

Inspection Evidence Table

Hilltops Medical Centre

(1-566368759)

Inspection Date: 19 October 2023

Date of data download: 20/06/2023

Overall rating: Requires improvement

At our last inspection, in August 2021, we rated the practice Good overall.

For this inspection, we have rated the practice Requires improvement overall. This is because:

- The practice's systems to assess, monitor and manage risks to patient safety were not always effective.
- Results for the National GP Patient Survey in 2023 showed a decline in performance in indicators relating to access, when compared with the National GP Patient Survey results in 2022.

Safe

Rating: Requires improvement

At our last inspection, in August 2021, we rated the practice good for providing safe care and treatment.

For this inspection, we have rated the practice requires improvement for providing safe services.

This is because the practice's systems to assess, monitor and manage risks to patient safety were not always effective. For example:

- the system for obtaining staff immunisation records and managing risks in relation to gaps in records required strengthening
- the system for ensuring locum GPs had a record of the required training in place was not comprehensive
- not all medical consumables held at the practice were managed in accordance with the manufacturers use by date
- the practice was unable to demonstrate that all of the significant events recorded within the previous 12 months had been discussed and learning shared with all relevant staff members.

Safety systems and processes

The practice had systems and processes to keep people safe and safeguarded from abuse, in most cases.

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes ¹
Partners and staff were trained to appropriate levels for their role.	Yes ²
There was active and appropriate engagement in local safeguarding processes.	Yes ³
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes ⁴
Disclosure and Barring Service (DBS) checks were undertaken where required.	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 ⁵
<p>Explanation of any answers and additional evidence: During our inspection visit in June we found:</p> <p>¹ Staff knew who the clinical leads were for safeguarding children and safeguarding adults and how to contact them.</p> <p>The practice's policies for safeguarding children and safeguarding adults had been reviewed in February 2023.</p> <p>² However, the training records provided for this inspection in June showed:</p> <ul style="list-style-type: none">• 1 of the 18 members of clinical staff had not completed training in safeguarding adults• a further 3 members of clinical staff had not completed training in safeguarding adults for at least 6 years• although 4 members of clinical staff were up-to-date with training in safeguarding children, this was not at the level the practice required• only 21 of the 28 non-clinical members of staff had completed training in safeguarding children and in safeguarding adults in the last 3 years, in line with the practice's requirements and national guidance. <p>Following our checks in June, the practice provided records showing all clinical staff and 4 of the 7 non-clinical members of staff had completed the appropriate training in safeguarding children and in safeguarding adults following our inspection.</p> <p>³ Staff told us about times when they had raised safeguarding concerns and worked with the local authority safeguarding team and with patients.</p> <p>⁴ The practice's safeguarding children lead did a monthly review of the register of children who had been identified as being more vulnerable to potential harm. The practice also held a register of adults who had been identified as living in circumstances that made them more vulnerable.</p>	

⁵ The practice's safeguarding children lead did a monthly review of the register of children who had been identified as being more vulnerable to potential harm. The practice also held a register of adults who had been identified as living in circumstances that made them more vulnerable.

The practice shared messages and records with other health and social care professionals, for example, community teams, out-of-hours services and health visitors, to protect children and adults at risk of harm. The practice discussed children at risk of harm, including those who had not had the recommended immunisations, and adults for whom potential safeguarding concerns had been identified were discussed at safeguarding meetings attended by staff from the practice.

At the time of our inspection, there were 110 children and adults on the practice's child protection or vulnerable adults registers. Staff told us safeguarding concerns were discussed in the weekly team meeting. However, records of these meetings for the 3 months leading up to our inspection showed the practice had discussed 12 patients, for whom they had more serious concerns or a safeguarding referral had been made.

During our checks in October, we found all clinical and non-clinical staff members had completed the required safeguarding adults and children training in line with the practice's policy and national guidance.

During our checks in October, we found there were 54 children and adults on the practice's child protection and vulnerable adults registers. Individuals on these lists were reviewed on a regular basis and we saw evidence confirming the practice held discussions and shared information with other health and social care professionals to protect children and adults at risk of harm.

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes ¹
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Partial ²
<p>Explanation of any answers and additional evidence: During our inspection visit in June we found:</p> <p>Recruitment checks help to protect people and systems by making sure people are suitable for the roles they are employed to do.</p> <p>¹ We looked at the staff records for 4 clinical and 2 non-clinical members of staff who had started working at the practice in the last year. There were no records the practice had completed all recruitment checks for all of these new staff in line with regulations and the practice's recruitment policy. For example, at the time the person was employed, the practice had not:</p> <ul style="list-style-type: none"> • carried out an identification check for 2 of the clinical members of staff • checked 2 of the clinical members of staff had the relevant and up-to-date professional registration • seen evidence 2 of the clinical staff had the appropriate qualifications for their roles. <p>Immediately following our inspection, the practice checked the identification, professional registration and qualification for 1 of the members of clinical staff.</p>	

The practice told us that they checked the identity for all staff as part of their pre-employment checks but would change their systems to make sure they record these details for staff joining the practice.

We also looked at the staff records for 2 locum clinicians. The practice was not able to show the appropriate checks had been completed for these staff and that they were suitable to work at the practice. There was no evidence to show the practice had checked either locum had suitable references and professional registration. Only 1 of the locum clinicians had a suitable curriculum vitae (CV) that included their employment history.

² The practice's systems for making sure staff had been vaccinated in line with guidance from the UK Health Security Agency (UKHSA) were not always effective. Staff vaccinations help to protect staff and patients from harm.

There were gaps in the immunisation records for 9 of the 22 clinical staff and 4 of the 28 non-clinical staff employed by the practice, including locum staff. There was no evidence the practice had identified the gaps nor put in place measures to assess and manage any risks to service users and staff.

During our inspection visit in October, we found the practice had taken the required action to ensure the recruitment records were now in place to demonstrate the practice had completed the appropriate checks for all staff members including locums. The practice had recently employed 3 new clinical staff and 1 non-clinical staff member and we found the practice had an effective recruitment system in place. The practice had records of appropriate recruitment checks for all of these new staff members.

During our checks in October, we found there were gaps in the immunisation records for 9 of the 22 clinical staff and 4 of the 28 non-clinical staff employed by the practice, including locum staff. During our inspection, the practice told us they would strengthen their processes to make sure all staff have the recommended immunisations and would complete risk assessments for staff members if appropriate. The practice told us this work would be completed by December 2023.

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Yes ¹
Date of last assessment: 12 June 2023	
There was a fire procedure.	Yes
Date of fire risk assessment: 1 September 2022	Yes ²
Actions from fire risk assessment were identified and completed.	
Explanation of any answers and additional evidence: During our inspection visit in June we found:	
¹ At the time of our inspection, the practice had contacted the owners of the building to arrange for the uneven steps and paths to access the building be repaired. In the meantime, the practice had taped off and put up signs to advise people not to use the steps and to take care on the uneven path.	
² The practice had addressed most actions identified in the fire risk assessment, including:	
<ul style="list-style-type: none">Weekly tests of the fire alarm system	

- Two fire drills in the last year
- The installation of additional fire evacuation signs
- Training records showed all staff except 2 clinical staff had completed fire safety training in the last year.

The practice had a fire and emergency evacuation plan, which they had reviewed in February 2023.

The practice had completed individual evacuation plans for staff with disabilities, with input from external occupational health specialists.

During our checks in October, we found the practice had completed all of the required actions identified in the fire risk assessment. However, we found 2 locum GPs did not have a record of completing fire safety training. Shortly after our inspection the practice told us the outstanding fire safety training had now been completed and we received evidence confirming this.

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.	Partial ¹
Infection prevention and control audits were carried out.	Yes
Date of last infection prevention and control audit: 8 June 2023	
The practice had acted on any issues identified in infection prevention and control audits.	Yes ²
The arrangements for managing waste and clinical specimens kept people safe.	Yes
<p>Explanation of any answers and additional evidence: During our inspection visit in June we found:</p> <p>¹ Training records provided for this inspection showed 3 of the 18 clinical staff and 1 of the 28 non-clinical members of staff employed directly by the practice were overdue appropriate training in infection prevention and control (IPC).</p> <p>² The practice responded to some IPC issues when they were identified, such as removing a fish tank from a clinical room. However, for other IPC issues identified, the practice had plans to address them.</p> <p>The practice's repair and improvement works schedule included fitting suitable flooring in the clinical areas that still had carpet flooring and replacing basins and taps in clinical rooms with suitable clinical handwash basins and taps.</p> <p>The practice acknowledged the works had been delayed but expected the improvement works to begin soon after our inspection. The repair and improvement plan, however, did not give a timeframe for when the replacement flooring and handwashing facilities were to be completed.</p> <p>However, the practice did not have arrangements for the regular cleaning of the carpets, particularly in clinical areas, whilst the practice was waiting for the new flooring to be fitted. However, the carpets were vacuumed</p>	

daily and had been deep cleaned following the COVID-19 pandemic. Following our feedback, the practice told us they would consider making arrangements for carpets to be cleaned regularly.

During our inspection in October, we found all but 2 locum GPs had completed the appropriate training in IPC. Shortly after our inspection, the practice provided us with evidence to confirm these 2 locum staff members had completed the appropriate training in IPC.

Staff completed a checklist at the end of each day to help keep clinical areas clean and make sure any equipment that was needed was available. During the inspection, we saw the practice was clean and tidy; appropriate personal protective equipment, such as gloves and aprons, was available; and clinical waste bins and 'sharps boxes', used to dispose of 'sharps' such as needles, were used safely.

The practice's IPC policy was up-to-date and staff were aware of what to do in the event of a needlestick injury.

Although the yearly check of the practice's water system, completed in January 2023, did not detect legionella bacteria, the practice had not carried out more frequent tests of the water temperature. These tests check the temperature of the water is suitable to reduce the risk of legionella bacteria growing in the water system. It is important to identify and take action if needed. This is because if these bacteria are breathed in, it can lead to Legionnaire's disease, a serious type of lung infection which can be fatal. In response to our feedback, the practice told us they would ask their maintenance contractor to do regular checks of the water temperature.

During our inspection in October, we found the practice had appropriate IPC standards in place. The practice's plans for improvement works had commenced and there were clear timeframes for the completion of this work.

During our inspection in October, we found the practice was conducting regular water temperature checks in accordance with the legionella risk assessment.

Risks to patients

There systems to assess, monitor and manage risks to patient safety were not effective in some cases.

	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.	Partial
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
There were enough staff to provide appointments and prevent staff from working excessive hours.	Yes
<p>Explanation of any answers and additional evidence: During our inspection visit in June we found:</p> <p>Electrical equipment had been tested and most medical equipment had been calibrated in the last year. It is important that equipment is calibrated to ensure that it provides correct readings to ensure patients receive appropriate treatment.</p>	

However, the monthly quality test of a glucose monitor, used to measure a person's blood sugar levels, had not been done since March 2023. The solution used for the quality check had gone past its expiry date.

The test strips needed to use the monitor on patients were 1 year past their expiry dates and the lancets needed to use the monitor had gone past their expiry dates by 2 months. This monitor was part of the emergency equipment kit.

Practice staff were aware glucose monitors had not been checked since the person who did these checks had recently left the practice. The practice told us they would check who would now be responsible for checking this equipment.

The practice kept appropriate medicines for use in an emergency. However, the systems to make sure the medicines and equipment were safe and available for use when needed were not always effective. We found that although the emergency medicines were in date, some consumables, such as cannulae, had past their expiry dates. The practice held emergency inhalers and nebulisers for patients experiencing breathing problems, such as a flare up of asthma. However, the practice was waiting for a delivery of masks and tubing to use with the nebuliser machine, and there was no spacer, a device used to help make sure the patient receives the medicine, to use with the inhaler.

Training records provided for this inspection showed that all staff had completed training in basic life support and were up-to-date with suitable training in sepsis awareness. Sepsis, sometimes called blood poisoning, happens when your body overreacts to an infection and starts to damage itself. Symptoms can be difficult to spot and sepsis can be life-threatening. Therefore, it is important that staff can recognise and act on symptoms.

During our inspection in October we found:

The practice was quality testing the glucose monitor and had replaced the solution used for the quality checks. The test strips and lancets were in date and the practice had implemented an effective system for ongoing monitoring and quality testing.

The practice kept appropriate medicines for use in an emergency. However, the systems to make sure the equipment was safe and available for use when needed were not always effective. The practice had replaced the cannulae and stocked masks, tubing and a spacer however, we found a pack of emergency gloves kept with a pocket mask located within the emergency medicines bag had gone past its recommended expiry date. The practice took immediate action and replaced the gloves.

The practice had a box of 23 needles used for administering the B12 injection and these needles had gone past its recommended expiry date of 1 August 2023. The practice took immediate action and disposed of the needles and replaced them during our site visit in October.

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 effective systems for the appropriate and safe use of medicines, including medicines optimisation.**

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2022 to 31/03/2023) <small>(NHSBSA)</small>	1.00	0.91	0.91	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). (01/04/2022 to 31/03/2023) <small>(NHSBSA)</small>	7.3%	7.8%	7.8%	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 (01/10/2022 to 31/03/2023) <small>(NHSBSA)</small>	4.96	5.48	5.23	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2022 to 31/03/2023) <small>(NHSBSA)</small>	124.1‰	101.7‰	129.8‰	No statistical variation

Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2022 to 31/03/2023) (NHSBSA)	0.65	0.67	0.55	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA)	7.2‰	6.9‰	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).	Yes ¹
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 ²
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	Yes ³
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 ⁴
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 and Improvement 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 UKHSA guidance to ensure they remained safe and effective.	Yes

Explanation of any answers and additional evidence, including from clinical searches.

During our inspection visit in June we found:

¹ The practice used Patient Group Directions (PGDs). A PGD provides a legal framework that allows specific registered health professionals to give a named medicine to certain groups of patients, without the need for an appropriate clinician to issue individual prescriptions. To make sure PGDs are used safely, staff who have the skills and knowledge to give the medicine safely sign the document. The PGD is then signed by the person responsible for its use, usually a doctor, who authorises the staff listed to use it. Although the PGDs we looked at for this inspection were all in date, some had been signed by staff after the doctor had signed the document. This meant that not all staff named on the PGD had the appropriate authorisation to use it, and the authorising doctor could not show how they were assured it was safe and appropriate for all the staff listed on the PGD to give the medicine. Following our feedback, the practice told us they would review the PGDs and consider changing their processes, possibly to using an electronic system.

² The practice did not demonstrate they monitored the prescribing practices of clinicians who were not doctors but had completed training to allow them to prescribe medicines, to make sure they prescribed medicines safely.

Two clinical staff at the practice were registered independent prescribers. This means they have successfully completed training and can prescribe medicines. One of these members of staff had begun working at Hilltops Medical Centre in the last 6 months. Both members of staff told us they could ask other clinical staff at the practice for support when needed and one told us they could meet with a GP, informally, once a week to discuss any complex cases.

Another clinician had recently completed training to become a non-medical prescriber. Although they had met with a GP weekly while they were training, a requirement of their training programme, there were no formal arrangements to continue this monitoring and support now they had completed their training.

The practice had recently started group meetings where these 3 clinicians could discuss cases with GPs.

However, neither of the independent prescribers were aware of regular reviews of their practice or prescribing, for example by audits. Although previously the clinician had met with their GP mentor individually, at the time of this inspection, there were no formal and regular arrangements for either nurse to monitor and check their competency, for example through individual meetings. This was not in line with the practice's Clinical Supervision Policy dated February 2023.

³ Our search of the practice's clinical records system found, in the 3 months leading up to our inspection, the practice had recorded they had completed medicines reviews for approximately 2,700 patients prescribed repeat medicines. We looked at the records for 6 of these patients, and found:

- there was no documentation of the review or evidence of an appointment for the review for 2 patients
- the medicines reviews for 2 of the patients were administrative tasks completed as part of the reviews of the patients' long-term conditions. For one of these patients, there was no evidence the practice had identified the patient was prescribed a combination of medicines that should prompt a discussion with the patient
- the practice did not always document if reviews included checking the patient was taking medicines as prescribed, having any side effects from the medicine and felt the medicine was effective for them

- the practice did not always document if the patient was aware of any risks of taking each medicine
- the practice did not always show the clinician completing the review had checked the patient was up-to-date with any required monitoring.

This meant we could not be sure the practice's systems for recording medicines reviews and identifying when reviews of patients' medicines were due were effective.

We also ran a search of the practice's clinical records system and found 2 patients prescribed 10 or more different medicines who last had a review of their medicines 22 months ago. There was no evidence the last medicines review for one of the patients included a review of all the medicines prescribed for them or that the practice and patient had discussed whether a painkiller known to be addictive was still needed. However, the patient had received the monitoring required for the medicines prescribed. Although the other patient had not had a medicines review, the practice had completed reviews of the patient's long-term conditions.

We then looked at the records for a further 5 patients for whom the practice had completed a structured medicines review. The quality of the records for these reviews was variable.

From the medicines reviews we looked at, we could not be sure patients received a thorough medicines review which included the relevant monitoring, discussion about any appropriate changes and addressed any concerns.

⁴ Our searches showed most patients prescribed various high-risk medicines had received the necessary monitoring to make sure it was safe to continue to prescribe the medicine and the dose prescribed was suitable. This specific and regular monitoring is needed because of the risks associated with taking the medicines. We found:

- Of the 56 patients at the practice prescribed Methotrexate or Leflunomide, 4 patients had not been monitored in line with guidance from the National Institute for Health and Care Excellence (NICE). Methotrexate and Leflunomide are medicines used to calm and control the body's immune system, to stop or slow the disease process in inflammatory conditions, such as rheumatoid arthritis.

For some patients, the practice had recorded in the patient's record that the monitoring was done by the hospital specialist team. The practice told us the hospital did the monitoring for all of these patients. Although the practice told us clinicians checked the patient's monitoring was up-to-date on the hospital system before issuing prescriptions, there was no evidence of this. The GP records for 3 of the patients showed monitoring was overdue, however, the monitoring was up-to-date for all 3 patients.

The practice did not record clear and agreed arrangements when a patient's care was shared with hospital teams. The practice told us they would review this.

- Of the 281 patients registered at the practice who were prescribed a direct acting oral anticoagulant (DOAC) medicine, 13 patients had not been monitored in line with guidance. These medicines are used to help prevent blood clots forming in people who are at high risk of developing them. Blood clots can lead to serious conditions such as strokes and heart attacks. We looked at the records for 5 of these 13 patients. While there was no evidence the clinician issuing the last prescriptions for all 5 patients had checked the patient's monitoring was up-to-date and it was safe to prescribe the medicine, the monitoring was overdue for only 2 of the patients. In response to our feedback, the practice told us they would repeat this search regularly to identify patients due monitoring.

During our inspection in October we found:

The practice had introduced an effective system for formal clinical supervision of the independent prescribers, and regular auditing was in place to assess competency.

The practice had reviewed all of the PGDs and had implemented a clear system to ensure PGDs were approved and monitored appropriately.

The practice had introduced significant changes to their systems and process for the management of medicine reviews. The practice used clinical templates and had a system of alerts on the clinical system to ensure the completion of medicine reviews was consistent and timely. From the sample of records we checked, we found patients were receiving appropriate reviews and monitoring.

The practice had an effective system in place for the safe monitoring of patients receiving high-risk medicines and medicines which required regular monitoring. From the sample of records we checked, we found patients receiving high-risk medicines had appropriate reviews and ongoing monitoring. The practice was pro-active in obtaining information and test results from secondary care services.

The practice had an effective system in place for managing patients prescribed a direct acting oral anticoagulant (DOAC) medicine. From the sample of records we checked, we found all of the patients we checked had been monitored in line with guidance.

Track record on safety and lessons learned and improvements made

The practice made improvements when things went wrong, in most cases.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes ¹
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 ²
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Partial ³
Number of events recorded in last 12 months:	58
Number of events that required action:	58
Explanation of any answers and additional evidence: During our inspection visit in June we found:	
³ Staff told us significant or learning events were discussed in the weekly 'clinicians' team meetings and learning was shared with them by email or the practice's document management system. However, 60% of staff who provided feedback for this inspection could not give an example of an event affecting the practice which had been shared with them.	

¹ We looked at the records for these meetings held between 1 March 2023 and 23 June 2023. There was no record the practice had discussed all significant and learning events they had recorded. However, meeting records showed the practice had discussed 2 unexpected deaths, although the practice had not recorded these as significant or learning events. There was no record the practice had investigated these deaths to identify learning and any actions that could reduce the risk of similar events happening again or taken action to make sure other patients were protected from avoidable harm. These were not in line with the practice's Significant Events Policy dated February 2023.

² The practice mostly recorded incidents on the practice's significant events log. However, we found the practice had recorded some other incidents on a learning events log.

³ There was limited evidence the practice fully investigated significant events to identify the causes and any learning and reduce the risk of them happening again. This included evidence the practice identified when similar events had reoccurred and addressed any themes. There was no evidence the practice reviewed the effectiveness of actions taken in response to incidents. For example:

- during the 9 months leading to this inspection, the practice recorded 4 times when the practice had added documents to the wrong patients record
- during the year leading up to our inspection, the practice recorded 7 events relating to letters and death notifications that had not been processed by the practice correctly. This resulted in additional distress for recently bereaved families and delays in the practice responding to requests from other services for investigations and treatment for patients and in making changes to a patient's medicines. For some patients investigations had been delayed by up to 5 months, monitoring and reviews of medicines and conditions had been missed, and changes to medicines had not been made promptly, for example, the practice continued to prescribe a medicine for one patient that had been stopped by the hospital 7 months before.

During our inspection in October we found:

From the discussions we had with staff about significant events we found the practice had an adequate system in place to ensure the learning from significant events discussed during weekly clinical meetings was shared with all relevant staff members. All of the significant events recorded between 29 June 2023 and 11 October 2023 had clear actions and learning recording in the significant event reporting forms. The practice had raised the unexpected deaths as significant events and records showed these events had been investigated and learning had been shared with staff.

However, we checked the records of the weekly clinical meetings which took place between 29 June 2023 and 11 October 2023 and found not all of the significant events recorded during this period had been discussed and learning shared with all relevant staff members. The practice told us they would review their system to ensure all learning from significant events is included in the weekly clinical meeting records prior to distributing the minutes to the relevant staff members.

The practice told us that the recording of previous significant events on a learning events log was a result of human error and the system had been reviewed to ensure this did not happen again. We found the practice had a clear system in place to ensure all significant events were recorded in the correct log.

The practice had improved their system for monitoring significant events over time to identify trends and themes. The practice undertook a quarterly review of all significant events.

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

Event	Specific action taken
Incorrect flu vaccine administered.	All clinicians were reminded to double check correct vaccine is being administered, paying particular attention to the age group for the vaccine. Learning from this event was shared with the wider clinical team.
Secondary care results and requirement for further testing was not correctly assigned to a clinician.	A member of the clinical team noticed the error and took the appropriate action. The learning from this event was shared with the relevant staff member and wider team.

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:</p> <p>During our inspection in June we found:</p> <p>There was a system for recording and acting on safety alerts. However, the practice had not always acted on safety alerts from the Medicines and Healthcare Products Regulatory Agency (MHRA) to protect patients affected by them.</p> <p>MHRA issued a drug safety alert in April 2018 stating Valproate medicines (used to treat epilepsy and bipolar disorder and occasionally to treat depression, pain or migraine) must not be used for women or girls who could become pregnant unless an effective pregnancy prevention programme is in place. This is because there is a high risk of birth defects and developmental disorders and of miscarriage or termination of pregnancies if Valproate medicines are taken during pregnancy.</p> <p>Our search of the practice's clinical records system identified 6 female patients of child bearing age who were prescribed valproate medicines. We looked at the records for all 6 patients.</p> <p>There was no evidence all of the patients were aware of the risks of taking the medicine.</p> <p>The alert says each of these patients must sign a risk acknowledgement form (ARAF), at least once a year, when their treatment is reviewed with a specialist. Clinicians issuing prescriptions for valproate medicines, for example GPs, should check that there is an up-to-date and signed form each time they issue a prescription. There was no evidence an ARAF had been completed with all 6 patients.</p> <p>We requested an action plan from the practice to protect these patients from avoidable harm. The practice told us all patients had been made aware of the risks verbally. This had been documented in the patients' records or in previous years' ARAFs. The practice told us they had asked hospital specialists to complete ARAFs with the patients, but these had not been actioned.</p> <p>Following our inspection, the practice identified these patients and told us what actions they planned to take to protect these patients from avoidable harm.</p>	

Guidance from MHRA also says GPs should refer patients affected by this safety alert to the relevant specialist if considering starting a valproate medicine. Valproate medicines for this group of patients must be started and monitored by a specialist. However, for one of the patients, a GP from the practice had started the medicine without advice from a specialist.

During our inspection in October, we found the practice had a clear process for managing safety alerts. From the searches we carried out, we found the system for recording and acting on safety alerts was effective. The practice had a programme of completing regular clinical searches and audits to ensure the system was safe and effective. The practice had completed a comprehensive audit of patients receiving medicines such as Sodium Valproate and all patients receiving these medicines were being appropriately managed.

Effective

Rating: Good

We rated the practice good for providing effective services.

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

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 ¹
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes ²
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
The practice had prioritised care for their most clinically vulnerable patients during the pandemic.	Yes
The practice prioritised care for their most clinically vulnerable patients.	Yes
Explanation of any answers and additional evidence: During our inspection visit in June we found: ¹ Our searches of the practice's clinical records system found 48 patients whose test results suggested they may have advanced chronic kidney disease (CKD) that had not been diagnosed. We looked at the records for 5 of these patients. We found:	

- all 5 patients could be diagnosed with CKD
- no evidence the test results and diagnosis had been discussed with any of the patients
- 3 patients had not been offered the appropriate follow-up investigations
- 4 patients were not prescribed appropriate treatment
- the diagnosis for one of the patients could have been made in January 2022. This missed diagnosis meant the patient had not been offered the appropriate yearly review and monitoring.

During our inspection in October, we checked the practice's clinical records system and found 19 patients whose test results suggested they may have chronic kidney disease (CKD) that had not been diagnosed. We found the practice had assessed all of these patients and had taken the necessary action where required.

Effective care for the practice population

Findings

The practice had completed NHS health checks with 75% of the patients registered with the practice aged between 40 and 74.

The practice had completed a yearly review with 86% of the 141 patients registered with the practice who had a learning disability.

Management of people with long term conditions

Findings

During our inspection visit in June we found:

² Approximately 13% of patients registered with the practice had 1 or more long-term conditions, such as asthma, chronic kidney disease (CKD), diabetes or hypothyroidism.

The practice offered patients with long-term conditions an annual review to check their health and medicines needs were being met. Searches of the practice's clinical records system for this inspection showed:

- the practice had, in the last 9 months, monitored and reviewed all 37 patients who had been diagnosed with severe CKD
- the practice had, in the last 18 months, completed a review for all 500 patients registered with the practice who had hypothyroidism
- 77 patients registered at the practice had diabetes that was less well controlled. These patients had diabetic retinopathy, a complication of diabetes that can lead to sight loss. We looked at the records for 5 of these patients and found the practice had monitored and reviewed these patients in line with national guidance

- 66 of the patients at the practice who had been diagnosed with asthma and had been given 2 or more courses of rescue steroids in the last year. Rescue steroids are medicines used to treat flare ups of asthma. Repeated use can indicate the patient's asthma could be better controlled. We looked at the records for 4 of these patients and saw the practice had assessed all 4 patients appropriately at the time they prescribed the rescue medicines. However, we did not see evidence the practice had followed-up the patients within 1 week to check their progress after the flare up of their asthma. National guidance recommends follow-up to make sure patients receive appropriate care and the best management of their asthma. However, the practice had completed asthma reviews with all 4 patients in the last year.

During our inspection in October, we reviewed the practice's system for managing patients who had been diagnosed with asthma and found the practice had followed up with patients after a flare up of their asthma in accordance with national guidance.

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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	138	141	97.9%	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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	165	176	93.8%	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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	165	176	93.8%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	163	176	92.6%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	170	195	87.2%	Below 90% minimum

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

Any additional evidence or comments

The practice monitored the numbers of children receiving immunisations. Data the practice gave us showed similar numbers of children to the above had received immunisations at the time of our inspection. However, these figures cannot be verified by CQC.

The practice also identified children who had not had the recommended immunisations and had a process describing the actions to take.

The practice had recently supported staff to complete training, which meant that more staff would soon be available to offer childhood immunisations.

Cancer Indicators	Practice	SICBL average	England	England comparison
Persons, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	64.4%	N/A	62.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	70.8%	N/A	70.3%	N/A
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (12/31/2022 to 12/31/2022) (UKHSA)	71.6%	N/A	80.0%	Below 80% target
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (4/1/2021 to 3/31/2022) (UKHSA)	46.8%	57.0%	54.9%	No statistical variation

Any additional evidence or comments

At the time of our last inspection in August 2021, the practice had not met the national target for the uptake of cervical screening among eligible patients. We saw 74% of patients eligible for cervical screening had been tested. We told the provider they should seek innovative ways to encourage eligible patients to have cervical cancer screening.

The latest information from the UKHSA available at the time of this inspection showed, of the number of patients registered with the practice who could have the test, the number who had been screened had lowered to 70% and remained below the national target of 80%.

The practice monitored the number of people attending for cervical screening. The practice shared with us their own unverified data in June 2023. This showed an increase in the number of patients being screened:

- 82% of patients aged between 25 and 49 who could have the test had been screened
- 81% of patients aged between 50 and 64 who could have the test had been screened.

The practice told us that there was a period when only 1 male member of staff was trained to take the test. The practice had recently employed more staff who could offer screening and had supported other staff to complete the required training, which meant more appointments were available with female sample takers.

The practice identified patients who were due screening and encouraged eligible patients to have the test.

A practice nurse contacted patients who had not responded to invitations for cervical screening to explore and address any worries the patient may have, offer them advice and reassurance and book another appointment if needed.

The practice had systems to make sure patients received the results of their cervical screening tests. A practice nurse contacted patients for whom the results recommended further investigations to offer them information and support.

Monitoring care and treatment

The practice had a programme of quality improvement activity.

	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
<p>Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years:</p> <p>The practice had completed an audit on 2 week-wait cancer referrals. This audit was undertaken to ensure the practice was following the referral criteria and following up referrals in accordance with local and national guidance. This audit was repeated 2 times and the results shared with all clinicians to ensure referrals were made in accordance with guidance and followed up within the required timeframe. The results from this audit led to the practice taking steps to ensure there was an improved level of consistency between clinicians making referrals, better access to the latest guidance and more peer support for clinicians.</p> <p>The practice completed repeated audits of their systems and processes for monitoring patients receiving high risk medicines and medicines requiring monitoring. These audits identified areas for improvement such as reducing missed opportunities for undertaking patient testing for monitoring and the system for identifying patients overdue testing. The practice implemented changes to their systems and this resulted in the establishment of a more systematic approach to identifying patients requiring monitoring tests and the process of system coding and contacting patients.</p> <p>The practice was an approved GP teaching and training practice. The practice told us doctors and students were positive about their training experiences at the practice. The practice had employed some doctors after they had completed their training at the practice.</p>	

The practice had also recently become a research practice. At the time of our inspection, some of the doctors and an experienced nurse were about to start contributing to research looking into effective management of asthma.

Effective staffing

The practice was able to demonstrate that staff had and maintained 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 ¹
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>During our inspection visit in June we found:</p> <p>¹ The practice did not demonstrate there were effective systems and processes to check and monitor the competence of non-clinical and clinical staff, to make sure patients were treated safely. This included nurses, paramedics and pharmacists working in advanced clinical roles and locum clinicians working at the practice. Therefore, opportunities for the practice to identify and address concerns and support clinicians in their professional development were limited.</p> <p>However, the practice offered time and support for staff to complete training programmes.</p> <p>During our inspection in October we found:</p> <p>The practice had implemented effective systems and processes to check and monitor the competence of non-clinical and clinical staff. Independent prescribers had named leads in place to provide regular clinical supervision and auditing of their work. All staff received annual appraisals which including identifying and addressing concerns and identifying requirements for further support in their individual roles and opportunities for professional development.</p> <p>We found 2 locum GPs did not have a record of IPC and fire safety training. Shortly after our inspection, the practice provided us with evidence to confirming this training had now been completed.</p>	

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

	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
<p>Explanation of any answers and additional evidence:</p> <p>The practice supported residents of several local nursing and residential homes. The practice carried out a 'care home round' at each of the homes once or twice a week and staff from the practice and various residential settings met via teleconference once a month. The practice told us this had led to improvements in care and communication and that other local practices saw Hilltops Medical Centre as a leader in this area.</p>	

Helping patients to live healthier lives**Staff were 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
<p>Explanation of any answers and additional evidence:</p> <p>The practice supported NHS health campaigns, and each month focused their health promotion activity on one particular topic, for example through sharing information on the practice's website and posters.</p> <p>There were noticeboards in the patient waiting areas with information for patients about a variety of topics.</p>	

Consent to care and treatment**The practice obtained consent to care and treatment.**

	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
<p>Explanation of any answers and additional evidence:</p> <p>The practice had systems to identify patients for whom a decision about DNACPR had been made.</p> <p>We looked at the records for 5 patients for whom a decision about DNACPR had been recorded. We saw:</p> <ul style="list-style-type: none"> • These assessments completed as required. • The practice had scheduled a reminder to review the DNACPR decision for 1 patient. This was in line with joint guidance from the British Medical Association (BMA), Resuscitation Council UK and Royal College of Nursing (RCN). • Evidence the practice discussed decisions with patients. 	

Responsive

Rating: Requires improvement

At our last inspection, in August 2021, we rated the practice Good for providing responsive services.

For this inspection, we have rated the practice Requires improvement for the responsive key question.

This is because the results for the National GP Patient Survey in 2023 showed a decline in performance in indicators relating to access, when compared with the National GP Patient Survey results in 2022. The practice's system to review complaints to drive continuous improvement had not been fully embedded.

Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Yes
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Yes
The facilities and premises were appropriate for the services being delivered.	Yes
The practice made reasonable adjustments when patients found it hard to access services.	Yes
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people, Travellers and refugees.</p> <p>The practice made arrangements to support patients to access services when challenges had been identified, such as offering homeless patients an appointment if they walked into the practice and offering refugees support and health checks.</p> <p>The practice held a register of patients living in circumstances that may make them more vulnerable, including patients who were housebound, lived in a care home, homeless, Travellers, carers, veterans or who had a learning disability.</p> <p>The practice supported a local Travellers' site and also a large number of patients with a learning disability. The practice did a weekly 'round' by telephone for those who lived in a local care home for people with learning disabilities.</p> <p>The practice also supported people staying in a local probation hostel.</p> <p>The practice was a 'Veteran Friendly' practice.</p>	

Practice Opening Times

The practice was open between 8am and 6.30pm on Mondays and Fridays and between 7am and 6.30pm on Tuesdays, Wednesdays and Thursdays.

When the practice was closed, patients were directed to access support, treatment and advice from the NHS 111 service or the emergency services.

Patients could book appointments online, or by telephoning or visiting the practice.

The practice offered a range of appointment types including face-to-face, telephone and video consultations and home visits.

The practice offered urgent, or 'same day', appointments and patients could pre-book routine appointments, with a clinician of their choice, up to 4 to 6 weeks in advance.

The practice offered longer appointments when needed, for example when an interpreter was needed, the appointment was for a yearly review of a long-term condition, the patient had a learning disability.

Appointments were offered with a suitable clinician. These included an advanced nurse practitioner, emergency care practitioner, doctor, healthcare assistant, paramedic, pharmacist, practice nurse or trainee nurse associate.

A community support team nurse, minor illness nurse, physiotherapist, occupational therapist, mental health practitioner, podiatrist, health and wellbeing coach, social worker and social prescriber link worker supported patients of Hilltops Medical Centre and 3 other local practices.

Patients registered with Hilltops Medical Centre could also access appointments with a doctor, pharmacist, paramedic or physiotherapist outside of the practice's normal working hours.

Patients could ask for prescriptions online or by telephoning or visiting the practice.

Access to the service

People felt they were not always able to access care and treatment in a timely way.

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice.	Partial
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Yes
Patients were able to make appointments in a way which met their needs.	Partial
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Yes
Patients with most urgent needs had their care and treatment prioritised.	Yes
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Yes
Explanation of any answers and additional evidence:	

The practice's telephone system featured a call monitoring service. The practice used this monitoring information to offer patients a call back service or make more staff available to answer calls at busy times.

The practice also ran an online GP triage system between 8am to 6:30pm Mondays to Fridays for requests made to the practice using online services. This system interacted with the practice's main records system and also meant the practice could respond to patients who contacted the practice by telephone more efficiently.

The practice reserved some appointments for duty doctors to book patients into if the patient needed further investigations, such as blood tests, or if the doctor wished to follow-up the patient.

However, we found the results for the National GP Patient Survey in 2023 showed a decline in performance in indicators relating to access, when compared with the National GP Patient Survey results in 2022.

The 2023 survey data shows a drop of approximately 10% satisfaction for the first 2 indicators compared to the 2022 data.

All 4 indicators for the 2023 results are below national averages, with the indicator relating to phone access being 10% below national averages (39.4%).

National GP Patient Survey results

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	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 (01/01/2023 to 30/04/2023)	39.4%	N/A	49.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2023 to 30/04/2023)	52.2%	42.8%	54.4%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2023 to 30/04/2023)	51.8%	42.6%	52.8%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2023 to 30/04/2023)	69.6%	66.6%	72.0%	No statistical variation

Source	Feedback
Online reviews from www.nhs.uk (formerly NHS Choices) and www.bestcarecompare.com	<p>4 reviews had been left in the last year about Hilltops Medical Centre.</p> <p>People who wrote 3 of the reviews were positive about Hilltops Medical Centre and said that they were either extremely likely or likely to recommend the practice to friends and family.</p> <p>The positive reviews included comments about kind, understanding, reassuring, friendly and helpful staff.</p> <p>People said the practice responded to queries and offered help promptly.</p> <p>One person was positive about the care for an elderly relative and another about the efficient flu clinic offered by the practice.</p> <p>The person who wrote the other review described the practice as terrible and said they were extremely unlikely to recommend the practice to family or friends.</p> <p>The negative review related to difficulties accessing a GP appointment.</p> <p>The practice had not responded to any of the reviews.</p>

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	48
Number of complaints we examined.	9
Number of complaints we examined that were satisfactorily handled in a timely way.	9
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Yes
There was evidence that complaints were used to drive continuous improvement.	Partial ¹
<p>At our last inspection in August 2021, we found the practice did not always provide patients with information about what they could do if they were unhappy with the practice's response to their complaint, for example information about how to contact the Parliamentary and Health Service Ombudsman (PHSO). PHSO review complaints that have not been resolved by the NHS in England. Following our last inspection, the practice told us they would introduce a complaint response letter template that would include information about the PHSO.</p> <p>During our inspection visit in June, we looked at the records for 13 complaints made to the practice in the last year. We found the practice's response to 4 of these complaints did not include information about the PHSO, or other support available if the complainant was not satisfied with the practice's response to their complaint.</p>	

The practice encouraged patients to raise complaints using the practice's website. The system automatically acknowledged complaints made online.

¹ There was limited evidence the practice fully investigated complaints to identify and address the concerns, any learning and any other patients who may be affected and take action to protect them from avoidable harm. The practice missed opportunities to use complaints to make improvements.

We did not see the practice reviewed the effectiveness of any actions taken in response to complaints.

Although staff told us complaints were discussed in the weekly 'clinicians' team meetings, the practice's Complaints Policy, dated February 2023, said the practice would report the findings of a complaints audit at these meetings every 3 months.

Of the variety of staff who provided feedback for this inspection, 50% told us they were not aware of any complaints made about the practice. Other staff told us about complaints affecting them, however, there was no evidence the practice had shared learning from other complaints with them.

During our inspection in October, we looked at 9 complaints made to the practice between June and October 2023. We found the practice's response to 1 of these complaints did not include information about the PHSO, or other support available if the complainant was not satisfied with the practice's response to their complaint. The practice told us that this information was omitted by mistake and the practice had introduced a standardised complaint response letter template which included information about the PHSO, we saw evidence confirming this.

The practice responded to complaints in an appropriate and timely manner. Complaints were investigated and information about complaints, including learning was discussed during weekly meetings and records showed this information was shared with relevant staff members and teams. The practice had conducted a review of recent complaints to identify trends and themes and had plans to audit complaints every 3 months.

Example(s) of learning from complaints.

Complaint	Specific action taken
A patient required hospital admission the day after being seen by a GP.	The practice investigated the complaint and provided a written response detailing the reasoning behind the clinical judgements made during the home visit. The practice explained the risk of a rapid deterioration of health should an individual develop an infection. The practice apologised, provided information about the PHSO and explained the steps they would take to learn from the incident.
A patient waiting several weeks for a repeat medicine.	The practice investigated the delay and identified several factors which contributed to the delay in issuing a prescription for the medicine. The practice explained the difficulties they experienced in knowing which products were available and stocked at local pharmacies on a week to week basis. The practice apologised and acknowledged communication between the practice and a local pharmacy could have been better. The practice provided information about the PHSO and explained the steps they would take to learn from the incident.

Well-led

Rating: Good

We have rated the practice good for providing well-led services.

Leadership capacity and capability

There was compassionate and effective leadership at all levels. Leaders 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

Vision and strategy

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

	Y/N/Partial
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
<p>Explanation of any answers and additional evidence:</p> <p>Of the variety of staff who provided feedback for the inspection visit in June, 12% said they had been involved in the development of the practice's values and vision and the plans to deliver them. 57% of staff told us they were aware of the practice's values and vision.</p> <p>During our inspection in October, we found the staff we spoke with were aware of the practice's vision and values. The practice's core values were listed on the practice website and displayed on the staff noticeboard. The practice worked closely with local GP practices, their Primary Care Network and local Integrated Care Service.</p>	

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 ¹
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 had access to a Freedom to Speak Up Guardian.	Yes ²
Staff had undertaken equality and diversity training.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>1 The practice supported the safety and wellbeing of staff, for example, the practice:</p> <ul style="list-style-type: none"> • offered staff the flexibility to work around their other long-term or temporary needs • offered time and support for staff to complete training programmes • assessed staffs' work areas and provided the necessary equipment for staff to work safely and reduce the risk of muscle or joint problems • encouraged staff to attend social events when they had been organised. <p>Several staff also told us about a local service they could access for support with their mental health if needed. Staff could access this support without needing to inform the practice.</p> <p>² Staff told us they felt able to raise concerns. However, of the staff who provided feedback for this inspection, 38% were not aware of who the practice's Freedom to Speak Up Guardian was or how they could contact them if they needed to. Staff told us there had been recent changes which meant that not all staff were aware of the new arrangements. Freedom to Speak Up Guardians offer support to staff to raise concerns, or speak up, when they feel they cannot in other ways.</p> <p>During our inspection in October, we found information about the practice's Freedom to Speak Up Guardian was available to all staff members and easily accessible. All of the staff we spoke with knew how to contact the Freedom to Speak Up Guardian.</p>	

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

Source	Feedback
Questionnaires sent to all staff at the practice by CQC.	Staff described a positive working environment.
Discussions with staff working at the practice.	Several staff described strong team working, where others were supportive, kind, helpful, caring, polite and friendly.
	Staff told us there were good relationships between staff members and all aspects of the practice worked well together.
	Staff liked working at Hilltops Medical Centre and were happy working there.

Governance arrangements

Governance arrangements were effective, in most cases.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice had reviewed their policies and procedures in the last year.</p> <p>Although staff could access the practice's policies and procedures, which were stored on an electronic document management system, we found systems and processes were not always clear. For example:</p> <ul style="list-style-type: none"> not all of the significant events recorded had been discussed during clinical meetings and learning shared with all relevant staff members. there were gaps in both clinical and non-clinical staff immunisation records. <p>Staff had time allocated to carry out any additional roles, such as checking equipment or for infection prevention and control (IPC) activities.</p> <p>Although staff were clear about their own roles and responsibilities, staff did not always know who was responsible for other tasks and roles in the practice, for example the Freedom to Speak Up Guardian, IPC lead and for doing equipment quality checks.</p> <p>The practice held meetings once a month for all practice staff to attend.</p> <p>Leaders encouraged staff to meet every morning during the coffee break to offer each other informal support and share information. The practice had a programme of regular meetings for all staffing groups.</p>	

Staff told us there were weekly ‘clinicians’ team meetings that clinical staff and team leaders could attend. However, 57% of the staff who provided feedback for this inspection told us they did not have opportunity to go to these meetings.

Staff told us the practice shared information with them by email and the practice’s electronic information management system.

Leaders shared with us examples of practice newsletters they sent to staff every 3 months and ‘round up’ emails they sent to staff every month to share information.

The GP partners and practice managers met once a week, and team leaders and practice managers met once a month.

During our inspection in October, we found the practice had reviewed the roles and responsibilities and all of the staff members we spoke with were clear on the various lead roles at the practice. Staff told us they had opportunities to go to staff meetings and would receive updates on key discussions if they were not able to attend these meetings.

Managing risks, issues and performance

The practice had clear processes for managing risks, issues and performance, in most cases.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial ¹
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.	Partial ¹
A major incident plan was in place.	Yes ²
Staff were trained in preparation for major incidents.	Yes ²
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>During our inspection visit in June we found:</p> <p>¹ The provider did not show there was always effective oversight of the running of the practice and there were effective systems for identifying and responding to risks. For example to make sure:</p> <ul style="list-style-type: none"> • all equipment calibration and quality checks were carried out, for example of blood glucose monitors • medicines and equipment for use in an emergency were always safe and available for use • all staff completed and stayed up-to-date with the appropriate required training, such as in safeguarding, fire safety and IPC • PGDs were used safely and in line with national guidance 	

- satisfactory recruitment checks were completed or measures put in place for all new staff
- staff worked in line with practice policies and national guidelines and legislation, for example following safety alerts, including historic alerts, to protect all patients affected by them from avoidable harm
- non-clinical and clinical staff had the skills and knowledge to treat patients safely, including monitoring to make sure staff maintained their competencies and to identify and address any concerns and support clinicians in their professional development. This included arrangements to monitor the prescribing practices of clinicians who were not doctors but could prescribe medicines
- systems were effective, for example to identify patients needing a review of their medicine or health condition or who had possibly undiagnosed conditions and make sure these patients are offered appropriate treatment, monitoring and high quality reviews
- staff complied with any changes made to the service, for example in response to audits, clinical searches, previous CQC inspections, complaints or significant events, and the changes were reviewed and improved.

During our inspection in October, we found the practice had taken steps to improve systems for identifying and responding to risks in some cases. For example the practice had implemented systems and process to ensure:

- all equipment calibration and quality checks were carried out, for example of blood glucose monitors
- medicines and equipment for use in an emergency were safe and available for use
- PGDs were used safely and in line with national guidance
- satisfactory recruitment checks were completed
- staff worked in line with practice policies and national guidelines and legislation, for example following safety alerts to protect all patients affected by them from avoidable harm
- non-clinical and clinical staff had the skills and knowledge to treat patients safely, including monitoring to make sure staff maintained their competencies and to identify and address any concerns and support clinicians in their professional development. This included arrangements to monitor the prescribing practices of clinicians who were not doctors but could prescribe medicines
- systems were effective, for example to identify patients needing a review of their medicine or health condition or who had possibly undiagnosed conditions and make sure these patients are offered appropriate treatment, monitoring and high quality reviews
- staff complied with any changes made to the service, for example in response to audits, clinical searches, previous CQC inspections, complaints or significant events, and the changes were reviewed and improved.

However, during our inspection in October we found some of the practice's systems for identifying and responding to risks required strengthening. For example:

- not all medical consumables were managed in accordance with the manufactures use by date

- not all clinical staff had an up-to-date record of completing fire safety and IPC training
- complaints were investigated and learning was shared. However, the practice did not always provide information about the PHSO when responding to complaints.

² The practice had a business continuity plan that outlined what staff should consider and what actions could be taken if the practice was affected by issues such as loss of computer systems; loss of utilities such as gas, electricity and water; fire or flood; pandemics and staff incapacity.

The practice had recently reviewed the plan, following a significant unexpected power outage affecting the practice.

Staff told us, during that power outage, they had worked well with other local practices, for example to transfer medicines that need to be kept in a fridge to fridges at other locations.

Appropriate and accurate information

The practice used data and information to 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
Staff whose responsibilities included making statutory notifications understood what this entailed.	Yes

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
Staff are supported to work remotely where applicable.	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 ¹
Staff views were reflected in the planning and delivery of services.	Yes ²
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>During our inspection visit in June we found:</p> <p>¹ Feedback from the Patient Participation Group (PPG) was positive.</p> <p>² Of the variety of staff who provided feedback for this inspection, 83% told us they felt their involvement in decisions affecting the practice and communication with them about changes at the practice could be better. Not all staff felt there was opportunity to discuss different views about, or felt involved in, the planning and delivery of the service.</p> <p>During our inspection in October, all of the staff we spoke with told us they felt involved in making decisions and felt they had opportunities to provide feedback and share ideas for improving working practices.</p>	

Continuous improvement and innovation

There were 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
<p>Explanation of any answers and additional evidence:</p> <p>The practice was an approved GP teaching and training practice and had recently become a research practice.</p> <p>The practice had introduced a new telephone system, which featured a call monitoring service. The practice used this monitoring information to offer patients a call back service or make more staff available to answer calls at busy times.</p> <p>The practice supported staff to complete nationally recognised training programmes, for example in diabetes management, to become independent prescribers and to gain skills and experience in practice nursing.</p>	

The practice had a programme of clinical searches and audits and were able to demonstrate how audits improved patient outcomes and the quality of the service.

The practice had made changes and improvements in the systems and processes for the safe and effective management of patients receiving high risk medicines and medicines requiring monitoring.

The practice worked closely with local GPs and key stakeholders and had shared their experiences and knowledge and offered support to other local practices, for example with regards to supporting care homes and introducing online triage tools.

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