Dr's Sidhu, Batra & Simon

Quality Report

Chancery Lane Surgery, Chapel End
Nuneaton, Warwickshire, CV10 0PB
Tel: 024 7639 4766
Website: www.chancerylane.warwickshire.nhs.uk

Date of inspection visit: 17 February 2015
Date of publication: 11/06/2015

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

Summary of this inspection

Page

Overall summary 2

The five questions we ask and what we found 3

The six population groups and what we found 5

What people who use the service say 7

Detailed findings from this inspection

Our inspection team 8

Background to Dr's Sidhu, Batra & Simon 8

Why we carried out this inspection 8

How we carried out this inspection 8

Detailed findings 10

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Dr's Sidhu, Batra and Simon (Chancery Lane Surgery) on 17 February 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also good for providing services for older people, people with long term conditions, families, children and young people, working age people (including those recently retired and students), people living in vulnerable circumstances and people experiencing poor mental health (including dementia).

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. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- 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.
- Patients said they found it easy to make an appointment with urgent appointments available the same day.
- 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

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 report incidents and near misses. The practice provided opportunities for the staff team to learn from significant events and was committed to providing a safe service. Information about safety was recorded, monitored, appropriately reviewed and addressed. The practice assessed risks to patients and managed these well. There were enough staff to keep people 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. Patients' care and treatment took account of guidelines issued by the National Institute for Health and Care Excellence (NICE). Patients' needs were assessed and care was planned and delivered in line with current legislation. The practice was proactive in the care and treatment provided for patients with long term conditions and regularly audited areas of clinical practice. There was evidence that the practice worked in partnership with other health professionals, for example, the district nursing team and community midwives. Staff received training appropriate to their roles and the practice supported and encouraged their continued learning and development.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients told us they were treated with compassion, dignity and respect and they were involved in their care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We saw that staff treated patients with kindness and respect and were aware of the importance of confidentiality. The practice provided advice, support and information to patients, particularly those with long term conditions and to families following bereavement.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice was aware of the needs of their local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice and said that urgent

Summary of findings

appointments were available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was a clear complaints system with evidence demonstrating that the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about 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 and events.

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

This practice is rated as good for the care of older patients The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services for example in avoiding unplanned admissions and providing flu vaccinations.

People with long term conditions

Good

This practice is rated as good for the care of patients with long term conditions, for example Chronic Obstructive Pulmonary Disease (COPD – the name for a collection of lung conditions), arthritis and diabetes. The practice had effective arrangements for making sure that patients with long term conditions were invited to the practice for annual reviews of their health. Clinics were held for a range of long term conditions, including those listed above. Members of the GP and nursing team at the practice ran these clinics. Patients whose health prevented them from being able to attend the surgery received the same service from one of the practice nurses as home visits were arranged. Patients told us they were seen regularly to help them manage their health.

Families, children and young people

Good

This practice is rated as good for the care of families, children and young people. The practice held weekly childhood vaccination clinics and its rates of immunisation for children was above average for the Warwickshire North Clinical Commissioning Group (CCG). Weekly antenatal, post natal and baby and children's clinics were held. The practice provided cervical screening and a family planning service.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age patients (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice provided extended opening hours on Saturday mornings for patients unable to visit the practice during the day. 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. NHS health checks were carried out for patients aged 40-75 and smoking cessation support was provided.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of patients whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for patients with a learning disability. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. 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.

People experiencing poor mental health (including people with dementia)

Good

This practice is rated as good for the care of patients experiencing poor mental health (including people with dementia). The practice had a register of patients at the practice with mental health support and care needs and invited them for annual health checks. Staff described close working relationships with the community mental health team, consultant psychiatrists and social services staff. These teams worked with the practice to identify patients' needs and to provide patients with counselling, support and information. The practice carries out dementia screening.

Summary of findings

What people who use the service say

We gathered the views of patients from the practice by looking at 24 CQC comment cards patients had filled in and by speaking with three patients in person and eight patients over the telephone on the day of our inspection. Two patients we spoke with were involved with the Patient Participation Group (PPG). The PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

The patients we spoke with were highly complimentary about Chancery Lane Surgery. Patients said GPs and practice nurses were professional and thorough at all times. Patients said clinical staff gave them the time they needed and practice staff were always friendly and helpful.

Some patients who gave us their views had been patients at the practice for many years and their comments reflected this long term experience. Data available from the 2014 national patient survey showed that the practice scored at or slightly above average within the Warwickshire North Clinical Commissioning Group (CCG) for satisfaction with the practice. For example, 72.9% of patients would recommend the practice to friends and family.

Most patients also said they were usually able to obtain appointments with ease and could usually get through to the practice on the telephone without difficulty. However, three patients we spoke with mentioned concerns about minor delays with appointment times. Some patients told us they would have no problem with recommending the practice to friends and family members.

Dr's Sidhu, Batra & Simon

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector. The inspection team also included a GP specialist advisor, a practice manager specialist advisor and an expert by experience (a person who has experience of using this particular type of service, or caring for somebody who has).

Background to Dr's Sidhu, Batra & Simon

Dr's Sidhu, Batra and Simon, known locally as Chancery Lane Surgery is located in Chapel End, a village adjoining the north-western border of Nuneaton. The practice has been at this location since 1987 and currently has approximately 5500 patients registered. It has a low patient turnover and has gained one patient and lost none within the last 12 months.

The practice is in a former coal mining area. As a result, the practice has a higher than average proportion of patients with long term medical conditions. For example, there are high rates of chronic obstructive pulmonary disease (COPD- the name for a collection of lung conditions and asthma). The area also has the highest rate of teenage pregnancies within Warwickshire. Chapel End is located next to a designated deprived area, Camp Hill in Nuneaton. This is one of the most deprived regions within Warwickshire with income deprived families more than double the national average and a high rate of unemployment. The practice has 1000 patients from the Camp Hill area.

Chancery Lane Surgery offers a range of NHS services including family planning, pre and post natal appointments, a baby clinic and phlebotomy (blood testing) service.

The practice has two male GP partners and two male locum GPs who are permanently working at the practice. One of the partners has now left the practice but at the time of our inspection was still registered as a partner GP with the Care Quality Commission (CQC). The practice has now asked CQC to remove this GPs name from their registration. The practice also has five practice nurses and a health care assistant. Two of the practice nurses are nurse prescribers, able to prescribe medicines. The clinical team are supported by a practice manager, and a team of administrative and reception staff. Although the practice did not have a female GP, we saw evidence they had formed a reciprocal arrangement with a nearby practice for patients to see a female GP there if they preferred.

A chaperone service is available patients who request the service. This is advertised throughout the practice.

The practice offers mentorship and placements to final year medical students from Oxford University and is involved in medical research in conjunction with the University of Warwick.

This was the first time the Care Quality Commission (CQC) had inspected the practice. Data we reviewed showed that the practice was achieving results that were average or in some areas slightly below average with the England or Clinical Commissioning Group in most areas.

The practice does not provide out of hours services to their own patients. Out of hours services are provided by Care UK Warwickshire which are located at George Eliot Hospital, Nuneaton. Patients can access this by using the NHS 111 phone number.

Detailed findings

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

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.

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

How we carried out this inspection

Before this inspection, we reviewed a range of information we held about Dr's Sidhu, Batra and Simon (Chancery Lane Surgery) and asked other organisations to share what they knew. These organisations included Warwickshire North Clinical Commissioning Group (CCG), NHS England area team and Healthwatch. We carried out an announced inspection on 17 February 2015. During the inspection we spoke with a range of staff (GPs, nurses, practice manager, reception and administrative staff). We spoke with 11 patients who used the service (three in person and eight over the telephone). This included two members of the Patient Participation Group (PPG). We also reviewed 24 comments cards received from patients.

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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and discussed how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where these had been discussed, for the last five years. There had been eight incidents in the last 12 months. This showed the practice had managed these consistently over time and could show evidence of a safe track record over the longer term. We saw an example of when a patient had failed to be contacted about a test result and saw that the incident had been correctly recorded and discussed with staff. The patient had also been contacted as soon as the error had been identified.

During our inspection, we were shown records that demonstrated information gained from clinical audits and health and safety audits was assessed with patient safety in mind and had been reviewed and discussed with all relevant members of staff.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last five years and we were able to review these. Significant events were discussed quarterly at practice meetings and complaints were reviewed. 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.

We were shown the system the practice used to manage and monitor incidents. We tracked four incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken when a patient who rarely attended the practice was diagnosed with a condition which had been present for some time. As a result, the practice introduced extra checks and alerts on the records of non-frequent attenders. This meant some non-frequent attenders would be invited to receive extra checks when they attended the practice. When patients had been affected by something that had gone wrong, they were given an apology and informed of the actions taken, in line with practice policy.

We saw that a parent had complained that the practice had not liaised with the health visitor about their child's care following attendance at the accident and emergency department. As a result of this, the practice introduced revised, clearer methods of liaising with the health visitor team.

We also saw when a parent complained that a member of clinical staff had not understood their concerns about their child, accident and emergency diagnosed an allergy which was referred to a health visitor for follow up. The health visitor team then contacted the practice. As a result of this, the practice introduced revised, clearer methods of liaising with other NHS organisations to ensure staff at the practice were fully aware of what should be expected and how information should be recorded within patient records.

National patient safety alerts were discussed in staff meetings with practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. For example, changes to medication for patients at risk of a stroke. Staff also told us alerts were discussed during meetings held for clinical staff to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

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. We asked members of medical, nursing and administrative staff about their 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 for relevant agencies were easily available to staff. The practice carried out regular safeguarding audits to ensure procedures and contact details were up to date. Safeguarding policies were based on those issued by

Good

Are services safe?

Warwickshire County Council. Safeguarding concerns were discussed at the monthly multi-disciplinary team meetings and GPs told us safeguarding alerts were placed on the records of vulnerable patients.

The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and children with a deputy appointed to act in their absence. They had received appropriate training. All staff we spoke with were aware who the lead was and who to speak to in the practice if they had a safeguarding concern. The lead safeguarding GP was aware of vulnerable children and adults who were registered at the practice and records demonstrated good liaison with partner agencies such as the local authority. There were regular multi-disciplinary meetings held.

There was a chaperone policy in place, which was visible on the waiting room noticeboard and in consulting rooms. We saw records that demonstrated nursing staff and some reception staff had been trained to be chaperones. Staff we spoke with understood the requirements. As the practice did not have a female GP, we asked all relevant staff about their understanding of the chaperone policy and to describe what they would do as a chaperone. All staff we asked demonstrated a thorough understanding of their responsibilities.

Systems were in place to identify potential areas of concern. For example, for clinical staff to identify children and young people with a high number of accident and emergency attendances and follow up children who failed to attend appointments such as childhood immunisations. The latter were followed up by the practice nurses.

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 clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. We saw that practice staff followed this policy.

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.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, changes to diabetes medication guidelines.

Vaccines were administered in accordance with directions that had been produced in line with legal requirements and national guidance. There was also a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. No stocks of controlled drugs were held.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. The practice had signed up to the electronic prescription service and employed a medicines co-ordinator to review prescribing within the practice.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. The practice employed its own cleaner. Patients we spoke with told us they always found the practice to be clean and tidy.

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 regular updates. We saw evidence that the lead had last carried out an infection control audit during February 2015 and they planned to repeat this in 12 months' time. The latest audit identified some minor action points. This included the need to wash mop heads after every use or use disposable ones. This had been implemented immediately.

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. They included the safe use and disposal of sharps, use of personal protective equipment (PPE), and spills of blood and bodily fluid amongst others.

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.

Good

Are services safe?

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice carried out annual checks in line with this policy to reduce the risk of infection to staff and patients. The latest legionella risk assessment had been carried out in February 2015. No actions were identified.

There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We saw evidence that their disposal was arranged through a suitable company.

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 June 2014. A schedule of testing was in place and equipment was due to be tested again in June 2015.

Staffing & Recruitment

We were shown how the practice ensured there were sufficient numbers of suitably qualified, skilled and experienced staff on duty each day. There was a staff rota throughout the week and always a member of clinical staff on duty when the practice was open. Some administrative staff were part time and able to work additional hours to provide staff cover if a staff member was unexpectedly absent. Staffing levels were reviewed on a monthly basis.

We saw how the practice had monitored their workforce and reviewed their workforce requirements to ensure sufficient staff were available to meet the needs of the population they served. Management confirmed they had sufficient staff on duty throughout the week.

We looked to see what guidance was in place for staff about expected and unexpected changing circumstances in respect of staffing. We saw a selection of policies and procedures in place, for example, staff sickness, and planned absences.

We were shown the business continuity plan which advised what to do should there be a shortage of GPs and practice staff due to sickness for example. This included arrangements for using locum GPs. This would help to ensure sufficient availability of GPs to continue the primary care service provision to patients.

The practice had a comprehensive and up-to-date recruitment policy in place. The policy detailed all the pre-employment checks to be undertaken on a successful applicant before that person could start work in the service. This included identification, references and a criminal record check with the Disclosure and Barring Service (DBS). These were checks to 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. We saw that the practice had undertaken a risk assessment to determine whether certain staff roles required a DBS check to be carried out or not.

We looked at a sample of recruitment files for GPs, administrative staff and nurses. They demonstrated that the recruitment procedure had been followed. The practice used a recruitment and induction checklist to assist with this and ensure nothing was missed.

The practice provided short term placements for final year medical students from Warwick University. They were given appropriate mentoring and support from the clinical team.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, 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 who had received appropriate training for the role.

Identified risks were included on a risk log. Each risk was assessed and rated and actions recorded to reduce and manage the risk. We saw that any risks were discussed during staff meetings.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. GPs explained how patients with long term medical conditions were monitored and appropriate alerts were placed on patients' medical records.

Good

Are services safe?

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 oxygen and an automated external defibrillator (AED). This is a portable electronic device that analysed life threatening irregularities of the heart and was able to deliver an electrical shock to attempt to restore a normal heart rhythm. When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. Staff had recently received refresher training for this. Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest and anaphylaxis (an allergic reaction). 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. Management confirmed copies of this were kept at the homes of GPs and practice management to access in the event of an emergency. Risks identified included power failure, adverse weather including flooding and access to the building. The practice had carried out a fire risk assessment in February 2014 and this was scheduled to be repeated in February 2015 after our inspection. All staff received regular fire safety training. If the practice building was unavailable, we saw arrangements were in place for the practice to use a local health centre and a local nursing home where emergency control rooms would be set up.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

Patients' needs were assessed and care and treatment was planned and delivered in line with their individual needs and preferences. All patients we spoke with were happy with the care they received and any follow-up needed once they obtained an appointment. They told us the GPs and practice staff provided high quality care.

Clinical staff managed the care and treatment of patients with long term conditions, such as diabetes, asthma and chronic obstructive pulmonary disease (COPD), the name for a collection of lung diseases including chronic bronchitis and emphysema. The practice had higher than average number of patients with this condition as it was located in former mining area. We found there were appropriate systems in place to ensure patients with long term conditions were seen on a regular basis.

We were shown action taken by the practice following concerns about patients who received blood thinning medication; a clinical audit had recently been completed for patients most at risk of a stroke. The practice reviewed a total of 76 patient records and established 27 of these did not receive blood thinning medicines. The practice arranged appointments to review the health of 11 of these patients because they were considered suitable for such medicines. Receiving blood thinning medicines had the potential to reduce the risk of these patients having a stroke by 65%.

The National Institute for Health and Care Excellence (NICE) is the organisation responsible for promoting clinical excellence and cost-effectiveness and producing and issuing clinical guidelines to ensure that every NHS patient gets fair access to quality treatment. The practice had recently changed its systems for treating patients at risk of a stroke following the introduction of new medical guidelines issued by NICE. This was carried out in conjunction with clinical audits of those patients most at risk of having a stroke.

Patients who required palliative care (palliative care is an holistic approach to care for patients with incurable illnesses and their families) were regularly reviewed. Their details were passed to the out of hours service each weekend to ensure care would continue when the practice was closed.

Staff showed us how they used the NICE templates for processes involving diagnosis and treatments of illnesses. We saw records of meetings that demonstrated revised guidelines were identified (for example with the treatment of patients at risk of a stroke) and staff were trained appropriately.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. Examples of completed clinical audits included medications for patients with osteoporosis and blood thinning medicines for patients most at risk of a stroke. We found other monitoring the practice had carried out included patients with chronic conditions, for example COPD. Some of this monitoring was carried out as part of 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 e.g. diabetes and implementing preventative measures. The results are published annually. The practice's performance was average or above average in some areas for the Warwickshire North Clinical Commissioning Group (CCG) for QOF.

The practice showed us evidence of one of their latest on-going clinical audits. This followed guidance issued by the National Osteoporosis Group that recommended patients with osteoporosis had their medication reviewed after five years. This was because it may be possible for them to have a break in their medication. Two clinical audit cycles had already been completed in October and December 2014. Patients who received repeat prescriptions for osteoporosis had their records examined. A total of 79 patients were identified in October 2014 who received such medication. Following this audit the practice had identified a number of patients whose medications were no longer necessary. The practice intends to check these patients again in April 2015

The practice was able to identify and take appropriate action on areas of concern. For example, the flu vaccination programme had a lower than average patient take up

Good

Are services effective?

(for example, treatment is effective)

during the 2014-2015 winter season. The practice intended to plan a bigger campaign during the next flu season and put an increased emphasis on the benefits of the flu vaccination.

One of the partner GPs had a particular interest and training for dementia and had worked with patients to diagnose those with dementia at an early stage. This included patients registered with the practice who lived in one of the local care homes.

The practice worked with a professor from Warwick University to promote medical research throughout the Nuneaton and Bedworth region. This has included research into early identification of bowel cancer. The practice had carried out an increased number of checks as a result and had identified patients most at risk.

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 attending courses such as annual basic life support and safeguarding. 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 had 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. Some administrative staff at the practice have completed or were currently studying for administrative apprenticeships in health and social care and business management. Nursing staff had trained for diplomas in the treatment of long term medical conditions and also prescribing. This training was supported and funded by the practice.

Practice nurses had clearly defined duties which were outlined in their job description and were able to demonstrate that they were trained to fulfil these duties. For example, in the administration of vaccines. We were shown certificates to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

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

The practice held team meetings every month to discuss concerns, for example, the needs of complex patients, those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers and palliative care nurses as appropriate and decisions about care planning were documented. Incidents and complaints were discussed at this meeting on a quarterly basis.

Clinical staff and the GP partners met regularly outside practice opening times. We saw evidence that subjects such as clinical updates and emergency admissions to hospital were discussed and actions identified. The practice had a plan in place for emergency admission avoidance. Levels of referrals to secondary health services were below the average for the CCG.

We saw records that confirmed the practice worked closely with other services. This included the community midwife service, health visitors, the community mental health team and community drug teams. Midwife clinics were held weekly and a health visitor came to the practice every two weeks. Clinics were held for blood testing, hypertension (high blood pressure), asthma and smoking cessation amongst others, to which patients were referred when appropriate.

There was a large range of information leaflets about local services in the waiting room. As almost all patients at the practice had English as a first language, no information in foreign languages was displayed, but staff told us it could be made available if required. Relevant information was also displayed on a screen within the patient waiting room.

Good

Are services effective?

(for example, treatment is effective)

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made most of its referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to the Accident and Emergency (A&E) department.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patient care. All staff were fully trained on the system.

Consent to care and treatment

There were processes to seek, record and review consent decisions. We saw the process in place to obtain signed consent forms for children before they received immunisations. The practice nurse was aware of the need for parental consent and what action to follow if a parent was unavailable. There was information available for parents informing them of potential side effects of the immunisations. The GPs and nurses that we spoke with demonstrated a clear understanding of the importance of determining if a child was Gillick competent especially when providing contraceptive advice and treatment. The Gillick test is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Staff we spoke with had an understanding of the Mental Capacity Act 2005 and demonstrated knowledge regarding best interest decisions for patients who lacked capacity. This act provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves.

The practice only had a very small number of patients who did not speak English as a first language and staff told us they came to the practice with a family member who could interpret. Staff explained they could use interpretation services to obtain patient consent if this was needed.

Health Promotion & Prevention

We saw all new patients were offered a consultation with a practice nurse or health care assistant when they first registered with the practice. If any medical concerns were found, the patient was referred to the GP or another healthcare professional if more appropriate. The practice also offered NHS health checks to all its patients aged 40-75 and advertised that all patients were entitled to a health check every three years.

The practice offered cervical screening and the practice's performance for this screening was above average compared to others in the Clinical Commissioning Group (CCG) area. They also provided cardio vascular screening to identify high blood pressure.

We were shown work the practice had carried out to identify and promote particular health needs within the area. For example, smoking cessation support and early diagnosis of COPD, due to its high level within the local community.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

All patients we spoke with and patient comment cards we received were complimentary about the care given by the practice and any follow-up needed once patients had obtained an appointment. All patients felt they were always treated with respect and dignity by all members of staff. Patients commented on how professional, friendly and helpful GPs and staff were.

During our inspection we observed within the reception area how staff and patients interacted with each other, in person and over the telephone. Staff were helpful, polite and understanding towards patients. Staff we spoke with told us patient care was the practice's top priority.

In March 2013, 150 patients completed a patient survey issued by the practice. This represented 2.7% of the patient list. Of those patients who responded 80% said they felt the practice was excellent, very good or good overall. This was below the national average measured by NHS England. The survey was carried out again in January 2015 and the results had been received, but were yet to be analysed at the time of our inspection. We saw the practice intended to put an action plan in place if this survey raised any concerns. The National Patient Survey carried out in 2014 had indicated that 79.2% of patients who responded said they would recommend the practice to friends and family members.

We saw curtains could be drawn around treatment couches in consultation rooms. This would ensure patients' privacy and dignity in the event of anyone else entering the room during treatment.

Care planning and involvement in decisions about care and treatment

We looked at patient choice and involvement. GPs explained how patients were informed before their treatment started and how they determined what support was required for patients' individual needs. Clinical staff told us they discussed any proposed changes to a patients' treatment or medication with them. Patients we spoke with confirmed this. GPs described treating patients with compassion and respect and said they kept patients fully informed during their consultations and subsequent investigations. Patients we spoke with confirmed this and told us decisions were clearly explained and options discussed when available.

Patients told us GPs and nursing staff listened to them and gave us examples of advice, care and treatment they had received. Some patients we spoke with had long term conditions and they told us they were seen regularly and patients with repeat prescriptions had their medicines reviewed on a regular basis.

Care plans were in place for patients who received home visits. This included those within the two care homes the practice served.

Patient/carer support to cope emotionally with care and treatment

We did not speak with or receive any comment cards from patients who were also carers. However the GP and staff described the support they provided for carers and links to refer patients to appropriate organisations, including a counselling service for professional support. The practice also referred patients to Independent General Health Advocacy for Warwickshire when this was felt to be beneficial. The service is open to all patients registered with a GP in Warwickshire. Information on these services was displayed in the waiting room. Information was also available about organisations specialising in providing bereavement support. After a family bereavement, all appropriate staff were informed to enable the practice to provide maximum compassion, care and support during this difficult time. Patients with learning disabilities were offered an appointment at the practice following the death of a parent to check on their welfare.

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 patients' needs and had appropriate systems in place to maintain the level of service provided. The needs of the practice population were understood, particularly within the context of the local area and systems were in place to address identified needs in the way services were delivered. For example, the practice had a register of patients with chronic obstructive pulmonary disease (COPD), the name for a collection of lung diseases, including chronic bronchitis and emphysema. The practice had higher than average number of patients with this condition as it was located in former mining area. They were regularly reviewed and clinical audits of these conditions were undertaken.

The practice planned its services carefully to meet the demand of the local population. We saw minutes of meetings that demonstrated meetings were held to discuss capacity and demand. As a result of this, changes were made to staffing and clinic times when required. GPs provided examples of how the practice responded to the needs of the local community. For example, a Saturday morning surgery had been introduced to ease pressure on appointment times during weekdays.

There was an established Patient Participation Group (PPG) in place at the practice. This was a group of patients registered with a practice who work with the practice to improve services and the quality of care.

This ensured that patients' views were included in the design and delivery of the service. We saw how the PPG played an active role and was a key part of the organisation. Regular meetings were held. We saw how the PPG had been involved with discussions to improve patient care and analyse the results of the patient survey. At the time of our inspection, the PPG was shortly to start analysing the results of the patient survey carried out in January 2015 and would be involved with any follow up needed.

Tackling inequity and promoting equality

Almost all patients who used Dr's Sidhu, Batra and Simon (Chancery Lane Surgery) spoke English as their first language. We noted that information leaflets in the practice were only available in English, but other languages could be provided if required.

The practice had an induction loop to assist people who used hearing aids and staff could also take patients into a quieter private room to aid the discussion if required. The practice was fully wheelchair accessible. This included fully accessible toilets and baby changing facilities. Health and safety risk assessments had been carried out for accessibility.

Access to the service

Appointments were available from 8.30am to 12.30pm and from 3.30pm to 6pm every weekday. There were some minor variations for some days of the week, but these were clearly displayed. The practice held a surgery every Saturday from 9am to 12pm primarily aimed at patients who worked during the week. In addition, a telephone triage system was operated for patients who could not be immediately offered same day appointments, but extra appointments were regularly slotted in when possible. When the GP called the patient back, if they decided the patient needed to be seen the same day they would be called into the practice. Outside of these times and during the weekend, an out of hours service was provided by Care UK Warwickshire and patients were advised to call the NHS 111 service to access this. This ensured patients had access to medical advice outside the practice's opening hours.

Appointments could be booked for the same day, within two weeks or further ahead. Patients could make appointments and order repeat prescriptions through an on-line service. The practice was the first practice within the Warwickshire North Clinical Commissioning Group (CCG) to offer on-line appointment booking. Home visits were available for patients who were unable to go to the practice.

In March 2013, 150 patients completed a patient survey issued by the practice. This represented 2.6% of the patient list. Of the patients surveyed, 60% were happy with the availability of appointments. This was examined again in the survey carried out in January 2015 which had yet to be analysed at the time of our inspection. Following the patient survey in March 2013, changes were made to the appointment system, the number of practice nurse sessions was increased and telephone triage was introduced. The practice planned to examine the success of these changes when they looked at the results of the January 2015 survey.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The information from CQC comment cards and patients we spoke with indicated that the service was easily accessible and that patients were usually able to get an appointment on the same day they phoned if this was needed. Two patients commented that appointments could be delayed.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. The 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. We were shown how patients' concerns were listened to and acted upon. There was information about how to complain displayed in the waiting area. All of the patients we spoke with said they had never had to raise a formal complaint. The complaints procedure identified how complaints would be dealt with. It also identified the timescales for responding to and dealing with complaints. The practice had a complaints summary which summarised the complaints for each year. This was used to identify any trends.

We looked to see whether the practice adhered to its complaints policy. During the last 12 months, four formal complaints had been received by the practice. None of these related to safety incidents. One patient complained that they had not been offered a particular vaccination when they should have been. When the practice examined this, it was discovered the consultation notes were unclear. The patient was invited into the practice within 24 hours to rectify the complaint.

We found that all complaints had been dealt with appropriately and within the timescales set out in the practice's complaints policy. Patients were given an explanation and when appropriate, an apology. The complaints policy also gave patients the opportunity to contact Healthwatch about any concerns and staff also confirmed this was the case. No patients had chosen to take up this option. It was also clear that verbal complaints were dealt with in the same way as written complaints.

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 and set of values that promoted high quality patient care and patient safety. Clinical staff explained how these aspects were prioritised throughout the practice. We spoke with two GPs and four members of staff and they all knew and understood the practice's vision and values. They recognised how they could meet them. For example, the practice had a desire to provide traditional patient centred care within the traditional ex-mining community, which was mentioned on the practice website and by one GP we spoke with. This included easy access to appointments with home visits for those unable to travel to the practice. GPs explained how they sought to achieve the best possible outcomes for patients and use the latest medical research and developments to help with achieving those goals.

In discussion with staff, it was evident that the team at the practice shared a desire to provide patients with a safe and caring service where people were treated with dignity and respect. Patients we spoke with reflected this in their comments about the practice. Staff told us the working environment within the practice was good and management and GPs were fully supportive.

The GP partners held regular partners' meetings outside of surgery opening times, to discuss important issues such as forward planning, succession planning, practice objectives and future direction and vision. The practice reviewed these objectives at staff meetings.

The practice had developed a future plan. This included identifying and tackling demands that would face the service. For example, managing an increasing patient demand, improving patient education and improving the uptake of flu vaccinations. Part of these considerations including working with or even combining with other local practices for some services if this was discovered to be beneficial for patients. Most of this planning was focussed on the next 12 months. GPs told us they wanted to now develop more detailed plans for a longer term period.

Governance Arrangements

The GP partners all had lead roles and specific areas of interest and expertise. This included governance with clearly defined lead management roles and responsibilities. During the inspection we found that all members of the team we spoke with understood these roles and responsibilities.

Dr's Sidhu, Batra and Simon (Chancery Lane Surgery) displayed an atmosphere of teamwork, support and open communication. The practice held quarterly meetings of clinical staff which included discussions about any significant event analyses (SEAs) that had been done. All of the clinical staff attended these meetings and where relevant, other staff also took part in the discussions about SEAs. This helped to make sure that learning was shared with appropriate members of the team. GPs also met regularly to discuss clinical and governance issues. Succession planning was in the process of development for GP partners as there was no immediate need. However, the GPs recognised this was one of the areas they needed to develop in the longer term plan.

The practice used information from a range of sources including their Quality and Outcomes Framework (QOF) results and the Clinical Commissioning Group (CCG) to help them assess and monitor their performance. 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, for example, diabetes and implementing preventative measures. The results were published annually. The practice's performance was average or above average in some areas for the Warwickshire North Clinical Commissioning Group (CCG) for QOF. We saw examples of completed clinical audit cycles, such as for osteoporosis medication. This demonstrated the practice reviewed and evaluated the care and treatment patients received.

Leadership, openness and transparency

The practice had two GP partners who had worked together over a number of years to provide stable leadership. A third partner had left the practice within recent months as a career development opportunity had arisen at another practice. They were supported by a practice manager who was described by clinical and other staff as playing a key role in the management of the practice. Staff told us they were well supported by GPs and the practice manager who were always approachable and open. The staff we spoke with were positive about working at Chancery Lane Surgery and told us they felt supported and cared for.

Are services well-led?

Good

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

Practice seeks and acts on feedback from users, public and staff

The practice had an established Patient Participation Group (PPG) in place. This was a group of patients registered with the practice who work with the practice to improve services and the quality of care.

This ensured patient views were included in the design and delivery of the service. We saw minutes of previous PPG meetings and saw how the PPG has been fully involved in initiatives such as increasing appointment availability and the patient satisfaction surveys.

All staff were fully involved in the running of the practice. We saw there were documented regular staff meetings. This included meetings for clinical staff and meetings that included all staff. This ensured staff were given opportunities to discuss practice issues with each other.

The practice asked patients who used the service for their views on their care and treatment and they were acted on. This included the use of surveys to gather views of patients who used the service. We saw that there were systems in place for the practice to analyse the results of the survey carried out in January 2015 so that any issues identified were addressed and discussed with all staff members. The practice had begun to promote the NHS Friends and Family Test December 2014, but had yet to analyse the results of this. This was due to be carried out after the analysis of the patient survey.

An action plan had been produced for the patient satisfaction survey that had been carried out in March 2013. This included additional appointments for GPs and practice nurses and the introduction of telephone triage. The practice was able to demonstrate an increased availability of patient appointments following this. We saw records of discussions within the minutes of staff meetings. All the patients we spoke with on the day of our inspection told us they received a high quality service from the practice. It was clear patients experienced a quality of service that met their needs.

Management lead through learning & improvement

We saw evidence that the practice was focussed on quality, improvement and learning. There was a staff development programme for all staff within the practice, whatever their role. As an example of staff learning and development, the practice had paid for practice nurses to study for diplomas in long term medical conditions and prescribing. Administrative staff had also studied for diplomas in health and social care and business management.

The whole practice team had sessions each year for 'protected learning'. This occurred for half a day each month. These half day events were organised by the CCG and attended by clinical staff from GP practices. Non clinical staff were also given the opportunity to have the same 'protected learning' training on appropriate topics. Subjects such as advances in diabetes diagnosis and treatment had been covered. GP's told us how the practice prioritised these learning times and through its relationship with the University of Warwick had enabled mentoring staff to attend relevant sessions to further share best practice.

One of the partner GPs is on the board of the Warwickshire North Clinical Commissioning Group (CCG) and the practice manager is the practice manager lead on the CCG board. This enabled the practice to be at the forefront of developments within the CCG and the wider local health economy. This had included a pilot scheme run in conjunction with a local care home for a discharge to care home plan from George Eliot Hospital, Nuneaton. One of the aims of this scheme was to ensure patients did not stay in hospital longer than they needed to.

The results of significant event analyses and clinical audit cycles were used to monitor performance and contribute to staff learning.