Care Quality Commission

DHSC – CQC external quality regulation programme

Manx Emergency Doctors' Service (MEDS)

Assessment report

Noble's Hospital

Strang

Braddan

Isle of Man

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www.gov.im/meds

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Our findings

Overall summary

We carried out this announced out of hours assessment on 9 November 2022. The assessment was led by a Care Quality Commission (CQC) inspector who was supported by a GP adviser.

This assessment is one of a programme of assessments that the CQC is completing at the invitation of the Isle of Man Government's Department of Health and Social Care (IOMDHSC) in order to develop an ongoing approach to providing an independent regime of health and social care providers delivered or commissioned by IOMDHSC and Manx Care.

The CQC does not have statutory powers with regard to improvement action for services on the Isle of Man, and providers on the island are not subject to CQC's enforcement powers. The assessment is unrated.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?

- Is it responsive to people's needs?
- Is it well-led?

These questions form the framework for the areas we look at during the assessment.

We based our view of the quality of care at this service on a combination of:

- what we found when we inspected
- information from data available on the service
- information from the provider, patients, the public and other organisations.

Our key findings were

- The service had clear systems, practices and processes to keep people safe and safeguarded from abuse.
- Recruitment checks were carried out in accordance to policy, and Disclosure and Barring Service (DBS) checks were undertaken regularly for all staff.
- Appropriate standards of cleanliness and hygiene were met.
- Some systems to assess, monitor and manage risks to patient safety were limited.
- The service had systems for the appropriate and safe use of medicines, including medicines optimisation. However, there was limited oversight and review of the work of all prescribers, including non-medical prescribers.
- The service learned and made improvements when things went wrong. However, information was not always shared with all staff.
- Patients' needs were assessed, and care and treatment were delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.
- There was limited monitoring of the outcomes of care and treatment.
- The service could not always demonstrate that all staff had the skills, knowledge and experience to carry out their roles.
- Staff worked together to deliver effective care and treatment. We found a lack of data sharing arrangements did not always allow staff to work effectively with other organisations.
- The service was able to demonstrate that it obtained consent to care and treatment in line with legislation and guidance.
- Staff treated patients with kindness, respect and compassion. Feedback from patients was positive about the way staff treated people. Staff helped patients to be involved in decisions about care and treatment, and respected patients' privacy and dignity.
- The service organised and delivered services to meet patients' needs.
- People were able to access care and treatment in a timely way.
- There was compassionate, inclusive and effective leadership at all levels. The service had a culture which drove high quality sustainable care.

- The service's governance structures and systems were effective. Processes for managing risks, issues and performance were effective.
- There was a demonstrated commitment to using data and information proactively to drive and support decision making. However, there was limited use and access to clinical quality indicators and outcomes.

We found areas where the service could make improvements. CQC recommends that the service:

- Improve processes to ensure all staff are aware of, and know how to access, relevant standard operating procedures such as safeguarding procedures.
- Improve staffing cover arrangements and staffing resilience to ensure there are adequate cover systems in place in the event of staff absence or illness.
- Continue to develop data sharing arrangements with other healthcare providers to ensure safeguarding concerns, information relating to care and treatment delivered by other services, or information relating to patient medications are effectively shared and actioned.
- Improve the supervision and oversight of the work of all non-medical prescribers.
- Improve the sharing of incidents and significant events to ensure staff are aware of any learnings or actions relevant to their role.
- Implement systems to monitor the quality and effectiveness of the clinical care provided, including through the obtaining and reviewing of clinical quality indicators and patient outcomes.
- Develop a formalised supervision programme for all staff, including all clinical staff.
- Develop a defined list of the required competences for all members of staff.
- Develop and implement patient care plans to ensure patients' care and treatment meets their needs and preferences.
- Develop a process to allow staff to raise concerns to an individual or organisation who is external to the service, in the event they did not feel comfortable to raise them internally to service managers.
- Improve the recording and distributing of meeting minutes to ensure all staff are aware of any actions agreed that are relevant to their role.
- Improve systems for collecting and acting upon feedback from staff and patients.

We have also identified areas we have escalated to the IOMDHSC:

- Staff reported challenges regarding Mental Health Act section assessments regarding availability of Section 12 approved doctors out of hours, which often posed delays and challenges in arranging timely assessments outside of normal working hours.

Background to assessment

The service is located at:

- Manx Emergency Doctors’ Service, Noble’s Hospital, Strang, Braddan, Isle of Man, IM4 4RJ

The service’s management team comprised of a lead GP, lead advanced clinical practitioner, lead advanced nurse practitioner and service manager. The clinical team comprised of a team of GPs, nurses, paramedics and other practitioners, who were largely employed on a bank or sessional basis. The management and clinical teams were supported by a team of urgent care assistants and receptionists.

Most appointments were initially a telephone triage and consultation. If a GP or practitioner needed to see a patient face-to-face, patients were usually offered an appointment at the service’s base, which was located on the grounds of the local hospital, or a home visit.

During our assessment process, we spoke with 10 members of staff, which included 5 GPs. We looked at the service’s policies and procedures and other records about how the service is managed.

You can find information about how we carry out our assessments on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-assessment

Is the service safe?

We found this service was not always safe in accordance with CQC's assessment framework.

Safety systems and processes

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

Safeguarding

Safeguarding systems, processes and practices were developed, implemented and communicated to staff. The service used cross-service safeguarding policies that outlined key staff responsibilities, the different types of abuse staff should be alert to, and details of local safeguarding teams. To support this, the service had implemented a separate safeguarding standard operating procedure that outlined to staff who the service’s safeguarding lead was and how to manage safeguarding concerns received outside of normal office hours. All staff had access to these policies through a link on each user’s computer desktop, but we found that not all staff were aware of who the service’s safeguarding lead was.

Training records evidenced that all staff had completed required safeguarding training for their role. For example, all clinical staff had completed a minimum of level three training, with receptionists and non-clinical staff completing a minimum of level two training.

There was appropriate engagement in local safeguarding processes. GPs explained how they attended safeguarding case conferences as required and sent written reports where they were unable to attend. Staff described how they had appropriately managed a recent child safeguarding concern, referring the child to on call safeguarding teams.

The patient’s registered GP was informed of relevant safeguarding information. The service held data sharing agreements with all GP practices on the island that allowed safeguarding information

to be shared, although we found this was reliant on prior consent from patients in order for information to be shared between services.

Systems to identify vulnerable patients were consistent. Staff explained how they could add flags to the care records of patients to alert staff to patients who were potentially vulnerable or at risk. Staff explained how alerts added by the service were generally visible to the patient's own GP, and likewise alerts added by the patient's GP practice could generally be seen by the service.

Disclosure and Barring Service (DBS) checks were undertaken when required. Managers explained how all staff were required to undergo yearly checks, with most staff signed up to the update service that allowed managers to automatically check for any changes.

Recruitment systems

Recruitment checks were carried out in accordance to policy. Managers explained all pre-employment checks were undertaken by the Isle of Man Government's Office of Human Resources, who checked each applicant's identity, qualifications, professional registrations (if applicable) and vaccination history, and obtained references from previous employers prior to employment. Managers explained these completed employment checks were reviewed by the service prior to each staff member's first shift.

All GPs were required to register onto the island's GP performers' list. Managers received updates when new staff had been added to the register, when existing staff had been removed, or if any conditions had been applied to an individual's registration. This register contained details whether an individual had an active contract in place to work for the service. Managers undertook yearly checks of the professional registrations of other clinical staff, such as nurses and paramedics, to ensure all staff remained appropriately registered with the respective body.

Safety systems and records

The service was based from a building located on the grounds of the hospital. At the time of our assessment, the service utilised the diabetic centre and had previously occupied an area next to the hospital emergency department. As the building was managed by the hospital, building risk assessments were largely completed by the hospital. This included health and safety risk assessments and fire evacuation procedures.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

The service building was visibly clean, tidy and well maintained, which minimised potential infection control risks. Cleaning of the building and clinic rooms was completed by hospital cleaning teams, with staff undertaking interim room cleans between patients. Cleaning of response vehicles and the associated equipment was completed by the ambulance service fleet teams who were based on the hospital grounds.

Staff received effective training on infection prevention and control.

Infection prevention and control audits were carried out. Audits were completed by the hospital, with the service completing regular hand hygiene audits.

The arrangements for managing waste kept people safe. The service had arrangements in place with the hospital for the disposal of clinical waste and used sharps. Staff had access to an infection prevention and control policy that outlined their personal responsibility under infection

control, which included the steps to take in the event of a potential infection control incident, such as a needlestick injury.

Risks to patients

Some systems to assess, monitor and manage risks to patient safety were limited.

There were limited systems in place to manage staff absences and busy periods. The service primarily operated with a single GP, who was supported by other practitioners such as nurses and paramedics, or non-clinical staff such as receptionists and urgent care assistants. Managers had implemented an ‘active on call’ rota whereby a nominated second GP could be called upon to provide cover in the event of sickness or high demand. However, we saw this position was not always covered, such as during the night of our assessment, and did not cover all hours the service was operational. During some periods of the rota, such as after midnight during weekday evenings, we saw the service was usually only staffed by a single GP and a single urgent care assistant. As the ‘active on call’ rota did not operate during this period, we raised a concern over the service’s staffing resilience.

We noted the majority of the clinical cover was provided by only one or two GPs, which could pose significant challenges in the event of their absence. Where suitable GP cover could not be found, the service would be forced to close, with patients being directed to the hospital emergency department. We saw managers were aware of this risk and were working to mitigate this, and explained how the service now rarely had to close as a result of staff absences, only closing twice over the past year.

There was an effective induction system for temporary staff, which was tailored to their role.

The service was equipped to deal with medical emergencies (including suspected sepsis). Staff had easy access to emergency equipment and medicines and could call hospital emergency teams in the event of a patient deteriorating.

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. Staff had access to a list of priority symptoms, which included sepsis warning signs. We saw the service used the National Early Warning Score 2 (NEWS2) system, a recognised scoring system used to identify acutely unwell patients, to monitor patients at risk of deterioration.

Information to deliver safe care and treatment

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

Individual patient care records and clinical data was managed securely. The service stored clinical information on a secure third-party system, which only authorised staff could access.

Patient care records and consultation notes were well documented and showed appropriate management and prescribing. Two of the 10 records we reviewed did not contain details of how the patient had been identified for a remote consultation, and two of the records reviewed did not contain all appropriate safety netting advice.

There were limited systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. Where data sharing agreements were held, and with the patient’s consent, the service could share information with other healthcare provider such as the patient’s registered GP. Where data sharing agreements were not in place, such as with hospital,

ambulance and other community services, we saw there was limited sharing of information which could impact on patient care.

Referrals to specialist services were documented, contained appropriate information and were actioned in a timely manner. For example, if a patient was referred to the hospital emergency department, details of the referral were sent to the hospital by secure email. If further tests were required and were arranged by the service, such as urine tests, there were arrangements in place for the patient's registered GP to be notified to check and action any results. Appropriate safety netting advice was given to patients to contact their own GP if they had not heard anything within five days of the tests.

Appropriate and safe use of medicines

The service had systems for the appropriate and safe use of medicines, including medicines optimisation. However, there was limited oversight and review of the work of all prescribers.

The service ensured medicines were stored safely and securely, with access restricted to authorised staff.

Blank prescriptions were kept securely. All blank prescriptions were stored in locked boxes and cupboards, which only authorised staff could access. The service kept logs of the serial numbers of all prescriptions issued, which allowed for the effective reconciliation of all blank stock.

Documentation demonstrated that all staff had the appropriate authorisations to administer medicines, including the use of Patient Group Directions (PGDs).

The systems and arrangements for managing medicines, including medical gases, emergency medicines, emergency equipment, controlled drugs and vaccines, minimised risks. Appropriate arrangements were in place to ensure medicines and medical gas cylinders carried in vehicles were stored appropriately. Regular checks of fridge temperatures were taken, with any anomalous temperatures escalated as appropriate.

Emergency equipment and medicines were available within the service's base and were managed and checked by the hospital. Further emergency equipment was available in response vehicles, which were maintained and checked by ambulance service fleet teams. The majority of emergency equipment was stored in tamperproof bags, which staff checked regularly. Staff wrote the expiry date of the medicine that was expiring first onto the tag to ensure any out of date medicines were removed and replaced. Although at the time of our assessment, the tag number was not recorded on check sheets, managers explained this would be added to provide an additional check.

The service carried out regular medicines audits to ensure prescribing was in line with best practice guidelines for safe prescribing.

Staff prescribed, administered and supplied medicines to patients and gave advice on medicines in line with legal requirements and current guidance. We saw there was limited oversight of the prescribing work and competency of non-medical prescribers, such as paramedic prescribers and advanced nurse practitioners. We saw the majority of supervision was undertaken through an individual's annual appraisal or performance review, but saw there was little-to-no oversight outside of this process. For example, we did not see any evidence of the regular reviewing or auditing of an individual's prescribing, any formalised or documented supervision, or the completion of any competency assessments.

Arrangements for dispensing medicines kept patients safe. Staff explained the majority of medicines were issued to patients through prescriptions, which patients could collect from their local pharmacy. Outside of community pharmacy opening hours, staff dispensed common medicines such as antibiotics and pain relief from their own medicine supply. Further medicines could be sourced from the hospital pharmacy if necessary. The service did not have its own prescribing formulary - a list of medicines that have been approved by the service for clinicians to prescribe. GPs explained they were able to prescribe any medicines as required, although were generally restricted by the range of medicines stocked by the service or available through community pharmacies outside of normal working hours.

The service audited antimicrobial prescribing and there was evidence of actions taken to support good antimicrobial stewardship. Antibiotics were dispensed in line with best practice guidelines, although staff did report difficulties with sourcing appropriate pack sizes. This meant at times staff had to prescribe patients more tablets than were required, with instructions issued to patients to only take a set number of the tablets.

Processes were in place for checking medicines and staff kept accurate records of medicines. Staff explained their medicine cabinets were stocked and replenished by the hospital pharmacy teams. Staff reported a good working relationship between the service and the hospital pharmacy and explained how they worked together to determine the medicines to be stocked by the service. For example, the pharmacy monitored the medicines the service was prescribing throughout the year and could alter the quantity stocked if the service was prescribing more or less of a particular medicine.

The service held a small number of controlled drugs, which were stored and checked appropriately. There were arrangements in place for raising concerns externally, such as to the hospital pharmacy team.

Patients' health was monitored in relation to the use of medicines and followed up on appropriately.

Palliative care patients were able to receive prompt access to pain relief and other medication required to control their symptoms.

Track record on safety and lessons learned and improvements made

The service learned and made improvements when things went wrong. However, information was not always shared with staff.

Significant events

The service monitored and reviewed safety information from a variety of sources. This included safety information shared through Manx Care, as well as other organisations such as the Medicines and Healthcare products Regulatory Agency (MHRA).

Staff knew how to identify and report concerns, safety incidents and near misses. Staff explained how they reported potential incidents and significant events using an online incident reporting form, which was reviewed by the service’s management team. If necessary, staff could escalate serious events to Manx Care through an established significant events process.

There was a system in place for recording, investigating and acting on significant events, although there was limited evidence of learning and dissemination of information. As part of our assessment, we reviewed completed reports for incidents reported within the last 12 months. We

saw several incidents had been reported by a range of different staff members, with each incident record containing an overview of the event, details of any investigation completed, and any learnings identified. The service discussed incidents during relevant meetings, depending on the severity and the actions and learnings documented. For example, we reviewed one recent incident regarding a patient receiving another patient's prescription. We saw this had been reported and investigated, and saw involvement from both their data protection officer and the patient's usual GP practice. Not all staff reported receiving information and updates from incidents that they were not directly involved in, and did not always report receiving minutes for meetings where other incidents were discussed.

Staff understood how to raise concerns and report incidents, both internally and externally. Staff explained how they used their incident reporting system to share incidents with their hospital or with the GP practices on the island through their primary care network.

Safety alerts

Staff understood how to deal with alerts, and the system for recording and acting on safety alerts was effective.

Managers shared external safety events and patient safety alerts with all members of staff, including sessional, bank and locum staff. Staff spoken with during our assessment reporting receiving regular safety alert communications from both service managers and from other organisations including Manx Care.

Is the service effective?

We found this service was not always effective in accordance with CQC's assessment framework.

Effective needs assessment, care and treatment

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

The service had systems and processes to keep clinicians up to date with current evidence-based practice. Clinical staff had access to guidelines from the National Institute for Health and Care Excellence (NICE) and used this information to help ensure that people's needs were met. The provider monitored that these guidelines were followed. Changes to clinical guidance or care pathways were shared with staff and were discussed in clinical meetings. This included through monthly educational meetings run by the service, which all clinicians on the island could attend, or through regular newsletters issued to all staff.

Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. Where patients' needs could not be met by the service, staff redirected them to the appropriate services.

Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. All patients requiring an appointment were initially required to speak with a receptionist, who confirmed their details and the reason for their call. Receptionists passed all requests to the service's clinical team who undertook telephone consultations with patients. If appropriate, patients could be booked face-to-face appointments at the service's base or home

visits could be arranged where a patient could not travel. Clinical staff regularly reviewed all pending appointment requests and undertook telephone consultations based on the severity of each patient’s condition. In the event receptionists were concerned over a patient’s symptoms, they could escalate the patient to the clinical team for a more urgent review. Receptionists could direct patients to other services, such as the hospital emergency department or the ambulance service, if their condition was deemed to be time critical.

We saw no evidence of discrimination when staff made care and treatment decisions.

Staff assessed and managed patients' pain where appropriate.

Monitoring care and treatment

There was limited monitoring of the outcomes of care and treatment.

There was limited evidence clinicians took part in national and local quality improvement initiatives or used care and treatment information to make improvements.

The service undertook some clinical audits to improve care and treatment. Recent audits completed by the service included controlled drugs prescribing, antibiotics usage and end of life care audits. Audits completed were comprehensive and included second cycles to check for improvement, with the results shared with staff.

The service was required to report on their performance against several standards, but we saw performance indicators were largely focused on appointment availability and other non-clinical metrics, rather than the clinical quality and effectiveness of the care provided. Managers explained they could check the conversion rates of any referrals submitted to the hospital emergency department, but had limited access to any other clinical performance measures or outcomes. We found managers had limited oversight and assurance systems in place to determine whether clinicians and the wider service were providing effective care. As a result, we saw the service was largely reliant on a lack of negative feedback to assess the clinical quality and effectiveness of its service, rather than reviewing specific information on patient outcomes and treatment.

The service no longer had access to island-wide prescribing data, so was unable to easily compare its prescribing performance with other services and practices.

Effective staffing

The service could not always demonstrate that all staff had the skills, knowledge and experience to carry out their roles.

The service could not demonstrate that all staff had the skills, knowledge and experience to deliver effective care, support and treatment. Staff completed mandatory training through an island-wide online training system, with face-to-face courses arranged where necessary, such as for resuscitation training. We saw all staff were required to complete training on several topics, which included safeguarding, infection prevention and control, fire safety and data protection. The majority of staff were seen to be compliant and had completed all required training.

The service had a programme of learning and development, and staff had protected time for training. Staff explained how they were supported to undertake additional training and learning, such as through the running of a recent dermatology education session that all clinical staff could attend. Managers ran a monthly educational meeting, which clinicians from all services on the island could attend.

There was an induction, training and mentoring programme in place, which all new staff were required to complete.

Most staff had access to regular appraisals, one-to-ones, coaching and mentoring. Clinical staff were supported to meet the requirements of professional revalidation. Most staff received quarterly performance reviews, which covered any development goals, training requirements and improvements for how the service was run. Managers explained they operated quarterly performance reviews rather than yearly appraisals, as the majority of staff were employed on a bank or sessional basis and received yearly appraisals from their substantive employer. They explained how quarterly reviews allowed managers to meet with staff more regularly and understand how they were performing in their role and discuss any needs for support.

The service could not demonstrate how they assured the competence of staff employed in advanced clinical practice, such as paramedics and advanced nurse practitioners. We saw there were no formal supervision arrangements in place for GPs, nurses or paramedics, and saw there was limited oversight of the quality of their work. With the exception of an annual review of their prescribing, there was little-to-no regular oversight of the prescribing of non-medical prescribers, such as nurse prescribers. For staff employed on a substantive basis at other services on the island, we found there were limited arrangements in place for concerns about an individual’s performance or competence to be shared between employers.

Managers explained the service historically did not have a defined list of competencies that were expected for each practitioner. Managers explained how they were actively working to address this and were developing a competency framework for each role. We saw evidence of a draft competency framework that was in the process of being developed for the new urgent care assistant role.

Nominated GP supervisors oversaw the training of GP trainees, but we saw there were limited arrangements in place for the supervision and oversight of all employed GPs. GPs described how they arranged their own appraisal and supervision through other services or GPs on the island.

There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together to deliver effective care and treatment. We found a lack of data sharing arrangements did not always allow staff to work effectively with other organisations.

Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved. For example, staff explained how they could easily refer patients to the hospital emergency department if necessary. The service did not utilise patient care plans, which meant patients may not receive all required or recommended care, in a way that met their individual needs or preferences.

If a patient consented, staff could access the patient’s GP record. This allowed staff to view a patient’s previous medical history, consultation records, medications and key information, such as allergies. This also allowed the patient’s registered GP to review the consultation notes entered by the service, including any care and treatment decisions.

Patients received consistent, coordinated, person-centred care when they moved between services. For example, the service sent a report to each GP practice on the island to inform them if

any of their patients had accessed out of hours' services, allowing the patient's usual GP to follow up on any care and treatment requirements or test results.

Helping patients to live healthier lives

Staff were consistent in helping patients to live healthier lives.

The service identified patients who may need extra support and could direct them to relevant services. This included signposting patients to local wellbeing services, hospice teams, long term conditions coordinators and/or voluntary services.

Staff encouraged and supported patients to be involved in monitoring and managing their own health. Where appropriate, staff gave people advice so they could self-care. Systems were available to facilitate this.

Patients in the last 12 months of their lives were supported by the service. This included home visits and working with hospice and home care teams to ensure the patient's needs were met.

Where patients' needs could not be met by the service, staff redirected them to the appropriate service for their needs, such as the hospital emergency department or ambulance service.

Staff discussed changes to care or treatment with patients and their carers as necessary.

The service supported national priorities and initiatives to improve the population's health, such as supporting stop smoking campaigns and tackling obesity.

Consent to care and treatment

The service was able to demonstrate that it obtained consent to care and treatment in line with legislation and guidance.

Clinicians understood the requirements of legislation and guidance when considering consent and decision making. Written consent forms were not generally used, although due to the nature of the service, invasive or surgical procedures were not usually undertaken.

Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

Staff reported challenges regarding Mental Health Act section assessments regarding availability of Section 12 approved doctors out of hours, which often posed delays and challenges in arranging timely assessments outside of normal working hours.

Is the service caring?

We found this service was caring in accordance with CQC's assessment framework.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was positive about the way staff treated people.

Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition. The service was proactive in sharing public health information and support groups that patients could access. This included information on safeguarding awareness and sepsis care. Call handlers gave people who phoned into the service clear information. There were

arrangements and systems in place to support staff to respond to people with specific health care needs such as end of life care and those who had mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients.

Staff displayed an understanding and non-judgemental attitude towards patients.

The service collected patient feedback and comments through an ongoing friends and family test, which all patients were invited to complete. Between April 2021 and March 2022, the service received seven responses. Of these, five respondents rated their overall experience as either 'good' or 'very good', one rated their experience as 'poor' or 'very poor', and one respondent rated their experience as 'neither good nor poor'. Positive comments largely related to efficiency of the service and helpfulness of staff. Negative comments largely related to delays in call backs and difficulties accessing the service's base overnight.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.

Interpretation services were available for patients who required them. We noted one member of staff was fluent in sign language.

For patients with learning disabilities or complex social needs, patients' family, carers or social workers were appropriately involved.

Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

Privacy and dignity

The service respected patients' privacy and dignity.

The service respected and promoted patients' privacy and dignity. Private rooms were available at the service's base if patients were distressed or wanted to discuss sensitive issues.

Staff respected patients' confidentiality at all times. There were arrangements to ensure confidentiality at the reception desk.

Is the service responsive?

We found this service was responsive in accordance with CQC's assessment framework.

Responding to and meeting people's needs

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

The service understood the needs of its local population and had developed services in response to those needs. This included the introduction of additional practitioners and roles to support GPs, such as the recruitment of paramedics, advanced nurse practitioners and urgent care assistants.

The importance of flexibility, informed choice and continuity of care was reflected in the services provided.

The facilities and premises were generally appropriate for the services being delivered. The service was based within the grounds of the local hospital, utilising the hospital diabetic centre building overnight and at weekends. The building included a waiting area, reception, several consultation rooms and toilet facilities. Disabled access was available throughout the building, with ample car parking nearby. Staff explained how the service had previously been based within the hospital, next to the emergency department, but had been moved to its current building as a result of the COVID-19 pandemic.

Although the building itself was appropriate for the services being delivered, staff described some challenges with the current arrangements. The service shared the use of the building with the diabetic centre, which managers explained restricted any future changes to the service's opening hours. As the service was based in a separate building away from the hospital emergency department, if a patient deteriorated and required emergency care, staff explained patients would be required to walk across to the hospital building which could pose additional risks at night or during poor weather. Managers explained how hospital porters or the ambulance service could be contacted to assist, such as where patients had reduced mobility, and explained how there had been no patient safety concerns reported regarding the current arrangements.

The service made reasonable adjustments when patients found it hard to access services. For example, if a patient was housebound and could not access the centre, staff could arrange for a home visit.

There were arrangements in place for people who need translation services. Staff explained how they could arrange a translator using the hospital switchboard service.

Further information about how the service is responding to the needs of their population

- The service was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The service liaised regularly with the patient's registered GP to discuss and manage the needs of patients with complex medical issues.
- All parents or guardians calling with concerns about a child were offered a same day or urgent appointment.
- There were arrangements in place for people to access the service who were not registered with a GP on the island, such as visitors.
- People in vulnerable circumstances were easily able to access the service, including those with no fixed abode, such as homeless people, refugees and Travellers.
- The service adjusted the delivery of its services to meet the needs of patients with a learning disability, such as the offering of face-to-face appointments or longer consultations.

Access to the service

People were able to access care and treatment in a timely way.

Patients were able to make appointments in a way which met their needs. The service operated from 6pm to 8am during weekday evenings, and 24 hours a day on weekends and bank holidays. Patients could not access the service without an appointment and could book appointments by telephoning the service. Where patients could not contact the service by telephone, alternative arrangements could be made, such as by visiting the centre in person.

Upon telephoning the service, trained receptionists registered the patient onto their system and took details for the reason for their appointment. The service's clinical team reviewed all appointment requests and contacted patients back to discuss their condition and treatment. Patients were contacted back according to their clinical need, with the service aiming to call all patients back within two hours of their request. If a receptionist was concerned over a patient's condition, they could escalate patients to the clinical team for urgent review. Where necessary, patients could be immediately signposted to other services, such as the hospital emergency department or ambulance service.

There was information available for patients to support them to understand how to access services, including on the Isle of Man Government website and on telephone messages.

Staff explained they operated an 'active on call' system whereby a nominated on call GP could be contacted during periods of high demand. As a result, staff explained it was rare for the service to be unable to contact or see all patients who had contacted the service during that day's opening hours.

Patients with the most urgent needs had their care and treatment prioritised. Where patient's needs could not be met by the service, staff redirected them to the appropriate service for their needs.

Listening and learning from concerns and complaints

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

Information about how to complain was available. The service followed the Manx Care complaints procedure, and patients could access a copy of the complaints procedure by speaking with a member of staff or contacting Manx Care. Staff explained how complaints could be raised verbally, in writing, by telephone or by email.

Managers explained how most complaints were initially received and acknowledged by the Manx Care Advice and Liaison Service (MCALS), who contacted the service if further information or an investigation was required.

There was evidence that complaints were used to drive continuous improvement. As part of our assessment, we reviewed completed complaint investigations and saw the service acknowledged and responded to all complaints promptly and provided an apology where appropriate. Complaints were usually investigated by the service managers and/or clinical teams. All complaints were discussed during relevant service meetings, such as management or clinical meetings, with any learnings or actions shared with staff as appropriate.

Is the service well-led?

We found that this service was well led in accordance with CQC's assessment framework.

Leadership capacity and capability

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

Leaders demonstrated they understood the challenges to quality and sustainability, and had taken actions to address these challenges. Current challenges reported by the service included

concerns over the premises, availability of GP staff, and lack of resilience with current staffing arrangements.

Managers explained how they were working to address these challenges, such as through the recruitment of additional practitioner roles including paramedics, advanced nurse practitioners and urgent care assistants to support GP teams.

Staff reported that leaders were visible and approachable. Most staff were positive about working for the service and reported how they felt supported, valued and respected in their roles.

Managers were accessible throughout the operational period, with an effective on-call system that staff were able to use.

The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service.

Vision and strategy

The service was in the process of developing a vision and strategy for what it wanted to achieve.

At the time of our assessment, the service was undergoing significant transformation. We saw managers had identified several potential future opportunities for the development and expansion of the service, such as closer integration with their local minor injury unit and increasing of their opening hours to reduce pressure on other urgent and emergency care services.

Managers explained that due to the ongoing transformation programme that could affect the future of the service, it was challenging to set realistic objectives and a future vision for the service at the present time.

Culture

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

Arrangements to deal with inconsistent or poor behaviour were effective. Most staff received regular performance reviews, during which their work performance and behaviours were reviewed. Where any poor behaviours were identified, managers took action to improve this.

Staff reported that they felt able to raise concerns without fear of retribution. This included raising concerns to colleagues, managers and/or senior clinicians. The service did not have arrangements in place for staff to raise concerns to an individual or organisation external to their service, in the event they did not feel comfortable to raise them to service managers.

There was a strong emphasis on the safety and well-being of staff. Staff spoke positively about working for the service, and described how they felt supported by colleagues and managers. Bank, locum and sessional staff were considered valued members of the team.

There were systems to ensure compliance with the requirements of the duty of candour.

When people were affected by things that went wrong, they were given an apology and informed of any resulting action.

The service encouraged candour, openness and honesty. Staff reported they were comfortable in raising concerns to managers, colleagues and/or senior clinicians.

Staff undertook equality and diversity training.

Governance arrangements

The service's governance structures and systems were generally effective.

The service had effective governance structures and systems in place. The service was run by Manx Care as part of its urgent and emergency care service, and was one of several services that were governed by its urgent and emergency care board. Other services governed by this board included the island's ambulance service, minor injury and ambulatory care units, and the hospital emergency department. This board was led by a triumvirate that comprised of a general manager, a clinical director and an associate director of nursing. The service's leadership, which comprised of a service manager, clinical lead GP, lead nurse and lead paramedic, fed into the triumvirate. We noted this governance structure was still in its infancy at the time of our assessment, with the terms of reference still being finalised at its last meeting.

Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The service had recently redeveloped its governance structure and planned on having regular governance meetings with different staff and management levels. This included weekly service management meetings, bimonthly patient safety and quality meetings, bimonthly staff specific role meetings and twice yearly full team meetings. Service managers attended urgent and emergency care board meetings with managers from the other services.

Staff were clear about their roles, responsibilities and accountabilities. The service primarily used Manx Care policies, which all staff had access to. To support this, the service had implemented standard operating procedures, such as a safeguarding standard operating procedure, to advise staff on any local service-specific procedures.

There were appropriate governance arrangements with third parties.

Managing risks, issues and performance

Processes for managing risks, issues and performance were effective.

There were assurance systems in place, which were regularly reviewed and improved. Managers held several different meetings, which included service manager meetings and all team meetings. All meetings were regular and followed a standard agenda. We found meeting minutes were not always taken following a meeting, and were not always shared with staff in a timely manner. Managers explained they were aware of this and were working to improve the quality and timeliness of all meeting minutes.

There were processes to manage performance. Arrangements for identifying, managing and mitigating risks were effective. During our assessment, we identified some potential areas of concern but saw the service were aware of all these areas and were taking appropriate action to mitigate any risks. For example, we saw how the service was working to establish a formalised scope of practice for all clinicians and roles at the service.

The service operated a risk register, which contained an overview of all risks that could affect the service. At the time of our assessment, we saw these risks included lack of formalised scope of practice for practitioners, drugs checking and reconciliation processes, lone working arrangements and the current staffing model. We saw each risk had been graded according to its severity, had been categorised and placed onto an appropriate risk register for the severity of the risk.

The providers had plans in place and had trained staff for major incidents.

When considering service developments or changes, the impact on quality and sustainability was assessed.

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

The service had adapted how it offered appointments to meet the needs of patients during the pandemic. This included the expansion of remote consultations and telephone appointments.

The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.

There were systems in place to identify and manage patients who needed a face-to-face appointment.

The service actively monitored the quality of access and made improvements in response to findings.

Staff were supported to work remotely where applicable, which included both clinical and non-clinical staff.

Appropriate and accurate information

There was a demonstrated commitment to using data and information proactively to drive and support decision making. However, there was limited use and access to clinical quality indicators and outcomes.

Staff used data to monitor and improve performance, but a lack of access to clinical quality indicators and outcomes limited the effectiveness of this. The service was required to set and achieve a number of key performance indicators, and we saw the majority of these indicators were related to non-clinical metrics.

The service used performance information, which was reported and monitored, to hold management and staff to account. The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.

The service used information technology systems to monitor and improve the quality of care.

There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Governance and oversight of remote services

The service used digital services securely and effectively and conformed to relevant digital and information security standards.

Patient care records were held in line with guidance and requirements. The service primarily used a secure third party clinical records system for the storage and management of confidential patient information.

Patients were informed and consent was obtained if interactions were recorded.

The service ensured patients were informed how their records were stored and managed.

Patients were made aware of the information sharing protocol before online services were delivered.

Online consultations took place in appropriate environments to ensure confidentiality. For example, all staff completed remote consultations in individual clinic rooms to ensure any confidential information could not be overheard.

The service advised patients on how to protect their online information.

Engagement with patients, the public, staff and external partners

There was limited involvement of patients, the public, staff and external partners to support high-quality sustainable services.

Staff and patient views were acted on to improve services and culture. The service collected patient feedback through their friends and family test survey and patient suggestions made to staff, and staff feedback through service meetings and individual performance reviews.

Staff were able to describe to us the systems in place to give feedback. Staff who worked remotely were engaged and able to provide feedback. However, we saw there were limited examples of changes made to the service as a direct result of staff or patient feedback.

The service worked with stakeholders to build a shared view of challenges and of the needs of the population. For example, we saw how the service worked with other healthcare providers, including their local hospital, the GP practices on the island, and the ambulance service to improve service delivery and align operational delivery. The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

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

There was a focus on continuous learning and improvement at all levels within the service. Staff knew about improvement methods and had the skills to use them. For example, we saw how staff had developed templates on their clinical records system to ease the inputting and recording of patient observations.

Learnings were shared effectively and used to make improvements. We saw how incidents, complaints and clinical audits were shared to improve services, and saw there were systems to support improvement and innovation work.

Staff worked with other services to help improve the quality of care for patients. Staff explained how they had worked with the ambulance service to develop a joint system to improve the ambulance service’s response to a call made by another healthcare professional.