked at seven of these policies and all seven policies and procedures had been reviewed annually and were up to date. The practice manager also maintained a schedule of review dates for all policies and procedures, and we could see this schedule was adhered to.

The GPs and management team took an active leadership role in assessing and monitoring the quality of service provision. They had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, audits for antibiotic and sedative prescribing. Evidence from other data from sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff.

The GP partners attended external meetings such as the CCG clinical governance meetings held every quarter and locality meetings with other GP practices within the area. The practice regularly submitted governance and performance data to the CCG.

Leadership, openness and transparency

At the start of the inspection we were given a presentation on the services provided by the practice by representatives from all teams within the practice. We observed how everyone interacted and supported each other during the practice presentation and this continued throughout the day. The atmosphere was friendly, open, supportive and welcoming.

The leadership of the practice was strong and consistent within the culture of striving for continuous improvement which was embedded in all systems and processes. The GP partners and management team had a visible presence in the practice. Responsibility for different areas was shared amongst GP partners. For example, all the partners had various lead responsibilities such as safeguarding, palliative care, business and the premises leads. Clinical staff also had lead roles such as the lead nurse for infection control. We spoke with six members of staff and they were all clear about their own roles and responsibilities.

Staff told us that the practice was well led. There were high satisfaction levels amongst the staff and a low turnover, with many of the staff members having worked at the practice for many years. Staff were positive about working at the practice which they described as patient focussed. They told us the team were close and supportive and everyone was included. They said they felt valued and that it was a great team to work with and there was a focus on good, effective team working at the practice. Staff said they could approach the GPs and management team at any time about any concern or query they had. GPs also confirmed that there was an open and transparent culture of leadership and encouragement of team working. GPs we spoke with told us that team work at the practice was one of their greatest strengths, which they referred to as the glue which kept the practice together.

We found the practice to be open and transparent and prepared to learn from incidents and near misses. Weekly practice meetings were held where these were discussed. The practice manager told us that they met with the GPs each week and information from those meetings was shared with staff.

Practice seeks and acts on feedback from its patients, the public and staff

Weobley Surgery was committed to continually improve their services by learning from and listening to their patients through feedback, taking part in local events, and patient surveys. The practice had a formed a patient participation group (PPG) early in 2015. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The initial meeting took place on 19 January 2015 and a second meeting was held on 13 April 2015. It was planned that future meetings would take place on a quarterly basis. The practice told us they were keen to develop the PPG to discuss services offered and improvements which could be made to the benefit of the practice and their patients.

We saw minutes of meetings where the PPG had met and discussed a range of topics. There was a dedicated page on the practice website for the group and minutes of the

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meetings and patient survey results were made available. Copies were also made available to patients at the practice reception. The practice also had a virtual PPG and encouraged all patients to enrol into this group.

We looked at the minutes of the meeting held in April 2015 and saw that a Message in a Bottle scheme was discussed with the intention to raise patient awareness of this. The scheme was a way of keeping personal and medical information that could be accessed quickly in an emergency. Clearly labelled plastic bottles were available in the reception areas of the practice. Each bottle contained a form and two special stickers. On the form patients could record all information that may be needed in an emergency such as name, next of kin, GP details, nature of any medical conditions, and details of medicines and dosage. Once completed this form was put back into the bottle and the bottle placed in the fridge where the emergency services would look for it if they were called to the patient's home. The emergency service would be alerted to the patient being a member of the scheme by the two stickers, one of which would be placed on the inside of the front door of their home and one on the outside of the door of the fridge. A care plan and Do Not Resuscitate (DNR) forms could also be kept in the bottle.

The practice had gathered feedback from staff through informal staff meetings and discussions. Staff confirmed this. Minutes from meetings were kept and we were able to see evidence of recent meetings between the practice manager and the GPs. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. Staff told us that they worked well together as a team and it felt more like being in a family than working with colleagues. However, if they had any concerns they confirmed that they would follow the whistleblowing policy which was available to all staff on their computers in the practice which gave them guidance to follow. Staff confirmed that they knew who to talk with in the event they had any concerns.

We saw from information recorded that the practice had responded to suggestions from staff about making alterations to the system of issuing and recording loan equipment to patients, such as blood pressure monitoring machines. We saw that the practice had responded positively to suggestions and a revised procedure had been implemented.

Management lead through learning and improvement

The practice held regular meetings that ensured continued learning and improvements for all staff. We saw minutes of staff meetings and management team meetings that showed discussions had taken place on a range of topics. This included significant events, complaints and palliative care for patients, with actions to be completed where appropriate.

The practice was able to evidence through discussion with the GPs and via documentation that there was a clear understanding among staff of safety and learning from incidents. Concerns, near misses, significant events and complaints were appropriately logged, investigated and actioned. For example, we saw that significant event reporting had been discussed at the practice meeting held on 15 April 2015. Staff we spoke with told us that there was a strong focus on learning, from practice and from each other in order to improve the services they provided for patients.

The practice told us they had a well-established staff development programme in place for all staff whatever their role. Staff told us that the practice supported them to maintain their clinical professional development through training, clinical supervision and mentoring. Staff told us that the practice was very supportive with training and that regular protected time was provided for learning. Staff told us that information and learning was shared with all staff at practice meetings. We saw evidence that protected time learning and meetings took place on a quarterly basis. Lunch time information sessions were also provided by one of the GPs for all staff to discuss topics such as new medicines, changes in practice and new guidelines.

The CCG confirmed no concerns were identified at the practice's most recent quality visit and clinical outcomes were consistently high and above CCG average. The practice volunteered for CCG pilot schemes such as the provision of intensive treatment for heart failure which resulted in positive outcomes for patients. For example, the practice told us there were high incidents of strokes in their patient population. The pilot scheme had assisted them to work in a more preventative way to reduce the risk and

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incidents of strokes. The GPs told us they found the pilots valuable in promoting a culture of continuous improvement and implementing evidence based practice in the delivery of patient care.

Weobley Surgery was a training practice for trainee GPs. A trainee GP is a qualified doctor who is training to become a GP through a period of working and training in a practice. Only approved training practices can employ trainee GPs and the practice must have at least one approved GP trainer. The practice was also a teaching practice and provided placements for medical students who had not yet qualified as doctors.