The Pinn Medical Centre

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?	Good ●
Are services responsive to people's needs?	Outstanding ☆
Are services well-led?	Outstanding ☆

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Pinn Medical Centre on 12 July 2016. Overall the practice is rated as Outstanding.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal incidents were maximised.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice. For example, the practice carried out 'Virtual Wards' for the multidisciplinary management of patients with long term conditions and to reduce the need for admission to hospital. They also accommodated and supported outreach clinics to provide specialist care locally in the community.
- Feedback from patients about their care was consistently positive.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group. For example, the practice had introduced a flexible appointment system and diabetes clinics.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice actively reviewed complaints and how they are managed and responded to, and made improvements as a result.
- The practice had a clear vision which had quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff.
- The practice had a strong and visible clinical and managerial leadership who sought to ensure services

Summary of findings

were developed in response to patient and staff feedback. There were effective governance arrangements which focussed on delivering good quality care .

We saw several areas of outstanding practice including:

- The practice's effectiveness in managing patients conditions locally, through delivering a high level of specialist care within the GP setting through the range of specialist interests provided through the GPs, supported by hospital consultants.
- The practice had the capacity to deliver unlimited telephone consultations to support patients with minor ailments.
- The practice had a very engaged PPG which influenced practice development which allowed the practice to set up a volunteer driver service comprising of 25 drivers who supported 60 patients with mobility issues including support with shopping and a befriending service. In collaboration with the PPG, the practice held information talks and organised patient education events.

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.

- There was an effective system in place for reporting and recording significant events.
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed and well managed.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were above average compared to the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for most aspects of care.
- 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 saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Summary of findings

Are services responsive to people's needs?

Outstanding ☆

The practice is rated as outstanding for providing responsive services.

- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet patients' needs with a strong focus on keeping patients out of hospital. For example, we saw evidence of close work with local palliative care teams, geriatricians, community nurses and hospital consultants.
- There were innovative approaches to providing integrated patient-centred care. For example, practice led diabetes clinics including insulin initiation and the initiation of a new class of injected medicine for the treatment of diabetes called glucagon-like peptide 1 (GLP-1), 'Virtual Wards' to provide multidisciplinary care management of complex patients and an enhanced nursing service (Virtual Wards work just like a hospital ward using the same staffing, systems and daily routines, except the patients stay in their own homes throughout with an aim to prevent readmissions to hospital).
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group. Examples of change from patient feedback included a more flexible appointment system, diabetic clinics, an electronic prescribing system, text messaging and phlebotomy and out of hospital services such as anticoagulation, dermatology, cardiology and paediatrics.
- Patients could access appointments and services in a way and at a time that suits them. The practice was open between 8:00am and 8:00pm Monday to Sunday, 52 weeks a year and the practice was a designated walk-in centre for both registered and unregistered patients.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and patients were involved in complaints reviews.

Are services well-led?

Outstanding ☆

The practice is rated as outstanding for being well-led.

- The practice had a clear vision and strategy in place to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it. The vision was to provide high quality care in

partnership with patients through the values of listening, learning and innovating. The key focus was on providing innovative services to keep patients out of hospital and improve care closer to home.

- 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. The leadership structure was organised to support continuity of care throughout the practices opening hours 8:00am to 8:00pm daily all the year round.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- High standards were promoted and owned by all practice staff and teams worked together across all roles to deliver the practices' vision.
- There was a high level of constructive engagement with staff and a high level of staff satisfaction. The leadership acted on staff feedback.
- The practice had a very engaged patient participation group which influenced practice development in collaboration with the leadership team. This allowed the practice to set up a volunteer driver service comprising of 25 drivers who supported 60 patients with mobility issues including support with shopping and a befriending service. In collaboration with the PPG, the practice held information talks and organised patient education events.
- There was a strong focus on continuous learning and improvement at all levels to deliver the practices' vision with an aim to keep patients out of hospital and provide care and treatment in the community. Including accommodating and supporting outreach clinics, up skilling staff to provide out of hospital services and involvement in pilot schemes such as the enhanced nursing pilot to provide care for housebound older patients and 'Virtual Wards' to prevent readmission to hospital.

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 ☆

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

The practice offered proactive, personalised care to meet the needs of the older people in its population. The practice was very responsive to the needs of older people. For example:

- Home visits and longer 30 minute appointments were carried out for those with enhanced needs.
- The practice had achieved maximum Quality and Outcomes Framework (QOF) points in disease indicators commonly found in older people including heart failure, osteoporosis, palliative care and rheumatoid arthritis.
- The practice had proactively completed over 600 care plans in the previous 12 months with six month reviews (including the top 2% at risk patients). Outcomes from these included referral to care home providers and review of medication with the support of a practice employed clinical pharmacist. The clinical pharmacist monitored compliance of patients taking several medications to minimise risk and support good clinical care.
- There was an enhanced scope practice nurse dedicated and trained to support the care and management of older housebound patients with an aim to prevent unnecessary hospital admissions.
- The Practice had a GP with a Post Graduate Diploma in Cardiology supported other clinicians in the treatment and care of possible cardiology related conditions reducing unnecessary delays in treatment and hospital visits in liaison with on-site Cardiology services with Consultant cardiologists.
- One of the GP partners led a special interest clinic catering to audiology and hearing aids for this population group within the surgery.
- There was a GP with special interest in case management and care planning for older patients working at the practice and also provided support to this and other practices in the local GP network through multi-disciplinary meetings.
- The practice shared a CCG employed care navigator who collaborated with the administrative team to monitor for older patients including newly registered who were at risk of an emergency hospital admission.

Summary of findings

- The practice through its patient participation group actively supported this population group. For example, by providing 25 volunteer drivers who supported 60 frail patients with mobility issues including support with shopping, transport to practice and the local hospital.
- The practice was supported by a GP with an interest in palliative care (Macmillan GP) who specialised in supporting education, training and delivery of end of life care to patients at this stage.

People with long term conditions

Outstanding ☆

The practice is rated as outstanding for the care of people 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.
- Quality and Outcomes Framework (QOF) performance in 2014/15 for diabetes related indicators was 94% which was above the CCG average of 87% and the national average of 89%. The practice provided unpublished data for 2015/16 which showed they had achieved 100%.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines 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 ran a weekly 'virtual ward' to provide multidisciplinary care management of patients with diabetes this prevented having to refer patients to hospital. This included a weekly virtual review of all diabetic patients due a review three months ahead. The GPs and administrator then planned their care and review.
- There was a strong focus on self management of long-term conditions with all diabetes patients invited to the practice to education programs.
- The practice provided in house spirometry for patients with asthma and chronic obstructive pulmonary disorder (COPD).
- The practice nurses had received additional training to provide leg ulcer and wound management clinics which were of benefit for this population group to avoid unnecessary hospital admissions.

Summary of findings

Families, children and young people

Outstanding ☆

The practice is rated as outstanding 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 comparable to others for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals.
- The practice's uptake for the cervical screening programme was 77%, which was the same as the CCG average of 77% and comparable to the national average of 82%.
- Appointments were available outside of school hours and the premises were suitable for children and babies including breast feeding facilities.
- One of the GP Partners was a GP with specialist interest in Paediatrics who ran an on-site Paediatric clinic supported by consultant Paediatrician. He supported Practice and neighbourhood GPs in the treatment and care of children reducing unnecessary delays in treatment and hospital visits for unwell children and their parents. The GP also provided an audiology clinic to adult patients at the surgery reducing the need for unnecessary visits for hearing tests and assessment for hearing aids.
- The practice provided a full range of services to cater for this population group. These included family planning and women's health services including Hormone Replacement Therapy (HRT) and long acting contraceptives such as implants and coils.
- The GPs provided shared antenatal and postnatal care to support mothers through their pregnancy and after birth of their child.
- The in house phlebotomy service could take blood tests from children five years of age upwards.
- Regular patient education evenings were held appropriate to this population group with invited clinicians to promote self care and health awareness. Recent events included embarrassing women's problems and men's health.

Working age people (including those recently retired and students)

Outstanding ☆

The practice is rated as outstanding for the care of working age people (including those recently retired and students).

Summary of findings

- 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.
- The practice opened between 8:00am and 8:00pm, seven days a week, 52 weeks a year.
- The practice opened 12 hours a day, seven days a week, as a walk in centre for the urgent and acute needs of patients. They provided a flexible appointment system allowing patients to book an appointment over ten hours a day during weekdays, allowing working people to access their GP at times convenient to them.
- There was an automated telephone system for booking appointments that operated 24 hours a day.
- The practice was a designated walk-in centre for both registered and unregistered patients was provided throughout the practice opening hours.
- Early morning phlebotomy appointments (from 8.00am Monday to Friday) were available which was of benefit for working patients.
- The practice provided unlimited telephone consultations to support working age patients with minor ailments who could not attend the practice due to work commitments.

People whose circumstances may make them vulnerable

Outstanding ☆

The practice is rated as outstanding for the care of people whose circumstances may make them vulnerable.

- The practice held a register of patients living in vulnerable circumstances those with a learning disability.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- One of the GP partners has a special interest in drug and alcohol dependence problems and supported a small group of patients through their detoxification programme with support from the Westminster drug project.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.

Summary of findings

- Staff knew how to recognise signs of abuse in vulnerable adults and children. 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.
- The practice reviewed all children and adults on the at risk register on a quarterly basis. The meeting was attended by all GPs, senior management, community nurses and health visitors with actions recorded on the register.
- Any patient considered to be vulnerable or at risk due to a change in circumstance or new to the register was discussed at a weekly clinical meeting to share management and awareness in the whole team.
- Any patient attending the practice who had no registered GP or no fixed abode would be registered at the practice.

People experiencing poor mental health (including people with dementia)

Outstanding ☆

The practice is rated as outstanding for the care of people experiencing poor mental health (including people with dementia)

- 93% of patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months, which was above the CCG average of 86% and the national average of 84%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.
- The practice nurses had received additional training to provide depot injections of anti-psychotic medicines.

Summary of findings

What people who use the service say

The national GP patient survey results were published in January 2016. The results showed the practice was performing above local and national averages. Two hundred and fifty two survey forms were distributed and 109 were returned. This was a response rate of 43% and represented 0.5% of the practice's patient list.

- 82% of patients found it easy to get through to this practice by phone compared to the CCG average of 64% and the national average of 73%.
- 86% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 81% and the national average of 85%.
- 86% of patients described the overall experience of this GP practice as good compared to the CCG average of 79% and the national average of 85%.
- 84% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 73% and the national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received ten comment cards which were all positive about the standard of care received.

We spoke with 13 patients during the inspection. All 13 patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. The latest results from the practices friends and families test showed that out of 492 responses, 86% said they were likely or extremely likely to recommend the practice.

Areas for improvement

Outstanding practice

- The practice's effectiveness in managing patients conditions locally, through delivering a high level of specialist care within the GP setting through the range of specialist interests provided through the GPs, supported by hospital consultants.
- The practice had the capacity to deliver unlimited telephone consultations to support patients with minor ailments.
- The practice had a very engaged PPG which influenced practice development which allowed the practice to set up a volunteer driver service comprising of 25 drivers who supported 60 patients with mobility issues including support with shopping and a befriending service. In collaboration with the PPG, the practice held information talks and organised patient education events.

The Pinn Medical Centre

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 specialist adviser, a second CQC inspector and an Expert by Experience.

Background to The Pinn Medical Centre

The Pinn Medical Centre is situated at 37 Love Lane, Pinner, HA5 3EE. The practice provides NHS primary care services through a Personal Medical Services (PMS) contract to approximately 20,000 patients living in the London Borough of Harrow. The practice is part of the NHS Harrow Clinical Commissioning Group (CCG). The practice is based in a health centre that provides a range of other services.

The practice has a higher than average older population (people over 65; 18.5% vs 14.8% CCG average, people over 75; 8.9% vs 6.8% CCG average). There is also a higher than average number of children. Male life expectancy is 83.4 years and female life expectancy 88.6 years. The predominant ethnicity is Asian (30.4%) with an above average prevalence of diabetes (6.4% vs 6.2% England average) and obesity. The practice area is rated in the least deprived decile of the Index of Multiple Deprivation (IMD). People living in more deprived areas tend to have greater need for health services.

The practice is registered with the Care Quality Commission (CQC) to provide the regulated activities of diagnostic and screening procedures; treatment of disease, disorder or injury; maternity & midwifery services; surgical procedures; family planning

The practice team consists of four GP partners, three male and one female (3.5 whole time equivalent (WTE)), 14 salaried GPs (11.5 WTE), eight nurses (6.5 WTE), three healthcare assistants (2.6 WTE), a clinical pharmacist (0.5 WTE), a practice manager (1 WTE), two assistant practice managers (2 WTE) and a large team of reception / administration staff (24.5 WTE).

The practice is open between 8:00am and 8:00pm Monday to Sunday, 52 weeks a year. For registered patients appointments can be booked by phone from 8:15am to 7:30pm, seven days a week. They can also be booked 24 hours a day online or through an automated telephone system. The practice is a designated walk-in centre for both registered and unregistered patients between 8:00am and 8:00pm, seven days a week, 52 weeks a year. For out-of-hours (OOH) care patients are instructed to contact the local OOH services or alternatively the NHS 111 service.

Services provided include cervical screening, family planning, antenatal and postnatal checks, breast cancer screening, six to eight weeks baby checks, childhood immunisations, adult and travel vaccinations, minor surgery, smoking cessation advice, chronic disease clinics including insulin initiation, anticoagulation initiation and monitoring warfarin, phlebotomy, dermatology, intrauterine contraceptive devices and implants, audiology, cardiology and paediatrics services.

In addition to the services provided by the practice the health centre provides X-ray and ultrasound facilities, on-site pharmacy and dental surgery as well as a growing number of consultant led specialist clinics from local hospitals.

The Pinn Medical Centre is an accredited training practice for medical students with two GP registrars in training. Two of the GP partners are approved trainers.

Detailed findings

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. The 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.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 12 July 2016. During our visit we:

- Spoke with a range of staff (three GP partners, three practice nurses, a healthcare assistant, the practice manager and six non-clinical staff) and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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 were provided for specific groups of people and what good care looked 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).

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.

Good

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of the significant events.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, an incident we reviewed related to a patient given the incorrect dose of Zoladex (an injectable medicine used in the treatment of prostate cancer) by a clinician. A GP realised the mistake when speaking with the patient who was advised of the error and the GP immediately informed the clinician. After discussion with the member of staff it was clear that they were not aware of the usual dosing for patients starting on Zoladex. The practice took action to prevent a similar incident reoccurring by implementing nurse competency assessments as part of induction and ongoing appraisal. Learning was shared in a staff meeting.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. 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 GPs 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 on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level 3 and nursing staff to at least level 2. GPs were able to discuss several cases as examples were safeguarding aspects were proactively and duly considered and further actions taken, even when things may have not been picked up in other healthcare settings.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (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).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. A designated nurse was the infection control clinical lead who liaised with the local infection prevention 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. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. For added safety we were told that all requests for repeat prescriptions were reviewed solely by a clinician rather than being generated by the reception team. The practice carried out regular medicines audits, with the support of an in house clinical pharmacist, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. One of

the nurses had qualified as an Independent Prescriber and could therefore prescribe medicines for specific clinical conditions. She received mentorship and support from the medical staff for this extended role. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Healthcare assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber.

- We reviewed ten personnel files which included salaried and locum doctors, nurses, health care assistants and non-clinical staff and found 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.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty. The practice had a buddy system in place for all the different staffing groups to ensure continuity of care during staff sickness or leave.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care 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 keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 97% of the total number of points available with an exception reporting of 6% (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

This practice was not an outlier for any QOF (or other national) clinical targets with the exception of asthma indicators. Data from 2014/15 showed:

- Performance for diabetes related indicators was 94% which was above the CCG average of 87% and the national average of 89%.
- Performance for mental health related indicators was 92% which was in line with the CCG and the national average.
- Performance for dementia related indicators was 95% which was above the CCG average of 92% and inline with the national average.
- Performance for cancer, chronic obstructive pulmonary disorder (COPD), depression and hypertension related indicators was 100%.
- Performance for asthma related indicators was 89% which was below the CCG average of 95% and the national average of 98%.

The practice showed us unpublished QOF results from 2015/16 which demonstrated they had achieved 99.5% of the total points available and they had maximised the number of points for asthma related indicators.

There was evidence of quality improvement including clinical audit.

- There had been six clinical audits completed in the last six months, two of these were completed audits where the improvements made were implemented and monitored. For example, one of the completed audits had been carried out to ensure patients were initiated on novel oral anticoagulants (NOACs) in accordance with NICE guidance and local shared care protocols. The initial audit identified a number of areas where the practice was not meeting the required standards. The practice implemented an action plan and on re-audit it was found that standards had improved in all areas. For example the initial audit identified that 81% of patients on NOACs were prescribed it in accordance with NICE and local guidance and the re-audit showed the number had increased to 90%. The initial audit identified that 6% had documented evidence of counselling on the side effects and risks of NOACs and the re-audit showed that the number had increase to 37%.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could

Good

Are services effective?

(for example, treatment is effective)

demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.

- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.
- The GP partners in the practice had a number of specialisations including cardiology, dermatology, paediatrics, audiology and minor surgery.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs. The practice also participated in multidisciplinary team meetings (MDTs) with other local practices to share learning and case review with other GPs, social services, geriatricians and community nurses.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to the relevant service.
- A dietician was available on the premises and smoking cessation advice was available from clinical staff.

The practice's uptake for the cervical screening programme was 77%, which was the same as the CCG average of 77% and comparable to the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by ensuring a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Childhood immunisation rates for the vaccinations given were comparable to CCG and national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 68% to 89% and five year olds from 74% to 94%.

.Patients had access to appropriate health assessments and checks. These included health checks for new patients

Good

Are services effective?

(for example, treatment is effective)

and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 10 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with three members of the patient participation group (PPG). They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was generally inline or above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 90% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 88% and the national average of 89%.
- 87% of patients said the GP gave them enough time compared to the CCG average of 85% and the national average of 87%.
- 96% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.
- 85% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 83% and the national average of 85%.
- 90% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 85% and the national average of 91%.
- 93% of patients said they found the receptionists at the practice helpful compared to the CCG average of 84% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us 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 available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were generally in line with local and national averages. For example:

- 88% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85% and the national average of 86%.
- 81% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 79% and the national average of 82%.
- 77% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 79% and the national average of 85%.
- 85% of patients said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 85% and the national average of 90%.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that translation services were available for patients who did not have English as a first language.
- Information leaflets were available in easy read format.

Patient and carer support to cope emotionally with care and treatment

Good

Are services caring?

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 339 patients as carers (1.7% of the practice list). Written information was available to direct carers to the various avenues of support available to them including posters in the patient waiting room, information in the new patient pack and information in the quarterly newsletter.

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. All deaths were discussed and shared at weekly staff meetings.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice 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. For example, the practice participated in the CCG Whole Systems Integrated Care Program and a variety of out of hospital services including anticoagulation and warfarin initiation. There was a strong focus on keeping patients out of hospital and treating them in the community and this was reflected in the practice's low hospital admissions compared to other practices within their locality. This included referrals for new outpatient appointments, outpatient attendance rates and elective / non-elective admissions.

The practice was responsive to all its population groups and their needs and preferences were central to the planning and delivery of tailored services. The services were flexible, provided choice and ensured continuity of care.

- The practice opened between 8:00am and 8:00pm Monday to Sunday, 52 weeks a year which was of particular benefit for working patients and families, children and young people who could not attend during normal daytime hours.
- There were longer appointments available for patients with a learning disability and those with complex needs.
- Unlimited telephone consultations were available to support patients with minor ailments which was of particular benefit for working patients who could not attend the practice due to work commitments.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice including visits to two learning disability care homes.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- There were disabled and breast feeding facilities, a hearing loop, translation services and a Health Pod (a secure computer system which has the capability to accurately record patient data and take readings, such as weight and blood pressure measurements).
- The practice used a text messaging service for patient recalls and the notification of test results. All patients received a text message reminder of their appointments the day before.
- The practice registered patients with no registered GP or fixed abode by using the practice as their address.
- The practice had completed 600 care plans for older patients in the previous year with six month reviews (including the top 2% at risk patients). Outcomes from these included referral to care home providers and the review of medication with the support of an employed clinical pharmacist. The clinical pharmacist monitored the compliance of patients taken several medications and minimise risk to support good care.
- There was an enhanced practice nurse dedicated and trained to support the care and management of older housebound patients at risk of emergency admission to hospital. The practice had employed two additional enhanced nurses to commence employment in August 2016.
- The practice shared a CCG employed care navigator who worked with the administrative team to monitor for at risk older patients including newly registered with an aim to avoid unnecessary hospital admissions.
- A methadone (used in the treatment of drug addiction) clinic was provided in collaboration with a nurse from the Westminster drug project (a drug and alcohol charity committed to helping those who are affected by substance misuse).
- The practice employed a clinical pharmacist who carried out medicine reviews to reduce polypharmacy issues and promote better patient compliance.
- The practice supported and accommodated other services such as an in house cardiology clinic supported by a GP with Special Interest (GPwSI) in cardiology, working along with hospital consultants to avoid having to treat patients in hospital. There were additional facilities available for elctrocardiogram and blood pressure monitoring and even X-ray facilities.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

- There was a GP with special interest in case management and care planning for older patients working at the practice and also provided support to this and other practices in the local GP network through multi-disciplinary meetings.
- The practice through its patient participation group actively supported this population group. For example, by providing 25 volunteer drivers who supported 60 frail patients with mobility issues including support with shopping, transport to practice and the local hospital.
- The practice was supported by a GP with an interest in palliative care (Macmillan GP) who specialised in supporting education, training and delivery of end of life care to patients at this stage.
- There were innovative approaches to providing integrated patient-centred care. For example, practice led diabetes clinics including insulin initiation and the initiation of a new class of injected medicine for the treatment of diabetes called glucagon-like peptide 1 (GLP-1) and 'Virtual Wards' to provide multidisciplinary care management of complex patients and avoid readmissions to hospital (Virtual Wards work just like a hospital ward with the same staffing, systems and daily routines, except the patients stay in their own homes throughout with an aim to prevent unnecessary hospital admissions).

Access to the service

People could access appointments and services in a way and at a time that suited them. The practice was open between 8.00am and 8:00pm Monday to Sunday, 52 weeks a year. For registered patients appointments with the GPs and nurses could be booked by phone from 8:15am to 7:30pm daily. In addition they could be booked online or through an automated telephone system 24 hours a day. Routine appointments could be booked up to two weeks in advance to see a doctor of choice or up to three weeks in advance if the preferred doctor was one of the partners. A proportion of appointments were also available to book 48 hours in advance. In addition, urgent appointments were available for people that needed them with the on-call doctor or nurse practitioner. The practice was also a designated walk-in centre for both registered and unregistered patients between 8:00am and 8:00pm, seven days a week, 52 weeks a year.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was generally above local and national averages.

- 91% of patients were satisfied with the practice's opening hours compared to the CCG average of 73% and the national average of 76%.
- 82% of patients said they could get through easily to the practice by phone compared to the CCG average of 64% and the national average of 73%.
- 49% of patients said they usually get to see or speak to a preferred GP compared to the CCG average of 49% and the national average of 59%.
- 86% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 81% and the national average of 85%.

People told us on the day of the inspection that they were able to get appointments when they needed them.

The practice had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures 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 saw that information was available to help patients understand the complaints system including patient leaflets and information on the website.

We looked at five complaints received in the last 12 months and found they were dealt with in a timely way. Lessons were learnt from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care. For example, a complaint we reviewed involved a prescription dosage error. The complaint was investigated and was found to be a one off error and therefore no change in practice implemented. The patient received a written apology and

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

learning from the complaint shared with staff in the weekly clinical meeting. There was active review of complaints by the practice and the patient participation group (PPG) produced an annual summary of complaints.

Are services well-led?

Outstanding ☆

(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.

- The practice had a mission statement and staff knew and understood the values. The vision was to provide high quality care in partnership with patients through the values of listening, learning and innovating. The key focus was on providing innovative services to keep people out of hospital and improve care closer to home.
- The practice had a comprehensive strategy and supporting business plans which reflected the vision and values and were regularly monitored.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities which included effective team working. All GPs were attached to one of three teams led by the partners with a buddy system in place supporting continuity of care 12 hours a day, 52 weeks a year.
- Practice specific policies were implemented and were available to all staff. These were reviewed on an annual basis.
- A comprehensive understanding of the performance of the practice was maintained.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were effective arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. The leadership team in the practice had an inspiring shared purpose to respond to patients' needs and strive to deliver and motivate staff to succeed. The partners told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

The leadership was fully engaged with the local Clinical Commissioning Group (CCG). The senior partner was the CCG chair and another partner was the information technology (IT) lead for the CCG.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by management. There were consistently high levels of constructive staff engagement.

- The practice held regular team meetings. Meeting minutes we reviewed showed that meetings were structured, detailed and well attended. Meetings included a two hour weekly clinical meeting attended by all clinical staff and the practice manager. The meetings included standing agenda items and educational sessions. Other meetings included regular governance meetings, administration and reception meetings, whole practice meetings, nurse meetings and partner meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. We noted team away days were held regularly. There was high levels of staff satisfaction with all staff we interviewed. Staff were proud of the organisation as a place to work and spoke highly of the culture.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were

Are services well-led?

Outstanding ☆

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

involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service. For example, through surveys, complaints received and the patient participation group (PPG). Examples of change from patient feedback included a more flexible appointment system, diabetic clinics, an electronic prescribing system, text messaging and phlebotomy and out of hospital services such as anticoagulation, dermatology, cardiology and paediatrics.

The practice had a very engaged PPG which influenced practice development. The PPG was known as the Pinn Medical Centre Patients' Association (PMCPA). The PPG worked in partnership with the leadership team. The PPG in collaboration with the practice was active in:

- Providing 25 volunteer drivers who supported 60 patients with mobility issues including support with shopping and a befriending service.
- Communicating with patients through a quarterly newsletter distributed to 5,000 homes. The newsletter included information on staff, services and health related topics such as cancer awareness.
- Additional communication with patients through a patient website: www.pinnpatients.org
- Collaborating with the practice on information talks and organising patient education events. Recent events included; how to prevent and manage diabetes, preventing heart disease, embarrassing women's problems and men's health. A coffee morning on diabetes had also been held and a health fair to promote local health and social services.
- Conducting patient satisfaction surveys in collaboration with the practice. For example, in collaboration with the PPG the practice had conducted a nurse survey in response to below average scores from the national GP survey for nurse consultations.
- Fundraising to provide equipment not covered by the NHS including equipment to provide Out of Hospital Services. For example, ambulatory electrocardiogram (ECG) and blood pressure recorders, and an audiometer for in house hearing tests.
- Developing and supporting Patient Participation Groups across the CCG through work with the local Patient Participation Network.
- The PPG had developed a three year strategic plan to develop engagement with the patient community which aligned with the practices' vision and values.

We found there was a high level of constructive engagement with staff and a high level of staff satisfaction with all the staff we interviewed. The practice had gathered feedback from staff through staff surveys, staff meetings, appraisals and discussion. 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 to improve how the practice was run. For example, in response to staff feedback, to help them deal with phone calls efficiently, the practice had put in place telephone monitoring software. There was also a staff suggestion box for staff to feedback comments to the management team.

Continuous improvement

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and had implemented some key innovations particularly in relation to keeping people out of hospital. For example:

- Diabetes clinics including out of hospital services such as insulin initiation and the initiation of a new class of injected medicine for the treatment of diabetes called glucagon-like peptide 1 (GLP-1).
- 'Virtual Wards' to provide multidisciplinary care management of patients with long-term conditions in particular for patients over 75 years of age and those with diabetes which prevented having to refer patients to hospital with an aim to reduce the complications associated with chronic disease.
- Access to outreach clinics (clinics run by hospital doctors) for cardiology, diabetes and dietetics (the branch of knowledge concerned with the diet and its effects on health, especially with the practical application of a scientific understanding of nutrition).

Are services well-led?

Outstanding ☆

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

These were supported and accommodated by the practice and practice employed special interest GPs who worked in conjunction with the consultants in some of these clinics to avoid having to treat these patients in hospital.

- The practice provided an enhanced practice nurse service (EPN) dedicated and trained to support the care and management of patients deemed to be at high risk of an emergency hospital admission. Patients were jointly managed by the EPN and a dedicated GP to prevent unnecessary hospital admissions.
- In house cardiology clinic including resting and ambulatory electrocardiogram (ECG) and ambulatory blood pressure monitoring supported by a GP with Special Interests in Cardiology (GPwSI) in collaboration with hospital consultants. This early assessment and management reduced delays in patient care and the need for hospital visits and admissions.
- In house paediatrics, audiology and dermatology clinics supported by GPwSI's which prevented unnecessary referrals and admission to hospital.
- Nurse led leg ulcer and wound management clinics provided by nurses with additional training with an aim to avoid unnecessary hospital admissions.
- The practice employed a clinical pharmacist working with the clinical team, who monitored polypharmacy and compliance of patients taking several medications to minimise risk and support good clinical care.
- The practice was an accredited training practice for medical students with two GP registrars in training. Two of the leadership team were approved trainers.