

Care Quality Commission

Inspection Evidence Table

Montpelier Health Centre (1-570904430)

Inspection date: 3 and 9 September 2021

Date of data download: 02 September 2021

Overall rating: add overall rating here

At our last inspection in June 2019 we rated the service as requires improvement overall. With the key questions of effective, caring and responsive rated as good; and the key questions of effective and well-led rated as requires improvement. Due to the overall rating of requires improvement, all population groups were rated as requires improvement.

We found governance systems did not clearly demonstrate an embedded programme of assessment, monitoring or mitigation of risk. Practice's systems did not ensure consistently appropriate exception reporting or give assurances that all patients received appropriate care and treatment. Staff training was not delivered in line with the practice's policy and oversight of staff's training compliance was not embedded. We identified a breach of the Regulation 17 (Good Governance) and issued a requirement notice.

At this inspection we found the practice had taken action to address the shortfalls and had complied with the requirement under the Regulation 17.

Please note: Any Quality and Outcomes Framework (QOF) data relates to 2019/20.

Safe

Rating: Good

Safety systems and processes

The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Yes
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
There were policies covering adult and child safeguarding which were accessible to all staff.	Yes
Policies and procedures were monitored, reviewed and updated.	Yes
Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes

Safeguarding	Y/N/Partial
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
Staff who acted as chaperones were trained for their role.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> All staff had received training on safeguarding to the appropriate level depending of their job their roles. The practice were aware of the diverse patient population and safeguarding concerns which may arise, such as female genital mutilation (FGM). Staff had been provided with specific training on FGM and were able to describe how they would identify a potential FGM concern. Monthly safeguarding meetings were carried out and patient records were coded to indicate safeguarding concerns. The practice were in the process of registering asylum seekers and were aware that this population group would need specific care and support, due to their experiences and ethnic backgrounds, to enable them to settle into their new homes. 	

Recruitment systems	Y/N/Partial
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	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: 03/11/2020	Yes
There was a record of equipment calibration. Date of last calibration: 29/9/2020 and 30/11/2020	Yes
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Yes
There was a fire procedure.	Yes
A fire risk assessment had been completed. Date of completion: 07/09/2020, a review was due in 2022 as stated on the risk assessment.	Yes
Actions from fire risk assessment were identified and completed.	Yes

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 14/06/2021 and 10/08/2021	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: On the 10 and 25 August 2021.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Fire doors were seen to be wedged open. This had been noted on a fire risk assessment carried out by NHS Estates that owned the site. We saw they recorded this action had been completed. However, this was not the case and appropriate fire closure systems are required to be fitted to ensure the health, safety and welfare of people using the premises. The action was needed to be taken by NHS Estates who were the responsible body for carrying out this work, as they were landlords of the property. • There had been an issue with ensuring stable room temperatures in the clinical room used by nurses. This area was situated in the building owned by NHS Estates. To address it, practice staff were using electric fans, which had been risk assessed, to try and cool the air temperature, as the design of the building did not allow for effective air flow. The practice had purchased ambient fridges to store medicines at the correct temperature. Ambient fridges protect medicines from being stored about the required temperature which can lead to medicines not being effective and needing to be destroyed. The local clinical commission group had inspected the building and recommended the premises were updated. 	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Yes
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 21/06/2021	Yes
The practice had acted on any issues identified in infection prevention and control audits.	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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • All staff had received infection control training in the past year. • Throughout the COVID-19 pandemic the practice had followed guidance on enhanced infection control measures and provided staff with regular updates on working practice. • There was an isolation room available for potential COVID-19 positive patients or those who were suspected of having an infectious condition. 	

- All clinical staff were responsible for cleaning their consulting rooms between patients, but clinicians did not always record the required cleaning had been carried out. Clinicians however confirmed to us, they carried out this task.

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation

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)	0.36	0.60	0.69	Significant Variation (positive)
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)	11.1%	10.5%	10.0%	No statistical variation
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)	5.27	4.64	5.38	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA)	64.2‰	94.0‰	126.0‰	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)	0.80	0.58	0.65	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2020 to 31/03/2021) (NHSBSA)	5.2‰	5.0‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions 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).	Partial

Medicines management	Y/N/Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	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
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	n/a
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
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Patient group directives were in place and in date. Where some of the PGDs had names added and authorised, blank spaces were not crossed out when the authorisation forms had been first completed. Staff were aware of this and had put measures in place to ensure this did not reoccur when new PGDs were used. • As part of our remote clinical searches we reviewed patient records to ascertain the appropriate monitoring and clinical review was being undertaken prior to providing patients with repeat prescriptions. Where we found checks had not always been carried out, there were systems and processes in place to make sure required blood tests were carried out prior to a prescription being issued. However, some patients declined to attend for blood tests at recommended intervals. For example, five patients who were on azathioprine (an immunosuppressant used to calm or control the body's immune system), had not been monitored as needed. Their records showed that multiple attempts had been made by the practice to invite these patients in for a blood test. Contact included use of text messages, telephone calls and letters. On occasion appointments had been booked and patients still did not attend. 	

Medicines management	Y/N/Partial
<ul style="list-style-type: none"> Other clinical searches carried out on disease modifying drugs, such as methotrexate and high-risk medicines such as warfarin (a blood thinning medicine) showed that appropriate monitoring was carried out. The practice was situated in an area of high deprivation and had a diverse patient population, some of whom had complex physical and mental health needs. The practice worked with these patients to ensure their required tests had been opportunistically carried out. When needed, intervals between prescriptions were reduced so that patients would need to come to the practice to have tests carried out prior to a new prescription being issued. The recent national shortage of blood test tubes had also impacted on the practice's ability to carry out routine monitoring of patients' conditions. 	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	52
Number of events that required action:	52

Example(s) of significant events recorded and actions by the practice.

Event	Specific action taken
A video was posted on social media claiming that if a patient died it would be the fault of a particular member of staff.	<ul style="list-style-type: none"> Support was provided for the staff member affected. Further support and training was provided to all staff to enable them to be empowered and assertive in situations like this. Consideration was given to informing the police of this incident.
A patient attended the treatment room and when they were leaving accidentally dropped a package containing a white powder.	<ul style="list-style-type: none"> The clinician in the treatment room was not sure what the package contained and was concerned it could be illegal drugs. The package was appropriately disposed of in the clinical waste bin.
A patient came to the health centre to enquire about a prescription. After checking, it was determined that patient was not due the medicine and there were concerns the patient had overused their	<ul style="list-style-type: none"> The patient was dealt with in a professional manner, but making it clear there was no tolerance for their actions. Additional training for dealing with challenging patients had been provided to reception staff.

<p>medicine. The patient was informed of this and they became distressed and frustrated. The patient then began to shout and made abusive comments. Staff requested the patient left the premises and said if needed the police would be contacted. The patient left the practice while still shouting.</p>	<ul style="list-style-type: none"> • A request was made to the hostel where the patient lived to have someone to accompany the patient when they attended the practice.
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Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes
<p>Explanation of any answers and additional evidence: A combined alert was raised regarding prescribing spironolactone (used to treat fluid retention) and ACE inhibitors (used to treat heart failure, which can cause fluid retention). The alert said to ensure that six monthly blood tests were carried out and patients were on the recommended dose of each medicine, to avoid interactions which could affect a patient's health. Our searches showed there were 15 patients on this combination of medicine, five had not received appropriate monitoring. Of these two patients were managed by secondary care, one patient was housebound, and attempts had been made to arrange a suitable time for review. The other two patients had also been recalled on numerous occasions but had not responded to messages from the practice. Practice staff continued to work to engage these patients with their treatment.</p>	

Effective

Rating: Good

At our inspection in June 2019 we rated this domain as requires improvement as oversight of staff training was not effective and not all staff had received the training deemed as mandatory by the practice. Practice systems to ensure that patient records were coded correctly to demonstrate that appropriate care and treatment had been provided were not effective.

The practice had provided us with an action plan how they were going to address these shortfalls and we found at this inspectional had been addressed. The practice were aware patients would not always engage with care and treatment plans. They had a variety of ways to contact patients and provide opportunistic screening to promote uptake of monitoring and reviews. They were aware this had affected the overall performance in the Quality and Outcome framework (QoF) achievement.

An additional impact on QoF had been the COVID-19 pandemic, when measurement of achievement had been suspended during the lockdown periods.

Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
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

Older people

Population group rating: Good

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice carried out structured annual medicines reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.

- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions

Population group rating: Good

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.
- Staff who were responsible for reviews of patients with long-term conditions had received specialist 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.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions. (01/04/2019 to 31/03/2020) <small>(QOF)</small>	90.5%	76.1%	76.6%	Variation (positive)
PCA* rate (number of PCAs).	39.7% (456)	16.9%	12.3%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	99.4%	90.1%	89.4%	Variation (positive)
PCA rate (number of PCAs).	35.8% (93)	15.2%	12.7%	N/A

*PCA: Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	84.4%	81.7%	82.0%	No statistical variation
PCA* rate (number of PCAs).	12.7% (26)	7.0%	5.2%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	75.2%	68.2%	66.9%	No statistical variation
PCA rate (number of PCAs).	32.4% (218)	23.4%	15.3%	N/A
The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	67.6%	71.6%	72.4%	No statistical variation
PCA rate (number of PCAs).	16.4% (197)	9.6%	7.1%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2019 to 31/03/2020) <small>(QOF)</small>	86.0%	90.5%	91.8%	No statistical variation
PCA rate (number of PCAs).	5.0% (6)	4.4%	4.9%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	81.6%	74.9%	75.9%	No statistical variation
PCA rate (number of PCAs).	25.7% (173)	15.2%	10.4%	N/A

*PCA: Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

Any additional evidence or comments

The practice were aware of high PCA rates and continued to work on ensuring that patient records were coded accurately. The practice had identified that information was recorded as free text within patient records, which was not automatically included in reporting systems. Additional audits were being made to ensure this information was correctly coded.

The practice continued to encourage patients to engage in their care and treatment and to carry out tests and screening opportunistically.

Families, children and young people

Population group rating: **Good**

Findings

- The practice has not met the minimum 90% for all five childhood immunisation uptake indicators. The practice has not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for all five childhood immunisation uptake indicators. The practice explained there were diverse population groups which included asylum seekers, transient patients and anti-vaccine population on its register, which impacted on the uptake. They offered initiatives to improve uptake, such as additional immunisation clinics and providing information in different languages to encourage uptake. The practice were proactive in contacting patients to book appointments and remind them to attend.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

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)	174	204	85.3%	Below 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)	133	186	71.5%	Below 80% uptake
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)	133	186	71.5%	Below 80% uptake
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)	129	186	69.4%	Below 80% uptake
The percentage of children aged 5 who have received immunisation for measles,	154	192	80.2%	Below 90% minimum

mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)				
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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>

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could order repeat medicines online without the need to attend the surgery.

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)	64.9%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	63.5%	70.3%	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)	51.0%	63.4%	63.8%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis (01/04/2019 to 31/03/2020) (QoF)	92.1%	93.9%	92.7%	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)	52.6%	54.8%	54.2%	No statistical variation

Any additional evidence or comments

- The practice was aware their uptake rates were below the national target. They advised it was partially because of their patient demographics. We saw evidence the patients who did not have English as their first language, would receive an invite for a cervical screening in their preferred language.
- We were also told, patients who did not attend for their cervical screening were sent text message reminders.

- Support was provided to female patients to explain the process of cervical screening and allay fears.
- The practice was leading on cancer screening programmes within the Primary Care Network (PCN) to improve uptake of bowel and breast screening at the practice and across the PCN.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check. The practice had links with local learning disability home and were in the process of arranging a Christmas event.
- 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 they had a system to identify people who misused substances.
- The practice were in the process of registering refugees. They worked closely with the organisation who were supporting these patients.
- The practice carried out outreach work to connect with black and ethnic minority groups to encourage them to have COVID-19 vaccines, as they had identified there was hesitancy in this group to take up the vaccines. A member of the practice staff who was able to speak with patients in their first language facilitated this work.
- The practice provided care for transgender patients and prescribed hormones until an NHS assessment was carried out. They used the patients' preferred pronouns and were aware of the need to continue with appropriate health screening, for example, patients transitioning from female to male, still needed cervical screening tests.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- The practice assessed and monitored the physical health of people living with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medicines.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- All staff had received dementia training in the last 12 months.
- Patients with poor mental health, including those living with dementia, were referred to appropriate services.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	97.0%	87.4%	85.4%	No statistical variation
PCA* rate (number of PCAs).	47.3% (149)	21.4%	16.6%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	86.5%	80.7%	81.4%	No statistical variation
PCA rate (number of PCAs).	19.6% (9)	7.1%	8.0%	N/A

*PCA: Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

Any additional evidence or comments

- The practice had reviewed the process for personalised care adjustments and had clinically assessed the most effective way to engage patients in their care and treatment. They had looked at communication sent to patients and included information of why a review was needed, highlighting the importance of reviews to patients. When patients were invited for a review this was recorded in their records, which enabled the practice to check whether they had taken up the offer of a review.
- Due to the patient demographics most of the care and treatment was provided on the day for acute care. A clinical member of staff had been led on long term conditions and work was ongoing to reorganise services to concentrate monitoring of conditions into regular clinic sessions. A monthly audit was made of reviews carried out; patients who had not attended were contacted to arrange a time for their review.
- The practice was also continuing to ensure coding of records was completed accurately to reflect work carried out. The aim was to achieve a lower level of exception reporting, through proactive management of long-term conditions.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

Indicator	Practice	England average
Overall QOF score (out of maximum 559)	544.6	533.9
Overall QOF score (as a percentage of maximum)	97.4%	95.5%
Overall QOF PCA reporting (all domains)	10.2%	5.9%

	Y/N/Partial
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

Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years

<p>An audit was carried out in June 2021 of patients with asthma prescribed 12 or more inhalers in the past 12 months or 2 or more courses of oral corticosteroids in the past 12 months.</p> <p>Results showed:</p> <ul style="list-style-type: none"> • 71 patients were identified as requiring review of their asthma treatment and this was arranged. • 14 patients had treatment stepped up • 2 patients were referred to secondary care. • An issue of potential over-ordering by pharmacies was identified and the need for targeted medicines reviews to be carried out during the season when patients' asthma is worse. <p>An action plan had been put in place to address these issues and further audits were planned to monitor outcomes.</p>

Any additional evidence or comments
<p>The practice manager was responsible for ensuring monthly monitoring of PCA rates and QOF achievement which were discussed at the monthly executive meetings and reported quarterly to partners. These reports were shared with all staff to encourage a deeper understanding of the process and promote opportunistic working. (PCA: Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.)</p>

Effective staffing

The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They 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, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
Explanation of any answers and additional evidence: Training records were reviewed, and these demonstrated that all staff had received training considered mandatory by the practice.	

Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice were part of a connecting care project, whose other members included district nurses, care homes and homeless health services. They worked together to provide care and treatment for patients within their local area. NHS 111 service were able to book patients into dedicated appointments with the practice. There were issues when callbacks were required as the practice was unable to accommodate the time frames set by NHS 111 so patients' expectation was not always met. The practice carried out re-triaging of these appointments and would call back within an appropriate timeframe. Training had been provided to staff to undertake this work. 	

Helping patients to live healthier lives

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

	Y/N/Partial
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

Any additional evidence or comments

The practice worked with the primary care network's dietician to promote health eating and facilitated a session on Saturday mornings on cooking healthy, budget friendly meals.

Consent to care and treatment

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

	Y/N/Partial
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

Montpelier Health Centre was rated Good for the provision of Caring services as a result of our inspection in June 2019. In accordance with Care Quality Commission's methodology, the rating from our previous inspection for this key question has been carried through to contribute to the overall rating for the practice.

Responsive

Rating: Good

Montpelier Health Centre was rated Good for the provision of Responsive services as a result of our inspection in June 2019. In accordance with Care Quality Commission's methodology, the rating from our previous inspection for this key question has been carried through to contribute to the overall rating for the practice.

Well-led

Rating: Good

At our inspection in June 20219 we rated this key question as requires improvement. We found governance systems did not clearly demonstrate an embedded programme of assessment, monitoring or mitigation of risk.

We found:

- There was not effective oversight of staff training. Not all staff were up to date or had received training in line with practice policy and national guidance.
- Systems to ensure policies were consistently followed, were not embedded.
- Practice systems for exception reporting did not ensure this was always appropriate and that patients received necessary care and treatment.
- Processes to mitigate risks to patients and staff were not embedded. For example, systems to monitor blank prescriptions stationery.

We identified a breach of the Regulation 17 (Good Governance) and issued a requirement notice. The provider put in place an action plan to address these issues and at this inspection we found that compliance with the regulation had been achieved.

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels. Leaders demonstrated that they had the capacity and skills to deliver high quality sustainable care.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">• Partners were aware of the workforce challenges facing primary care and used staff appraisals across all teams to identify how staff wanted to develop and put in place opportunities for this to happen. For example, lead reception roles had been created since our previous inspection to provide oversight of this area of work.• GP partners were from different age groups and as some were planning for retirement, the skill mix of staff had been looked at. This resulted in new roles being introduced to assist with managing patients with long term conditions and urgent care, such as associate physicians.	

Vision and strategy

The practice had a clear vision and credible strategy to provide high quality sustainable care.

	Y/N/Partial
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
Progress against delivery of the strategy was monitored.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> The practice's strategic vision was to provide and support wellbeing at the heart of the community. There were four strategies underpinning the vision, which consisted of clinical, people, leadership and estates and business. High quality clinical care was a priority, along with making every contact with a patient count to meet their needs. The vision and strategy of the practice was documented in detailed plans and covered areas such as wellbeing, being a mindful employer and working together as a whole practice team. This work was supported by protected away days for leaders to monitor and discuss progress against the plan and team building days when constraints of the pandemic allowed. 	

Culture

The practice had a culture which drove high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes
Explanation of any answers and additional evidence:	

- Staff had received training on Freedom to Speak up and were actively encouraged to raise any concerns they may have. Staff confirmed they were able to speak freely and openly when needed.
- There was an emphasis on staff wellbeing, with checks made to ensure staff were taking annual leave and were able to take breaks at work if a situation had been stressful or upsetting. Staff said that they were able to take time out when needed and reception staff had access to a personal alarm when they worked on the front desk and in the reception area, due to the potential of some patients becoming abusive.

Examples of feedback from staff or other evidence about working at the practice

Source	Feedback
Staff feedback	Comments included the work of the care navigators being effective and cohesive, whereby patients were triaged appropriately and signposted to relevant sources of support if needed. Other comments included being supported at work and not being seen as part of a machine, with wellbeing of staff prioritised. The navigation process at the practice is cohesive and effective. The navigation staff triaged patient appropriately.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The practice had a schedule of regular meetings which covered areas such as significant events; clinical governance; complaints and performance. Daily coffee meetings were held to discuss patients and also provide wellbeing support for staff, as the practice experienced abusive patients at the practice regularly. • Learning was shared with staff groups through their meetings and a clinician would attend administration meetings to share learning and provide further information if needed. • The practice had a system to stored action plans from significant events, where updates on progress were recorded and monitored. A learning point document was sent to all staff, this document included themes and trends identified. Leaders were able to monitor whether staff had read the document. • Staff teams were structured, and responsible roles were allocated. The practice used transferable skills staff had to provide resilience and to promote positive communication between staff groups, such as operations and clinical teams. • A new system of monitoring blank prescriptions stationery had been put in place to comply with national guidance. • All risk assessments were logged on a database and action needed from these assessment were monitored, and actions taken recorded. 	

- There was also a focus on resilience of staff following the pressures of working during a pandemic, lockdowns and increased patient expectation and appointments requested.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Yes
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes

The practice had systems in place to continue to deliver services, respond to risk and meet patients' needs during the pandemic

	Y/N/Partial
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 in place to 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 in place to 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

There was a demonstrated commitment to using data and information proactively to drive and support decision making.

	Y/N/Partial
Staff used data to monitor and improve performance.	Yes
Performance information was used to hold staff and management to account.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes
Explanation of any answers and additional evidence: The practice maintained oversight of performance data and continued to work with patients to engage them in their care and treatment.	

Governance and oversight of remote services

	Y/N/Partial
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 sustain high quality and sustainable care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group.	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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> An annual report was produced for patients by the practice which detailed complaints received and actions taken to address concern. There was also information on how the practice made changes in response to national patient surveys. Information was also included on specific challenges facing the practice, such as changes to access during the COVID-19 pandemic. For example, use of eConsult, with an explanation of the reasoning behind using this so patients understood what constraints there were on appointments. 	

Feedback from Patient Participation Group.

Feedback
We did not receive feedback from the patient participation group as part of this inspection.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes

Examples of continuous learning and improvement
<ul style="list-style-type: none"> The practice was a training practice for doctors wanting to become GPs. Two GPs were Educational Supervisors and directly involved in supervising GP trainees. They hoped trainees would come back and work for the practice when they qualified. The medical student placements had been expanded and the practice provided experience for medical students from years one, two and three. Leaders actively encouraged learning and development, including leadership development and supporting newly qualified GPs to join the fellowship programme and having a programme of training in place which was monitored on a monthly basis. Other routes for development included personal reading, online learning, national and local guidance, daily clinical discussions. There was an ongoing project which was addressing patient access to make sure patients had the most appropriate appointment for their needs and increasing face to face appointments.

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 practice's 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.
- ***PCA:** Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see [GMS QOF Framework](#)). Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.
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- ‰ = per thousand.