Care Quality Commission

Inspection Evidence Table

Hilltops Medical Centre (1-566368759)

Inspection date: 9 December 2020

Date of data download: 01 December 2020

Overall rating: Requires Improvement

At the last inspection in October 2019 we rated the practice as requires improvement overall, good for all population groups and requires improvement for providing safe and well-led services because of failure to comply with Regulation 12 HSCA (RA) Regulations 2014 Safe Care and treatment.

These ratings remain unchanged following this remote review.

This report details our findings following the remote review of Hilltops Medical Centre undertaken 9 December 2020 as part of our transitional monitoring approach (TMA details on https://www.cqc.org.uk/guidance-providers/how-we-inspect-regulate/transitional-monitoring-approach-what-expect) to follow up on risks identified both from the previous inspection and our own intelligence monitoring. This inspection looked at the following key questions:

- **Safe**
- **Well-led**

During this remote review we asked the practice to comment on the lower than expected patient satisfaction to the latest GP survey in relation to the caring and responsiveness domain and looked at the practice complaints log.

We did not include the Effective domain in this remote review as it was rated Good in our previous inspection of 15 October 2019.

We did not undertake a site visit as part of this review.

Please note: Any Quality Outcomes Framework (QOF) data relates to 2017/18.

Safe Rating: Requires Improvement

The practice was previously rated as requires improvement for providing safe services because:

- Systems and processes to reduce risks to patient and staff safety needed strengthening.
- Risks to patients and staff had not adequately been assessed, in particular, those relating to staff immunity status, infection prevention and control (IPC), appropriate background checks for staff, significant events and safety alerts.

During this remote review we were provided with evidence to demonstrate:

- Patient and staff safety had not always been assessed and evidence of appropriate action taken to minimize identified risks was not always available.
- Previously identified concerns relating to IPC and appropriate background checks for staff, had been resolved.
- There were still some gaps in records maintained for staff immunity status and the practice submitted an action plan for the completion of these.
- There were some gaps in recording of significant events.
- Systems for responding to safety alerts still needed strengthening.

Safety systems and processes

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

Safeguarding	Y/N/Partial
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Explanation of any answers and additional evidence: During our inspection in October 2019 we found: • Two recently appointed members of staff did not have a DBS check in place. We were informed by the practice they had been advised that the staff members did not require enhanced DBS checks. However, standard DBS checks had not been undertaken. In addition, the practice had not undertaken a risk assessment of the lack of DBS for these staff members. On the day of inspection, the practice advised they would undertake standard DBS checks as a matter of urgency. In addition, they advised a risk assessment would be undertaken immediately. The day after our inspection we were sent evidence that a risk assessment had been undertaken for both staff. During this remote review we were sent a spreadsheet demonstrating DBS checks had been undertaken appropriately for all staff. The practice was awaiting the certificate for one new member of staff who had started employment the week before our review.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	N
Explanation of any answers and additional evidence: During our inspection in October 2019 we found: • We reviewed five staff files and found gaps in recruitment records for three members of staff. Two staff members were without DBS checks and two staff members did not have interview summaries or CVs. Immediately following our inspection, we were sent evidence that retrospective copies of	

CVs had been received and filed accordingly by the practice.

- The practice was unable to provide evidence of records of staff vaccinations and immunity status for all clinical staff. Evidence of immunity status for non-clinical staff was not available and a risk assessment had not been undertaken. On the day of inspection, we saw the practice had arranged blood tests for all staff to investigate their immunity status. We were informed appropriate vaccinations would be arranged accordingly.

During this remote review:

- We were sent an up to date recruitment policy detailing specific checks and documentation to be recorded for all staff. We were also sent assurance DBS checks were being routinely undertaken for all staff.
- We were sent a spreadsheet of staff vaccination status. This demonstrated there were still some gaps in record keeping. The practice submitted an action plan to outline a timeline for completion.

Safety systems and records	Y/N/Partial
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y

Explanation of any answers and additional evidence:

During our inspection in October 2019 we found:

- COSHH assessments were available for substances used by the cleaning contractors but not for items used by practice staff. Immediately following our inspection, the practice submitted a COSHH policy and advised safety data sheets were being collated for all applicable chemicals and substances used.

During this remote review we were sent a copy of the practice's COSHH policy. In addition, we spoke with the Infection Prevention and Control (IPC) lead who detailed actions taken since our last inspection to compile a comprehensive COSHH file and how it was maintained. We were advised the COSHH file included all relevant data sheets for products used by practice staff and the contracted cleaners.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	P
Infection prevention and control audits were carried out. Date of last infection prevention and control audit:	P
The practice had acted on any issues identified in infection prevention and control audits.	P

Explanation of any answers and additional evidence:

During our inspection in October 2019 we found:

- Two members of staff had been appointed as infection prevention and control (IPC) leads but neither had undertaken advanced IPC training to support them in the role. Three monthly room checks had been introduced, however, these checks were relatively basic. There were no daily cleaning schedules in place for clinical rooms or specific equipment, although the cleaning company did use schedules. All staff had received IPC training via an e-learning platform. We saw an attempt had been made to partially complete a full audit and risk assessment using a template provided by the Milton Keynes Clinical Commissioning Group (CCG). It was unclear when this had been done. We noted that some items had been incorrectly marked as compliant. For example, one item relating to staff immunisation records had been marked as compliant contrary to our findings on the day. Some items had not been actioned at all, such as those relating to audits and cleaning schedules. The policy made available was dated February 2011. Immediately following our inspection, the practice submitted a newly adopted, comprehensive IPC policy and evidence to support that a full IPC audit had been undertaken with actions identified.

During this remote review we spoke with the IPC lead nurse who detailed many improvements made since our last inspection. We were informed but did not see evidence that:

- An IPC team had been formulated and three out of four members had completed advanced training in IPC. Training had been undertaken with staff within the practice's Primary Care Network (PCN) and this had led to improved communication and standards across the network.
- Improvements had been introduced following a comprehensive audit of IPC, including use of improved cleaning schedules, decontamination logs, general cleaning standards, accountability and responsibility had been assigned for specific tasks.
- Changes had been made to the management of hazardous clinical waste to improve safety and a comprehensive COSHH file had been developed.
- Changes had been made to flooring throughout the building and the minor operations room had been redesigned to improve IPC compliance.
- A comprehensive IPC induction was now in place for all staff, including temporary staff and medical students.
- Regular audits were undertaken to provide assurance that standards were being met and guidelines followed. Identified issues were discussed routinely in meetings which were minuted and outstanding actions followed up.
- All staff were encouraged to be responsible for IPC and logs were maintained and checked to ensure compliance.
- Improvements had been made to the availability and maintenance of spillage kits
- Additional time had been provided to appointments to allow staff adequate time to clean and change any personal protective equipment in line with guidelines issued in response to the Covid-19 pandemic.

Appropriate and safe use of medicines

Medicines management	Y/N/Partial
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.	Y
Explanation of any answers and additional evidence: During this remote review a GP specialist adviser logged into the practice clinical system remotely to check systems in place to support appropriate medicines management for high risk medicines. They looked specifically at medicines used to help prevent blood clots known as novel oral anticoagulants	

Medicines management	Y/N/Partial
(NOACs). They found that for five out of 10 patients reviewed, creatinine clearance levels had not been recorded. (Creatinine clearance levels are used an indicator of kidney function). However, it was noted appropriate review and testing had been undertaken for all ten patients and there was no evidence of risk to patient safety. Shortly after our review the practice submitted an action plan confirming a timeline for ensuring all patients had the creatinine clearance levels noted in their records.	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong. However, there were gaps in systems used and risks were not always minimised.

Significant events	Y/N/Partial
There was a system for recording and acting on significant events.	P
There was evidence of learning and dissemination of information.	P

Explanation of any answers and additional evidence:

During our inspection in October 2019, we found:

- Records relating to significant events had not been systematically maintained, there were no records of significant events from August 2018 to March 2019. The practice system included the use of 'significant event forms', which were to be completed following the occurrence of an event. We were shown a register that listed nine events since March 2019. However, there were only two significant event forms available for review. In addition, we spoke with staff who advised us of a recent significant event and subsequent change to practice policy. However, upon investigation there were no records available for this event. We reviewed three sets of practice meeting minutes and saw evidence of four significant events being discussed. These events were on the overarching log but did not correspond with either of the event forms evidenced. Evidence of outcomes following events was limited.
- Immediately following our inspection, the practice submitted an updated significant event management policy and advised all staff had been informed of the new systems adopted.

During this remote review we were sent a copy of the practice's significant event log. This demonstrated there had been 19 significant events since our inspection in October 2019. The log demonstrated events were discussed and responsibility was assigned for follow up where needed. However, three items on the log did not appear to have complete records with details on learning, improvement or action taken left blank.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	P

Explanation of any answers and additional evidence:

During our inspection in October 2019:

- We identified gaps in the practice's system for managing safety alerts. For example, we reviewed action taken following a recent alert regarding sodium valproate. (Sodium valproate is used to treat epilepsy and the most recent alert advises it should not be prescribed to women of child bearing age who are not on long term contraception). We identified three patients affected by

this alert. One of the patients notes clearly identified they were not at risk. For the remaining two patients there was insufficient evidence to demonstrate appropriate action had been taken to reduce risks. One of these patients' notes evidenced the patient should not be prescribed sodium valproate, however, subsequent prescriptions had been issued.

- On the day of inspection, the practice advised they had arranged for these patients to be reviewed. Immediately following our inspection, the practice advised that further action had been taken to reduce risks to patients, through the implementation of templates within the practice's electronic patient record system. These templates would automatically appear and require completion before patient records be closed, further reducing the risk of missed actions occurring.

During this remote review, a GP specialist adviser logged into the practice clinical system remotely to check whether adequate improvements had been made to the practice's safety alert system. They found:

- Evidence of a systematic approach to safety alert management and review was lacking.
- Of the four alerts reviewed, sufficient action to reduce risk had not been taken for three alerts. For example, they reviewed an alert for a medicine's device used to treat anaphylaxis. Out of ten patient records reviewed, it was not clear whether five patients had been informed of potential risks.
- Upon reviewing an alert for a medicine used to treat gout, three out of seven patient records did not demonstrate patients had been appropriately informed of risks.

Caring Rating: Not rated

Kindness, respect and compassion

Through our routine monitoring of services, we saw patient satisfaction regarding their experience at the practice had fallen. As part of this remote review we asked the practice for details of any action taken in response to this.

National GP Survey results

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 (01/01/2020 to 31/03/2020)	79.3%	87.0%	88.5%	Tending towards variation (negative)
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 (01/01/2020 to 31/03/2020)	72.7%	83.9%	87.0%	Variation (negative)
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 (01/01/2020 to 31/03/2020)	84.4%	93.9%	95.3%	Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2020 to 31/03/2020)	54.9%	77.4%	81.8%	Variation (negative)

Involvement in decisions about care and treatment

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
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 (01/01/2020 to 31/03/2020)	83.1%	91.7%	93.0%	Variation (negative)

Any additional evidence or comments
The practice advised they were surprised and disappointed by the results of the national GP patient survey. They noted the survey had been undertaken prior to the Covid-19 pandemic and advised that some measures implemented during the course of the pandemic would hopefully improve patient satisfaction going forward. In addition, the practice informed they had recruited two new GPs with hopes that further stability to the clinical team would improve patient satisfaction going forward. The practice continued to run the NHS Friends and Family survey and hoped to run a more comprehensive in-house patient survey in the future.

Responsive Rating: Not rated

Through our routine monitoring of services, we saw patient satisfaction regarding access had fallen. Our intelligence also demonstrated some patients were dissatisfied with the handling of complaints. As part of this remote review we asked the practice for details of any action taken in response to this.

Timely access to the service

National GP Survey results

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 (01/01/2020 to 31/03/2020)	32.8%	N/A	65.2%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2020 to 31/03/2020)	31.0%	56.7%	65.5%	Variation (negative)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2020 to 31/03/2020)	33.6%	56.2%	63.0%	Variation (negative)
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2020 to 31/03/2020)	49.1%	67.4%	72.7%	Variation (negative)

Any additional evidence or comments
The practice informed they were surprised and disappointed by the findings of the national GP patient survey. Since the survey results were captured the practice had introduced new IT systems which granted patients access to GP contact using the practice website. They advised this had alleviated some pressures on the telephone. The system had been implemented in response to the Covid-19 pandemic and the need to reduce the footfall of patients within the practice. Using new IT systems patients were able to send queries to clinicians, which were normally responded to within 24 hours. The practice continued to offer face to face appointments where necessary alongside telephone and virtual web-based consultations.

Listening and learning from concerns and complaints

Since our inspection in October 2019, we received information from the public that suggested some patients were not satisfied with the handling of complaints. We asked the practice to provide some assurance on how complaints were handled.

Complaints	
Number of complaints received since January 2020.	69
Number of complaints we examined.	n/a
Number of complaints we examined that were satisfactorily handled in a timely way.	n/a
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	n/a

Any additional evidence or comments

As part of our remote review we asked the practice to share information on how they handle complaints. This was due to information shared by the public with us that suggested patients were not always receiving consistent responses to complaints. The practice submitted their complaints log in the form of a spreadsheet. It demonstrated 69 complaints had been recorded since January 2020. We noted the spreadsheet was largely completed, however there were some gaps. In particular, it appeared patients did not always receive an acknowledgement of their complaints and details of the outcome of complaints was not always clearly documented within the log.

Well-led Rating: Requires Improvement

At the last inspection in October 2019, we rated the practice as requires improvement for providing well-led services because:

- Systems and processes to reduce risks to patient and staff safety were lacking.
- There was limited evidence of improvements made following our inspection in November 2018.

During this remote review we were provided with evidence to demonstrate:

- Some improvements had been made to reduce risks to staff and patients. For example, improvements to infection prevention and control (IPC) standards and recruitment checks for staff.
- Improvements to systems to manage and respond to safety alerts were lacking and potential risks were identified.
- Sufficient action had not been taken to seek assurance on immunity status for all staff and reduce risks to staff and patient safety.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support governance and management. However, we found systems were not always managed effectively.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	P

Explanation of any answers and additional evidence:

During our inspection in October 2019, we found:

- The practice was in the process of transferring many governance systems to a digital platform to enable more effective management of governance systems and processes. However, upon review we found records were muddled and there was a lack of cohesion. For example, whilst searching for information on IPC on the digital platform we reviewed a contents document for IPC policies. We found that some of the items listed on the contents table were not available. We also noted that policies appeared to have been blindly uploaded, with no evidence of review or appropriateness. Immediately following our inspection, the practice advised all policies had been reviewed.

During this remote review we spoke with staff who advised us the digital platform was being used to maintain practice policies and was being actively utilised by staff on a daily basis. We did not have the opportunity to look at the platform during this review.

Managing risks, issues and performance

The practice had processes for managing risks, issues and performance however, some needed strengthening.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	P
There were effective arrangements for identifying, managing and mitigating risks.	P

Explanation of any answers and additional evidence:

During our inspection in October 2019 we found:

- Although the practice had developed systems and protocols to provide assurance, we found evidence of regular review was lacking.
- The practice had not established effective systems for managing all risks including those relating to safety alerts, staff vaccinations, infection prevention and control (IPC), significant events and COSHH.
- Evidence of action taken in response to concerns raised on the day of inspection was submitted the day following our inspection, to provide reassurance that some risks had been minimised.

During this remote review we found:

- Some improvements had been made to systems and protocols, for example those regarding staff recruitment checks and infection prevention and control. However, some systems still needed strengthening to ensure risks were minimized where possible. In particular, those relating to the management of safety alerts.
- Whilst logs of complaints and significant events were reviewed, there were gaps in the records that suggested a lack of consistency.
- Risks regarding staff immunity status were still present for some staff. The practice submitted an action plan for completion of these during the review.

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.
- ***PCA**: Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see GMS QOF Framework).
- ‰ = per thousand.