CQC Inspection 12th May 2022

Heathcot Medical Practice welcomed the Care Quality Commission (CQC) Inspection Team to the practice on 12th May. CQC is the independent regulator of health and adult social care in England. They make sure health and social care services provide people with safe, effective, compassionate, high-quality care and encourage care services to improve. Heathcot Medical Practice were open, honest, and valued CQC's comments and advice.

Below is a summary of the key points raised by CQC, what they mean to you as a patient and what Heathcot are doing/have done to improve to the raised concerns.

What CQC said	What this means	What we are doing/have done
1. Staff told us they felt well supported and that leaders were approachable.	CQC asked practice staff to complete feedback forms to gain an understanding of the working environment	
2. Although the provider had a system in place to record and act on recent safety alerts, we identified a historic alert which had not been acted upon.	Medication Safety alerts are completed by our team of clinical pharmacists and patients are contacted as necessary. Since introducing our new Practice Management system, TeamNet, in 2020 all safety alerts are uploaded and managed on this system. However, there was no evidence on TeamNet of historic alerts, from before the system was introduced.	Historic alerts, pre-introduction of TeamNet, were documented on a spreadsheet. We are in the process of reviewing historic alerts.
3. We found gaps in processes relating to the monitoring of vaccine fridge temperatures to ensure those medicines remained safe to use.	All fridges containing vaccines have data loggers placed inside to ensure that any adjustment in temperature is captured, to ensure vaccines remain safe to use. Not all data from the data loggers had been recorded on TeamNet, our Practice Management system.	All of our Nursing Team, responsible for fridge monitoring, have undergone further training and our Cold Chain Policy has been updated. We have now blocked out dedicated time in clinics every day to act as a prompt, and ensure that the fridge data is logged.
4. Medicine reviews were not always completed in the required time frames.	Due to the onset of the Pandemic, NHS England directed Primary Care to postpone conducting the majority of annual health reviews, which was reinstated in April 2022. Since then, we have been gradually working through the backlog of overdue reviews.	We have employed a team of additional admin staff to call through the lists of overdue reviews and book appointments with the relevant clinician. We are setting up additional out-of-hours clinics to help reduce the backlog.
5. The practice adjusted how it delivered services to meet the needs of patients during the COVID-19 pandemic.	At the onset of the pandemic services and systems were adapted to reduce risk of transmission of COVID. Since then, services and	

	systems continue to be adapted to suit the most efficient and balanced working environment	
6. Staff recruitment files contained all of the required information.	All staff files contained important information such as DBS checks, references, training certificates, CVs etc	
7. The practice was innovative in the use of technology.	The practice utilises a total-triage online consultation system, a cloud-based telephony system and multiple different pieces of software to improve productivity and increase efficiency	
8. The system for monitoring two-week-wait referrals for suspected cancer was not working as intended	Urgent Two Week Rule referrals are safety netted by the practice to ensure that patients have been seen by Secondary Care in the required time. The practice sends SMS prompts to patients when their referral has been sent, and again in 2-weeks time to advise the patient to get in touch if they have not received an appointment from Secondary Care. The aim of our monitoring was to also capture the date of the first hospital appointment, but this was not always forthcoming and led to gaps in our documentation.	The spreadsheet now includes a column to document when a weekly safety netting search search is run and, if any, how many patients were identified to have not received their appointment from Secondary Care. There is an additional column to document the actions taken to remedy this.
9. We found evidence of insufficient monitoring of a number of patient during our searches of patient records	Due to the onset of the Pandemic, NHS England directed Primary Care to postpone conducting the majority of annual health reviews, which was reinstated in April 2022. CQC identified a selection of patients where there was no evidence of continued monitoring.	We have employed a team of additional admin staff to call through the lists of overdue reviews and book appointments with the relevant clinician. We are setting up additional out-of-hours clinics to help reduce the backlog.
10. The internal fire risk assessment did not cover all notable risks and there was no fire risk assessment completed for Knaphill Surgery.	Knaphill Surgery is a shared building and an updated fire risk assessment was not in our possession.	Since the inspection, a fire risk assessment company have visited all 3 practice sites and produced updated and comprehensive risk assessments for each site.
11. Complaints investigation needed to be reviewed to ensure all of the concerns raised were investigated.	Complaints are logged onto our Practice Management system and are shared in our 6-weekly staff meeting. Whilst the process of handling complaints is sufficient, CQC identified some examples where further investigation was needed.	Our complaints handlers have enrolled on NHS complaints training and the complaints policy has been reviewed and updated.

12. The details recorded for complaints and significant events needed to be strengthened to ensure trend analysis and the wider learning for all staff	Complaints and significant events are logged onto our Practice Management system and are shared in our 6-weekly staff meeting. CQC identified that the log needed extra considerations to be included and that trend analysis should be completed and reported regularly.	Our complaints handlers have enrolled on NHS complaints training and the complaints policy has been reviewed and updated. The complaints manager will provide quarterly root-cause analysis reports.
13. Staff dealt with patients with kindness and respect and involved them in decisions about their care.	Using patient feedback, CQC identified that staff were considerate towards patients	

We recognise all of CQC's comments and continue to use their recommendations to improve our services and patient care.