DHSC – CQC external quality regulation programme

Ballasalla Medical Centre

Assessment report

Main Road

Ballasalla

Isle of Man

IM9 2RP

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Date of assessment: 17 August 2022

Date of publication: 26 October 2022

Our findings

Overall summary

We carried out this announced assessment on 17 August 2022. The assessment was led by a Care Quality Commission (CQC) inspector who was supported by a CQC national professional 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

- Safeguarding processes were not always effective, as not all staff were trained to appropriate levels for their roles, systems to identify vulnerable patients on record were not consistent, and data sharing arrangements did not always allow for the effective sharing of safeguarding information.
- Recruitment checks were carried out in accordance with policy, with Disclosure and Barring Service (DBS) checks undertaken regularly for all staff.
- The practice's oversight of health and safety risk assessments was not always effective.
- Appropriate standards of cleanliness and hygiene were met.
- Patient clinical information was stored appropriately and securely.
- The practice's system for the appropriate and safe use of medicines, including medicines optimisation, was not effective as patients prescribed high-risk medicines did not always receive all required monitoring. Medication reviews were not always completed when required and documentation regarding completed reviews was limited. Blank prescriptions were not always kept securely. The practice could not demonstrate the prescribing competence of all staff, and there was no direct supervision of all prescribers.
- Staff had access to emergency equipment and medicines, although the storage of medicines was not always in line with recommendations.
- The practice had effective systems in place to learn and make improvements when things went wrong.
- Patients' needs were assessed, and care and treatment were delivered in line with current legislation and standards. However, the oversight and management of patients with long term conditions was not always effective.
- There was limited monitoring of the outcomes of care and treatment, and the practice did not have an established clinical audit programme in place.
- The practice was able to demonstrate that all staff had the skills, knowledge and experience to carry out their roles. However, the practice could not demonstrate how they assured the competence of staff employed in advanced clinical practice.
- 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 practice always 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 practice organised and delivered services to meet patients' needs. People were able to access care and treatment in a timely way. Patient complaints were listened and responded to, and used to improve the quality of care.
- There was compassionate, inclusive and effective leadership at all levels.
- The practice had a culture which drove high quality sustainable care.
- Processes for managing risks, issues and performance were effective.

We found the following areas of notable practice:

- The practice was proactive in identifying and supporting patients who were carers or had caring responsibilities, with approximately 2.64% of the practice list identified as carers at the time of our assessment.

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

- Improve safeguarding processes to ensure the identification of all vulnerable adults and children is consistent, and that all staff are trained to appropriate levels for their role.
- Improve staff recruitment processes to ensure there is an evidenced check of staff professional registrations.
- Improve the management and oversight of health and safety risk assessments.
- Improve the management and oversight of requested referrals, tasks and correspondence.
- 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 changes made to patient medications are effectively shared and actioned.
- Improve systems to ensure out of date equipment and consumables are identified and removed.
- Improve the security, storage and oversight of blank prescriptions.
- Implement a formalised programme to review clinical staff competencies, including the prescribing competencies of non-medical prescribers.
- Improve the oversight of Patient Specific Directions (PSDs) to ensure all staff have appropriate authorisation to supply and administer medicines.
- Improve the documentation of completed patient medication reviews to ensure there is evidence of an effective medication review taking place, which includes checks to ensure all monitoring is up to date, all prescribing is in line with guidance, and checks for any side effects and interactions.
- Improve the monitoring and oversight of patients prescribed high risk medicines to ensure patients receive all required monitoring, assessments, follow-up appointments and medication reviews.

- Improve the storage of emergency medicines to ensure they are stored in line with recommendations.
- Improve processes for the management and recording of safety alerts, including historic drug safety and medication alerts.
- Improve the management of patients with long term conditions to ensure all patients receive all required monitoring, assessments, diagnoses, follow-up appointments and medication reviews.
- Improve systems to ensure all patients living with a learning disability are offered a minimum of an annual review.
- Improve childhood immunisation uptake rates.
- Implement a formalised programme of regular and repeat clinical audit.
- Improve the oversight and management of staff competencies to ensure all staff remain competent in their roles.
- Develop a practice vision and values that are supported by an effective and credible strategy.
- Improve systems to identify, address and manage any inconsistent or poor behaviours.
- Improve practice governance systems to ensure they are effective and provide effective oversight of all practice areas.
- Improve systems to collect and review feedback from patients and people who use the service.

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

- The practice did not have effective oversight of the monitoring of patients prescribed high risk medicines or who had long term conditions, and did not ensure all patients received all required monitoring, assessments, follow-up appointments, medication reviews and diagnoses.
- The practice did not have effective processes for the management of safety alerts, which included historic drug safety and medication alerts.
- The practice did not have an effective system in place regarding the use of patient specific directions (PSDs).
- The practice's safeguarding processes were not always effective, as not all staff were evidenced as having completed appropriate training for their roles, systems to identify vulnerable patients on record were not consistent, and data sharing arrangements did not always allow for safeguarding information to be shared between services.
- The practice did not have effective processes in place for the supervision and oversight of all staff, including non-medical prescribers.

Background to assessment

The practice is located at:

- Ballasalla Medical Centre, Main Road, Ballasalla, Isle of Man, IM9 2RP

The practice is part of a wider network of GP practices, as all GP practices on the island are members of a primary care network.

There is a team of two GPs and two practice nurses. The clinical team are supported at the practice by a practice manager who provides managerial oversight, and a team of reception and administration staff.

Due to the enhanced infection prevention and control measures put in place since the pandemic and in line with the national guidance, some GP appointments were telephone consultations. If the GP needs to see a patient face-to-face, then the patient is offered an appointment at the practice.

Out of hours services are provided by the Manx Emergency Doctor Service (MEDS), which provide appointments between 6pm and 8am Monday to Friday, and 24 hour cover on weekends and public holidays.

During our assessment process, we spoke with four patients and six members of staff, which included two GPs. We looked at practice 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-inspection.

Is the service safe?

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

Safety systems and processes

The practice did not have 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 practice had separate policies in place for the safeguarding of adults and children that outlined key staff responsibilities. We found the policy outlined different types of abuse staff should be alert to, although did not include details of the practice's safeguarding lead or contact information of teams that staff could raise a safeguarding concern to. One of the practice's GPs acted as their safeguarding lead, which staff were aware of.

Training records did not evidence that all staff had completed required safeguarding training for their role. For example, reception and non-clinical staff generally completed level one training, rather than the recommended level two.

There was engagement in local safeguarding processes. Safeguarding featured as a regular agenda item on monthly practice meetings, whereby new safeguarding referrals and safeguarding registers were reviewed. Prior to the pandemic, the practice explained they used to have monthly meetings with their local school nurses, health visitors, long term conditions nurses and district nurses to discuss patients of concern and review admission avoidance. Since the pandemic, the practice explained these had not returned through a combination of some posts now being vacant or teams not having capacity to attend. There were no formalised transitional safeguarding arrangements in place at an island level, but the practice had worked locally with children's and

adult services to develop suitable processes. The practice described a recent example whereby they had established a process with neurology services to allow children receiving neurological care to transition to adult services.

The out of hours service was informed of relevant safeguarding information. The practice held data sharing agreements with out of hours services to enable safeguarding information to be shared. We found this relied on prior consent from patients for their information to be shared between services. Where the practice did not hold such data sharing agreements, there was limited-to-no sharing of safeguarding information between other healthcare services.

Systems to identify vulnerable patients were not consistent. The practice maintained several child safeguarding registers, which included children in care, children in need, looked after children and children under a child protection plan. We found safeguarding alerts were not always placed on the records of siblings or parents of vulnerable children, and saw instances whereby alerts had not been removed from records in a timely manner when they were no longer applicable. Alerts for vulnerable adults were placed on some care records, but this was inconsistent and was mainly completed where there were drug or alcohol concerns. We identified one incident whereby concerns over the potential exploitation of a patient had been raised, but saw that no safeguarding alert or notes had been entered into the patient's care record.

Disclosure and Barring Service (DBS) checks were undertaken when required. All staff were required to complete an annual check, with clinical staff receiving an enhanced level check.

Discussions were held 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.

Recruitment systems

Recruitment checks were carried out in accordance with policy (including for agency staff and locums). This included the obtaining of references, review of ID and completion of an induction programme. Staff professional registrations were not always checked, either on recruitment or on an ongoing basis.

Safety systems and records

Health and safety risk assessments were carried out, but the practice's oversight of these were not effective. The practice explained their building landlord was responsible for completing fire risk assessment and understood this was completed annually. The practice did not receive a copy of this assessment and therefore was unsure if any defects or concerns had been identified, or if any mitigating actions were required. The practice had not undertaken a legionella risk assessment, but had recently started participating in an island-wide programme of regular water testing for legionella. At the time of our assessment, the practice was awaiting the first set of results from the laboratory.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

Staff received effective training on infection prevention and control.

Infection prevention and control audits and hand hygiene audits were carried out.

Date of last audit: July 2022

The practice had acted on any issues identified in infection prevention and control audits.

The arrangements for managing waste and clinical specimens kept people safe. Clinical waste, including used sharps, were collected and disposed of through agreements with their local hospital.

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

There was an effective approach to managing staff absences and busy periods.

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

The practice was equipped to respond to medical emergencies (including suspected sepsis). The practice explained all staff received annual basic life support training.

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. Where receptionists had concerns over a patient's condition, they could escalate patients to the GP team for review.

Information to deliver safe care and treatment

Staff did not always have all the information they needed to deliver safe care and treatment.

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

Patient care records and consultation records were not always written in line with current guidance and legislation. We saw instances whereby medication reviews had been coded into patient care records, but consultation notes did not evidence that an effective medication review had taken place. Notes did not always include checks to ensure all monitoring was up to date, all prescribing was in line with guidance, and any side effects or interactions had been checked for. Consultation notes for the review and management of patients with long term condition were not always comprehensive, and did not always include all required monitoring.

There was a system for processing information relating to new patients including the summarising of new patient notes.

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 practice could share information with other healthcare providers such as to out of hours GP services. We found data sharing agreements were not in place for all key healthcare providers, such as with local acute hospital, community and ambulance services, which meant there was a risk key information may not be shared.

Referrals to specialist services were documented and contained the required information. Each GP usually managed their own referrals, and undertook a practice-wide two-monthly audit to confirm all referrals had been sent appropriately. In the event of GP leave or absence, other GPs checked the status of all requested referrals although a potential risk was identified whereby any responses or queries were usually returned to the referrer, which may be missed in the event of GP leave or absence. The practice was aware of this and were working to implement a process whereby all referrals were requested by a central email that all staff could access.

The practice reported that the receiving of clinic letters, discharge summaries and other correspondence from secondary care was not consistent or always timely, with significant delays reported in some specialities such as cardiology.

There was a documented approach to the management of test results.

There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.

The oversight of other tasks was not always effective, as during our assessment, we saw several tasks outstanding that dated back to April and May 2022. Upon closer review, the majority of these appeared to have been actioned but with the original task not updated. There was a risk that important tasks could be missed, and the process to identify this was not effective.

Appropriate and safe use of medicines

The practice did not have systems for the appropriate and safe use of medicines, including medicines optimisation.

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

The practice's system for the oversight of medical equipment and consumables was not always effective as during our assessment, we found several items of equipment across the practice that had exceeded recommended use by dates.

Blank prescriptions were not always kept securely, as during our assessment, we found instances whereby blank prescriptions were stored in unlocked printer trays within unlocked rooms. The practice explained all prescriptions were removed from all rooms overnight and stored securely, with appropriate reconciliation logs held. To mitigate the risk during the day, individual room door locks had been ordered and were due to be installed to prevent unauthorised access to all rooms.

Documentation did not demonstrate that all staff had the appropriate authorisations to administer medicines, including the use of Patient Specific Directions (PSDs). The practice advised a PSD was not required for all medicines where a prescription was in place. We reviewed these prescriptions, but saw they did not contain all required and necessary information, such as the name of the person administering the medicine, the route of administration and dosage, or details of the authorising clinician. Patient Group Directions (PGDs) were managed effectively, with appropriate oversight of all clinicians operating under them.

The practice could not demonstrate the prescribing competence of non-medical prescribers, such as nurse prescribers, and there was no regular review of their prescribing. The practice did not have access to island-wide prescribing data, so could not review each clinician's prescribing performance.

The process for the safe handling of requests for repeat medicines was not always effective, and the quality of medication reviews for patients on repeat medicines was variable. As part of our assessment, we reviewed five recently completed medication reviews. Although a review had been coded into each patient's care record, there was not always evidence that an effective review had taken place. The practice explained they were in the process of improving their medication reviews, with all reviews being migrated to the patient's month of birth.

We saw several instances whereby patients appeared to be non-compliant with requests for monitoring. The practice was largely aware of affected patients, but there was limited evidence of steps taken by the practice to address this. For example, we did not see any steps whereby the practice had encouraged patients to attend their review appointments, had reduced the quantity

of medication prescribed per prescription, or had clinically risk assessed how best to manage the affected patients.

The practice had a process for the management of information about changes to a patient's medicines. We found changes made by other services were not always shared with the practice in a timely manner, which impacted the practice's ability to make timely amendments to patient medications.

The process for monitoring patients' health in relation to the use of medicines, including high risk medicines with appropriate monitoring and clinical review prior to prescribing, was not always effective.

As part of our assessment, we conducted a series of clinical searches and random sample of associated patient clinical record reviews to assess the practice's procedures on medicines management and prescribing. One search reviewed the prescribing of a high risk medicine used as an immunosuppressant. Our search identified four patients prescribed this medicine, all of whom were being prescribed the medicine through secondary care.

Another search reviewed the prescribing of a high risk medicine primarily used to treat high blood pressure and heart failure. Our search identified 18 patients who had not received all recommended monitoring. We undertook a detailed review of five patients' care records and found three patients were potentially at risk due to being overdue monitoring. This included one patient who had not received any monitoring since 2020, when their last results were abnormal. We noted two of the five patient care records reviewed had been coded to indicate a medication review had been completed, but there was no evidence within the notes to confirm that this had taken place.

Another search reviewed the prescribing of a high risk medicine primarily used to treat cardiac dysrhythmias. Our search identified two patients who were prescribed this medicine who had not received all recommended monitoring. We reviewed both patients' care records in detail and saw both patients were being effectively managed, with both patients already contacted by the practice and advised to book an appointment for monitoring.

Another search reviewed the potential overprescribing of a short acting reliever inhaler used to treat asthma, as the high prescribing or overuse of short acting reliever inhalers is associated with an increased risk of asthma death. Our search identified six patients who had been prescribed more than 12 reliever inhalers within the last 12 months. We undertook a detailed review of five patients' care records and saw most patients were overdue asthma reviews, including one patient who had not received a review since 2020. Several patients were seen to have had a medication review coded into their records, but with little-to-no evidence that a review had actually taken place. Patients with an overuse of inhalers were not always identified by the practice, and those who reported symptoms that suggested poor control were not always escalated or addressed. We saw the quality of completed asthma reviews was variable, with some reviews not covering all recommended examinations and observations, and saw patients were not always followed up after changes to treatment to ensure the changes were effective.

The practice's systems for the monitoring of prescribing of controlled drugs were effective.

The practice held a small quantity of controlled drugs, which were not subject to safe custody requirements. There were arrangements for raising concerns externally regarding controlled drugs.

The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.

For remote or online prescribing there were effective protocols for verifying patient identity. Staff explained how they verified each patient's identity before undertaking a consultation.

The practice held appropriate emergency medicines, which were checked monthly. Checklists were completed to confirm medicines were available and in date.

There was medical oxygen and a defibrillator on site, and systems were in place to ensure these were regularly checked and fit for use.

The practice had emergency medicines and equipment available, but did not store these in line with recommendations. For example, some emergency medicines were stored within a locked medicines cabinet, with other emergency equipment stored on a separate resuscitation trolley. This was not in line with guidance from the Resuscitation Council, which recommends for emergency medicines to be stored in tamperproof containers, and emergency equipment and medicines to be stored together in a strategic and accessible location and not locked away.

Vaccines were stored appropriately, monitored and transported in line with appropriate guidance to ensure they remained safe and effective. Staff undertook twice daily temperature checks of all medicine fridges and escalated any anomalous temperatures as appropriate. A second thermometer was in place in case to allow temperature recordings to continue in the event of a fridge or power failure.

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong. However, the oversight and management of safety alerts was not always effective.

Significant events

The practice 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 practice management team.

There was a system in place for recording, investigating and acting on significant events, with evidence of learning and dissemination of information. As part of our assessment, we reviewed completed incident reports for incidents reported within the last 12 months. Each incident report contained a score for its severity, as well as description of the incident, an overview of the causes, any learnings identified, and any changes made.

Staff understood how to raise concerns and report incidents, both internally and externally.

Safety alerts

Staff understood how to deal with alerts, although the system for recording and acting on safety alerts was not always effective.

As part of our assessment, we conducted a series of patient clinical records searches to review the practice's management of safety alerts. One search reviewed an alert from 2012 regarding a potential negative interaction between two medicines when prescribed together. Our search

identified one patient who was prescribed both medicines, and although the patient had only recently started one of the medicines, there was no mention of the alert or acknowledgement of the risk when the medication was started.

Another search reviewed a safety alert from 2014 regarding a potential negative interaction between two medicines when prescribed together. Our search identified six patients who were prescribed both medicines. We reviewed five patients' clinical records, and with the exception of one patient where it was clinically advised, saw none of the patients had been informed of the risk. We saw instances whereby medication reviews had been completed but did not see evidence the alert had been identified or discussed with the patient.

Is the service effective?

We found this practice 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 generally delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools. However, the oversight and management of patients with long term conditions was not always effective.

The practice had systems and processes to keep clinicians up to date with current evidence-based practice. Changes to clinical guidance or care pathways were shared with staff and were discussed in clinical meetings.

Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.

Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. Patients with urgent symptoms were generally offered same day or next day appointments, which could be undertaken by telephone or in person. Where there were concerns over a patient's condition or symptoms, staff escalated these appointment requests to GPs for review.

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

Patients' treatment was not always regularly reviewed and updated. As part of our assessment, we conducted a series of patient care records searches and associated notes reviews to assess the practice's procedures for the management of patients with long term conditions. We found not all patients were seen to have received all recommended monitoring, follow-ups and medication reviews, or appropriate diagnoses for their conditions.

There were appropriate referral pathways to make sure that patients' needs were addressed. This included referrals to specialists, hospital teams and community services.

Patients were told when they needed to seek further help and what to do if their condition deteriorated.

The practice had prioritised care for their most clinically vulnerable patients during the pandemic.

Effective care for the practice population

- Flu, shingles and pneumonia vaccinations were offered to patients, where relevant.

- Patients generally had access to appropriate health assessments and checks, when recommended.
- Patients living with a learning disability were not always offered regular health checks.
- Extended length appointments were available, where appropriate.
- End of life care was delivered in a coordinated way, which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder
- Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

As part of our assessment, we conducted a series of clinical searches and random sample of associated patient clinical record reviews to assess the practice's procedures for the management of patients with long term conditions:

- Our first search reviewed patients with a potential missed diagnosis of diabetes. Our search did not identify any patients who had a potential missed diagnosis.
- Another search reviewed patients with a potential missed diagnosis of chronic kidney disease (CKD) stages three to five. Our search identified 42 patients who had a potential missed diagnosis. We undertook a detailed review of five patients' care records and saw all patients had CKD, but only two patients had been informed of their diagnosis. Of the three patients who had not been informed of their diagnosis, two were at an increased risk due to lack of monitoring.
- Another search reviewed the management of patients with asthma who had been prescribed two or more courses of rescue steroids within the last 12 months for exacerbations of asthma. Guidance from the National Institute for Health and Care Excellence (NICE) recommends patients should be reviewed within 48 hours of an acute asthma exacerbation to review the patient's response to treatment. This search identified 625 patients who were diagnosed with asthma, of which 17 patients had been prescribed two or more courses of rescue steroids. We conducted a detailed review of five patients' care records and saw the practice's management of patients with exacerbation of asthma was not always effective. Patients did not always have a follow-up arranged following an exacerbation and there was limited-to-no safety netting recorded within patient care records. Some asthma reviews were of poor quality and did not always contain information of the examinations performed, the patient's history and/or their response to treatment. Patients did not always have their treatment adjusted following an exacerbation to prevent further asthma attacks, and the steroid dosages prescribed in some instances were not in line with recommendations. Staff did not always escalate patients to GPs for a further review when they failed to respond effectively to initial treatment.
- Another search reviewed the monitoring of patients with chronic kidney disease (CKD) at stages four and five. This search identified eight patients who were indicated as not having received a relevant blood test within the last nine months. We saw the majority of patients

were being managed effectively through secondary care. We did identify one patient at high risk who had not received all recommended monitoring and was not under the care of the hospital.

- Another search reviewed the monitoring of patients with hypothyroidism. This search identified seven patients who were indicated as not having received all thyroid function test within the last 18 months. We undertook a detailed review of five patients' care records and saw instances whereby a medication review had been coded into the patients' care record but there was no evidence of a review taking place or identification of overdue monitoring. We saw one patient had continued to be issued medication past their review date, with no actions taken to address this.
- Another search reviewed the care and treatment of patients diagnosed with diabetic retinopathy – a complication of diabetes. Our search identified seven patients with diabetic retinopathy and a high blood sugar reading on their last test, which suggested poor control of their diabetes. We undertook a detailed review of five patients' care records and saw most patients were known to secondary care. We did identify one patient who was not having regular blood sugar monitoring, and saw a medication review had been coded into the patient's care record but there was no evidence of a review taking place as the lack of monitoring and poor diabetic control had not been identified or acted upon.

Child Immunisation

The below table shows the practice's childhood immunisation performance. The practice performed below or in line with the average for the Isle of Man for all vaccination categories, and failed to achieve the World Health Organisation's (WHO) target of 95% uptake for any of the below vaccination groups listed below.

Percentage of eligible patients vaccinated by GP as of 1 January 2022		
Vaccine:	Ballasalla Medical Centre	Isle of Man Average:
5-in-1	90.91%	95.77%
Measles, Mumps and Rubella	90.91%	90.68%
Meningitis C	90.91%	90.28%
Pre-school Boosters	88.46%	88.94%

Cancer Indicators

The below table shows the practice's cervical screening performance. All practices were required to meet a minimum uptake target of 80%.

During our assessment, CQC were informed of a potential reporting issue on how cervical screens were recorded on all practice systems, which was causing cervical screening uptake data to be under reported. This was being investigated for all practices on the island.

Percentage of persons eligible for cervical cancer screening who have been adequately screened as of 30 June 2022	
Ballasalla Medical Centre	Isle of Man Average:
76.94%	76.84%

Percentage of persons eligible for bowel cancer screening who have been adequately screened between 1 October 2021 and 31 December 2021

Ballasalla Medical Centre	Isle of Man Average:
61.21%	60.74%

Monitoring care and treatment

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

Clinicians took part in national and local quality improvement initiatives.

Information about care and treatment was used to make improvements. We found the practice had a limited programme of quality improvement in place. Examples of recent audits completed by the practice included audits to review the recording of consent for phlebotomy and joint injections, and the prescribing of benzodiazepines. Although some evidence of clinical audit was seen, there was no formalised programme of clinical audit in place.

The practice did not regularly review unplanned admissions and readmissions and take appropriate action.

Effective staffing

The practice was able to demonstrate that most staff had the skills, knowledge and experience to carry out their roles. However, the practice could not demonstrate how they assured the competence of staff employed in advanced clinical practice.

The practice demonstrated that most staff had the skills, knowledge and experience to deliver effective care, support and treatment. Staff completed mandatory training through a combination of online and face-to-face courses, which managers recorded on an electronic training log. Training data viewed during our assessment showed most staff undertook regular training in basic life support, data protection, safeguarding, infection prevention and control, and fire safety.

The practice had a programme of learning and development, although staff did not always have protected time for learning and development. The practice explained training for reception and non-clinical staff had been challenging recently due to reduced staffing levels and the COVID-19 pandemic.

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

Staff had access to regular appraisals, one to ones, coaching and mentoring. They were supported to meet the requirements of professional revalidation. All staff received annual appraisals with a senior clinician or member of staff.

The practice could not always demonstrate how they assured the competence of staff employed in advanced clinical practice, such as nurse prescribers. Staff reported a supportive working environment, and explained how they were encouraged to raise any queries with senior clinicians. We did not see a formalised programme of either regular supervision or of the clinical audit of the work of all members of staff, which included reviewing the prescribing of non-medical prescribers.

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. We found as data sharing arrangements were not in place for all key services, such as hospital and ambulance services, important care and treatment information was not always shared between services to support the delivery of effective care and treatment.

Patients received consistent, coordinated, person-centred care when they moved between services. For example, the practice was one of three practices that were part of a local wellbeing partnership, which aimed to improve outcomes for patients through enabling local health and social care services to work more effectively and closely together.

Helping patients to live healthier lives

Staff were consistent in helping patients to live healthier lives.

The practice identified patients who may need extra support and directed them to relevant services. The practice reported a close working relationship with other local services, such as hospices.

Patients in the last 12 months of their lives were supported by the practice.

Staff encouraged and supported patients to be involved in monitoring and managing their own health.

Patients had access to appropriate health assessments and checks.

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

The practice 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 practice always 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. Consent forms were used when minor surgeries were undertaken, such as dermatological procedures or vasectomies.

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

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.

As part of our assessment, we undertook a review of four DNACPR decisions processed by the practice. We saw copies of completed DNACPR decision forms had been retained where possible and were easy for staff to view. Patient clinical records were clear and comprehensive, and included reference to the involvement of the patient's friends, family and relatives, where appropriate. However, we did not always see evidence that completed DNACPR decisions had been regularly reviewed or updated.

Is the service caring?

We found this practice 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.

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

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

Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.

The practice 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 practice received five responses. Of these, two respondents rated their overall experience as either 'good' or 'very good', two rated their experience as 'poor' or 'very poor', and one respondent rated their experience as 'neither good nor poor'. Comments were largely positive about the quality of care and the kindness of staff, with negative comments largely relating to difficulties booking appointments.

The practice explained the low response rate to their survey was due to the practice obtaining most of their feedback through their patient participation group. Since March 2022, the practice had worked to improve the uptake of their survey, with a new process implemented whereby all patients were texted a survey link following their appointment inviting them to share their feedback.

During our assessment, we spoke with four patients and people who use the service. Feedback was generally positive, with patients speaking positively about the care and treatment they receive from doctors and nurses.

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.

Staff helped patients and their carers find further information and access community and advocacy services. We found the practice was proactive in identifying patients who were carers or had caring responsibilities. At the time of our assessment, the practice advised they had 124 patients recorded as carers from a patient list of approximately 4,700 (2.64%).

The practice was proactive in improving the care for patients who were potentially vulnerable. For example, the practice had developed and strengthened ties with local wellbeing services to ensure the practice's most vulnerable patients were effectively supported.

Interpretation services were available for patients who required them.

Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.

Information leaflets were available in other languages and formats.

Information about support groups was available on the practice website.

Privacy and dignity

The practice respected patients' privacy and dignity.

A private room was available if patients were distressed or wanted to discuss sensitive issues.

There were arrangements to ensure confidentiality at the reception desk. The reception area was located away from the main waiting area, and receptionists answered telephone calls away from the front desk, to minimise the risk of confidential information being overheard.

Is the service responsive?

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

Responding to and meeting people's needs

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

The practice understood the needs of its local population and had developed services in response to those needs. This included standard services, such as minor surgery, health checks and vaccinations, and additional services, such as vasectomies and phlebotomy. The practice explained their phlebotomy service, whereby patients could have blood taken for tests within the practice rather than needing to travel to hospital, was a popular service with appointments usually booked three weeks in advance. The practice offered blood appointments between 8.30am to 10.30am daily, but explained they could not offer blood appointments after this due to samples being collected at around 11am.

The importance of flexibility, informed choice and continuity of care was reflected in the services provided. For example, the practice worked to offer patients the choice of whether they would prefer a face-to-face or telephone appointment.

The facilities and premises were appropriate for the services being delivered. The practice was located within a shared use government building. Disabled access was available throughout, with ample car parking available immediately outside.

The practice made reasonable adjustments when patients found it hard to access services. For example, the practice had installed a hearing loop to support patients who used hearing aids.

There were arrangements in place for people who need translation services.

The practice provided information in accessible formats.

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

- Patients had a named GP who supported them in whatever setting they lived.
- The practice 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 practice liaised regularly with the community services 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 appointment when necessary.
- The practice held certain registers of patients living in vulnerable circumstances, including those with a learning disability. Although, registers were not in place for all potentially vulnerable patients.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode, such as homeless people, refugees and Travellers.

- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability, such as the offering of longer appointments.

Access to the service

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

There was information available for patients to support them to understand how to access services (including on websites and telephone messages). The practice had offered online services, which allowed patients to order repeat prescriptions and view their medical record. Prior to the pandemic, patients could also book appointments online, but this had been deactivated to allow for COVID-19 screening questions to be asked.

Patients were able to make appointments in a way which met their needs. Patients could book routine appointments in advance, or urgent appointments on the day. To ensure all patients could contact the practice when they needed to, the practice had implemented a digital phone system that allowed for around 10 callers to contact the practice at once. In the event a patient had been unable to book an appointment on several consecutive days, staff could escalate this and book patients in to be seen the next day.

Between April 2021 and March 2022, the practice received five responses to their friends and family test survey. Feedback relating to appointment booking system was mixed. Four out of the five patients reported issues booking appointments, including challenges booking face-to-face appointments or booking routine appointments in advance. This feedback was similar to additional feedback submitted to other online services and social media pages.

During our assessment, we spoke with four patients and people who use the service. All patients spoken with were satisfied with the appointment booking process, although two patients explained how the practice often ran behind during clinics.

The practice offered a range of appointment types to suit different needs, which included face-to-face appointments and telephone consultations, and generally gave patients the choice of the type of appointment they wanted to book. The practice supported patients to access care and treatment in a way that met their needs, such as through offering flexible and longer appointments.

There were systems in place to support patients who face communication barriers to access treatment.

Patients with urgent needs had their care prioritised. In the event an urgent appointment was required, and no appointments were available, receptionists could book patients onto the end of each GP's clinic for a telephone triage or could escalate patients to the GP team for review.

The practice had systems to ensure patients were directed to the most appropriate person to respond to their immediate 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. Patients could access a copy of the practice's complaints policy and procedure in reception or by speaking with a member of staff. The practice did not have any information on their website about how to raise a complaint, but did publish their direct telephone number, email address and address clearly on their website.

There was evidence that complaints were used to drive continuous improvement. Complaints received by the practice largely related to changes to the practice catchment area and GP team. We reviewed completed complaint investigations and saw the practice acknowledged complaints promptly, and included a copy of their complaints policy with the acknowledgement letter. Resolution letters were issued once each complaint had been investigated, which included an apology and response directly from the GP or member of staff involved. Completed complaint investigations were discussed during practice and clinical meetings. The practice did not have a process in place for feedback or concerns raised by patients, who did not wish to raise a formal complaint, to be recorded and reviewed.

Is the service well-led?

We found this practice 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 practice included departure of GP partners and increased patient demand following COVID-19.

Managers explained how they were working to address these challenges, such as upskilling receptionists to handle more advanced queries at the first point of contact, supported by new IT and technology.

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

There was a leadership development programme and succession plan in place. The practice had recently undergone significant changes in their clinical teams following the departure of two GP partners, and were in the process of recruiting new GPs and nurses.

Vision and strategy

The practice did not have an established vision or set of values, which were supported by a credible strategy.

Although all staff were committed to providing high quality and sustainable care, the practice did not have a formalised vision, set of values or mission statement in place, supported by a credible strategy for what it wished to achieve.

Culture

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

Arrangements to deal with inconsistent or poor behaviour were not always effective, as during our assessment we identified areas of potentially poor practice that had not been identified or addressed by the practice. The practice explained all staff received annual appraisals, during which their work performance and behaviours were reviewed, and where any poor behaviours were identified, managers could take 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.

There was a strong emphasis on the safety and well-being of staff. Staff reported the practice had a ‘nice atmosphere’, and described how there was a ‘good team’ which made them ‘feel comfortable raising concerns’.

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 practice 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 practice’s governance structures and systems were not always effective.

The practice’s governance structures and systems were not always effective, as during our assessment we identified several concerns regarding medicines management and the management of patients with long term conditions that had not been identified or addressed by the practice. The practice explained that, at the time of our assessment, they had recently undergone a period of significant change owing to several key staffing and management changes. The practice explained that at times this had left the practice with only one GP partner, who had to take on the lead for all areas and overall responsibility. The practice had recently recruited a new GP partner and planned to update their governance structures and systems to share lead roles and responsibilities between the partners.

Staff were clear about their roles and responsibilities. The practice maintained a comprehensive set of policies and procedures that outlined each staff member’s duties, including who to contact in the event of any concerns being identified.

There were appropriate governance arrangements with third parties. For example, the practice held appropriate data sharing and information governance arrangements in place with third parties and other healthcare providers.

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 monthly clinical meetings, during several which several regular topics were discussed. This included complaints, incidents, interesting new diagnoses, clinical audits, safeguarding and pharmacy-related issues. Meetings were regular, followed an agenda, with minutes shared with staff who could not attend. Meeting minutes were not always promptly written and shared after each meeting, which the practice attributed due to managing their recent staffing changes.

There were processes to manage performance, although the performance of each staff member was not always monitored or assessed effectively.

There was a quality improvement programme in place.

Arrangements for identifying, managing and mitigating risks were generally effective. During our assessment, we identified several areas of concern but saw the practice were largely aware of

these areas and were in the process of putting appropriate actions to address this. For example, the practice was in the process of undertaking clinical audits and searches to improve medication monitoring and drug safety alerts. Regarding the inconsistent recording of medication reviews, the practice had already identified this as a concern and was in the process of reviewing recently completed medication reviews.

Some concerns identified during our assessment had not been identified by the practice, such as the management of patients with asthma, but the practice was responsive in addressing these concerns.

A major incident plan was in place, and staff were trained in preparation for major incidents. The practice explained they had formed a close working relationship during COVID-19 with two other practices located in the south of the island, where patients could be seen in the event the practice building had to close.

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

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

The practice had adapted how it offered appointments to meet the needs of patients during the pandemic. This included the expansion of remote consultations, including 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 practice actively monitored the quality of access and made improvements in response to findings.

There were recovery plans in place to manage backlogs of activity and delays to treatment.

Changes had been made to infection control arrangements to protect staff and patients using the service.

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.

Staff used data to monitor and improve performance. The practice monitored the quality of care and treatment through a combination of patient satisfaction survey results, practice meetings, staff appraisals and clinical audit.

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

Governance and oversight of remote services

The practice 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 practice primarily used a secure third party clinical records system for the storage and management of confidential patient information.

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

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

Engagement with patients, the public, staff and external partners

The practice did not always involve the public, staff and external partners to sustain high quality and sustainable care.

Systems to collect feedback from patients and people who use the service was limited.

The practice explained they did not actively promote their friends and family survey, as they had a Patient Participation Group (PPG) in place. But as a result of the COVID-19 pandemic, the group had not met since January 2020 and there were limited methods of collecting patient feedback in the interim. The practice explained since March 2022, they had started promoting their friends and family test by texting patients a link to the survey after their appointment and hoped to re-establish their PPG soon.

Staff views were reflected in the planning and delivery of services.

The practice worked with stakeholders to build a shared view of challenges and of the needs of the population. For example, the practice gave examples of how they had recently worked with secondary care teams to develop transitional care arrangements, and had worked with local adult social care services to support patients during the COVID-19 pandemic.

Continuous improvement and innovation

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

At the time of our assessment, there was a limited focus on continuous learning and improvement, mainly due to the practice managing significant changes within their GP partnership. The practice had now recruited a new GP partner and were in the process of implementing new processes and protocols that were focused on improving care and treatment.

Learnings were shared effectively and used to make improvements. We saw how incidents, complaints and clinical audits were shared, both internally and externally, and used to improve services. For example, the practice explained how they had worked with other services to investigate and manage a recent significant event regarding the outbreak of COVID-19 at a local nursing home.