

Dr Prakashchandra Jain

Quality Report

The Surgery
2 Parklands Drive
Askam in Furness
Cumbria
LA16 7JP
Tel: 01229 462464
Website:

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

Ratings

Overall rating for this service

Good



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of Dr P Jain's Practice on 27 May 2015.

Overall, we rated the practice as good. We found the practice to be good for providing, effective, caring, responsive and well-led services. We also found the practice requires improvement for providing safe services. Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Staff reported feeling able to voice any concerns or make suggestions for improvement
- Health and Safety risks to patients and staff were not always regularly assessed or well managed.
- The practice learned from incidents and took action to prevent any recurrence.

- Patients' needs were assessed and care was planned and delivered following best practice guidance. Feedback from patients was positive; they told us staff treated them with respect and kindness.
- Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Information about services and how to complain was available and easy to understand.
- The practice offered an open access service. All patients who attended the surgery were seen the same day. In addition patients who were unable for clinical reasons to attend the surgery but telephoned for an appointment were also seen on the same day.
- Patients said they found it easy to make an appointment with the GP and nurse and there was continuity of care.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- There was a clear leadership structure and staff felt supported by management.

However, there were also areas of practice where the provider needs to make improvements.

Importantly, the provider must:

- Ensure all staff have received annual fire training and that a record of fire drills and fire alarm testing is maintained. Ensure that effective fire risk assessments are undertaken in accordance with the regulations.
- Ensure that the practice has an adequate supply of emergency oxygen at the premises and staff are appropriately trained to administer it.
- Arrange for the testing of their portable electrical equipment.
- Ensure the testing (or risk assessment) for the presence of legionella is undertaken.

- Ensure effective infection control audits are undertaken at appropriate intervals and that any concerns are addressed.

In addition the provider should:

- Introduce management systems to ensure records are maintained which ensure policies and procedures are regularly reviewed, up dated and shared with staff.
- Introduce a system to ensure that there is a record of all discussions with staff about risks and significant events.
- Ensure systems are in place to obtain patients views and feedback including reviewing the use of a patient participation group.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as requires improvement for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated to relevant staff to support improvement.

The GP received all alerts and took the appropriate action to comply with the alert and advised relevant staff. The alerts were either stored as a hard copy or electronically on the practice computer system for future reference.

The staff we spoke with had a good knowledge and understanding of the safeguarding procedures and what action should be taken if abuse was witnessed or suspected.

The practice had a process to highlight vulnerable patients on their computerised records system. This information would be flagged up on patient records when they attended any appointments so that staff were aware of any issues.

Prescriptions were stored in a lockable room and only accessible to authorised staff.

There was no evidence of regular infection control audits having been undertaken.

The practice had not undertaken all necessary health and safety measures to protect patients and staff such as the testing of water systems for legionella contamination, portable appliance testing and ensuring all staff had attended fire safety training. Emergency oxygen was not available at the practice

Requires improvement



Are services effective?

The practice is rated as good for providing effective services. Care and treatment was being delivered in line with current published best practice. They used the data from the Quality Outcomes Framework (QOF) to assess how the practice was performing. For 2014 the practice achieved an overall total score of 93.8% which was 1.1% below the local CCG average, but 0.3% above the England average.

The practice had processes in place to ensure current guidance was being followed. They used the data from the QOF to assess how they were performing following the current guidance. The practice was aware of their achievements in comparison to other local practices and nationally. The QOF data showed the practice achieved overall scores above the local CCG and England averages

Good



Summary of findings

in respect of 15 of the 20 clinical areas reported on. In respect of the other five areas the practice was below the local CCG and England averages. For example, the overall individual score for epilepsy was 100% which was above the local CCG average by 5.5% and 10.6% above the England average. The individual score for peripheral arterial disease was below the local CCG average by 1.7% and 1.2% below the England average.

Patients' needs were being met and referrals to other services were made in a timely manner. The practice regularly undertook two cycle clinical audits. The GP discussed the outcomes and learning from the audits with the nurse and dispensing staff as appropriate.

Are services caring?

The practice is rated as good for providing caring services. We spoke with four patients during our inspection. They were very complimentary about the services they received. Comments left by patients on the 33 CQC comment cards we received also reflected this.

We looked at data from the National GP Patient Survey, published in January 2015. The results showed that patients who responded were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, 99% of patients who responded to the survey said they thought their overall experience was good, compared to the local CCG average of 88.4% and the England average 85%. We saw 98.4% of patients who responded said they had confidence and trust in their GP, compared to the local CCG average of 93.5% and the England average of 91.8% and 87.2% said their GP was good at treating them with care and concern, compared to the local CCG average of 85.6% and the England average of 82.7%.

Accessible information was provided to help patients understand the care available to them. We also saw staff treated patients with kindness and respect ensuring confidentiality was maintained.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services. All patients said they found it easy to make an appointment with a GP; there was continuity of care and urgent appointments available on the same day.

Patients we spoke with commented on the open access appointments system. They said they were satisfied with the appointment system operated by the practice. They commented it was easy to get an appointment. This was reflected in the results of the most recent National GP Patient Survey (2015). This showed 100% of respondents described their experience of making an

Good



Summary of findings

appointment as 'very good' or 'fairly good', in comparison to the local CCG average of 78.6% and the England average of 73.8% and 100% said the last appointment they got was 'convenient for them', in comparison to the local CCG average of 93.1% and the England average of 91.8%.

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.

Are services well-led?

The practice was rated as requires improvement for well-led. The practice had a clear mission statement which was, 'The only purpose we have is the welfare of our patients.' The staff we spoke with all knew and understood the vision and values and what their responsibilities were in relation to these.

The practice did not have a patient participation group (PPG) but were considering forming one. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

The GP and staff told us they were in continuous dialogue with each other on a daily basis about practice issues and patients. However, there were no independent management records kept of important discussions about practice issues neither where there any dedicated staff meetings.

Good



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

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

Nationally reported data showed outcomes for patients were good for conditions commonly found in older people. They offered proactive, personalised care to meet the needs of the older people in its population. For example, all patients over the age of 75 had a named GP. Patients at high risk of hospital admission had care plans. The practice was responsive to the needs of older people, including offering home visits.

The practice maintained a palliative care register and offered immunisations for pneumonia and shingles to older people.

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions.

The practice had systems to ensure care was tailored to patients' individual needs and circumstances. We spoke with the GP and nurse who told us regular patient care reviews, for example for patients with chronic obstructive pulmonary disease (COPD - severe shortness of breath caused by chronic bronchitis, emphysema, or both) or asthmatic conditions, took place. Nationally reported data showed the outcomes were good for patients with long-term conditions. For example, for patients with COPD who had been reviewed by a health care professional in the preceding 12 months the practice achieved 100% which was 8.8% above the local CCG average and 10.4% above the England average. For patients with asthma who had an asthma review in the preceding 12 months the practice achieved 78.7% which was 3.4% above the local CCG average and 3.2% above the England average.

The practice ensured timely follow-up of patients with long-term conditions by adding them to the practice registers. Patients were then recalled as appropriate, in line with agreed recall intervals.

Good



Families, children and young people

The practice is rated as good for the care of families, children and young people.

The practice provided antenatal clinics on Mondays by appointment. The practice operated an open access service and all patients who attended the practice were seen on the day. Appointments were available outside of school hours. The premises were suitable for children and babies. Arrangements had been made

Good



Summary of findings

for new babies to receive the immunisations they needed. Childhood immunisation rates were in line with or slightly above averages for the local Clinical Commissioning Group (CCG). For example, MMR vaccination rates for two year old children were 100% compared to 96.4% across the local CCG; and MMR dose 2 rates for five year old children were 78.9% compared to 70.1% across the local CCG.

Working age people (including those recently retired and students)

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

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, they offered open access appointments. All patients who attended the practice were seen on the day.

Cervical screening rates for women aged 25-64 were 89.7%, which was above the local CCG average by 6.9% and above the England average by 7.8%.

For caring for patients with hypertension (high blood pressure) the practice achieved an overall score of 96% which was 7.9% higher than the local CCG average and 7.6% above the England average.

Good



People whose circumstances may make them vulnerable

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

Systems were in place to identify patients, families and children who were at risk or vulnerable. The practice worked in collaboration with other agencies, for example, health visitors and district nurses, to ensure vulnerable families and children and other patients were safe.

The practice maintained a register of patients with learning difficulties.

The practice sign-posted vulnerable patients to various support groups and other relevant organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children and were aware of their responsibilities to ensure they were safeguarded.

Good



People experiencing poor mental health (including people with dementia)

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

Good



Summary of findings

For patients experiencing poor mental health national reported data showed the practice achieved an overall score of 100% for providing care to these patients, which was 8.8% above the local CCG average and above the England average by 9.6%. For patients with dementia the practice achieved 100% for providing care to these patients, which was 4.4% above the local CCG average and above the England average by 6.6%.

The practice worked with patients experiencing poor mental health and provided personalised support.

Summary of findings

What people who use the service say

We spoke with four patients during our inspection. They told us the staff who worked there were caring and understanding, and there were no problems getting appointments. They also told us they found the premises to be clean and tidy.

We reviewed 33 CQC comment cards which had been completed by patients prior to our inspection. All were very complimentary about the practice, staff who worked there and the quality of service and care provided.

The latest National GP Patient Survey published in January 2015 showed the majority of patients who responded were satisfied with the services the practice offered. The results were:

- 86.3% of patients who responded said they would recommend their GP surgery, compared to the local CCG average of 80.5% and the England average of 78%;

- 98.7% of patients who responded said they were 'fairly satisfied' or 'satisfied' with the opening hours, compared to the local CCG average of 79.7% and the England average of 75.7%;
- 88.9% of patients who responded said it was 'very easy' or 'easy' to get through on the telephone, compared to the local CCG average of 77.7% and the England average of 77.8%;
- 100% of patients who responded said their experience of making an appointment was 'fairly good' or 'very good', compared to the local CCG average of 78.6% and the England average of 73.8%;
- 99% of patients who responded said their practice was 'fairly good' or 'very good', compared to the local CCG average of 88.4% and the England average of 85%.

These results were based on 111 surveys were returned from a total of 279 sent out; a response rate of 39.8%.

Areas for improvement

Action the service **MUST** take to improve

- Ensure all staff have received annual fire training. Ensure a record of fire drills and fire alarm testing is maintained.
- Ensure that the practice has an adequate supply of emergency oxygen at the premises and staff are appropriately trained to administer it.
- Ensure that effective fire risk assessments are undertaken in accordance with the regulations.
- Arrange for the testing of their portable electrical equipment.
- Ensure the testing (or risk assessment) for the presence of legionella is undertaken.

- Ensure effective infection control audits are undertaken at appropriate intervals and that any concerns are addressed.

Action the service **SHOULD** take to improve

- Introduce management systems to ensure records are maintained which ensure policies and procedures are regularly reviewed, up dated and shared with staff.
- Introduce a system to ensure that there is a record of all discussions with staff about risks and significant events.
- Ensure systems are in place to obtain patients views and feedback including reviewing the use of a patient participation group.

Dr Prakashchandra Jain

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team also included a GP specialist advisor.

Background to Dr Prakashchandra Jain

Dr Prakashchandra Jain's Practice provides services to 1,593 patients, from The Surgery, 2 Parklands Drive, Askam in Furness, Cumbria, LA16 7JP. The practice provides their services under a NHS General Medical Services (GMS) contract to patients in their catchment area, post code LA16. The practice also dispenses medication to their patients.

The practice is located in a single storey building. It also offers a disabled WC, wheelchair and step-free access. There is a car par at the rear of the premises.

This is a single handed practice run by the GP. There is no practice manager. There is a practice nurse and three receptionists/dispensers and a medicines manager.

The practice offers its services throughout the core hours of 8am to 6.30pm Monday to Friday. The opening hours for the practice are 9am to 6pm Monday, Tuesday, Thursday and Friday. For the periods between 8am to 9am (including Wednesdays) and 6pm to 6.30pm calls are taken by the receptionist who then contacts the GP to respond. On Wednesdays the practice is open 9am to 11.30am. For the period 11.30am to 6.30pm calls are directed the GP to respond to. The GP offers open access consultations between 10am to 11am Monday to Friday and 5pm to 6pm Mondays, Tuesdays, Thursdays and Fridays.

Routine appointments with the nurse are available between 9am to 5pm Monday and Thursday and 2pm to 5pm on Tuesdays.

The service for patients requiring urgent medical attention out of hours is provided through the 111 service and Cumbria Health on Call between 6.30pm and 8am Monday to Friday.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme.

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 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 the time.

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?

Detailed findings

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

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

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

Before visiting we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. This included the local Clinical Commissioning Group (CCG). This information did not highlight any areas of risk across the five key question areas.

We carried out an announced visit on 27 May 2015. We spoke with four patients. We also spoke with the GP, a nurse two reception/dispensing staff. We observed how staff received patients as they arrived at or telephoned the practice and how staff spoke with them. We reviewed 33 CQC comment cards where patients and members of the public had shared their views and experiences of the service. We also looked at records the practice maintained in relation to the provision of services.

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. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

The practice had a record of significant events and incidents, however there were no records of significant events occurring in the last 12 months.

Patients we spoke with said they felt safe when they came into the practice to attend their appointments. Comments from patients who completed CQC comment cards were complimentary about the service they had received and raised no concerns about their safety.

Learning and improvement from safety incidents

The practice was open and transparent when there were 'near misses' or when things went wrong. There was a system in place for reporting, recording and monitoring significant events and incidents. We saw an example of where the practice had raised a concern with a local hospital. The practice received a letter from the hospital which contained information concerning a different patient. The practice advised the hospital of their error and destroyed the letter to avoid any confusion.

We discussed the process for dealing with safety alerts with the GP. Safety alerts inform the practice of problems with equipment or medicines or give guidance on clinical practice. The GP received all alerts and took the appropriate action to comply with the alert and advised relevant staff. The alerts were either stored as a hard copy or electronically on the practice computer system for future reference and audit purposes.

Reliable safety systems and processes including safeguarding

We saw the practice had safeguarding policies in place for both children and vulnerable adults. This included a contact list of other agencies that may need to be informed when concerns arise such as the local police and Social Services.

The GP was the safeguarding lead for both children and adults with responsibilities for overseeing safeguarding within the practice. We saw that the GP had been trained to Level 3 in respect of safeguarding children. We saw training records that confirmed all staff had received training in safeguarding adults and children. The staff we spoke with had a good knowledge and understanding of the safeguarding procedures and what action should be taken if abuse was witnessed or suspected.

The practice had a process to highlight vulnerable patients on their computerised records system. This information would be flagged up on patient records when they attended any appointments so that staff were aware of any issues.

The practice had a chaperone policy. There were notices on display in the waiting area to inform patients of the availability of chaperones. The nurse is the chaperone at the practice. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure.) The nurse had been checked by the Disclosure and Barring Service (DBS). The DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

Medicines management

We checked vaccines stored in the medicine refrigerator. We found they were stored securely and were only accessible to authorised staff. Maximum and minimum temperatures of the vaccine refrigerators were monitored daily. We saw records of these checks for the period January 2015 to May 2015. Vaccines were administered by nurses using patient group directions (PGDs) and patient specific directions (PSDs). PGDs and PSDs are specific guidance on the administration of medicines authorising nurses and health care assistants to administer them.

Prescriptions were stored in a lockable room and only accessible to authorised staff. The GP kept a record the batch numbers of prescriptions received and those prescriptions the GP had taken for use on home visits which we saw.

We saw the practice had a safe system for dealing with repeat prescriptions and other medication requests. The two dispensing staff we spoke with told us the GP would complete the prescription request and label electronically

Are services safe?

and send them to the dispensers to action. This system provided a clear audit of what had been prescribed by the GP. The dispensers would prepare the prescriptions and check each other's work before packaging the prescriptions ready for collection. The prescriptions were stored ready for the GP's signature at the end of the day.

The GP managed the dispensary and was supported by a part time medicines manager. The GP told us, and this was confirmed by the dispensers, that if the dispensers had any concerns about the prescriptions they would advise the GP before dispensing any medication. In addition the dispensing staff told us they would also raise any issues or concerns with the medicines manager. We spoke to the medicines manager over the telephone who confirmed this and stated they had a good working relationship with the dispensers. We saw the dispensary had the latest version (2015) of the standard operating procedures the practice produced which governed the dispensing of medicines.

The dispensing staff told us they did not prepare any medicines. All medicines they dispensed were pre-prepared and packaged by the manufacturers ready for dispensing. They also told us they regularly undertook a stock rotation to ensure the medication they dispensed was within the manufacture's expiry dates. The sample we looked at were all within the manufacture's expiry dates.

We saw controlled drugs were stored securely. The dispensing staff told us the practice did not keep a stock of controlled drugs. They only stored ones that had been prescribed, specifically ordered and were ready to be dispensed. This was confirmed when we checked the medication within the controlled drugs cupboard.

The practice participated in the Dispensing Service Quality Scheme (DSQS) which rewards practices for providing high quality services to their dispensing patients by for example having in place qualified dispensing staff and standard operating procedures to be followed and regularly reviewed.

The dispensing staff acted under the supervision of the GP.

Cleanliness and infection control

The practice was clean and tidy. The patients we spoke with about the cleanliness of the practice told us that it was always clean and tidy.

The GP was the lead for infection control. They showed us a copy of the last infection control audit which had been

undertaken in October 2012. The audit highlighted the nurses' treatment room was carpeted and recommended its removal. We saw that the treatment room was still carpeted and asked the GP why. They explained that they had no current plans to remove the carpet and replace it with more suitable floor covering. There was no evidence of any further infection control audits having taken place since October 2012.

There was a privacy curtain and blind at the window in the GP's consulting room. We saw a basic cleaning schedule covering January to May 2015 which indicated curtains and blinds in the practice were cleaned at six monthly intervals. However, we saw the carpet in the GP's consulting room was visibly stained and it was threadbare in the reception area.

The risk of the spread of infection was reduced as all instruments used to examine or treat patients were single-use, and personal protective equipment (PPE), such as aprons and gloves, were available for staff to use. Hand washing instructions were also displayed by hand basins and there was a supply of liquid soap and paper hand towels. We saw training records that showed all staff had received infection control training.

We saw there were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades.

There was no evidence the practice had undergone a legionella test (legionella is a bacterium that can grow in contaminated water and can be fatal) or risk assessment had taken place. We asked the GP why this was; they were unable to give an explanation.

Equipment

The practice had processes in place to make sure equipment was regularly checked to ensure it was safe and effective to meet patients' needs. The practice had contracts in place for medical equipment to be checked or calibrated. We saw certificates which showed that the weighing scales and blood pressure machines were calibrated in March 2015. However, there was no evidence that a portable electrical appliance test (PAT) had ever been undertaken. (Portable appliance testing (PAT) is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use.) There was evidence the GP checked the fire extinguishers.

Are services safe?

Staffing and recruitment

We saw the practice had a recruitment policy and records we looked at showed us that appropriate recruitment checks had been undertaken prior to employment. Staff we spoke with confirmed this..

All clinical staff had been subject to Disclosure and Barring checks (DBS). This demonstrated the practice had taken reasonable steps to help ensure the staff they employed were suitable to work with vulnerable patients. The GP told us that they annually checked the nurse's professional registration to ensure that it was current. We saw a copy of their registration certificate which confirmed that they were registered. We also saw records which confirmed that the GP was registered with the General Medical Council.

Staff told us the practice employed sufficient numbers of suitably qualified, skilled and experienced staff. Staff helped each other out to deal with routine absences such as sickness.

Monitoring safety and responding to risk

The practice had a health and safety policy, which reminded staff of their individual responsibility for the health and safety of themselves and other people who may be affected by the practice's activities.

The GP told us they tested the fire alarms at weekends when no staff were present. The practice did not keep records to show these tests had been regularly undertaken. In addition there were no records showing the practice had undertaken regular fire drills which included an evacuation of the practice. However, the GP told us the last one took place in May 2015 and staff we spoke with confirmed this.

Arrangements to deal with emergencies and major incidents

The practice had detailed plans in place to ensure business continuity in the event of any foreseeable emergency, for example, a fire or flood. The plans included essential contact numbers such as electricity suppliers and the water authority.

The practice had medication available for emergencies, for example they had emergency medication for treating patients who may have an allergic reaction. Arrangements were in place to check emergency medicines were within their expiry date and suitable for use. Staff we spoke with told us they had either attended CPR (resuscitation) training or it had been scheduled. We looked at records which confirmed this.

However, the practice did not have a defibrillator or emergency oxygen. The GP told us that they relied on the emergency services such as the Community First Responder (CFR) service to provide care until an ambulance arrives. CFR are volunteers have been trained to attend emergency calls received by the ambulance service. The responders carry automated external defibrillators (AEDs) and are trained and equipped to provide oxygen therapy. However, it is best practice for practices to have oxygen available on the premises. The National Resuscitation Council has the following view that: 'Current resuscitation guidelines emphasise the use of oxygen, and this should be available whenever possible.'

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Care and treatment was considered in line with recognised best practice standards and guidelines.

GPs and nurses demonstrated an up-to-date knowledge of clinical guidelines for caring for patients.

We saw the practice used the Information from the Quality and Outcomes Framework (QOF) to monitor their patients. For 2014 the practice achieved an overall total score of 93.8% which was 1.1% below the local CCG average, but 0.3% above the England average. (The 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 had processes in place to ensure current guidance was being followed. They used the data from the QOF to assess how they were performing following the current guidance. The practice was aware of their achievements in comparison to other local practices and nationally. The QOF data showed the practice achieved overall scores above the local CCG and England averages in respect of 15 of the 20 clinical areas reported on. For example, the overall individual score for epilepsy was 100% which was the above the local CCG average by 5.5% and 10.6% above the England average however the individual score for peripheral arterial disease was below the local CCG average by 1.7% and 1.2% below the England average.

The practice coded patient records using specific READ Codes. These are codes which provide the standard vocabulary by which clinicians can record patient findings and procedures in health and social care IT systems. This enabled them to easily identify patients with long-term conditions and those with complex needs. We found from our discussions with the GPs and the nurses staff completed, in accordance with the National Institute for Health and Care Excellence (NICE) guidelines, thorough assessments of patients' needs and these were reviewed when appropriate. For example, the practice had planned for, and made arrangements to deliver, care and treatment to meet the needs of patients with long-term conditions. There were regular clinics where patients were booked in for an initial review of their condition; they were then

scheduled for recall appointments. This ensured patients had routine tests, such as blood or spirometry tests to monitor their condition (A spirometer measures the volume and speed of air that can be exhaled and is a method of assessing lung function).

The nurse was responsible for chronic disease management. They kept a record of when patients were due their clinical reviews and invited them in for review. They also followed up any patients who failed to attend and offered them another appointment.

We saw evidence the practice was appropriately reviewing the healthcare needs of people with long term conditions. The practice achievement was variable, for example, patients with asthma the QOF data showed 78.7% had an asthma review within the previous 12 months, which was 3.4% above the local CCG average and 3.2% above the England average. For patients with hypertension (high blood pressure) aged 16 or over, 92.2% had an annual assessment of physical activity in the preceding 12 months, which was 14.5% above the local CCG average and 13.6% above the England average. For patients diagnosed with heart failure 71.4% had their diagnosis confirmed three months before or 12 months after entering on to the register, which was 24.1% below the local CCG average and 23.9% below the England average.

All patients over the age of 75 had a named GP who was responsible for their care. This helped to ensure continuity of care.

The practice kept a register of patients with learning disabilities which enabled them to monitor their care effectively. There were two patients on the register.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles, which led to improvements in clinical care. We saw records of nine audits that had been undertaken in the last 12 Months. We looked in detail at two audits. Full two cycle audits had been completed and changes had been made where necessary. For example the practice reviewed their prescribing procedures for a range of antibiotic medication. The practice introduced changes where the second audit showed a decrease in antibiotic prescribing levels of 8.9%. The second audit we looked at related to

Are services effective?

(for example, treatment is effective)

inadequate cervical smears. The audit covered a period of three years (2012/13 to 2014/15). The 2012/13 showed two inadequate smears and for both 2013/14 and 2014/15 there were no inadequate smears.

We saw evidence patients with complex needs had their care planned. For example QOF data showed 100% of patients with mental health issues had a comprehensive care plan documented in the record, in the preceding 12 months; this was above the average for the local CCG by 12.8% and 14.1% above the England average. There were 10 patients on the practice's mental health register. The practice also achieved 92.7% in respect of patients with diabetes who had a record of retinal screening in the preceding 12 months, which was 3.6% above the local CCG average and 2.7% above the England average.

The GP told us the practice was the lowest in the area for patients using the out of hours services. We saw data from the CCG which confirmed this.

Effective staffing

Practice staffing included the GP, a nurse, two receptionists, dispensing staff and a medicines manager. We reviewed staff training records and saw the practice had a method of recording training undertaken and when the training needed updating. Clinical staff maintained their individual continuing professional development (CPD) records. Good medical practice requires doctors and nurses to keep their knowledge and skills up to date throughout their working life and to maintain and improve their performance. CPD is a key way for them to meet their professional standards.

We saw from the staff training records staff had attended courses which included safeguarding for children and vulnerable adults. Staff were up-to-date with mandatory courses such as basic life support. Staff undertook 'Protective Learning Time' training courses which gave the staff an opportunity to undertake undisturbed formal and informal training. We saw the practice had completed a training needs assessment for the local CCG which indicated which training courses staff required.

The GP was up to date with his yearly continuing professional development requirements and had been revalidated. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation.

Only when revalidation has been confirmed by the General Medical Council (GMC) can the GP continue to practice and remain on the performers list with NHS England). We saw the GP had been revalidated in January 2015.

All staff had received an annual appraisal. We saw records confirmed this. During the appraisals, training needs were identified and personal development plans put into place. The practice had an 'open door' policy whereby all staff were encouraged to freely raise any issues or concerns with the GP on a daily basis. Staff we spoke with confirmed this and told us they would have no problems in raising any issues and also said they felt well supported by the practice. Nursing staff told us they worked well as a team and were mutually supportive.

We looked at the training records for the practice and saw they offered staff training that covered safeguarding and cardiopulmonary resuscitation (CPR), among other courses appropriate to their work. However, there was no evidence staff had undertaken annual fire safety training.

The patients we spoke with were complimentary about the staff. There were very positive comments, about staff in the 33 CQC comment cards we reviewed.

Working with colleagues and other services

The practice worked closely with other health and social care providers to co-ordinate care and meet their patients' needs. The GP told us they worked closely with the district nurses and health visitors but did not formally meet with them. They also told us they had undertaken joint visits with district nurses which helped coordinate effective care for patients in their own homes. The GP gave us an example of how they had worked the district nurse to coordinate their visit to a patient to avoid inconveniencing a house bound patient twice in a short period of time.

Although the GP and nurse worked closely with other care providers the practice did not hold multidisciplinary meetings. The GP showed us they recorded their interactions with other care providers within individual patient records.

Correspondence from external health care and service providers, such as letters from hospital including discharge summaries, blood tests, information from out-of-hours providers and the 111 service, were received both electronically and by post and where all seen by the GP and distributed to relevant staff to action.

Are services effective?

(for example, treatment is effective)

Information sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. These records generated alerts which included prompts to staff when a patient needed medical reviews such as blood tests and if for example a patient was a carer.

Staff told us they shared patient information with the out of hour's service which helped ensure their patients received appropriate care. For example, the practice had care plans in place for patients at risk of admission to hospital which were available to the out of hours service and emergency services. Copies of the care plans were kept electronically in the practice and hard copies were available at the patients' home.

Although there were no practice meetings. The GP and staff confirmed all information including information about risks and significant events was shared openly on a daily basis. Patient specific issues were also discussed with appropriate staff and other health care professionals to enable continuity of care. We saw evidence that patients' records had been updated accordingly.

Consent to care and treatment

Staff we spoke with were able to give examples of how they obtained consent to care and treatment.

We saw training records which showed all clinical staff had received training in the Mental Capacity Act (MCA) 2005 Act. We found staff were aware of the MCA and their responsibility in respect of consent prior to giving care and treatment. They described the procedures they would follow where patients lacked capacity to make an informed decision about their treatment.

The GP and nurse we spoke with showed they were knowledgeable about how and when to carry out Gillick competency assessments of children and young people. Gillick competence is a term used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

Health promotion and prevention

A range of health promotion information was available to patients in the reception and waiting area of the practices. This included information about spotting the signs of cancer for women and meningitis awareness.

The practice proactively identified patients who needed ongoing support. In particular, they identified carers and placed a flag on their records so clinicians were made aware of this before these patients attended appointments. The practice offered annual reviews for patients with long term conditions or more frequently when needed.

The practice identified patients who would benefit from treatment and regular monitoring, for example, they offered flu vaccinations and immunisations for children in line with current national guidance. Childhood immunisation rates were in line with or slightly above averages for the local Clinical Commissioning Group (CCG). For example, MMR vaccination rates for two year old children were 100% compared to 96.4% across the local CCG; and MMR dose 2 rates for five year old children were 78.9% compared to 70.1% across the local CCG.

Cervical screening rates for women aged 25-64 were 89.7%, which was above the local CCG average by 6.9% and above the England by 7.8%.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with four patients during our inspection. They were very complimentary about the services they received. Comments left by patients on the 33 CQC comment cards we received also reflected this.

We looked at data from the National GP Patient Survey, published in January 2015. The results showed patients who responded were satisfied with how they were treated and this was with compassion, dignity and respect. For example, 99% of patients who responded to the survey said they thought their overall experience was good, compared to the local CCG average of 88.4% and the England average 85%. For the helpfulness of reception staff the practice achieved 99.4%, compared to the local CCG average of 90% and the England average 86.9%. We saw 98.4% of patients who responded said they had confidence and trust in their GP, compared to the local CCG average of 93.5% and the England average of 91.8% and 87.2% said their GP was good at treating them with care and concern, compared to the local CCG average of 85.6% and the England average of 82.7%. We also saw 79.3% of patients who responded said they had confidence and trust in their nurse, compared to the local CCG average of 89.4% and the England average of 85.5% and 71.6% said their nurse was good at treating them with care and concern, compared to the local CCG average of 89.4% and the England average of 85.5%. We spoke to the GP about this and they told us that they thought the reason for the nurse's low scores in the survey was because the nurse worked part-time.

Staff we spoke with told us how they would protect patient's dignity. Consultations took place in purposely designed consultation rooms with an appropriate couch for examinations and curtains to maintain privacy and dignity. We noted consultation and treatment room doors were closed during consultations and conversations taking place in those rooms could not be overheard.

We saw the reception staff dealt with patients pleasantly and warmly. They were aware of the need for confidentiality. They ensured conversations were conducted in a confidential manner. Reception staff spoke quietly so their conversations could not be overheard. In addition patients were offered a private room to speak to reception staff in confidence if they wished.

Care planning and involvement in decisions about care and treatment

Patients told us they felt they had been involved in decisions about their care and treatment. They told us the clinical staff took their time with them and always involved them in decisions. The results of the National GP Patient Survey published in January 2015 showed patients felt the GPs and nurses involved them in decisions about their care. Of the patients who responded 76.6% rated the GPs good at involving them in decisions, compared to the local CCG average of 76.9% and the England average of 74.6%. For nurses this was 67.2% compared to the local CCG average of 70.1% and the England average of 66.2%. In addition 79% of patients who responded rated GPs good at explaining the need for any test or treatments, compared to the local CCG average of 84.1% and the England average of 82%. For nurses this was 73.7% compared to the local CCG average of 80.3% and the England average of 76.7%. These figures show that the practice achieved scores were broadly in line with the local CCG and England averages. This demonstrated most patients who responded were satisfied with the way they were treated.

We saw access to interpreting services was available to patients, should they require it.

Patient/carers support to cope emotionally with care and treatment

The practice offered open access appointments where patients were seen on the same day and no one was refused an urgent appointment. These services gave patients assurance their needs would be met on the day they contacted the practice. The practice also undertook home visits for those patients not well enough to attend the practice.

The practice offered support to patients receiving end of life care at home. Each patient receiving palliative care had a named GP and the practice had arrangements in place to ensure another GP was available should the named GP be unavailable.

Staff told us bereaved relatives and carers would be contacted by the practice to offer them support shortly after the bereavement. The practice also signpost bereaved relatives and carers to other support if they required further support.

Are services caring?

We saw there was a variety of patient information on display throughout the practice. This included information on health conditions, health promotion and various support groups and services.

The practice worked with patients experiencing poor mental health and provided personalised support.

The GP told us they planned care for patients who would benefit from coordinated support from other health care

providers in conjunction with the care provided by the practice. They recorded the decisions and actions required from their contacts with other health care providers within individual patient records. We saw evidence of this.

The GP gave us an example of the care they provided. The GP was contacted by a local petrol station and was advised they were serving one of his patients who appeared to be confused. The GP went to the petrol station and attended to the patient. They then drove them home in the patient's own car to ensure they got home safely and had access to transport.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The time allocated to appointments varied in accordance with the patients' needs, for example, patients suffering from some long term conditions were given longer appointment times if necessary. Patients we spoke with told us they felt they had sufficient time during their appointment. Results of the National GP Patient Survey published in January 2015 confirmed this with 97.1% of patients who responded stating the doctors gave them enough time, compared to the local CCG average of 88.6% and the England average of 85.6%. For the nurses 73.3% had sufficient time, compared to the local CCG average of 84.2% and the England average of 80.2%. These figures demonstrated the GP achieved higher levels of patient satisfaction compared to the local CCG and England averages. However, the nurse achieved a lower level of patient satisfaction compared to the local CCG and England averages. As previously stated the GP felt when asked that the lower score may have been because the practice nurse only worked part time.

The practice undertook care planning for patients diagnosed with diabetes. The practice maintained a register of all patients aged 17 or over with diabetes. The practice achieved an overall QOF score of 100% for caring for these patients which was 7.2% above the local CCG average and 9.9% above the England average.

The practice used electronic notes and alerts which were attached to medical records to advise staff that patients had additional needs such as, for example, a learning disability or that they were a carer.

The practice offered personalised care to meet the needs of the older patients in its population. For example, the practice had identified patients who needed support and they each had a care plan.

All patients over the age of 75 years and those patients on the palliative care register had a named GP.

There was information available to patients in the waiting room and reception area about support groups, for example the Furness Breast Cancer Support Group, various clinics such as the flu clinics, and health and wellbeing advice.

Tackling inequity and promoting equality

The practice had recognised the needs of the different groups in the planning of its services.

Nationally reported data showed the practice had achieved good outcomes in relation to meeting the needs of patients whose circumstances may make them vulnerable. Registers were maintained, which identified which patients fell into these groups. The practice used this information to ensure patients received an annual healthcare review and access to other relevant checks and tests. Patients experiencing poor mental health had their needs reviewed. Seventy-five per cent of patients on the dementia register had their needs reviewed within the preceding 12 months which was broadly in line with the local CCG and England averages. For example, this was 9.8% lower than the local CCG average and 8.8% lower than the England average. The practice achieved 100% in respect of recording agreed comprehensive care plans in the preceding twelve months for patients suffering from certain mental health conditions, which was 12.9% above the local CCG average and above the England average by 14.1%.

The GP told us the time allocated to a GP appointment varied in accordance with the patients' needs. Patient we spoke with confirmed this.

The consulting and treatment rooms were accessible for all patients. There was a disabled toilet available at the practice.

The practice had arrangements in place to access interpreting services for patients whose first language was not English.

Access to the service

The practice offered its services throughout the core hours of 8am to 6.30pm Monday to Friday. The opening hours for the practice were 9am to 6pm Monday, Tuesday, Thursday and Friday. For the periods between 8am to 9am (including Wednesdays), and 6pm to 6.30pm calls are taken by the receptionist who then contacted the GP to respond. On Wednesdays the practice was open 9am to 11.30am. For the period 11.30am to 6.30pm calls were directed the GP to respond to. The GP offered open access consultations between 10am to 11am Monday to Friday and 5pm to 6pm Mondays, Tuesdays, Thursdays and Fridays. When the GP was not undertaking his consultations he was available

Are services responsive to people's needs?

(for example, to feedback?)

throughout the day Monday to Friday to respond to calls from patients. Routine appointments with the nurse were available between 9am to 5pm Monday and Thursday and 2pm to 5pm on Tuesdays.

The service for patients requiring urgent medical attention out of hours is provided through the 111 service and Cumbria Health on Call between 6.30pm and 8am Monday to Friday.

Antenatal I clinics were held Mondays by appointment.

The practice operated an open access appointments system for consultations with the GP where patients were not required to book an appointment. Patients arrived at the practice and waited to be seen. In addition patients who called the practice between 8am and 6.30pm where responded to by the GP. The GP told us that he would triage the patient and decide if they needed to be seen immediately or at a GP consultation. However, if the patient was concerned the GP would see the patient on the day they called either at the practice or visit them at home. All patients who arrived at the practice were seen on the day. Patients we spoke and some comments made on the CQC comment cards confirmed this. The GP also undertook home visits to those patients too unwell to attend the surgery. Feedback from patients we spoke with, and those who completed CQC comment cards, did not raise any concerns about getting an appointment with a clinician on the day if their need was urgent.

Patients were able to book appointments either by calling into the practice, on the telephone. Home visits were available and telephone consultations for patients who needed them.

Patients we spoke with commented on the open access appointments system. They said they were satisfied with the appointment system operated by the practice. They commented it was easy to get an appointment. This was reflected in the results of the most recent National GP Patient Survey (2015). This showed 100% of respondents

described their experience of making an appointment as 'very good' or 'fairly good', in comparison to the local CCG average of 78.6% and the England average of 73.8% and 100% said the last appointment they got was 'convenient for them', in comparison to the local CCG average of 93.1% and the England average of 91.8%.

The practice had a practice leaflet which provided information about the services available, contact details and repeat prescriptions. However, the leaflet was not up-to-date for example it referred to services such as ear piercing and off shore medicals which were no longer available. The details for the practice on the NHS Choices website did not indicate that their services were available throughout the core hours 8am to 6.30pm. It displayed the GP's daily consultation times. We spoke to the GP about this and they told us that they would look at revising the information on the website and the leaflet.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice.

There was information displayed in the waiting room and within the practice complaints leaflet, informing patients of the practice complaints process. The practice leaflet explained complaints or comments can be made to any member of staff in writing or verbally.

None of the four patients we spoke with on the day of the inspection said they had felt the need to complain or raise concerns with the practice. In addition, none of the 33 CQC comment cards completed by patients indicated they had felt the need to make a complaint.

The GP told us they had not received any complaints about the services provided in the last 12 months and the last complaint made was seven years ago.

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 mission statement which was, 'The only purpose we have is the welfare of our patients.' The staff we spoke with all knew and understood the vision and values and what their responsibilities were in relation to these.

The GP told us the practice had an open culture where staff were encouraged to seek advice and discuss issues with colleagues and GPs when the need arose. Staff we spoke with confirmed this and told us that the practice was very supportive and they had no concerns about raising any matters with colleagues and the GP.

Governance arrangements

The GP was responsible for all aspects of patient care and treatment. In addition they were the lead for all areas of the practice which included infection control and safeguarding patients. The practice used data to monitor their performance. The GP kept themselves aware of their progress against the key QOF indicators to ensure patients' needs were met.

The practice had a number of policies and procedures in place which governed their day-to-day activities. We reviewed nine policies which included safeguarding, health and safety, confidentiality and chaperoning. Some had been reviewed in May 2015. The policies and procedures were available to staff either in hard copy or on computer. However, the GP confirmed these policies had yet to be shared with staff.

Staff told us they interacted with their colleagues throughout the day, supporting each other to provide their services to patients. The GP told us and the nurse confirmed that they had regular discussions about practice issues and daily discussions about patients when necessary. However, there were no records of discussions with staff about risks and significant events. The GP stated they did not keep a record of any discussions and there were no formal practice meetings. With regard to any interactions with health visitors, palliative care nurses, community matron, and district nurses the GP told us any decision or actions were recorded in the patient records. We saw an example of this where the GP and district nurse had arranged a joint home visit.

All correspondence goes to the GP to action and code before being scanned in patient records if relevant or elsewhere. The GP told us this process ensured nothing is missed.

The provider did not ensure staff received annual fire training. The practice had not undertaken an effective fire risk assessment. For example we saw the fire risk assessment dated 24 May 2015 which indicated that portable electrical appliance test (PAT) had been regularly undertaken. However, there was no evidence that this had ever taken place. (Portable appliance testing (PAT) is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use.) In addition, we did not see a record of fire drills and fire alarm testing.

Leadership, openness and transparency

The GP was responsible for everything. They undertook the lead roles for all areas which included infection control, health and safety, monitoring QOF data and practice performance.

Staff told us they worked in a supportive team and there was an open culture in the practice and were able to freely discuss any topics. They also felt they could report any incidents or concerns they might have. This environment helped to promote honesty and transparency at all levels within the practice.

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

The practice gathered feedback from staff through appraisals and informal discussions in their day-to-day activities. Staff we spoke with told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and the GP. The GP gave us an example of where a patient suggested the practice provide a dog ring so patients could tie their dogs up in the porch when visiting the surgery. We saw this had been provided.

The provider had sought patients' views by undertaking the continuous NHS Friends and Family test (FFT). The FFT is an opportunity for patients to provide feedback on the services they received from GP practices since December 2014. Of the 18 responses to date 17 said they would recommend the practice and one was neutral.

The practice did not have an active patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services.

Are services well-led?

Good 

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

and the quality of care. We spoke to the GP about this and they told us they were aware that it was a contractual requirement to have a PPG and were looking into forming one.

Management lead through learning and improvement

The practice had management systems in place which enabled learning and improved performance. The GP reviewed and agreed the training objectives for staff at their annual appraisals.

Staff told us they had received the training they needed or it had been scheduled, both to carry out their roles and responsibilities and to maintain their clinical and professional development. We saw training records which confirmed this. Staff were given protected learning time (PLT) to undertake training. PLT is where staff were given

uninterrupted time to undertake training. We saw staff attended formal training session and undertook training online. The training included infection control, safeguarding adults and children and equality and diversity.

The practice had an effective approach to incident reporting in that it encouraged reporting and the review of all incidents. Staff told us they would discuss incidents with the GP. The nurse gave the example of an incident they reported where two patients had the same. To reduce the likelihood of any confusion in the future the patient's electronic records now have an alert to warn staff to check to ensure information is recorded in the correct record. The practice had completed reviews of significant events and other incidents and shared these with staff and other relevant health care providers.

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
Maternity and midwifery services	Regulation 12 Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment
Surgical procedures	How the regulation was not being met: People who use services and others were not protected against the risks associated with unsafe portable electrical equipment; fire or infection. The provider had not undertaken an effective fire risk assessment; or provided fire training. The provider did not maintain a record of fire drills and fire alarm testing. There were no regular infection control audits and not all concerns had been addressed when identified and no legionella tests had been undertaken. The practice did not have emergency oxygen available on the premises. Regulation 12(2)(a), (b),(e) and (h)
Treatment of disease, disorder or injury	