

Dr Sanjeev Juneja

Quality Report

Marlowe Park Medical Centre
Wells Road Strood Rochester Kent ME2 2PW
Tel: 01634 719692
Website: www.marloweparkmedicalcentre.nhs.uk

Date of inspection visit: 19 and 20 May 2015
Date of publication: 17/09/2015

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?

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 Sanjeev Juneja (also known as Marlowe Park Medical Centre) on 19 and 20 May 2015. The inspection was carried out over two days as there was insufficient time to establish enough information in one day. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing effective, caring, responsive and well-led services. It required 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. Information about safety was recorded, monitored, reviewed and addressed.
- Not all risks to patients were assessed and well managed.

- Patient's needs were assessed and care was planned and delivered in line with current legislation. Staff had received some training appropriate to their roles. However, not all training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. Staff treated patients with kindness and respect, and maintained confidentiality.
- Patients said they experienced few difficulties when making appointments and urgent appointments were available the same day.
- There was a leadership structure and staff felt supported by management. The practice took into account the views of patients and those close to them as well as engaging with staff when planning and delivering services.

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

Summary of findings

Importantly the provider must;

- Review medicines management records and the system used to monitor blank prescription forms.
- Ensure all staff are up to date with relevant training.
- Review infection control management to ensure all areas of the practice are clean and comply with national infection control guidance.
- Review risk assessment activity to include all risks to patients.
- Ensure the practice is able to respond to medical emergencies in line with national guidance.

The provider should also;

- Revise its governance processes and ensure that all documents used to govern activity are up to date and contain relevant contact details.
- Ensure all relevant staff are made aware of clinical audit results.

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 safe. The practice was unable to demonstrate it was fully compliant with national guidance on infection control. Marlowe Park Medical Centre had systems to monitor, maintain and improve safety and demonstrated a culture of openness to reporting and learning from patient safety incidents. The practice had policies to safeguard vulnerable adults and children who used services. They monitored safety and responded to some identified risks. There were systems for medicines management. However, the practice did not have a system to monitor blank prescription forms. Sufficient numbers of staff with the skills and experience required to meet patients' needs were employed. Although the practice was unable to demonstrate that all staff were adequately trained for all the roles they carried out. There was equipment to enable staff to care for patients and the practice had plans to deal with foreseeable emergencies. However, the practice was unable to demonstrate it was able to respond to a medical emergency in line with national guidance.

Requires improvement



Are services effective?

The practice is rated as good for providing effective services. Staff at the Marlowe Park Medical Centre referred to guidance from the National Institute for Health and Care Excellence and had systems to monitor, maintain and improve patient care. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. The practice carried out clinical audit cycles to improve the service. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Good



Are services caring?

The practice is rated as good for providing caring services. Data showed that patients rated the practice equal to others in the locality and nationally for several aspects of care. Patients were satisfied with the care provided by Marlowe Park Medical Centre and were treated with respect. Staff were careful to keep patients' confidential information private and maintained patients' dignity at all times. Patients were supported to make informed choices about the care they wished to receive and felt listened to.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services. The practice was responsive to patients' individual needs such as

Good



Summary of findings

language requirements and mobility issues. Access to services for all patients was facilitated in a wide variety of ways, such as routine appointments with staff at Marlowe Park Medical Centre and home visits. The practice provided an on-line booking service for appointments and repeat prescriptions. Patients could get information about how to complain in a format they could understand and the practice demonstrated that learning from complaints and action as a result of complaints had taken place.

Are services well-led?

The practice is rated as good for providing well-led services. It had a clear vision and strategy. Most staff were clear about the vision and their responsibilities in relation to this. There was a leadership structure and staff felt supported by management. The practice had written documents that governed activity and governance was discussed regularly at staff meetings. There were systems 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 was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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. Patients over the age of 75 had been allocated a dedicated GP to oversee their individual care and treatment requirements. Patients were able to receive care and treatment in their own home from practice staff as well as district nurses and palliative care staff. There were plans to help avoid older patients being admitted to hospital unnecessarily. Specific health promotion literature was available as well as details of other services for older people. The practice held regular multi-professional staff meetings that included staff who specialised in the care of older people.

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions. Service provision for patients with long-term conditions included dedicated clinics with a recall system that alerted patients as to when they were due to re-attend. The practice employed staff trained in the care of patients with long-term conditions. The practice supported patients to manage their own long-term conditions. Specific health promotion literature was available.

Good



Families, children and young people

The practice is rated as good for the care of families, children and young people. Services for mothers, babies, children and young people at Marlowe Park Medical Centre included access to midwives and health visitor care. Specific health promotion literature was available. The practice held regular multi-professional staff meetings that included staff who specialised in the care of mothers, babies and children.

Good



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 practice provided a variety of ways this patient population group could access primary medical services. These included appointments from 8am to 12noon and 3pm to 6pm Monday to Friday as well as 7am to 8am on Tuesdays and Wednesdays. Appointments and repeat prescriptions could be accessed on-line. Specific health promotion literature was available.

Good



Summary of findings

People whose circumstances may make them vulnerable

The practice is rated as good for the care of people living in vulnerable circumstances. The practice offered primary medical service provision for people in vulnerable circumstances in a variety of ways. Patients not registered at the practice could access services and interpreter services were available for patients whose first language was not English. Specific health promotion literature was available. Specific screening services were also available.

Good



People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). This patient population group had access to psychiatrist and community psychiatric nurse services as well as local counselling services. Specific health promotion literature was available. The practice held regular multi-professional staff meetings that included staff who specialised in the care of patients experiencing poor mental health.

Good



Summary of findings

What people who use the service say

During our inspection we spoke with four patients who told us they were satisfied with the care provided by the practice. They considered their dignity and privacy had been respected and that staff were polite, friendly and caring. They told us they felt listened to and supported by staff, had sufficient time during consultations and felt safe. They said the practice was well managed, clean as well as tidy and they experienced few difficulties when making appointments. Patients we spoke with reported they were aware of how they could access out of hours care when they required it as well as the practice's telephone consultation service.

We looked at 49 patient comment cards. 44 comments were positive about the service patients experienced at Marlowe Park Medical Centre. Patients indicated that they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said that staff

treated patients with dignity and respect. Patients had sufficient time during consultations with staff and felt listened to as well as safe. Seven comments were less positive with a common theme of difficulties in obtaining an appointment that suited their needs. However, seven positive comments indicated patients had no difficulties in obtaining an appointment that suited their needs.

We looked at the NHS Choices website where patient survey results and reviews of Marlowe Park Medical Centre were available. Results ranged from 'among the best' for the percentage of patients who would recommend this practice, through 'average' for scores for consultations with doctors and nurses. The GP patient survey score for opening hours was 75% and 89% of patients rated their ability to get through on the telephone as very easy or easy. 91% of patients rated this practice as good or very good.

Areas for improvement

Action the service **MUST** take to improve

- Review medicines management records and the system used to monitor blank prescription forms.
- Ensure all staff are up to date with relevant training.
- Review infection control management to ensure all areas of the practice are clean and comply with national infection control guidance.
- Review risk assessment activity to include all risks to patients.

- Ensure the practice is able to respond to medical emergencies in line with national guidance.

Action the service **SHOULD** take to improve

- Revise its governance processes and ensure that all documents used to govern activity are up to date and contain relevant contact details.
- Ensure all relevant staff are made aware of clinical audit results.

Dr Sanjeev Juneja

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Dr Sanjeev Juneja

Marlowe Park Medical Centre is situated in Strood, Kent and has a registered patient population of approximately 4,100.

The practice staff consist of one GP (male), one practice manager, one practice nurse (female), one healthcare assistant (female) as well as administration and reception staff. The practice also employs locum GPs directly and through locum agencies. There is a reception and a waiting area on the ground floor. All patient areas are accessible to patients with mobility issues as well as parents with children and babies.

The practice is not a training or teaching practice (teaching practices take medical students and training practices have GP trainees and F2 doctors).

The practice has a general medical services (GMS) contract with NHS England for delivering primary care services to local communities.

Primary medical services are provided Monday, Tuesday, Wednesday and Friday between the hours of 8am to 12noon and 3pm to 6pm, and Thursdays 8am to 12noon. Extended hours surgeries are offered Tuesday and Wednesday 7am to 8am. Primary medical services are available to patients registered at Marlowe Park Medical

Centre via an appointments system. There are a range of clinics for all age groups as well as the availability of specialist nursing treatment and support. There are arrangements with other providers (MedOCC) to deliver services to patients outside of Marlowe Park Medical Centre's working hours.

Services are provided from Marlowe Park Medical Centre, Wells Road, Strood, Rochester, Kent, ME2 2PW, only.

Why we carried out this inspection

We inspected this service as part of our new 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.

This provider had not received a comprehensive inspection before and that was why we included them.

How we carried out this inspection

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

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

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
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problems

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations, such as NHS England, the local clinical commissioning group, the Local Medical Committee and the local Healthwatch, to share what they knew. We carried out announced visits on 19 and 20 May 2015. The inspection was carried out over two days as there was insufficient time to establish enough information in one day. During our visit we spoke with a range of staff (one GP, the practice manager, one practice nurse, one phlebotomist and one receptionist) and spoke with four patients who used the service. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risk and improve quality regarding patient safety. For example, reported incidents and accidents, national patient safety alerts as well as comments and complaints received. The staff we spoke with were aware of their responsibilities to raise concerns and knew how to report incidents and near misses.

We reviewed safety records and incident reports for the last 12 months. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system for reporting, recording and monitoring incidents, accidents and significant events. We reviewed records of three significant events that had occurred in the last 12 months and saw this system was followed appropriately. All reported incidents, accidents and significant events were managed by dedicated staff. Staff told us that feedback from investigations was discussed at significant event meetings and records confirmed this.

National patient safety alerts were disseminated electronically as well as in paper form to practice staff and there was a written protocol that guided staff on sharing and acting on alerts received at Marlowe Park Medical Centre.

Reliable safety systems and processes including safeguarding

The practice had systems to safeguard vulnerable adults and children who used services. There was written information for safeguarding vulnerable adults and children as well as other documents readily available to staff that contained information for them to follow in order to recognise potential abuse and report it to the relevant safeguarding bodies. For example, a safeguarding children policy. Contact details of relevant safeguarding bodies were available for staff to refer to if they needed to report any allegations of abuse of vulnerable adults or children. The practice had a dedicated GP appointed as lead in safeguarding vulnerable adults and children. Records showed they were trained to level three in safeguarding. All

staff we spoke with were aware of the dedicated appointed lead in safeguarding as well as the practice's safeguarding policies and other documents. All but one of the staff we spoke with told us they were up to date with training in safeguarding. Records confirmed this and demonstrated that safeguarding training was booked for the one member of staff who required it. When we spoke with staff they were able to describe the different types of abuse patients may have experienced as well as how to recognise them and how to report them.

The practice had a whistleblowing policy and other documents that contained relevant information for staff to follow that was specific to the service. The policy detailed the procedure staff should follow if they identified any matters of serious concern. The documents contained the names and contact details of external bodies that staff could approach with concerns, such as the General Medical Council. All staff we spoke with were able to describe the actions they would take if they identified any matters of serious concern and most were aware of this policy.

The practice had a monitoring system to help ensure staff maintained their professional registration. For example, professional registration with the General Medical Council or Nursing and Midwifery Council. We looked at the practice records of four clinical members of staff which confirmed they were up to date with their professional registration.

The practice had a chaperone policy and information about it was displayed in public areas informing patients that a chaperone would be provided if required. (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). Patients we spoke with told us they were aware this service was available at the practice. Records showed that staff who acted as chaperones had received training to do so or were due to attend such training in the near future.

Medicines management

Marlowe Park Medical Centre had documents that guided staff on the management of medicines such as a repeat prescribing policy. Staff told us that they accessed up to date medicines information and clinical reference sources when required via the internet and through published reference sources such as the British National Formulary (BNF). The BNF is a nationally recognised medicines

Are services safe?

reference book produced by the British Medical Association and Royal Pharmaceutical Society of Great Britain. There was a GP lead in prescribing and the practice received input from the local clinical commissioning group's pharmacy advisor.

Patients were able to obtain repeat prescriptions either in person or by completing paper repeat prescription requests as well as on-line. Patients' medicines reviews were carried out during GP appointments and during dedicated clinic appointments such as asthma clinics.

The practice did not have a system to monitor blank prescription forms. Although blank prescription forms were stored securely the practice did not keep a record of their serial numbers. The practice would not therefore be able to identify the serial numbers of any blank prescription pads if they were lost or stolen.

Medicines and vaccines were stored securely in areas accessible only by practice staff. The practice did not hold any controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). The practice kept records of the ordering and receipt of medicines. However, inventories of medicines and vaccines held were not maintained. Staff told us that stock levels and expiry dates of medicines and vaccines held were not routinely audited, although they said that the expiry date of all medicines were checked before staff administered them to patients. Medicines and vaccines that we checked were within their expiry date and fit for use.

Appropriate temperature checks for refrigerators used to store medicines and vaccines had been carried out and records of those checks were made. There was written guidance available for staff on the monitoring of refrigerator temperatures that included details of the action to be taken in the event that storage temperatures for vaccines went outside of acceptable limits.

The practice nurse administered vaccines using patient group directions (PGDs) that had been produced in line with legal requirements and national guidance. Records showed that nursing staff had received appropriate training to administer vaccines. However, one administrator conducted influenza clinics and administered influenza vaccinations. Although this member of staff was a doctor registered with the General Medical Council they were not on the performers list and therefore not permitted to work

clinically at the practice. The practice was unable to demonstrate this member of staff was trained to administer influenza vaccinations. There was also no PGD authorising this member of staff to administer influenza vaccinations.

Cleanliness and infection control

The premises were generally clean and tidy. Patients we spoke with told us they always found the practice clean and had no concerns regarding cleanliness or infection control at Marlowe Park Medical Centre. Chairs in some clinical rooms were cloth covered and one was visibly stained. As the fabric was porous, cleaning would not therefore always be effective. Cleaning schedules were used and there was a supply of approved cleaning products. Records were kept of domestic cleaning carried out in the practice and audits of domestic cleaning were undertaken. However, the practice was unable to demonstrate there were plans to clean stained chairs other than vacuuming.

Antibacterial gel was available throughout the practice for staff and patients to use. Antibacterial hand wash, paper towels and posters informing staff how to wash their hands were available at all clinical wash-hand basins in the practice. Some clinical wash-hand basins at the practice did not comply with Department of Health guidance. For example, some clinical wash-hand basins contained overflows and plugs. There was, therefore, a risk of cross contamination when staff used them. The practice was unable to demonstrate that there were plans to replace these basins at their next refurbishment. The infection prevention risk assessment failed to identify risks associated with cloth covered chairs in clinical rooms and clinical wash-hand basins that were non-compliant with national guidance.

The practice had infection control policies that contained procedures for staff to refer to in order to help them follow the Code of Practice for the Prevention and Control of Health Care Associated Infections. The code sets out the standards and criteria to guide NHS organisations in planning and implementing control of infection.

The practice had an identified infection control lead and all relevant members of staff were up to date with infection control training.

Personal protective equipment (PPE) including disposable gloves, aprons and coverings were available for staff to use.

Are services safe?

There was a system for safely handling, storing and disposing of clinical waste. This was carried out in a way that reduced the risk of cross contamination. Clinical waste was stored securely in locked, dedicated containers whilst awaiting collection from a registered waste disposal company.

A site waste audit had been carried out in March 2015 and an action plan implemented to address issues identified by the audit.

The practice had a system that monitored and recorded the hepatitis B status of GPs and nurses at Marlowe Park Medical Centre. However, it had failed to identify the hepatitis B status of the member of staff who conducted influenza clinics.

The practice was unable to demonstrate there was a system for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). The practice infection prevention risk assessment failed to address the risk of infection to staff and patients from legionella and was unable to demonstrate that testing was carried out to help reduce this risk.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment (including clinical equipment) was tested, calibrated and maintained regularly and there were equipment maintenance logs and other records that confirmed this. The practice also had a portable appliance testing policy that guided staff.

Staffing and recruitment

The practice had policies and other documents that governed staff recruitment. For example, a recruitment policy. Personnel records contained evidence that appropriate checks had been undertaken prior to employment. For example, proof of identification, references and interview records.

Records demonstrated all relevant staff had Disclosure and Barring Service (DBS) clearance (a criminal records check) or an assessment of the potential risks involved in using those staff without DBS clearance.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The staffing policy guided staff on the minimum number of staff required at the practice in normal circumstances. Locum GPs were employed directly to cover any shortfall in GP sessions and the permanent GP's planned leave such as annual leave. Other staff covered each other's leave to help ensure the practice had sufficient staff at all times. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Monitoring safety and responding to risk

The practice had a health and safety policy to help keep patients, staff and visitors safe. Health and safety information was displayed for staff to see and the practice had a designated health and safety representative.

There was a record of identified risks and action plans to manage or reduce risk. A fire risk assessment had been undertaken that included actions required in order to maintain fire safety. Permanent staff told us they had received fire safety training and records confirmed this. However, the practice was unable to demonstrate that locum GPs employed directly were up to date with fire safety training.

Staff told us there were a variety of systems to keep them, and others, safe whilst at work. They told us they had the ability to activate an alarm via the computer system as well as panic alarms to summon help in an emergency or security situation.

There was a system governing security of the practice. For example, visitors were required to sign in and out using the designated book in reception. Non-public areas of the practice were secured with coded key pad locks to help ensure only authorised staff were able to gain access.

Arrangements to deal with emergencies and major incidents

There were documents that guided staff in dealing with medical emergency situations. For example, the emergency procedures policy. Staff we spoke with told us they were up to date with basic life support training and records confirmed this.

Emergency equipment was available in the practice, including access to emergency medicines. However,

Are services safe?

medical oxygen was not available and the automated external defibrillator's (AED) (used to attempt to restart a person's heart in an emergency) battery was flat rendering it inoperable. There was an inventory of the emergency medicines held. Staff told us these were checked regularly and records confirmed this. There was not an inventory of

the emergency equipment held. Some emergency equipment we checked was out of date and the practice was unable to demonstrate such equipment was checked on a regular basis.

There was a disaster handling and business continuity plan document that indicated what the practice would do in the event of situations such as a temporary or prolonged power cut and loss of the practice premises.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Clinical Excellence (NICE) and from local commissioners. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

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

The GP told us they lead in specialist clinical areas such as diabetes, heart disease as well as asthma and the practice nurse and healthcare assistant supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to review and discuss best practice guidelines, such as the management of respiratory disorders, and records confirmed this.

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

Discrimination was avoided when making care and treatment decisions. Interviews with clinical staff showed

that the culture in the practice was that patients were cared for and treated based on need and the practice took account of each patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

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

Staff told us the practice had a system for completing clinical audit cycles. For example, an obesity audit. Records demonstrated analysis of its results and an action plan to address its findings. There were plans to repeat this and other audits such as the smoking denominator population audit, and complete cycles of clinical audit.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice. Where the 2013 / 2014 QOF data for this practice showed it was not performing in line with national standards the practice had taken action and made improvements. For example, records demonstrated that the practice was now holding regular multidisciplinary case review meetings (at least three monthly) where all patients on the palliative care register were discussed.

The practice's prescribing rates were similar to national figures. Staff followed national guidance for repeat prescribing. They regularly checked patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as chronic obstructive pulmonary disease (a breathing problem) and that the latest prescribing guidance was being used.

The practice kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups such as patients with learning disabilities, dementia and those on the mental health register. Structured annual reviews were undertaken for patients with long-term conditions. For example, diabetes.

Are services effective?

(for example, treatment is effective)

Effective staffing

Practice staffing included medical, nursing, managerial and administration staff. We reviewed staff training records and saw that all staff were either up to date with attending mandatory courses such as annual basic life support, or were due to receive this training. Staff underwent induction training on commencement of employment with the practice. The GPs were up to date with their yearly continuing professional development requirements and either had plans to be revalidated or had been revalidated. (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 practice and remain on the performers list with NHS England).

The practice had a staff appraisal system that identified learning needs from which action plans were documented. The practice had processes to identify and respond to poor or variable practice including policies such as the disciplinary procedure and the capability / disciplinary appeal procedure.

Staff had job descriptions outlining their roles and responsibilities as well as providing evidence that they were trained appropriately to fulfil these duties. For example, the practice nurse was trained in the administration of vaccinations. Those with extended roles, such as nurses carrying out reviews of patients with long-term conditions (for example, asthma), were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with community nursing teams and other service providers to deliver care to patients. Records confirmed that multi-disciplinary meetings took place in order to discuss and plan patient care that involved staff from other providers.

The practice also worked with district nurses and palliative care services to deliver end of life care to patients.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients'

care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

The practice had a system to refer patients to other services such as hospital services or specialists.

Staff told us that there was a system to review and manage blood results on a daily basis. There was a written protocol that guided staff when reviewing and acting on correspondence, reports and results. Results that required urgent attention were dealt with by the GP at the practice promptly, and out of hours doctors as well as palliative care staff were involved when necessary.

Information sharing

Relevant information was shared with other providers in a variety of ways to help ensure patients received timely and appropriate care. For example, staff told us the practice met regularly with other services, such as hospice staff, to discuss patients' needs.

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

Consent to care and treatment

The practice had a consent protocol and procedural documents that governed the process of patient consent and guided staff. The policy described the various ways patients were able to give their consent to examination, care and treatment as well as how that consent should be recorded.

Staff told us that they obtained either verbal or written consent from patients before carrying out examinations, tests, treatments, arranging investigations or referrals and delivering care. They said that parental consent given on behalf of children was documented in the child's medical records. Some staff had received formal training on the Mental Capacity Act 2005. Staff we spoke with were able to describe how they would manage the situation if a patient

Are services effective?

(for example, treatment is effective)

did not have capacity to give consent for any treatment they required. Staff also told us that patients could withdraw their consent at any time and that their decisions were respected by the practice.

Health promotion and prevention

All new patients registering with the practice were offered a health check. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture amongst clinical staff to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic smoking cessation advice to smokers.

Specific health promotion literature was available for all patient population groups such as shingles vaccination information for older patients, respiratory organisation information for patients with long-term breathing problems, information for men and women on contraception, sexual health advice for young people, alcohol and drugs recovery services details, details about how to recognise signs and symptoms of lung cancer as well as contact details of a dementia charity for patients who were worried about their memory.

The practice provided dedicated clinics for patients with certain conditions such as diabetes and asthma. Staff told

us these clinics helped enable the practice to monitor the on-going condition and requirements of these groups of patients. They said the clinics also provided the practice with the opportunity to support patients to actively manage their own conditions and prevent or reduce the risk of complications or deterioration. Patients who used this service told us that the practice had a recall system to alert them when they were due to re-attend these clinics.

Patients told us they were able to discuss any lifestyle issues with staff at the practice. For example, issues around eating a healthy diet or taking regular exercise. They said they were offered support with making changes to their lifestyle. For example, referral to a smoking cessation service. The practice had a written protocol that guided staff when providing lifestyle information to patients.

The practice offered a full range of immunisations for children, travel vaccines and influenza vaccinations in line with current national guidance. Child immunisation rates were slightly lower than the national average at Marlowe Park Medical Centre. Influenza vaccination rates was above the national average for patients aged 65 years and over, as well as patients aged 6 months to 65 years in the defined influenza clinical risk groups, was slightly above national averages.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We looked at the NHS Choices website where patient survey results and reviews of Marlowe Park Medical Centre were available. Results ranged from 'among the best' for the percentage of patients who would recommend this practice, through 'average' for scores for consultations with doctors and nurses. The GP patient survey score for opening hours was 75% and 89% of patients rated their ability to get through on the telephone as very easy or easy. 91% of patients rated this practice as good or very good.

We looked at 49 patient comment cards. 44 comments were positive about the service patients experienced at Marlowe Park Medical Centre. Patients indicated that they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said that staff treated patients with dignity and respect. Patients had sufficient time during consultations with staff and felt listened to as well as safe. Seven comments were less positive with a common theme of difficulties in obtaining an appointment that suited their needs. However, seven positive comments indicated patients had no difficulties in obtaining an appointment that suited their needs.

We spoke with four patients, all of whom told us they were satisfied with the care provided by the practice and that their dignity and privacy had been respected. Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains or screens were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained whilst they undressed / dressed and during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

The practice had documents that guided staff in order to keep patients' private information confidential. For example, the confidentiality policy and the information governance policy.

Incoming telephone calls answered by reception staff and private conversations between patients and reception staff that took place at the reception desk could be overheard by others. However, when discussing patients' treatments

staff were careful to keep confidential information private. Staff told us that a private room was available near the reception desk should a patient wish a more private area in which to discuss any issues.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff.

Patients' records were in electronic and paper form. Records that contained confidential information were held in a secure way so that only authorised staff could access them.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, the proportion of respondents to the GP patient survey who stated that the last time they saw or spoke with a nurse, the nurse was good or very good at involving them in decisions about their care was above the national average.

Patients told us health issues were discussed with them and they felt involved in decision making about the care and treatment they chose to receive. Patients told us they felt listened to and supported by staff and had sufficient time during consultations in order to make an informed decision about the choice of treatment they wished to receive.

Patient/carer support to cope emotionally with care and treatment

Timely support and information was provided to patients and their carers to help them cope emotionally with their care, treatment or condition. Support group literature was available in the practice such as information about a support group for carers.

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated better than average in this area. For example, the proportion of respondents to

Are services caring?

the GP patient survey who stated that the last time they saw or spoke with a GP, the GP was good or very good at treating them with care and concern was above the local clinical commissioning group average.

The patients we spoke with on the day of our inspection and the comments cards we received were consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

The practice supported patients to manage their own health, care and wellbeing and to maximise their independence. Specialised clinics provided the practice with the opportunity to support patients to actively manage their own conditions and prevent or reduce the risk of complications or deterioration.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The GP partner, as the only permanent GP at the practice, had been allocated as the dedicated GP to oversee patients' care and treatment requirements. This included patients over the age of 75 years as well as patients with long-term conditions and poor mental health. Staff told us that patients over the age of 75 years were informed of this by letter. Records demonstrated that the practice held regular multi-disciplinary staff meetings that included staff from other services. For example, palliative care staff.

The practice had a large number of patients whose first language was not English. The practice had access to a translation service and employed staff who spoke Polish, Russian, Hindi, French and Spanish. This had attracted patients from outside the practice's catchment area whose first language was amongst those spoken by practice staff. The practice had accepted a large number of these patients which had resulted in the practice patient population becoming too large. This had proved difficult for the practice to cope with and they had ceased this practice. They were also working with the local clinical commissioning group to transfer patients living out of the practice's catchment area to other local GP practices to reduce their workload to a more manageable level.

The practice employed staff with specific training in the care of all patient population groups. For example, one GP had training in the diagnosis and management of learning disability, nurses were trained in the care of patients with long-term conditions such as diabetes, cervical screening and immunisation / vaccination of all age groups. Other staff were trained in smoking cessation, phlebotomy (the taking of blood samples), chlamydia screening (a sexually transmitted disease) as well as travel health and general mental health issues. Records showed the practice had plans that identified patients at high risk of admission to hospital as well as implement care plans to reduce the risk and where possible avoid unplanned admissions to hospital.

Patients were able to receive care and treatment in their own home from practice staff as well as community based staff such as district nurses and palliative care staff. Staff external to the practice provided midwifery services to patients from Marlowe Park Medical Centre.

Patients told us they were referred to other services when their condition required it. For example, one patient told us they were referred to the local hospital for treatment that the practice was not able to provide this locally.

Tackling inequity and promoting equality

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as patient areas were all on one level. The consulting rooms were also accessible for patients with mobility difficulties and there was an access enabled toilet and baby changing facilities. There was a waiting area with space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

The practice maintained registers of patients with learning disabilities, dementia and those on the mental health register that assisted staff to identify them to help ensure their access to relevant services. All patients on the register with learning disabilities had received a physical health check within the last 12 months.

Staff told us that they did not have any patients who were homeless but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records.

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available when patients with learning disabilities received their annual review.

Access to the service

Primary medical services were provided Monday, Tuesday, Wednesday and Friday between the hours of 8am to 12noon and 3pm to 6pm, and Thursdays 8am to 12noon. Extended hours surgeries were offered Tuesday and Wednesday 7am to 8am. Primary medical services were available to patients registered at Marlowe Park Medical Centre via an appointments system. Staff told us that patients could book appointments on-line, by telephoning the practice or by attending the reception desk in the practice. The practice also provided a telephone consultation service and carried out home visits if patients were housebound or too ill to visit Marlowe Park Medical Centre. There was a range of clinics for all age groups and

Are services responsive to people's needs?

(for example, to feedback?)

conditions as well as the availability of specialist nursing treatment and support. There were arrangements with another provider (MedOCC) to deliver services to patients when the practice was closed.

Continuity of care was provided to patients by one permanent GP, one permanent practice nurse and one permanent healthcare assistant conducting appointments. The practice employed regular locum GPs to cover appointment shortfalls, annual leave and staff sickness to help maintain continuity of care to patients. Patients we spoke with said they experienced few difficulties when making appointments and were happy with the continuity of care provided by Marlowe Park Medical Centre.

The practice opening hours as well as details of how patients could access services outside of these times were not available for patients to take away from the practice in written form. For example, in a practice leaflet. However, they were available on the practice's website and were displayed on the front of the building.

Listening and learning from concerns and complaints

The practice had a system 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. Timescales for dealing with complaints were clearly stated and details of the staff responsible for investigating complaints were given. Information for patients was available in the practice that gave details of the practice's complaints procedure and included the names of relevant complaints bodies that patients could contact if they were unhappy with the practice's response. However, this did not contain contact details for these organisations. Patients we spoke with were aware of the complaints procedure but said they had not had cause to raise complaints about the practice.

The practice had received one complaint in the last 12 months. Records demonstrated that the complaint was investigated, the complainant had received a response, the practice had learned from the complaint and had implemented appropriate changes.

Staff told us that complaints were discussed at staff meetings. Records confirmed this and demonstrated that learning from complaints and action as a result of complaints had taken place.

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

Marlowe Park Medical Centre had a vision statement that set out its strategy to meet patients' healthcare needs. Most staff were aware of the practice's mission statement and it was displayed in the waiting area. There was also an up to date business development plan that set out the practice's planned business activities from 2013 to 2018.

Governance arrangements

There were documents that set out Marlowe Park Medical Centre's governance strategy and guided staff. For example, the clinical governance policy and the information governance policy. The GP was the clinical governance lead and clinical governance issues were discussed at staff meetings. For example, prescribing practices. There was a variety of policy, protocol, procedural and other documents that the practice used to govern activity. For example, the chaperone policy, the consent protocol, the complaints procedure as well as the disaster handling and business continuity plan document. We looked at 26 such documents and saw that four were not dated so it was not clear when they were written or when they came into use. Fourteen documents did not contain a planned review date. The practice was unable to demonstrate that they had a system to help ensure all governance documents were kept up to date.

There was a leadership structure with named members of staff in lead roles. For example, the GP had lead responsibilities such as safeguarding vulnerable adults and children. All staff we spoke with were clear about their own roles and responsibilities. Staff we spoke with said they felt valued by the practice and able to contribute to the systems that delivered patient care.

The practice operated a clinical audit system that improved the service and followed up to date best practice guidance. There were plans to repeat audits to complete cycles of clinical audit. Some clinical staff we spoke with were not aware if the practice carried out any clinical audits and the practice was unable to demonstrate how results of clinical audits were shared with relevant staff.

The practice identified, recorded and managed some risks. It had carried out risk assessments where risks had been identified and action plans had been produced and

implemented. For example, a fire risk assessment. However, the practice had failed to identify risks associated with the some infection control issues in line with national guidance. For example, legionella.

The practice demonstrated human resources practices such as comprehensive staff induction training. Staff told us that they received yearly appraisals and GPs said they carried out relevant appraisal activity that now included revalidation with their professional body at required intervals and records confirmed this. There was evidence in staff files of the identification of training needs and continuing professional development.

Leadership, openness and transparency

The lead GP and practice manager were visible in the practice and staff told us that they were always approachable and always took time to listen to all members of staff. All staff were involved in discussions about how to run the practice and how to develop the practice.

Staff told us they felt well supported by colleagues and management at the practice. They said they were provided with opportunities to maintain skills as well as develop new ones in response to their own and patients' needs.

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

The practice took into account the views of patients and those close to them via feedback from the patient participation group (PPG), patient surveys, as well as comments and complaints received when planning and delivering services.

The practice was proactive in endeavouring to ensure that the PPG was representative of the practice population in terms of gender, age, ethnic background and included all patient population groups. Records demonstrated where comments and suggestions were put forward by PPG members were considered by the practice and improvements made where practicable. For example, improving patient awareness of the practice website.

The practice carried out a 2014 / 2015 patient survey that canvassed opinion from all patient population groups. Results had been collated and identified positive aspects of the practice. For example, patients rated positively the way

Are services well-led?

Good 

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

they were treated by reception staff. Records demonstrated that the practice had plans to address any changes required identified by the survey. For example, increasing awareness of the ability to book appointments on line.

The practice monitored comments and complaints left in reviews on the NHS Choices website. Five reviews had been left on this website in the last 12 months. Two were positive and three were negative. All the negative comments related to poor staff attitude. The practice had not responded to any of these reviews.

There were a variety of meetings held in order to engage staff and involve them in the running of the practice. For example, team meetings. Staff we spoke with told us they felt valued by the practice and able to contribute to the systems that delivered patient care. Minutes of staff

meetings demonstrated that staff suggestions were supported. For example, one member of staff suggested ways to reduce noise levels at reception which were implemented by the practice.

Management lead through learning and improvement

The practice valued learning. There was a culture of openness to reporting and learning from patient safety incidents. All staff were supported to update and develop their knowledge and skills. All staff we spoke with told us they had an annual performance review and personal development plan.

The practice had a system to investigate and reflect on incidents, accidents and significant events. All reported incidents, accidents and significant events were managed by dedicated staff. Staff told us that feedback from investigations was discussed at meetings and records confirmed this.

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 Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>How the regulation was not being met:</p> <p>Care and treatment was not always provided in a safe way for service users.</p> <p>The registered person was not: assessing all risks to the health and safety of service users receiving the care and treatment; doing all that was reasonably practical to mitigate any such risks; ensuring that persons providing care or treatment to service users had the qualifications, competence, skills and experience to do so safely; where equipment or medicines were supplied by the service provider, ensuring that there were sufficient quantities of these to ensure the safety of service users and to meet their needs; managing medicines safely and properly; assessing the risk of, and preventing, detecting and controlling the spread of infections, including those that are health care associated.</p> <p>Regulation 12(1)(2)(a)(b)(c)(f)(g)(h).</p>