West Barnes Surgery

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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at West Barnes Surgery on 26 May 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led services. It was good at providing services for all the population groups including older people; people with long term conditions; mothers, babies, children and young people; the working age populations and those recently retired; people in vulnerable circumstances and people experiencing poor mental health.

Our key findings across all the areas we inspected were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses.
- Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

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 enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. The practice was able to give a number of examples of recently completed clinical audit cycles. Results were used to inform and drive improvements to patient treatment outcomes .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 and 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.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality. However some data from the GP patient survey showed that patients rated the practice lower than other local practices for some aspects of care. The practice were aware of this and were working with the participation group (PPG) to ensure improvements were made.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good

Summary of findings

facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?
GOOD

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff understood the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings on a regular basis

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

Good

The practice is rated as good for the care of older people.

The practice had a named GP for all patients over 75. All patients above 90 years, as well as frail patients living alone even without long term conditions received regular reviews. All patients at risk of falls and needing bone health treatment were referred for specialist care. The practice followed up older patients that were discharged from hospital following emergency admission and their care plans were constantly reviewed. Appointments were flexible to deal with emergencies and the practice had introduced a winter clinic to support older patients with emergency access. The practice arranged and held meetings with the district nurses, the end of life care team and the hospice on a regular basis.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions.

The practice offered patients diagnosed with conditions such as diabetes, epilepsy, coronary heart disease and chronic obstructive pulmonary disease (COPD) ongoing care monitoring and they had a lead GP for this. These patients were offered annual flu vaccination as per national guidance and reminders were sent for those who had not attended, this included a home visit from the GP. The practice also offered yearly holistic cancer care reviews for patients diagnosed within the past five years. The nurses offered disease management reviews and referred patients to the GPs if change of medicines was required.

Asthmatic patients had regular reviews which included checks to ensure they were using their devices according to instructions. Patients with diabetes were offered a foot assessment and referral to specialist services.

Families, children and young people

Good

GOOD

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were

Summary of findings

recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Good

GOOD

The practice is rated as good for the care of working-age people (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. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

GOOD

The practice is rated as good for the population group of people whose circumstances may make them vulnerable.

The practice had a small number of patients with learning disabilities. The practice had carried out annual health checks for people with learning disabilities and all of these patients had received a follow-up. The check also covered general health, social environment, medication review, mood and lifestyle.

Screening services such as smear testing, blood pressure monitoring and smoking cessation advice was offered. The practice offered advice on availability of HIV testing and other sexual health facilities available locally to their patients.

People experiencing poor mental health (including people with dementia)

Good

GOOD

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia)

The practice maintained a register of patients experiencing poor mental health. These patients were reviewed on a regular basis and had a named GP. Ninety per cent of people diagnosed as having mental health issues had received an annual physical health check while all patients with a diagnosed dementia had received yearly checks.

Summary of findings

Reviews involved medication, general health, and psychiatric assessment. The practice made appropriate referrals to the community psychiatric team. Leaflets were available on local services that patients could self-refer to such as “Mind”. The practice offered patients general practice services such as smear testing, breast screening and advice on prostate cancer symptoms.

Summary of findings

What people who use the service say

We spoke with 8 patients during our inspection and received 32 completed comments cards.

Patients reported being happy with the care and treatment they received. All patients we spoke with reported feeling well cared for and respected.

All respondents were complimentary about the practice with many comments referring to the helpful nature of reception staff as well as the listening skills and caring nature of clinicians at all levels. Patients reported being happy with the appointments system which they felt suited their needs.

The 2014 national GP survey published in January 2015 had a 33% completion rate for the practice. Ninety per cent of respondents said the last GP they saw or spoke to was good at listening to them, compared to a national average of 88%. Eighty-seven per cent of respondents showed the last GP they saw or spoke to was good at treating them with care and concern, compared to a national average of 84%. Ninety three percent of the respondents said the last appointment they got was convenient and 75% found the receptionists at the surgery helpful, compared to a national average of 87%. Most of the figures were above the Clinical Commissioning Group average.

West Barnes Surgery

Detailed findings

Our inspection team

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Background to West Barnes Surgery

The surgery is located in the London Borough of Kingston, and provides a general practice service to around 7600 patients. Kingston Clinical Commissioning Group (CCG) is comprised of 26 member GP practices serving a population of approximately 190,000. The CCG covers the geographical area within the boundary of the Royal Borough of Kingston upon Thames.

On average, people in Kingston have a longer life expectancy than found in England or in London

The main ethnic minority groups in the borough are Indian/ British Indian (4%), Sri Lankan (2.5%), African (2.3%) and Korean (2.2%). The practice patient population is predominantly white British and recently patients form African and East European origin. The Indices of Deprivation rank Kingston upon Thames as the third least deprived local authority in London.

The practice is located in a converted building and has been there since the 1930s.

The practice is registered as a partnership with the Care Quality Commission (CQC) to provide the regulated activities of: treatment of disease, disorder or injury; family planning services; and maternity and midwifery services at one location.

The practice has five GP partners with a good mix of female and male staff. The practice team also consists of a practice manager, one practice nurse, one health care assistant and one GP registrars. Ten administrative staff are employed at the practice .West Barnes Surgery is a GP training practice.

The practice has a General Medical Services (GMS) contract and provides a full range of essential, additional and enhanced services including maternity services, child and adult immunisations, family planning, sexual health services and minor surgery. The General Medical Services (GMS) contract is the contract between general practices and NHS England for delivering primary care services to local communities.

Detailed findings

The practice is currently open five days a week from 8:00am-19:00pm. In addition, the practice offers extended opening hours from 7:30am to 8:00am on Wednesday morning and Fridays 18:30pm until 19:40pm. Consultation times are 08:00am until 13:15pm and 14:00pm until 18:00pm. When the practice was closed, the telephone answering service directed patients to contact the out of hours provider.

There were no previous performance issues or concerns about this practice prior to our inspection.

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.

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 is 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.

This provider had been inspected before but this was not part of our new comprehensive inspection system, and as such it was re-inspected.

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 26 May 2015. During our visit we spoke with a range of staff GPs, practice nurses, practice manager, healthcare assistants and administrative staff and spoke with eight patients who used the service. We observed how people were being cared for and talked with carers and family members and reviewed the personal care or treatment records of patients. We received 32 completed comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety, such as, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example the practice had noted that patients' electronic letters from local hospital were not being received on time. Patients were bringing in their copies but GPs had not received any of the correspondences. The GP partners worked with the practice manager and identified that this was mainly due to faults with the practice's own electronic system. The error was fixed and the practice manager set up a manual system that acted as backup and ensured administrative staff checked all mail boxes regularly to ensure all correspondence from hospitals was received to ensure continuity to patients care.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last two years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of three significant events that had occurred during the last 12 months and saw this system was followed appropriately. Significant events were a standing item on the practice meeting agenda and a dedicated meeting was held once monthly to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We tracked the three incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning had been shared. For example an incident had occurred that had resulted in a patient being diagnosed with cancer of the pancreas nine weeks from the first presentation. The practice investigated this and worked with consultants from the local hospital who advised that to avoid future occurrences, GPs should consider looking for underlying causes in individuals aged 40 with newly diagnosed type 1 diabetes , such as negative antibodies as well as excessive weight loss, abdominal pain or abnormal LFTs (Liver function tests) to ensure a faster diagnosis. We found that the practice had included this in their clinical protocols.

Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

National patient safety alerts were disseminated by the GP who was the clinical lead to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for such as vaccines updates and medicines recalls. They also told us alerts were discussed at team meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action. Clinical meeting records we saw confirmed this.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. The GPs responsible for child protection had completed Level 4 and all other clinical staff had completed level 3 child protection. All administrative staff had completed Level 1 training. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed GPs as leads in safeguarding vulnerable adults and children. They had been trained and

could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with knew who these leads were and who to speak within the practice if they had a safeguarding concern.

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 children subject to child protection plans had alerts on their clinical notes to ensure clinical staff were aware of any issues. The practice also worked with other health and social care organisations to identify children with a higher than normal accident and emergency attendance rate or unexplained injuries to detect abuse or neglect. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms and on the practice web site. (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). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. 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 people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice were comparative with other practices within the Clinical Commissioning Group.

There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which included regular monitoring in accordance with national guidance. Appropriate action was taken based on the results. We checked six anonymised patient records which confirmed that the procedure was being followed.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. The health care assistants administered vaccines and other medicines using Patient Specific Directions (PSDs) that had been produced by the prescriber. We saw evidence that nurses and the health care assistant had received appropriate training and been assessed as competent to administer the medicines referred to either under a PGD or in accordance with a PSD from the prescriber. A member of the nursing staff was qualified as an independent prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed.

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. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again.

Good

Are services safe?

The practice had established a service for patients to pick up their dispensed prescriptions at a number of locations and had systems in place to monitor how these medicines were collected. They also had arrangements in place to ensure that patients collecting medicines from these locations were given all the relevant information they required.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. The practice had carried out audits for infection control with the assistance of the CCG infection control team and the new nurse in post was planning formal internal control audits in July 2015

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

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

Equipment

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 displayed stickers indicating the last testing date which was September 2014. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometers.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Newly appointed staff had this expectation written in their contracts.

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. The practice manager showed us records to demonstrate that actual staffing levels and skill mix met planned staffing requirements.

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 annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed, rated and actions recorded to reduce and

Good

Are services safe?

manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, the practice monitored repeat prescribing for people receiving medication for long term conditions. Patients who had been admitted to hospital were contacted by the practice to arrange for a follow-up appointment to fully understand any changes in need.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date. The notes of the practice's significant event meetings showed that staff had discussed a medical emergency concerning a patient and that the practice had learned from this appropriately.

Emergency medicines 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, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. 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. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed. The plan was last reviewed in November 2014.

The practice had carried out a fire risk assessment in early 2015 that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw that guidance from local commissioners was readily accessible in all the clinical and consulting rooms.

We discussed with the practice manager, GPs and nurses how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated to staff. We saw minutes of clinical meetings which showed this was then discussed and implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes were having regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to review and discuss new best practice guidelines, for example, for the management of asthmatic conditions. Our review of the clinical meeting minutes confirmed that this happened.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up by the GP practice.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had designated roles These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits and improve outcomes for patients.

The practice showed us three clinical audits that had been undertaken in the last 12 months. All of these were completed full audits where the practice was able to demonstrate the changes resulting since the initial audit. The first audit had been conducted in October 2014. The purpose was to check how well patients with asthma were managing to self-care and to check if the practice was delivering care according to guidelines including the number of patients who had received a competency check on using their devices from a professional. The audit found that 50% of patients had been assessed using the In-check device by a competent health care professional in the last year. One hundred percent of patient's inhaler technique had been assessed by a competent health care professional in the last year. One hundred percent of patients had been identified as requiring a reduction in corticosteroid dose and this had been considered at reviews. Following this audit the practice concluded that educational sessions for all health care professionals involved in asthma reviews needed to continue regularly to ensure they all provide consistent advice. All clinical rooms should have an In-check device to ensure all patients get this checked at every opportunity. The clinical lead for asthma also reviewed the asthma template and simplified it so that it prompted clinicians to consider a reduction in corticosteroid dose and allowed them to record the

Good

Are services effective?

(for example, treatment is effective)

discussion with the patient. A re- audit was carried out in March 2015 and the practice found that there was an improvement in all areas except for one over a six month period. Overall asthma care was improving with increased number of patients having annual reviews and being considered for a step down in their treatment.

Other examples included audits to confirm that the GPs who undertook minor surgical procedures, contraceptive implants and the insertion of intrauterine contraceptive devices were doing so in line with their registration and National Institute for Health and Care Excellence guidance. Nurses undertaking cervical smears also conducted audits to ensure their inadequate rates were within acceptable levels and, where needed, training was offered.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of analgesics and nonsteroidal anti-inflammatory drugs. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice to ensure it aligned with national guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes and shared this with all prescribers in the practice.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets, It achieved 98% of the total QOF target in 2014, which was above the national average of 86%.

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.

The practice's prescribing rates were similar to national figures. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check that patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GPs were prescribing medicines. We saw evidence that after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary.

The practice had made use of the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. As a consequence of staff training and better understanding of the needs of patients, the practice had increased the number of patients on the register by 10 percent over the last 12 months.

The practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups such as those with HIV, homeless, travellers and learning disabilities. Structured annual reviews were also undertaken for people with long term conditions such as Diabetes, Chronic obstructive pulmonary disease (COPD), and Heart failure. We were shown data that 95% of these had been carried out in the last year

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with mandatory courses such as annual basic life support. We noted a good skill mix among the doctors with one GP having a diploma in children's health, another with a diploma in Geriatric Medicine , four with diplomas in Obstetrics' and Gynaecology , two with diplomas in Occupational

Good

Are services effective?

(for example, treatment is effective)

Medicine and One GP with a Diploma in Diabetes .All GPs were up to date with their yearly continuing professional development requirements and all either have 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).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, in customer service care. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a GP throughout the day for support. We received positive feedback from the trainee we spoke with. One of the partners had previously been a registrar at the practice and they had found the practice to be supportive.

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 and cervical cytology. Those with extended roles such as seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles.

Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. 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 these communications. Out-of hours reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within five days of receipt. 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. There were no instances identified within the last year of any results or discharge summaries that were not followed up.

The practice held multidisciplinary team meetings every three months to discuss patients with complex needs. For example, those with multiple long term conditions, mental health problems, people from vulnerable groups, those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

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.

There was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency when referred in an emergency. The practice had also signed up to the electronic Summary Care Record and planned to have this fully operational by end of 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

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. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

Good

Are services effective?

(for example, treatment is effective)

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff. For example, with making do not attempt resuscitation orders. The policy also highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. In addition, the practice obtained written consent for significant minor procedures and all staff were clear about when to obtain written consent. We were shown an audit that confirmed the consent process for minor surgery had being followed in 100% of cases.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health Promotion & Prevention

It was practice policy to offer a health check to all new patients registering with the practice. The 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, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and 10 out of 15 were offered an annual physical health check. Practice records showed 90% had received a check up in the last 12 months. The remaining 10% had declined this check.

The practice had also identified the smoking status of 64% of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to these patients. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs. The practice also had systems for identifying 'at risk' groups so that they could offer additional support. For example, the practice aimed to follow up people who had been discharged from hospital within two days and practice records showed that this system had been successfully completed for 90% of people.

The practice's performance for cervical smear uptake was 71% for the 2013 /2014 period which was lower than other practices in the CCG. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend annually. There was a named nurse responsible for following-up patients who did not attend screening. Records we saw demonstrated that staff made all efforts possible to offer patients follow up appointments or opportunistic appointments to have their smear tests.

National screening for bowel cancer and breast cancer was managed by the local Hospital. The practice worked with the hospital to send reminder letters to patients who failed to attend screening appointments and non-responders

The practice offered a full range of immunisations for children, adults and travel, in line with current national guidance. The practice's performance on childhood immunisations during the 2013/2014 period, for children aged three months to 12 months were as follows; Dtap/IPV/Hib (Diphtheria, Tetanus, acellular pertussis (whooping cough), poliomyelitis and Hemophilus influenza type b)

Good

Are services effective?

(for example, treatment is effective)

95.9%, Meningitis C and PCV (Pneumococcal conjugate vaccine) 94% and MMR (measles, mumps, and rubella) 92%; all were above the CCG average . The practice had a clear policy for following up non-attenders by the named practice nurse and GPs. We saw records that confirmed this was being followed.

The practice offered patients a variety of health promotion leaflets. The practice nurse offered a range of health promotion clinics, including child immunisations, travel information and vaccinations, chronic disease management for asthma, diabetes, epilepsy, and HIV. Due to the high prevalence of diabetes in the local area, additional clinics were run by the nurses to manage these conditions.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The 2014 GP survey results (latest results published in Jan 2015; 367 surveys were sent out, with 120 returned giving a 33% completion rate) 90% of respondents said the last GP they saw or spoke to was good at listening to them, compared to a national average of 88% and 87% of respondents showed the last GP they saw or spoke to was good at treating them with care and concern, compared to a national average of 84%. Ninety three percent of the respondents said the last appointment they got was convenient and 75% found the receptionists at the surgery helpful, compared to a national average of 87%. Most of the figures were above the Clinical Commissioning Group average. The practice were aware of the areas they had not scored as well in and were working on improvements.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 32 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / 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. The practice switchboard was located away from the reception desk which helped keep patient information private. Seventy five percent of patients said they found the receptionists at the practice helpful compared to the CCG average of 75% and national average was 86%.

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 she would investigate these and any learning identified would be shared with staff. We were shown an example of a report on a recent incident that showed appropriate actions had been taken. There was also evidence of learning taking place as staff meeting minutes showed this has been discussed.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example 82% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85% and national average of 87%. Sixty four percent said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 70% and national average of 74%. The practice were aware of the areas they had not scored well in and were working on improvements.

Patients we spoke with on the day of 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 and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet

Good

Are services caring?

the family's needs and/or by giving them advice on how to find a support service. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's 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 in the way services were delivered. The practice was working with the CCG to identify patients who required help with weight loss and so were part of a "Get Active programme". Get Active is a structured 12-week exercise programme which is fully supported by qualified exercise referral specialists. The programme includes activities such as: one to one sessions, supervised gym workouts, group exercise classes, organized health walks, outdoor exercise sessions, women only gym and active gardening).The practice was routinely offering patients weight checks and referrals for this service where needed.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG), such as the continuous review of the appointments system.

The practice engaged regularly with the NHS England Area Team and Kingston Clinical Commissioning Group (CCG) and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where service improvements had been discussed and actions agreed in order to better meet the needs of its population.

The practice had met with the Public Health team from the local authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the population in the local area. This information was used to help focus services offered by the practice.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities and late appointments were accessible for those that attend day centres and colleges. The majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties. Facilities were on two floors but patients with mobility difficulties or the elderly were all seen on the ground floor. There were access enabled toilets and baby changing facilities.

Staff told us that they did not have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records.

There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team events.

Access to the service

The surgery was open five days a week from 8:00am-19:00pm. In addition, the practice offered extended opening hours from 7:30pm to 8:00am on Wednesday morning and Fridays 18:30pm until 19:40pm. Consultation times were 08:00am until 13:15pm and 14:00pm until 18:00pm. Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse.

Sixty one percent of respondents to the 2014 GP survey were satisfied with the practice's opening hours compared to the CCG average of 72% and national average of 75%. Sixty five percent described their experience of making an appointment as good compared to the CCG average of 67% and national average of 73 %.Seventy four percent said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 68% and national average of 65%. Sixty three percent said they could get through easily to the surgery by phone compared to the CCG average of 63% and national average of 71%.The practice were aware of the areas they had not scored as well in and were working on improvements with the help of the PPG.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could see a doctor on the same day if they felt their need was urgent although this might not be their GP of choice. They also said they could see another doctor if there was a wait to see the GP of their choice. Routine appointments were available for booking four weeks in advance. Comments received from patients also showed that patients in urgent need of treatment had often been able to make appointments 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 was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice and this was the practice manager.

We saw that information was available to help patients understand the complaints system. This was included in the practice information leaflet and displayed in the reception area. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice.

We looked at five complaints received in the last 12 months. All complaints had been dealt with in a timely manner and had been resolved. Examples of complaints received included an incident were a patient had waited for fifty five minutes to see the nurse. We saw that the practice responded by sending an apology letter to the patient and internally concluded that the reception staff should have notified all patients that the nurse was running late. We also noted all complaints had been discussed and shared with all staff at practice meetings.

The practice reviewed complaints on an annual basis to detect themes or trends. These were split into complaints relating to GPs, nursing staff, administration staff, reception and the general management of the practice. We saw that the practice manager had shared all the complaints with all staff and learning points had been identified such as training for reception staff on how to handle difficult situations.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and five year business plan. We saw evidence the strategy and business plan were regularly reviewed by the practice and also saw the practice values were clearly displayed in the waiting areas and in the staff room. The practice vision and values included to offer a friendly, caring good quality service that was accessible to all patients and to be innovative and keep abreast with new developments.

We spoke with six members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these and had been involved in developing them. We looked at minutes of the practice meetings and saw that staff had discussed and agreed that the vision and values were still current.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. However a new computer system had been introduced to the practice so most staff were still making use of manual policies and procedures. We looked at all of these policies and procedures and most staff had completed a cover sheet to confirm that they had read the policy and when. All policies and procedures we looked at had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding. 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.

The GP partners and practice manager took an active leadership role in overseeing the systems in place to monitor the quality of the service to ensure they were consistently being used and were effective. The included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice also 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 on asthma device use and minor surgery. 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 to ensure that action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the CCG.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented, for example on child protection. The practice was aware of the changes that local services were going through and for this reason they had risk assessed the need to ensure all children of concern are known and information is shared when needed and so were in touch with all local boroughs. The practice monitored risks on a monthly basis to identify any areas that needed addressing.

The practice held monthly staff meetings where governance issues were discussed. We looked at minutes from these meetings and found that performance, quality and risks had been discussed.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example disciplinary procedures, induction policy, and management of sickness which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff in the staff handbook and electronically on any computer within the practice.

Are services well-led?

Good

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

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. All staff were involved in discussions about how to run the practice and how to develop the practice: the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

We saw from minutes that team meetings were held every month. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. Staff said they felt respected, valued and supported, particularly by the partners in the practice.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), surveys and complaints received. It had an active PPG which included representatives from various population groups; including, older patients, students and working patients and the group reflected the cultural diversity of the population. The PPG had carried out quarterly surveys and met every quarter. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website.

We also saw evidence that the practice had reviewed its' results from the national GP survey to see if there were any areas that needed addressing. The practice was actively encouraging patients to be involved in shaping the service delivered at the practice.