Care Quality Commission

Inspection Evidence Table

Hilltops Medical Centre (1-566368759)

Inspection date: 15 October 2019

Date of data download: 30 September 2019

Overall rating: Requires Improvement

At the last inspection in November 2018 we rated the practice as good overall, good for all population groups and requires improvement for providing safe services because of failure to comply with Regulation 12 HSCA (RA) Regulations 2014 Safe Care and treatment.

We have now rated this practice as requires improvement overall and good for all population groups. The practice was rated as requires improvement for providing safe and well-led services.

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:

- Risks to patients and staff had not adequately been assessed, in particular with regard infection prevention and control (IPC) and the management of blank prescription stationery.
- Recruitment records reviewed did not demonstrate a consistent approach to staff recruitment.

During this inspection we saw some of these systems had been improved. However, the practice had not made sufficient progress to assess and minimise risks to patient and staff safety.

The practice is still 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, appropriate background checks for staff, significant events and safety alerts.

Safety systems and processes

The practice had some systems, practices and processes to keep people safe and safeguarded from abuse. However, there were areas in need of development.

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y

Safeguarding	Y/N/Partial
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	N
Staff who acted as chaperones were trained for their role.	Y
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.	Y

Explanation of any answers and additional evidence:

We saw the practice maintained comprehensive registers of vulnerable children and adults. There was an additional register of patients maintained known as the 'Team around the Child', for those who had been identified as at risk of being vulnerable. These patients were receiving regular monitoring from the health visiting team and could be escalated to higher levels of support if needed.

We noted the policy for adult safeguarding did not have a review date.

On the day of inspection 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 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.

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

Explanation of any answers and additional evidence:

During our inspection in November 2018, we found gaps in recruitment records relating to contract provision and records of reference requests. During this inspection, 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.

During our inspection in November 2018, 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. We were provided with assurance following our inspection that an audit was to be undertaken and assurance sought on staff immunity status to support accurate record keeping. During this inspection, we found appropriate action had not been taken and there were still gaps in records relating to staff immunity status. 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.

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: February 2019	Y
There was a record of equipment calibration. Date of last calibration: October 2019	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	P
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: 4 July 2019	Y
There was a log of fire drills. Date of last drill: 10 October 2019	Y
There was a record of fire alarm checks. Date of last check: 9 October 2019	Y
There was a record of fire training for staff. Date of last training: Various dates, online training	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 10 April 2019	Y
Actions from fire risk assessment were identified and completed.	Y

Explanation of any answers and additional evidence:

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.

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 25 June 2019	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 25 June 2019	Y

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not met.

	Y/N/Partial
There was an infection risk assessment and policy.	P
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
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y

Explanation of any answers and additional evidence:

During our inspection in November 2018, we saw systems developed to manage infection prevention and control (IPC) needed strengthening. We were advised the IPC lead for the practice had left and the role had been assigned to one of the health care assistants. The practice informed the new lead would be undertaking advanced training to support them in the role. We saw an infection control checklist had been completed in March 2018 and was in the process of being completed again in November 2018.

During this inspection, we found limited evidence of improvement. Two members of staff had been appointed as 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. Although the practice had submitted an updated IPC policy to the CQC following our last inspection, during this inspection the only 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.

We were advised the practice was in the process of installing new flooring throughout the building. We reviewed flooring in consultation rooms and saw carpets were being replaced with a laminate wood effect flooring. The edges of the floors were yet to be sealed in the rooms we inspected. In addition, we

inspected the flooring in the treatment room and nurses' room. These rooms had IPC compliant flooring with coved edges. However, we noted the edging had separated from the wall in multiple areas. We were advised by the practice that these areas would be repaired during the ongoing works. In addition, we noted the treatment couch in the treatment room was torn. We were advised the couch would be replaced immediately following our inspection.

Risks to patients

There were gaps in 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.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	N
Risk management plans for patients were developed in line with national guidance.	Y
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Y
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.	Y
There was a process in the practice for urgent clinical review of such patients.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y
Explanation of any answers and additional evidence: Risks to patients and staff had not adequately been assessed, in particular those relating to staff immunity status, infection prevention and control, appropriate background checks for staff, significant events and safety alerts.	

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.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referral letters contained specific information to allow appropriate and timely referrals.	Y

Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	P
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Y
Explanation of any answers and additional evidence: The practice did not have a documented policy for the management of test results, but we saw evidence to support that all results were handled appropriately. The practice had a documented clinical buddy system for all GP tasks, which ensured reviews were not delayed.	

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) (01/07/2018 to 30/06/2019) (NHS Business Service Authority - NHSBSA)	0.90	0.91	0.87	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). (01/07/2018 to 30/06/2019) (NHSBSA)	6.7%	7.5%	8.6%	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 (01/01/2019 to 30/06/2019) (NHSBSA)	5.78	5.98	5.63	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/01/2019 to 30/06/2019) (NHSBSA)	1.66	2.07	2.08	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to	Y

Medicines management	Y/N/Partial
authorised staff.	
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
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.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
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.	Y
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
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
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.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
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.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong, however we identified gaps in records.

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

Explanation of any answers and additional evidence:

During our inspection, 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.

Example of significant events recorded and actions by the practice.

Event	Specific action taken
Discrepancy on patient record due to administrative error	Staff informed of error. Patient record was corrected.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	P
Staff understood how to deal with alerts.	Y

Explanation of any answers and additional evidence:

The practice had developed a system to ensure appropriate oversight of safety alerts. The practice manager received safety alerts and sent them to the practice pharmacist and clinicians for review. We saw the practice maintained a log of all safety alerts, which documented action taken. We saw audits were undertaken where appropriate to identify patients at risk and support decision making. However,

we identified gaps in the practice's system. 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.

Effective Rating: Good

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.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2018 to 30/06/2019) (NHSBSA)	0.64	0.82	0.75	No statistical variation

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 medication 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 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.
- 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.
- Nurses provided leg ulcer and Doppler services.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	79.2%	77.8%	78.8%	No statistical variation
Exception rate (number of exceptions).	9.9% (78)	14.0%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) (QOF)	70.2%	77.1%	77.7%	No statistical variation
Exception rate (number of exceptions).	8.5% (67)	11.2%	9.8%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) (QOF)	79.8%	82.9%	80.1%	No statistical variation
Exception rate (number of exceptions).	9.0% (71)	13.7%	13.5%	N/A

Other 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, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) (QOF)	73.0%	77.5%	76.0%	No statistical variation
Exception rate (number of exceptions).	1.4% (13)	11.0%	7.7%	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 (01/04/2017 to 31/03/2018) (QOF)	91.8%	90.4%	89.7%	No statistical variation
Exception rate (number of exceptions).	12.2% (22)	14.3%	11.5%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) (QOF)	80.2%	80.0%	82.6%	No statistical variation
Exception rate (number of exceptions).	5.3% (106)	5.5%	4.2%	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 (01/04/2017 to 31/03/2018) (QOF)	92.0%	90.6%	90.0%	No statistical variation
Exception rate (number of exceptions).	9.1% (15)	5.0%	6.7%	N/A

Families, children and young people Population group rating: Good

Findings

- The practice met the minimum 90% target for all four childhood immunisation uptake indicators. The practice met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for one of four childhood immunisation uptake indicators.
- 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.
- A range of contraceptive and family planning services were available. This included fitting of contraceptive implants.
- 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) (01/04/2018 to 31/03/2019) (NHS England)	171	177	96.6%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	163	173	94.2%	Met 90% minimum
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) (01/04/2018 to 31/03/2019) (NHS England)	163	173	94.2%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	162	173	93.6%	Met 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

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 book or cancel appointments online and order repeat medication 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) (01/04/2017 to 31/03/2018) (Public Health England)	76.0%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	69.3%	72.6%	72.1%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5-year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	55.3%	53.5%	57.3%	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. (01/04/2017 to 31/03/2018) (PHE)	57.4%	61.8%	69.3%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE)	73.3%	50.4%	51.9%	Tending towards variation (positive)

Any additional evidence or comments

The practice's uptake for cervical screening was 76%, which was below the 80% coverage target for the national screening programme. We were informed of efforts made to improve uptake, for example, through the provision of appointments outside of normal working hours and through opportunistic discussions with patients.

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.
- 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 held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- The practice assessed and monitored the physical health of people 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 medication.
- 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 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 (01/04/2017 to 31/03/2018) (QOF)	97.1%	85.6%	89.5%	No statistical variation
Exception rate (number of exceptions).	7.9% (6)	18.2%	12.7%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	90.1%	90.8%	90.0%	No statistical variation
Exception rate (number of exceptions).	6.6% (5)	16.7%	10.5%	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 (01/04/2017 to 31/03/2018) (QOF)	88.5%	85.0%	83.0%	No statistical variation
Exception rate (number of exceptions).	7.1% (10)	7.1%	6.6%	N/A

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	CCG average	England average
Overall QOF score (out of maximum 559)	551.6	542.3	537.5
Overall QOF score (as a percentage of maximum)	98.7%	97.0%	96.2%
Overall QOF exception reporting (all domains)	5.4%	7.1%	5.8%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Y
Quality improvement activity was targeted at the areas where there were concerns.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

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

The practice was actively involved in and demonstrated a proactive approach to quality improvement activity. We saw multiple examples of audits undertaken including a two-cycle audit on patients prescribed a medicine to treat gout. These patients required annual blood tests. The first cycle audit completed in April 2018 identified 54% of patients were overdue a blood test. Improvements were made, and the second cycle audit undertaken in September 2019 identified 24% of patients who were overdue a blood test.

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. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Y
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Y
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.	P
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y

Explanation of any answers and additional evidence:

During our inspection in November 2018, we found evidence that up-to-date records of skills, qualifications and training were maintained was not readily available for all staff. We saw evidence that the new practice manager had appropriate records for newly appointed staff and was in the process of reconciling records for historic staff to improve accessibility in the future. Following our inspection, we were sent an up- to- date training matrix for the practice.

During this inspection, we found this matrix had not been maintained and records for staff training were not accurately recorded within it.

During our inspection in November 2018, the practice advised that due to significant changes in staffing the appraisal system had been interrupted and delayed. We saw evidence that clinical staff had received regular appraisals annually. On the day of inspection, the practice manager evidenced a recently developed appraisal policy and supporting documentation and advised of the intention for all

staff to receive appraisals by the end of January 2019.

During this inspection we found five members of staff were outstanding their appraisals. The practice manager advised she had arranged for these to be undertaken by the 24 October 2019.

We saw evidence of an effective mentorship scheme for clinical staff which included support for staff employed in advanced clinical practice and medical students. Staff we spoke with reflected positively on the support they received, describing monthly mentorship sessions and daily access to clinical advice and support.

Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) (QOF)	Y
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Y
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	n/a

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.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Y

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	93.5%	94.5%	95.1%	No statistical variation
Exception rate (number of exceptions).	1.0% (34)	0.9%	0.8%	N/A

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.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	Y
Policies for any online services offered were in line with national guidance.	Y

Well-led Rating: Requires Improvement

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.**

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: The practice leadership team were forthcoming in describing challenges they faced, including difficulties with the recruitment of GPs and ongoing challenges with the recruitment of additional support for the practice manager. The successful recruitment of advanced nurse practitioners, the diabetic nurse and paramedic had supported the formulation of an 'urgent access team' to improve same day access for patients. This had alleviated the burden on GP appointments. However, on the day of inspection we identified multiple failings in relation to the practice management and administrative functions of the practice, further highlighting the need for additional support in this area. We were informed by the leadership team that recruitment for a deputy practice manager was ongoing and that further support had been sought from the local medical council (LMC) in Hertfordshire. The LMC were due to send practice manager support to the practice for five days. In addition, we were advised the practice was seeking support from its primary care network (PCN) and local federation to help improve some of the areas identified during our inspection.	

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.	Y
There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence:	

During our previous inspection in November 2018, we were shown a three-step improvement plan to be undertaken over the following two years. During this inspection, we saw that the first phase had been successfully completed and the practice was in the course of phase two.

The practice had developed a mission statement which read:

'Hilltops Medical Centre – providing the best clinical outcomes and highest quality care in a safe, friendly, well-led environment. We are constantly striving to raise standards and put patients first, treating them in accordance with their needs. We aim to deliver effective, caring and responsive and accessible services to patients, when it is most convenient to them, by maximising our operational efficiency and productivity'.

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

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

Source	Feedback
Interviews with staff	Staff we spoke with were largely positive about working at the practice. We were told staff were able to access support when needed and found the team environment friendly and cohesive.

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
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y

Explanation of any answers and additional evidence:

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.

The practice had clearly assigned clinical leads for all areas, including but not limited to audits, complaints, long-term conditions, clinical governance, safeguarding and prescribing. There were buddy arrangements in place for all assigned responsibilities to ensure care and quality were not compromised due to staff absence or limited availability.

Managing risks, issues and performance

The practice did have 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 processes to manage performance.	Y
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	N
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y

Explanation of any answers and additional evidence:

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.

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 adjust and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y

	Y/N/Partial
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Any unusual access was identified and followed up.	Y

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.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y

Explanation of any answers and additional evidence:

- The practice demonstrated its commitment to working with local stakeholders and was part of a primary care network (PCN) with other local practices, known as the Watling Street PCN.
- The practice worked in accordance with local guidelines and worked collaboratively to support the Milton Keynes Clinical Commissioning Group (CCG) by undertaking pilot programmes and working to achieve targets.
- The practice was aware of some areas of lower performance in the national GP patient survey, in particular with regard to appointment access and GP consultation quality. We saw the practice had responded proactively to make changes to the appointment system to improve patient experience. For example, the practice had successfully recruited advanced nurse practitioners and a paramedic, who worked collectively with the duty doctor to provide an urgent access

service for same day appointments.

- We reviewed 21 CQC comments cards received in the two weeks prior to our inspection and noted that 19 of these were positive. There were repeat comments from patients commending the same day access service and the care patients felt they received.
- The practice had an active PPG who met regularly and were involved in supporting practice improvements.
- The practice sought patient feedback by utilising the NHS Friends and Family test. The NHS Friends and Family test (FFT) is an opportunity for patients to provide feedback on the services that provide their care and treatment.
- The practice was utilising an SMS text message service called MJog to gauge patient satisfaction.

Feedback from Patient Participation Group.

Feedback
We spoke with a representative of the PPG who advised that the group was active and that the practice regularly engaged with them. We were told the PPG were also consulted in the development of the patient survey questions and with proposed changes to the website. We were informed that the practice was open and honest in sharing information with the PPG and that members felt their input was valued particularly by the new practice manager.

Continuous improvement and innovation

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

	Y/N/Partial
There was evidence of continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y

Explanation of any answers and additional evidence:

- The practice worked actively alongside the other two practices within its PCN. Meeting as a locality helped to map out service provision and plan for future developments. This enabled services to be planned and delivered effectively and for better sustainability of service provision in the future. We were provided with multiple examples of pilot work undertaken by the PCN which had led to improvements across the locality. For example, the development of a specialist team to support vulnerable patients through provision of a social prescriber and link worker (Integrated Community Support Team) and the recruitment of a community matron. The PCN was also piloting a counselling service for young people aged 12 to 26 years.
- The PCN were also facilitating bi-monthly patient education evenings to provide further information on specific health concerns and topics.
- The practice had successfully recruited two advanced nurse practitioners, a paramedic and a diabetic nurse. The practice pharmacist had also been supported to qualify as a prescriber. These staff were all working in advanced roles to support improved services for patients.
- The practice had invested in digital services through a new website with increased functionality. The new website allowed for additional patient services and a reduction in appointment demand. For example, for some medical queries and/or concerns patients could complete an online questionnaire template. The completed template was reviewed by a clinician and action was taken accordingly. This applied to items such as repeat medication requests.

- The practice was able to demonstrate a commitment to training and education and regularly welcomed students from Buckingham Medical School.
- On the day of inspection, we found actions had not been taken to improve all areas identified as of concern during our inspection in November 2018, particularly those relating to infection prevention and control.

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.