

Care Quality Commission

Inspection Evidence Table

Marlowe Park Medical Centre (1-8970380005)

Inspection date: 2 November 2021

Date of data download: 06 October 2021

Overall rating: Good

Safe

Rating: Good

Safety systems and processes

The practice's systems, practices and processes helped to keep people safe and safeguarded from abuse.

| Safeguarding | |
|---|-----|
| There was a lead member of staff for safeguarding processes and procedures. | Yes |
| Policies and other documents covering adult and child safeguarding were accessible to all staff. They clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. | Yes |
| GPs and staff were trained to appropriate levels for their role and knew how to identify and report concerns. | Yes |
| The practice worked in partnership with other agencies to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect. Information about patients at risk was shared with other agencies in a timely manner. | Yes |
| Disclosure and Barring Service (DBS) checks were undertaken where required. | Yes |
| Staff who acted as chaperones were trained for their role. | Yes |
| Notices in the practice advised patients that chaperones were available if required. | Yes |

| Additional evidence or comments | |
|---|--|
| <p>The practice's computer system alerted staff of children that were on the risk register. Records showed there was only one child on the practice register that was subject to safeguarding at the time of our inspection. However, we looked at the records of this child and found that the practice's computer system did not alert staff of all family and other household members of this child.</p> <p>After our inspection the provider wrote to us and told us that appropriate alerts had now been added to the records of all family and other household members of this child.</p> | |

| Recruitment systems | |
|---|-----|
| Recruitment checks were carried out in accordance with regulations (including for agency staff and locums). | Yes |
| Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role. | Yes |
| There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored. | Yes |

| Safety systems and records | |
|--|-----|
| There were up to date fire risk assessments that incorporated an action plan to address issues identified. | Yes |
| The practice had a fire evacuation plan. | Yes |
| Records showed fire extinguishers were maintained in working order. | Yes |
| Records showed that the practice carried out fire drills. | Yes |
| Records showed that the fire alarm system was tested regularly. | Yes |
| The practice had designated fire marshals. | Yes |
| Staff were up to date with fire safety training. | Yes |
| All electrical equipment was checked to help ensure it was safe to use. | Yes |
| All clinical equipment was checked and where necessary calibrated to help ensure it was working properly. | Yes |

Infection prevention and control

There were systems and processes to help maintain appropriate standards of cleanliness and hygiene.

| | |
|--|---------|
| We observed the premises to be clean and all areas accessible to patients were tidy. | Partial |
| There was a lead member of staff for infection prevention and control who liaised with the local infection prevention teams to keep up to date with best practice. | Yes |
| There was an up to date infection prevention and control policy. | Yes |
| There was an up to date infection prevention and control audit that incorporated an action plan to address issues identified. | Yes |
| Relevant staff were up to date with infection prevention and control training. | Yes |
| There was a system to notify Public Health England of suspected notifiable diseases. | Yes |
| The arrangements for managing waste and clinical specimens kept people safe. | Yes |

Additional evidence or comments

At our inspection on 2 November 2021 we saw that all relevant staff were adhering to current best practice guidance on COVID-19. For example, wearing face coverings when interacting with patients face to face and maintaining social distancing in all area of the practice.

Hand sanitising gel was available throughout the practice for patients, staff and visitors to use.

We looked at the pull cords used to activate lights in four toilets and the cleaning storeroom at the practice and found that they were not covered in cleanable sleeves and were all visibly dirty.

We looked at three clinical wash-hand basins at the practice and found that all three had a plug in situ. This was not in line with Department of Health guidance.

We looked at the infection prevention and control (IPC) audit carried out on 31 August 2021 and found that it did not include any reference to the dirty pull cords. It also recorded that all clinical wash-hand basins were free from plugs which was incorrect.

The provider took action after our inspection and made necessary improvements to IPC issues found at this inspection. The provider wrote to us and told us that pull cords to activate lights in toilets had now been replaced with new cords and protective plastic sleeves so that they were able to be cleaned. The provider also wrote to us with evidence to show that plugs in clinical wash-hand basins at the practice had now been removed.

Risks to patients, staff and visitors

Risks to patients, staff and visitors were assessed, monitored or managed effectively.

| | |
|--|---------|
| The provider had systems to monitor and review staffing levels and skill mix. | Yes |
| There was an effective approach to managing staff absences and busy periods. | Yes |
| Staff knew how to respond to emergency situations. | Yes |
| All staff were up to date with basic life support training. | Yes |
| Emergency equipment and emergency medicines were available in the practice including medical oxygen and an automated external defibrillator (AED). | Partial |
| Records showed that emergency equipment and emergency medicines were checked regularly. | Yes |
| Emergency equipment and emergency medicines that we checked were within their expiry dates. | Yes |
| There was up to date written guidance for staff to follow in the event of major incidents that contained emergency contact telephone numbers. | Yes |
| There was written guidance for staff to follow to help them identify and manage deteriorating or acutely unwell patients. | Yes |
| Staff were up to date with training in how to identify and manage patients with severe infections. For example, sepsis. | Yes |
| There were a variety of health and safety risk assessments that incorporated action plans to address issues identified. | Partial |
| There was an up to date health and safety policy available with a poster in the practice which identified local health and safety representatives. | Yes |
| There was an up to date legionella risk assessment and an action plan to address issues identified. | Yes |

Additional evidence or comments

We looked at the training records of six members of staff and found that they were all up to date with basic life support training. However, records of one clinical member of staff's basic life support training showed that they had only completed this training online. After the inspection the provider wrote to us and told us that this member of staff planned to attain the practical element of this training in 2022.

We looked at emergency equipment and emergency medicines kept at Marlowe Park Medical Centre. There were inventories of the emergency equipment and emergency medicines held by the practice

as well as records to show checking took place regularly. However, we looked but could not find a spare set of adult defibrillation pads available in the practice. After the inspection the provider told us that a spare set of adult defibrillation pads had been purchased and were now available in the practice.

We found that some substances hazardous to health were not always stored securely in the locked cleaning storeroom of the practice. For example, we found two bottles of sink unblocker in an unlocked cupboard under the sink of the upstairs kitchen. We asked to see the control of substances hazardous to health (COSHH) risk assessments for the items we found. However, staff told us that COSHH risk assessments had not been completed for these items.

After our inspection the provider wrote to us and told us that these substances had now been removed.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment.

| Referral letters contained specific information to allow appropriate and timely referrals. | Yes |
|--|-----|
| Referrals to specialist services were documented. | Yes |
| The practice had a documented approach to the management of test results, and this was managed in a timely manner. | Yes |
| The practice demonstrated that when patients used multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols. | Yes |

Appropriate and safe use of medicines

The arrangements for managing medicines did not always keep patients safe.

| Indicator | Practice | CCG average | England average | England comparison |
|--|----------|-------------|-----------------|--------------------------|
| Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2020 to 30/06/2021) (NHS Business Service Authority - NHSBSA) | 0.68 | 0.73 | 0.69 | No statistical variation |
| The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2020 to 30/06/2021) (NHSBSA) | 10.4% | 10.6% | 10.0% | No statistical variation |

| Indicator | Practice | CCG average | England average | England comparison |
|--|----------|-------------|-----------------|--------------------------------------|
| Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2021 to 30/06/2021) (NHSBSA) | 7.79 | 5.89 | 5.38 | Variation (negative) |
| Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA) | 67.2‰ | 129.7‰ | 126.1‰ | Tending towards variation (positive) |
| Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2020 to 30/06/2021) (NHSBSA) | 0.47 | 0.67 | 0.65 | No statistical variation |
| Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA) | 4.4‰ | 6.7‰ | 6.7‰ | No statistical variation |

Note: ‰ means *per 1,000* and it is **not** a percentage.

| Medicines management | |
|---|-----|
| The practice ensured medicines were stored safely and securely with access restricted to authorised staff. | Yes |
| Blank prescription forms and pads were kept securely, and their use monitored in line with national guidance. | Yes |
| Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions). | Yes |
| There was a process for monitoring patients' health in relation to the use of medicines including high-risk medicines with appropriate monitoring and clinical review prior to prescribing. | Yes |
| The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance. | Yes |
| For remote or online prescribing there were effective protocols for verifying patient identity. | Yes |
| Medicines that required refrigeration were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective in use. | No |
| Up to date local prescribing guidelines were in use. | Yes |
| The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services. | Yes |
| Additional evidence or comments | |
| We looked at five patient group directions (PGDs) and found that all of them had been completed | |

correctly. However, none of the PGDs we looked at had had blank areas crossed through (to prevent the addition of more staff names after the authorising manager had signed the PGD). Two of the PGDs we looked at had expired on 31 October 2021. However, records showed that the practice had contacted Public Health Screening (PHS) on 28 October 2021 and been advised to continue to use the existing PGDs that were due to expire until replacement ones that were awaiting PHS regional sign off were sent to them.

After our inspection the provider wrote to us and told us that blank areas on all PGDs had now been crossed through and that their policy on PGDs had been revised to reflect this required action.

We looked at the records of:

- Five patients who were prescribed warfarin. We found that all these patients' records showed that best practice guidance for the management of this high-risk medicine had been followed.
- Five patients who were prescribed methotrexate. We found that all these patients' records showed that best practice guidance for the management of this high-risk medicine had been followed.
- One patient who was prescribed lithium. We found that this patients' records showed that best practice guidance for the management of this high-risk medicine had been followed.
- Four patients who were prescribed morphine sulphate (a controlled drug). We found that all these patients' records showed that best practice guidance for the management of this high-risk medicine had been followed.

Medicines that required refrigeration were stored in one designated medicines refrigerator at Marlowe Park Medical Centre. We looked at the temperature monitoring records for this refrigerator. Records showed that the temperature of the medicines refrigerator had been recorded as being outside of the acceptable limits (of between two and eight degrees centigrade) on 11 occasions between 2 January 2021 and 2 November 2021. Staff told us that there was written guidance for staff to follow if the temperature of the designated medicines refrigerator went outside of acceptable limits. For example, the cold chain policy. However, we looked at this policy and could only find guidance for staff to follow if the designated medicine refrigerator failed. We asked if there was any other guidance available for staff to follow in this situation. Staff gave us another document entitled 'fridge monitoring flowchart'. However, the document was dated 2012-2013 so we could not be sure it was up to date. The document did not carry any reference to Marlowe Park Medical Centre. The document indicated it was for use by staff at NHS Greater Manchester, therefore, we could not be sure it was specific to the practice. The document indicated that staff should complete an IR1 form if the temperature of the designated medicines refrigerator was recorded as being outside of acceptable limits. However, staff told us that no such forms were used at the practice.

We asked to see evidence that showed the action taken by staff on every occasion when records showed that the temperature of the designated medicines refrigerator went outside of the acceptable limits. However, staff told us that there were no such records kept.

After our inspection the provider sent us evidence to show that written guidance for staff to follow in the event of a break in the cold chain storage of medicines that required refrigeration had been revised. The provider also told us that this revised guidance had been disseminated to all relevant staff.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

| Significant events | Y/N/Partial |
|---|-------------|
| There was a system for recording and acting on significant events. | Yes |
| There was up to date written guidance available for staff to follow to help them identify, report and manage any significant events. | Yes |
| Staff knew how to identify and report concerns, safety incidents and near misses both internally and externally. | Yes |
| Number of events recorded in last 12 months: | 9 |
| Records showed that the practice had carried out a thorough analysis of reported significant events. | Yes |
| There was evidence of learning and dissemination of information from significant events. | Yes |
| Additional evidence or comments | |
| <p>We looked at the records of one significant event that had been recorded as taking place at Marlowe Park Medical Centre within the last 12 months. We saw that details of the events reported by staff had been investigated, and necessary action taken. Records showed that learning had been discussed at a practice meeting to help reduce the risk of it happening again.</p> | |

| Safety alerts | |
|--|---------|
| The practice had systems for managing safety alerts. | Yes |
| Information from safety alerts was shared with staff. | Yes |
| Staff understood how to deal with safety alerts. | Yes |
| The practice acted on and learned from safety alerts. | Partial |
| The practice kept records of action taken (or if no action was necessary) in response to receipt of all safety alerts. | Yes |
| Additional evidence or comments | |
| <p>During our clinical searches, we reviewed two safety alerts and found recent alerts had been managed well. For example, an alert relating to the medicine sodium valproate. However, one alert relating to the medicine mirabegron had not been managed appropriately. For example, we looked at the records of five patients who were prescribed mirabegron but could not find evidence to show that any of these patients had been informed of the risks associated with taking this medicine.</p> <p>After our inspection the provider wrote to us and told us that four of these patients had now received relevant counselling. They also told us that the remaining patient had been contacted and advised to book for a medicine review where they would provide relevant counselling.</p> | |

Effective

Rating: Requires Improvement

QOF requirements were modified by NHS England for 2020/21 to recognise the need to reprioritise aspects of care which were not directly related to COVID-19. This meant that QOF payments were calculated differently. For inspections carried out from 1 October 2021, our reports will not include QOF indicators. In determining judgements in relation to effective care, we have considered other evidence as set out below.

We rated the practice as Requires Improvement for providing effective services because:

- Patients' needs were assessed, but care and treatment were not always delivered in line with current legislation, standards and evidence-based guidance.
- The practice had a programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. The pandemic had had a detrimental effect on the practice's ability to deliver some care as well as treatment. However, improvements were required for some types of patient reviews as well as some subsequent follow up activities.

Effective needs assessment, care and treatment

Patients' needs were assessed, but care and treatment were not always delivered in line with current legislation, standards and evidence-based guidance.

| | |
|--|---------|
| | |
| The practice had systems and processes to help keep clinicians up to date with current evidence-based practice. | Yes |
| Staff had access to guidance from NICE and used this information to deliver care and treatment that met patients' needs. | Yes |
| Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. | Partial |
| Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. | Partial |
| We saw no evidence of discrimination when staff made care and treatment decisions. | Yes |
| Patients' treatment was regularly reviewed and updated. | Partial |
| There were appropriate referral pathways to make sure that patients' needs were addressed. | Yes |
| Patients were told when they needed to seek further help and what to do if their condition deteriorated. | Yes |
| Additional evidence or comments | |
| Patients with long-term conditions, such as asthma, chronic obstructive pulmonary disease (COPD), | |

diabetes, hypertension, atrial fibrillation (AF) and patients experiencing poor mental health (including dementia) were receiving relevant reviews. However, records showed that one patient had not received an AF review since September 2019 and another patient had not been followed up since July 2021 when their diabetes blood test result at the time of their review was higher than normal limits.

Monitoring care and treatment

The practice had a programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. The pandemic had had a detrimental effect on the practice's ability to deliver some care as well as treatment. However, improvements were required for some types of patient reviews as well as some subsequent follow up activities.

| Clinicians took part in national and local quality improvement initiatives. | Yes |
|--|-----|
| The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements. | Yes |
| The practice regularly reviewed unplanned admissions and readmissions and took appropriate action. | Yes |

Effective care for the practice population

| Findings |
|--|
| <p>The practice used a clinical tool to identify older patients who were living with moderate or severe frailty.</p> <p>Those identified received a full assessment of their physical, mental and social needs.</p> <p>Health checks, including frailty assessments, were offered to patients over 75 years of age.</p> <p>Influenza, shingles and pneumonia vaccinations were offered to relevant patients in this age group.</p> <p>The practice had systems to inform eligible patients to have the meningitis vaccine. For example, before attending university for the first time.</p> <p>Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74.</p> <p>There was an automated blood pressure monitoring device in the reception area for patients to self-check their blood pressure readings.</p> <p>Patients with suspected hypertension were offered ambulatory blood pressure monitoring.</p> <p>All patients with a learning disability were offered an annual health check.</p> |

End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.

The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

The practice demonstrated that they had a system to identify people who misused substances.

The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder.

Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long-term conditions

Findings

Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.

We looked at the records of:

- Five patients who were diagnosed with asthma. Records showed that all five patients had received an asthma review in line with best practice guidance.
- Five patients who were diagnosed with chronic obstructive pulmonary disease (COPD). Records showed that all five patients had received a COPD review in line with best practice guidance.
- Five patients who were diagnosed with diabetes. Records showed that all five patients had received a diabetes review in line with best practice guidance. One of these patient's records showed that their diabetes blood test result from 12 July 2021 required further action by the practice. However, we looked but could not find evidence to show that any action had been taken. After our inspection the provider wrote to us and told us that they had carried out searches of their computer records and identified patients whose blood test results from July 2021 required further action by the practice. They also told us that two of these patients were receiving care and treatment from the local community diabetes team and the remaining patient failed to attend two appointments with practice nursing staff and had now been referred to the local community diabetes team.
- Five patients who were diagnosed with hypertension. Records showed that all five patients had received a hypertension review in line with best practice guidance.
- Five patients who were diagnosed with atrial fibrillation (AF). However, we looked but could not see that one of these patients was on the practice's AF register. Another of these patient's records showed that they had not received an AF review since September 2019. This was not in line with best practice guidance. After our inspection the provider wrote to us and told us that a review of all patients suspected or confirmed with AF had been undertaken and they were confident that their AF register was now up to date. They also told us that the patient that had not received an AF review since September 2019 had now been reviewed.
- Five patients who were diagnosed with mental health conditions. Records showed that all five had received a mental health review in line with best practice guidance.
- Five patients who were diagnosed with dementia. Records showed that all five had received a dementia review in line with best practice guidance.

- Five patients who were receiving palliative care and found that end of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.

Staff who were responsible for reviews of patients with long-term conditions had received specific training.

GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.

The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.

We completed a series of searches on the practice’s clinical record system. These searches were completed to review if the practice was assessing and delivering care and treatment in line with current legislation, standards and evidence-based guidance. Our searches identified:

The practice could demonstrate how they identified patients with commonly undiagnosed conditions. For example, chronic kidney disease (CKD). However:

- Ten patients were identified as having a potential missed diagnosis of diabetes. We reviewed all ten of these patients’ records and found all ten met the criteria for having a diagnosis of diabetes. The national recommendation for diagnosing diabetes is a blood test result (HbA1c) of 48mmol/mol and above. All ten of these patients’ records contained a record of an HbA1c over the national recommendation. It was unclear if these patients had diabetes as they had not been followed up appropriately in line with national guidance and diabetes management. We looked but could not find evidence to show that any of these patients had been referred to eye screening, commenced medication, received a foot check or been invited for further or annual reviews.
- After our inspection the provider wrote to us and told us that they had taken action to help ensure these patients were followed up appropriately.
- 69 patients (out of a total of 228) who were diagnosed with hypothyroidism had not had a thyroid stimulating hormone blood test carried out and noted in their records in the last 18 months. This was not in line with best practice guidance for the management of this condition.
- After our inspection the provider wrote to us and told us that, following investigation, they had discovered significant historic coding issues existed that were inherited from the previous provider of services at Marlowe Park Medical Centre. They also told us that the coding issues had been rectified since our inspection and an updated search revealed that 177 patients were diagnosed with hypothyroidism, of which 21 had not had a thyroid stimulating hormone blood test carried out and noted in their records in the last 18 months.

| Child Immunisation | Numerator | Denominator | Practice % | Comparison to WHO target of 95% |
|--|-----------|-------------|------------|---------------------------------|
| The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2019 to 31/03/2020) (NHS England) | 38 | 41 | 92.7% | Met 90% minimum |

| | | | | |
|---|----|----|-------|--------------------------|
| The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2019 to 31/03/2020) (NHS England) | 43 | 45 | 95.6% | Met 95% WHO based target |
| The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2019 to 31/03/2020) (NHS England) | 43 | 45 | 95.6% | Met 95% WHO based target |
| The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England) | 43 | 45 | 95.6% | Met 95% WHO based target |
| The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England) | 43 | 49 | 87.8% | Below 90% minimum |

Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

| Additional evidence or comments |
|---|
| Childhood immunisations were carried out in line with the national childhood vaccination programme. NHS England results (published in March 2020) showed that uptake rates were lower than the target percentage of 90% or above in one out of the five indicators. However, unverified data showed that uptake rates had improved since then and 100% had been achieved for the indicator that had been below the target percentage. |

| Cancer Indicators | Practice | CCG average | England average | England comparison |
|--|----------|-------------|-----------------|--------------------|
| The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 31/03/2021) (Public Health England) | 73.7% | N/A | 80% Target | Below 80% target |
| Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE) | 67.7% | 70.6% | 70.1% | N/A |
| Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2019 to 31/03/2020) (PHE) | 50.6% | 64.3% | 63.8% | N/A |

| | | | | |
|---|-------|-------|-------|--------------------------|
| Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2019 to 31/03/2020) (PHE) | 42.9% | 55.3% | 54.2% | No statistical variation |
|---|-------|-------|-------|--------------------------|

Additional evidence or comments

Published results showed that the practice's uptake for cervical screening as at March 2021 was below the 80% coverage target for the national screening programme. However, unverified data showed that uptake rates had improved since then and:

- 85% of eligible patients aged 50 to 64 years registered at the practice had received cervical screening.
- 80% of eligible patients aged 25 to 49 years registered at the practice had received cervical screening.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

| There was an induction programme for new staff. | Yes |
|---|-----|
| The learning and development needs of all staff were assessed. | Yes |
| All staff were up to date with essential training. | Yes |
| All staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. | Yes |
| Clinical staff were supported to meet the requirements of professional revalidation. | Yes |
| The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice. | Yes |
| There was a clear approach for supporting and managing staff when their performance was poor or variable. | Yes |

Coordinating care and treatment

Staff worked together and with other organisations to deliver effective care and treatment.

| Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved. | Yes |
|---|-----|
| Patients received consistent, coordinated, person-centered care when they moved between services. | Yes |

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

| The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers. | Yes |
|---|-----|
| Staff encouraged and supported patients to be involved in monitoring and managing their own health. | Yes |
| Patients had access to appropriate health assessments and checks. | Yes |
| Staff discussed changes to care or treatment with patients and their carers as necessary. | Yes |
| The practice supported national priorities and initiatives to improve the population's health. For example, stop smoking campaigns and tackling obesity. | Yes |

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

| Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented. | Yes |
|--|-----|
| Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision. | Yes |
| Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. | Yes |

Caring

Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

| | |
|---|-----|
| Staff understood and respected the personal, cultural, social and religious needs of patients. | Yes |
| Staff displayed understanding and a non-judgmental attitude towards patients. | Yes |
| Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition. | Yes |

National GP Patient Survey Results published in July 2021

| Indicator | Practice | CCG average | England average | England comparison |
|---|----------|-------------|-----------------|--------------------------|
| The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2021 to 31/03/2021) | 86.9% | 87.9% | 89.4% | No statistical variation |
| The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2021 to 31/03/2021) | 84.0% | 87.0% | 88.4% | No statistical variation |
| The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2021 to 31/03/2021) | 92.7% | 95.2% | 95.6% | No statistical variation |
| The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2021 to 31/03/2021) | 76.7% | 79.8% | 83.0% | No statistical variation |

| | | | | |
|--|-------|-------|-------|--------------------------|
| The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2021 to 31/03/2021) | 88.1% | 92.9% | 92.9% | No statistical variation |
|--|-------|-------|-------|--------------------------|

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

| | |
|---|-----|
| Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given. | Yes |
| Staff helped patients and their carers find further information and access community and advocacy services. | Yes |

| | |
|---|-----|
| Interpretation services were available for patients who did not have English as a first language. | Yes |
| Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations. | Yes |
| Information about support groups was available on the practice website. | Yes |

| Carers | Narrative |
|---|---|
| Percentage and number of carers identified. | The practice had identified 41 (1%) patients who were carers. |
| How the practice supported carers (including young carers). | <p>During phase one of the covid vaccination programme, patients proactively contacted the practice to inform them that they were a carer.</p> <p>The practice signed up with Carers First as part of their Health and Wellbeing Project to review the carer's register at Marlowe Park Medical Practice and help identify new carers.</p> <p>There were plans for Carers First information to be included in the next newsletter produced by the practice's patient participation group (PPG).</p> <p>Carers have been proactively contacted by the practice and invited to attend for an annual influenza vaccination and are offered NHS Health Checks.</p> <p>The practice's computer system alerted staff to patients who were carers and clinicians had been instructed to ask if help was required so that referral to the Social Prescriber could be made when necessary.</p> |

| | |
|--|--|
| How the practice supported recently bereaved patients. | Bereaved patients were sent a sympathy card and offered a telephone call to speak with practice staff about their bereavement. There were also posters in the practice that directed patients to bereavement support services. |
|--|--|

Privacy and dignity

The practice respected patients' privacy and dignity.

| Privacy and dignity | |
|---|-----|
| A private room was available if patients were distressed or wanted to discuss sensitive issues. | Yes |
| There were arrangements to ensure confidentiality at the reception desk. | Yes |

Responsive

Rating: Good

Responding to and meeting people's needs

The practice organised and delivered services to help meet patients' needs.

| | |
|--|-----|
| | |
| The practice understood the needs of its local population and had developed services in response to those needs. | Yes |
| The importance of flexibility, informed choice and continuity of care was reflected in the services provided. | Yes |
| The facilities and premises were appropriate for the services being delivered. | Yes |
| The practice made reasonable adjustments when patients found it hard to access services. | Yes |
| There were arrangements for people who need translation services. | Yes |
| All patients had been allocated to a designated GP to oversee their care and treatment. | Yes |
| The practice complied with the Accessible Information Standard. | Yes |

Further information about how the practice is responding to the needs of their population

Patients had a named GP who supported them in whatever setting they lived.

The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.

The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.

Appointments were available outside of school hours so that school age children did not need to miss school in order to receive care and treatment.

The practice hosted sexual health clinics on behalf of Public Health.

The practice held a register of patients living in vulnerable circumstances including homeless people, Travelers and those with a learning disability. Services were delivered to patients with learning disabilities who lived locally in three residential homes.

People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travelers.

The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

The practice had its own car park with designated parking available for patients with mobility issues.

Patient toilets were available that included ones that were suitable for use by people with mobility issues.

Baby changing facilities were available.

A hearing loop was available at the practice reception to assist patients who were hard of hearing or deaf.

Access to the service

People were able to access care and treatment in a timely way.

The COVID-19 pandemic has affected access to GP practices and presented many challenges. In order to keep both patients and staff safe early in the pandemic practices were asked by NHS England to assess patients remotely (for example by telephone or video consultation) when contacting the practice and to only see patients in the practice when deemed to be clinically appropriate to do so. Following the changes in national guidance during the summer of 2021 there has been a more flexible approach to patients interacting with their practice. During the pandemic there was a significant increase in telephone and online consultations compared to patients being predominantly seen in a face to face setting.

| Practice Opening Times | |
|------------------------|------------------------------|
| Day | Time |
| Monday | 8am to 1pm and 3pm to 6.30pm |
| Tuesday | 8am to 1pm and 3pm to 6.30pm |
| Wednesday | 8am to 1pm and 3pm to 6.30pm |
| Thursday | 8am to 12pm |
| Friday | 8am to 1pm and 3pm to 6.30pm |

| | |
|--|-----|
| There was information available for patients to support them to understand how to access services. | Yes |
| The practice had a website and patients were able to book appointments via the triage system or order repeat prescriptions online. | Yes |
| The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online). | Yes |
| There were systems to support patients who face communication barriers to access treatment. | Yes |
| Patients with urgent needs had their care prioritised. | Yes |

| | |
|--|-----|
| The practice had systems to ensure patients were directed to the most appropriate person to respond to their immediate needs. | Yes |
| There were arrangements with other providers to deliver services to patients outside of the practice's working hours. | Yes |
| The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention. | Yes |

National GP Patient Survey Results published in July 2021

| Indicator | Practice | CCG average | England average | England comparison |
|-----------|----------|-------------|-----------------|--------------------|
|-----------|----------|-------------|-----------------|--------------------|

| | | | | |
|---|-------|-------|-------|--------------------------|
| The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2021 to 31/03/2021) | 42.7% | N/A | 67.6% | Variation (negative) |
| The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2021 to 31/03/2021) | 57.6% | 66.3% | 70.6% | No statistical variation |
| The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2021 to 31/03/2021) | 57.8% | 62.8% | 67.0% | No statistical variation |
| The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2021 to 31/03/2021) | 81.6% | 80.5% | 81.7% | No statistical variation |

Additional evidence or comments

Staff told us that action had been taken to address the results of the national GP patient survey results published in July 2021. For example, a specific telephone system had been introduced to help improve telephone access. Staff also told us that the practice had plans to carry out their own patient survey to establish if the new telephone system had improved patient satisfaction scores or if any other improvements were required.

Listening and learning from concerns and complaints

Complaints were listened to and used to improve the quality of care. However, acknowledgement of complaints and outcome replies to complainants were not always recorded.

| Complaints | |
|---|-----|
| The practice had a system for handling complaints and concerns. | Yes |
| The practice's complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. | Yes |
| Information was available to help patients understand the complaints system. | Yes |
| Number of complaints received in the last 12 months. | 6 |
| Additional evidence or comments | |
| We looked at the records of one complaint reported within the last 12 months. Staff told us that this complaint had been acknowledged verbally and, after investigation, was replied to verbally. However, there were no records to confirm this. Records did show that the complaint had been investigated and that learning from the complaint had been shared with relevant practice staff at practice meetings. | |

Well-led

Rating: Good

Leadership, capacity and capability

There was compassionate and inclusive leadership at all levels.

| | |
|---|-----|
| | |
| Leaders demonstrated that they understood the challenges to quality and sustainability. | Yes |
| Leaders had identified the actions necessary to address these challenges. | Yes |
| Staff reported that leaders were visible and approachable. | Yes |
| Additional evidence or comments | |
| <p>Clinical leadership (including clinical supervision) at Marlowe Park Medical Centre was provided by one of the GP partners although all staff were able to contact any of the GP partners at any time if required.</p> <p>Overall leadership was provided by Aspire Medical Health centrally by staff. This included three GP partners, a Director of Operations, and an Operations Manager.</p> <p>Staff told us that the GP partners and practice management were approachable and always took time to listen to all members of staff.</p> | |

Vision and strategy

The practice had a vision to deliver high quality care and promote good outcomes for patients.

| | |
|---|-----|
| | |
| The practice had a clear vision and set of values that prioritised quality and sustainability. | Yes |
| There was a realistic strategy to achieve their priorities. | Yes |
| The vision, values and strategy were developed in collaboration with staff, patients and external partners. | Yes |
| Staff knew and understood the vision, values and strategy and their role in achieving them. | Yes |
| Additional evidence or comments | |
| <p>The provider had an aims, mission and vision statement and a statement of purpose which reflected the visions of the practice.</p> | |

Culture

The practice had a culture of high-quality sustainable care.

| Staff told us there was an open culture within the practice and they felt confident and supported to raise any issues. | Yes |
|--|-----|
| The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy. | Yes |
| Additional evidence or comments | |
| Staff told us they felt respected, valued and supported locally by the practice and by their colleagues. They also told us that felt supported by the Aspire Medical Health management team. | |

Governance arrangements

There were processes and systems to support good governance and management.

| There was a clear staffing structure and staff were aware of their own roles and responsibilities. | Yes |
|--|-----|
| The provider had systems that helped to keep governance documents up to date. | Yes |
| Governance documents that we looked at were up to date. | Yes |

Managing risks, issues and performance

There were processes for managing risks, issues and performance. However, improvements to the management of some risks were required.

| There were effective arrangements for identifying, recording, managing and mitigating risks. | Partial |
|--|---------|
| There were processes to manage performance. | Yes |
| Clinical and internal audit was used to monitor quality and to make improvements. | Yes |
| Records showed that the provider had analysed all clinical audit results and implemented action plans to address findings. | Yes |
| Records showed that all clinical audits had been repeated or were due to be repeated to complete the cycle of clinical audit. | Yes |
| There was written guidance for staff to follow in the event of major incidents that contained emergency contact telephone numbers. | Yes |

Additional evidence or comments

Improvements were required to the provider's processes and systems for the management of risks from:

- Management of medicines that required refrigeration.
- Management of one historic safety alert.
- Management of some patient reviews and some subsequent follow up activities.

After our inspection the provider wrote to us and told us that they had taken action and made improvements to their processes and systems that managed these risks.

The provider had systems to continue to deliver services, respond to risk and meet patients' needs during the pandemic.

| | |
|---|-----|
| The practice had adapted how it offered appointments to meet the needs of patients during the pandemic. | Yes |
| The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access. | Yes |
| There were systems to help identify and manage patients who needed a face-to-face appointment. | Yes |
| The practice actively monitored the quality of access and made improvements in response to findings. | Yes |
| There were recovery plans to help manage backlogs of activity and delays to treatment. | Yes |
| Changes had been made to infection control arrangements to protect staff and patients using the service. | Yes |
| Staff were supported to work remotely where applicable. | Yes |

Appropriate and accurate information

The practice acted on appropriate and accurate information.

| | |
|---|-----|
| Quality and operation information was used to help monitor and improve performance. | Yes |
| The provider submitted data or notifications to external organisations as required. | Yes |
| There were arrangements in line with data security standards for the integrity and confidentiality of patient identifiable data, records and data management systems. | Yes |

Governance and oversight of remote services

| The practice used digital services securely and effectively and conformed to relevant digital and information security standards. | Yes |
|---|-----|
| The provider was registered as a data controller with the Information Commissioner's Office. | Yes |
| Patient records were held in line with guidance and requirements. | Yes |
| Patients were informed and consent obtained if interactions were recorded. | Yes |
| The practice ensured patients were informed how their records were stored and managed. | Yes |
| Patients were made aware of the information sharing protocol before online services were delivered. | Yes |
| The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services. | Yes |
| Online consultations took place in appropriate environments to ensure confidentiality. | Yes |
| The practice advised patients on how to protect their online information. | Yes |

Engagement with patients, the public, staff and external partners

The practice involved the public, staff and external partners to help ensure they delivered high-quality and sustainable care.

| Patient views were acted on to improve services and culture. | Yes |
|---|-----|
| The practice had an active Patient Participation Group (PPG). | Yes |
| The practice gathered feedback from patients through the PPG. | Yes |
| The practice gathered feedback from patients through analysis of the results of the national GP patient survey. | Yes |
| Staff views were reflected in the planning and delivery of services. | Yes |
| The practice worked with stakeholders to build a shared view of challenges and of the needs of the population. | Yes |

Reviews left on the NHS Choices website

| | |
|--|---|
| Total reviews | 2 |
| Number of reviews that were positive about the service | 2 |

| | |
|--|---|
| Number of reviews that were mixed about the service | 0 |
| Number of reviews that were negative about the service | 0 |

| Experience shared with CQC directly via our website | |
|---|---|
| Total received | 4 |
| Number received which were positive about the service | 0 |
| Number received which were mixed about the service | 0 |
| Number which were negative about the service | 4 |

| Examples of feedback received | Source |
|---|---|
| <ul style="list-style-type: none"> All reviews left on the NHS Choices website about services at Marlowe Park Medical Centre were positive. The main theme from feedback we received from patients was that they found it difficult contacting the practice by telephone. | Reviews left on the NHS Choices website and experience shared with CQC directly via our website over the last 12 months |

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

| The practice made use of reviews of incidents. | Yes |
|---|-----|
| Learning was shared effectively and used to make improvements. | Yes |
| Additional evidence or comments | |
| Significant events and complaints were used to make improvements and any learning shared with relevant staff. Staff were made aware at a clinical meeting that more care was to be taken when sending tasks to reception. Meeting minutes indicated that clinicians' workloads were reviewed and that the standard operating procedure for making referrals was included in the clinical pack (used by clinical staff to guide them whilst working at Marlowe Park Medical Centre). | |

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a “z-score” (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator, but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

N.B. Not all indicators in the evidence table are part of the GP insight set and those that aren't will not have a variation band.

The following language is used for showing variation:

| Variation Bands | Z-score threshold |
|--------------------------------------|------------------------|
| Significant variation (positive) | ≤ -3 |
| Variation (positive) | > -3 and ≤ -2 |
| Tending towards variation (positive) | > -2 and ≤ -1.5 |
| No statistical variation | < 1.5 and > -1.5 |
| Tending towards variation (negative) | ≥ 1.5 and < 2 |
| Variation (negative) | ≥ 2 and < 3 |
| Significant variation (negative) | ≥ 3 |

Note: for the following indicators the variation bands are different:

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have “Met 90% minimum” have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link:
<https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Note: The CQC GP Evidence Table uses the most recent validated and publicly available data. In some cases at the time of inspection this data may be relatively old. If during the inspection the practice has provided any more recent data, this can be considered by the inspector. However, it should be noted that any data provided by the practice will be unvalidated and is not directly comparable to the published data. This has been taken into account during the inspection process.

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **PHE:** Public Health England.
- **QOF:** Quality and Outcomes Framework.
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.
- ‰ = per thousand.