Care Quality Commission

DHSC – CQC external quality regulation programme

Castletown Medical Centre

Assessment report

Sandfield

Castletown

Isle of Man

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Our findings

Overall summary

We carried out this announced assessment on 15 September 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 practice had clear systems, practices and processes to keep people safe and safeguarded from abuse. Staff were trained to appropriate levels for their roles, and systems to identify vulnerable patients were consistent.
- Recruitment checks were carried out in accordance with policy, and Disclosure and Barring Service (DBS) checks were undertaken regularly for all staff.
- Health and safety risk assessments were carried out, which included infection prevention and control assessments.
- Staff had all the information they needed to deliver safe care and treatment.
- The practice's system for the appropriate and safe use of medicines, including medicines optimisation, was effective. Patients prescribed high-risk medicines received all required monitoring and medication reviews were completed when required. Blank prescriptions were stored appropriately.
- Staff had access to emergency equipment and medicines, but the storage of emergency medicines was not always in line with guidance.
- 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, standards and evidence-based guidance supported by clear pathways and tools.
- There was limited monitoring of the outcomes of care and treatment.
- The practice was able to 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 practice demonstrated 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 practice organised and delivered services to meet patients' needs. Patient complaints were listened and responded to and used to improve the quality of care.
- People were always able to access care and treatment in a timely way.

- 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.
- The practice involved the public, staff and external partners to sustain high quality and sustainable care.

We found the following areas of notable practice:

- The practice had implemented effective safeguarding processes that kept people safe and safeguarded from abuse, and involved patients in their process. The practice maintained a comprehensive set of policies and procedures, which referred to appropriate guidance and legislation. For key policies such as safeguarding, the practice had extracted the most important contact details and information and had summarised this in a quick reference section at the beginning of the policy. This allowed staff to quickly refer to critical information in the event of an incident occurring. The practice had created dedicated patient safeguarding leaflets, which outlined to patients the importance of safeguarding, information on how patients could raise safeguarding concerns, and how they could obtain help and advice.

- The practice maintained an effective oversight of all referrals requested to specialist services. The practice recorded all requested urgent and routine referrals on a tracker, and regularly reviewed this to ensure all referrals were acted on in a timely manner and that patients had attended all required appointments. Where necessary, the practice contacted the hospital to discuss the status of the referral, and in the event there was a delay in the patient being seen, the practice updated their tracker and proactively contacted the patient to advise of the delay and set their expectations when patients were likely to be seen.

- The practice took a proactive approach to encourage patients to attend required chronic disease management clinic appointments and medication review appointments, and had implemented an effective system to manage situations where patients were not compliant with the practice's requests. The practice initially invited patients to their appointment by letter, which was followed by up to three text messages. If patients did not respond, the patient's GP was alerted who sent out a personal letter, followed by a direct phone call. If this failed, the practice moved the patient onto a 'red list'. All GPs discussed patients on the red list during each clinical meeting to decide and determine the most appropriate way forward. Examples of actions taken by the practice included reducing the number of prescription issues on each prescription, or stopping the prescribing of the medicine altogether where it was no longer clinically safe or justified.

- The practice had implemented an effective system to manage childhood immunisations and vaccinations. The practice maintained an antenatal to preschool immunisation register, where staff recorded all patients who were pregnant along with their estimated due date. If the due date had passed and the practice had not been notified of the birth, the practice liaised directly with the hospital for an update. Once the baby was born, the practice called the family to congratulate them, find out the baby's name and date of birth to register them at the practice, and booked the child their first immunisation appointment. Following the call, staff sent out a practice welcome leaflet, a letter that contained details on all recommended immunisations and the dates when they were due, and contact information for the practice. When patients attended their immunisation appointment, staff

booked in the patient's next immunisation appointment and updated their tracker to monitor this. In the event there were complications or difficulties during the birth, the patient's GP was alerted, who contacted the family directly to offer them their support.

- The practice took several steps to ensure that all children and babies were seen in a timely manner. This included a dedicated child appointment slot that was reserved at the end of each clinical session for receptionists to directly book any poorly children in who needed urgent or emergency care. In the event this was filled, the practice made arrangements for further emergency appointment slots to be made available.
- Staff worked together to ensure care and treatment was coordinated between services. To achieve this, the practice hosted regular multidisciplinary clinical team meetings, where local health visitors, hospice nurses and school nurses were invited to join the practice GP clinical team to discuss relevant clinical cases. The meeting followed a standard agenda where health visitors initially discussed any safeguarding concerns, followed by hospice teams who discussed any new patients receiving palliative or end of life care, ending with the practice GPs discussing any relevant clinical cases.

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

- Improve recruitment checks to ensure staff vaccination history checks include all recommended vaccinations and immunisations.
- 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 the quality of patient care records to ensure consultation notes are detailed, contain all red flag exclusions and safety netting advice, and medication reviews contain information on the medications reviewed.
- Improve the storage of emergency medicines to ensure they are stored in line with guidance.
- Improve the management of patients who have had an exacerbation of asthma to ensure they are followed up promptly after their exacerbation.
- Implement a formalised programme of regular and repeat clinical audit.
- Improve systems for the identification of patients who are carers or have caring responsibilities.
- Improve systems for the obtaining of interpreters and translators for patients if required.
- Develop a formalised vision and set of values that is supported by a credible strategy.

Background to assessment

The practice is located at:

- Castletown Medical Centre, Sandfield, Castletown, Isle of Man, IM9 1EX

The practice is part of a wider network of GP practices, as the practice is affiliated with the island's primary care network.

There is a team of three GPs, three practice nurses and a healthcare assistant. 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 five members of staff, which included one GP partner. 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 providing safe care in accordance with CQC's assessment framework.

Safety systems and processes

The practice 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 practice had dedicated safeguarding policies that outlined key staff responsibilities, the different types of abuse staff should be alert to, details of the practice's safeguarding lead and contact information for local safeguarding teams. At the start of their safeguarding policy, the practice had inserted a quick reference section that allowed staff to easily see key safeguarding details and contact information without needing to find it within the policy. This included details of the practice's safeguarding lead, who was one of their GP partners. In the event staff had a safeguarding query or concern, staff raised this to senior clinicians or the practice safeguarding lead who could advise or escalate their concerns accordingly. As part of our assessment, the practice demonstrated how they had appropriately managed a child safeguarding concern. The practice had created a practice safeguarding leaflet that patients could access, which contained information on how patients could raise safeguarding concerns or obtain help and support.

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

There was engagement in local safeguarding processes. The practice held safeguarding meetings and discussed individual safeguarding cases during practice clinical meetings. Meetings with health visitors and school nurses, who were also based within the practice building, took place. GPs explained they were invited to attend and/or write reports for safeguarding case conferences. Whilst there were no transitional safeguarding arrangements in place at an island level, the

practice explained due to their small patient list size clinicians were aware of any patients leaving their child safeguarding registers and would discuss each patient's needs during this transition.

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 consistent. The practice maintained and regularly reviewed several safeguarding registers, which included vulnerable adults, children under child protection plans and children in need. Safeguarding alerts were placed onto any patients whereby there were safeguarding concerns, which the practice could evidence. The practice explained how they were aware and appropriately managed other potential safeguarding concerns, including where there was no legal duty on the island to report, such as escalating concerns over potential female genital mutilation (FGM).

Disclosure and Barring Service (DBS) checks were undertaken when required. All staff working at the practice were required to undertake a check upon recruitment, with repeat checks completed as appropriate.

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. This included the obtaining of references, review of ID and completion of an induction programme.

The practice had a process in place for staff professional registrations to be checked upon recruitment, and on an ongoing basis, to ensure all clinical staff remained registered with the appropriate body.

The practice undertook a check of staff vaccination status upon employment for hepatitis B, but this did not include all recommended vaccinations, such as tetanus, polio, diphtheria, measles, mumps and rubella vaccinations. The practice advised they would discuss this during their next clinical meeting as how best to improve their processes.

Safety systems and records

Health and safety risk assessments were carried out, which included electrical safety, legionella, and building assessments.

There was a fire procedure.

Date of fire risk assessment: March 2022

Actions from fire risk assessment were identified and completed.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

The practice was visibly clean, tidy and well maintained, which minimised potential infection control risks. Cleaning was undertaken through a third party, with cleaning checklists and schedules present. Most flooring within the practice was wipeable, and the practice had

arrangements in place for any carpeted areas to be deep cleaned. All curtains were disposable and were changed regularly, or when soiled.

Staff had received effective training on infection prevention and control.

Infection prevention and control audits were carried out. The practice had completed an audit in May 2022, which had highlighted shortfalls around the lack of clinical sinks and paper towel dispensers. We saw the practice had addressed this, and had undertaken a repeat audit in August 2022 to check for improvement.

Date of last infection prevention and control audit: August 2022

The arrangements for managing waste and clinical specimens kept people safe. The practice had arrangements in place with their local 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, as well as the steps to take in the event of a potential infection control incident, such as a needlestick injury.

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 or nursing team for review.

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 practice stored clinical information on a secure third-party system, which only authorised staff could access.

Patient care records and consultation notes were generally satisfactory and showed appropriate management and prescribing, but the quality of completed consultation reviews was variable. We saw some consultation notes were brief and did not always include all red flag exclusions. Follow-up information was generally included, but safety netting advice was not always appropriately recorded and documented.

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.

The practice reported that the receiving of discharge summaries, clinic letters and other correspondence from hospital and secondary care services was inconsistent, with some letters taking weeks-to-months to arrive. The practice explained how this caused significant challenges and difficulties in managing patients who were receiving care from multiple services.

Referrals to specialist services were documented, contained the required information and actioned in a timely manner. The practice recorded all requested urgent and routine referrals on a tracker, and regularly reviewed this to ensure all referrals were acted on in a timely manner and that patients had attended all required appointments. Where necessary, the practice contacted the hospital to discuss the status of the referral, and in the event there was a delay in the patient being seen, the practice updated their tracker and proactively contacted the patient to advise of the delay and set their expectations when patients were likely to be seen.

There was a documented approach to the management of test results. All results were returned to the referring GP, but could be accessed by any practice GP in the event of sickness or absence. During our assessment, we saw all test results were up to date and had been actioned promptly, with evidence seen in patient care records of appropriate safety netting and the effective handling of results.

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

Appropriate and safe use of medicines

The practice had 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.

Blank prescriptions were kept securely. All blank prescriptions were stored within locked cabinets that only authorised staff could access, with printer trays kept empty when rooms were not in use. The serial numbers of blank prescriptions were recorded on delivery to the practice and were recorded when allocated out to a room or a prescriber, allowing for the effective reconciliation of all blank stock. Blank prescription pads were rarely used by the practice, but followed a similar reconciliation process.

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

There was a process for the safe handling of requests for repeat medicines. We found the quality of medication reviews for patients on repeat medicines were variable. As part of our assessment, we reviewed five recently completed medication reviews. We saw a review had been entered into each patient’s care record, but notes did not always contain a detailed list of which medications had been reviewed, whether all monitoring was up to date, and whether any concerns had been identified.

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 practice raised additional concerns over the handwritten nature of changes made to patient medications within secondary care, as staff reported regularly being unable to

accurately read the changes to medications and/or dosages and were concerned this could lead to errors being made.

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 effective.

The practice took a proactive approach to encourage patients to attend required chronic disease management clinic appointments or medication review appointments, and had implemented an effective system to manage situations where patients were not compliant with the practice's requests. The practice explained patients were initially invited to their appointment by letter, which was followed by up to three text messages. If patients did not respond, then the patient's GP was alerted who sent out a personal letter, followed by a direct phone call. If this failed, the practice moved the patient onto a 'red list'. All GPs discussed patients on the red list during each clinical meeting to decide and determine the most appropriate way forward. Examples of actions taken by the practice included reducing the number of prescription issues on each prescription, or stopping the prescribing of the medicine altogether where it was no longer clinically safe or justified. The practice explained they acted on any opportunity to support the patient to attend required monitoring appointments and encouraged patients to book and attend monitoring appointments if they attended the practice for another reason, such as an acute appointment.

As part of our assessment, we conducted a series of clinical searches and random sample of associated patient care record reviews to assess the practice's procedures on medicines management and prescribing. One search reviewed the prescribing of a high risk medicine primarily used to treat high blood pressure. Our search identified 526 patients prescribed this medicine, with 12 patients indicated as not having received all recommended monitoring. We undertook a detailed review of five patients' care records and saw the practice had an effective system in place for monitoring and took actions as appropriate to maintain the safe prescribing of this medicine. We saw the practice was aware of each patient and had made numerous, documented attempts to encourage patients to attend monitoring appointments. Where patients remained non-compliant with attempts to monitor, the practice discussed and risk assessed each patient, in some cases halting the prescribing of the medicine where it became clinically unsafe to continue to prescribe.

Another search reviewed the prescribing of a high risk medicine primarily used as a blood thinner. Our search identified 119 patients prescribed this medicine, with 48 patients identified as not having received all recommended monitoring. We undertook a detailed review of five patients' care records and saw all patients were being monitored by the hospital anticoagulation clinic. We saw most monitoring was up to date by the hospital clinic, but did identify a concern as none of the patients appeared to be receiving regular liver function tests (LFT) or full blood count (FBC) tests. This was not in line with recommendations that advise for at least annual LFT and FBC tests and potentially placed these patients at increased risk. This had not been identified by the practice, who had continued to prescribe the medicine. There was a separate known issue at the time of our assessment that was affecting the monitoring of patients prescribed these medicines. This was due to patients not being correctly referred to the hospital anticoagulation clinic when patients were started on this medicine outside of primary care, and was under investigation across the island at the time of our assessment.

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 31 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 all patients were receiving appropriate care. We saw two out of the five patients were overdue their asthma review, but saw the practice was aware of both patients and had made regular attempts to encourage the patient to attend an appointment.

The practice monitored the prescribing of controlled drugs.

The practice did not hold any controlled drugs, and there were arrangements for raising concerns externally.

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 regularly. We saw the practice did not stock atropine at the time of our inspection, a medicine recommended to be stocked by practices who fit coils or undertake minor surgery, but shortly following our assessment the practice confirmed this had been sourced and stored with their other emergency medicines.

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, on the day of our assessment, emergency medicines and some emergency equipment were stored within locked cupboards. 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.

The practice explained the storage of their emergency medicines had been an error on the day of our assessment and usual process was for all emergency equipment to be stored together, with equipment and medicines only locked away overnight. Following our assessment, the practice advised they had improved the storage of their emergency medicines, implementing a tagging system that would be checked regularly.

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, recording temperatures on an electronic log and escalating any anomalous temperatures as appropriate.

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

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 and saw each report contained an overview of the incident, details of the investigation completed, and an overview of any learnings identified. The practice discussed incidents during relevant meetings, depending on their severity and the actions and learnings documented. For example, we reviewed one incident regarding a potential drug error and saw the practice had reported this as an incident. Duty of candour had been followed, and the incident had been discussed as a practice with a new antibiotic template being introduced to improve processes.

Staff understood how to raise concerns and report incidents, both internally and externally. The practice explained how they could share any incident with their primary care network if it could affect other practices or services. Staff explained how they could also receive incidents from other practices within their primary care network, but had not yet received any incidents.

Safety alerts

Staff understood how to deal with alerts, and the system for recording and acting on safety alerts was 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 2018 regarding an increased risk of skin cancer in patients prescribed this medicine. Our search identified five patients who were prescribed this medicine. We undertook a detailed review of all five patients' care records and saw there was a clear awareness of the safety alert and actions, with all patients informed of the increased risk.

Another search reviewed a safety alert from 2014 regarding a potential negative interaction between two medicines when prescribed together. Our search identified three patients who were prescribed both medicines. We undertook a detailed review of all three patients' care records and saw there was a clear awareness of the safety alert and actions, with all patients informed of the potential risk.

Is the service effective?

We found this practice was 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 practice had systems and processes to keep clinicians up to date with current evidence-based practice. GPs attended quarterly educational meetings, and supported this regularly with other third party clinical update and education tools. 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.

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

Patients' treatment was regularly reviewed and updated. As part of our assessment, we conducted a series of patient clinical records searches and associated notes reviews to assess the practice's procedures for the management of patients with long term conditions. We found most patients received all recommended monitoring, follow-ups and medication reviews, and/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 had access to appropriate health assessments and checks, when recommended.
- The practice maintained chronic disease registers, and used these to ensure all recommended monitoring and reviews were undertaken.
- All patients with a learning disability were 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 care 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 identified three patients with a potential missed diagnosis. We undertook a detailed review of all three patients' care records and saw all patients were receiving appropriate care and treatment, with no patients having an incorrect or missed diagnosis.
- 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 531 patients who were diagnosed with asthma, with six patients identified as being prescribed two or more courses of rescue steroids. We undertook a detailed review of five patients' care records and saw only two of these patients were prescribed steroids for asthma. We saw the practice's management of patients with exacerbation of asthma was effective. Both patients had received or been invited to an asthma review within the last 12 months and had been followed up following their exacerbation, although this follow-up was not always held within seven days of the exacerbation.

- Another search reviewed the monitoring of patients with chronic kidney disease (CKD) at stages four and five. This search identified three patients with CKD at stages four and five, with two patients indicated as not having received a relevant blood test within the last nine months. We undertook a detailed review of both patients' care records and saw both patients were receiving appropriate care at the hospital nephrology clinic.
- Another search reviewed the monitoring of patients with hypothyroidism. This search identified 157 patients with hypothyroidism who were treated with thyroxine, with six patients identified as not having received a thyroid function test within the last 18 months. We undertook a detailed review of five patients' care records and saw the practice had an evidenced and effective system in place for monitoring. Most patients identified by the search appeared to be non-compliant with the practice's attempts at monitoring but had been reviewed and discussed by the practice. We did identify one patient who appeared to have been missed by the practice and had not received all recommended monitoring since 2020.
- Another search reviewed the care and treatment of patients diagnosed with diabetic retinopathy – a complication of diabetes. Our search identified 257 patients with diabetes, with 10 patients identified as having both 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 receiving appropriate monitoring. Most patients identified by the search appeared to be non-compliant with the practice's attempts at monitoring but had been reviewed and discussed by the practice. We did identify one patient who appeared to have been missed by the practice and had not received all recommended monitoring since 2021. At the time of our assessment, there was not a funded or formalised diabetic retinal screening programme available on the island. This meant patients were usually only diagnosed with diabetic retinopathy if they were seen in hospital or had known complications of diabetes. As a result, there were likely to be several patients who had diabetic retinopathy but had not been diagnosed.

Child Immunisation

The below table shows the practice's childhood immunisation performance. The practice performed above the average for the Isle of Man for all vaccination categories and had achieved the World Health Organisation's (WHO) target of 95% uptake for one of the four vaccination groups listed below, with the other three groups slightly below the target.

The practice took a proactive approach to childhood immunisation and vaccination and had implemented an effective system to improve uptake rates. The practice maintained an antenatal to

preschool immunisation register, where staff recorded all patients who were pregnant along with their estimated due date. If the due date had passed and the practice had not been notified of the birth, the practice liaised directly with the hospital for an update. Once the baby was born, the practice called the family to congratulate them, find out the baby's name and date of birth to register them at the practice, and book the patient their first immunisation appointment. Following the call, staff sent out a practice welcome leaflet, a letter that contained details on all recommended immunisations and the dates when they were due, and contact information for the practice. In the event there were complications or difficulties during the birth, the patient's GP was alerted who contacted the family directly to offer them their support. When patients attended their immunisation appointment, staff explained how they booked in the patient's next immunisation appointment and updated their tracker to monitor this.

The practice explained this had improved their childhood immunisation rates, with the only patients not to have been immunised being those that had actively declined or who were not contactable. For patients who were not contactable, the practice liaised with other healthcare professionals who were in contact with the family, such as health visitors, and worked with them to ensure the family were alerted to their missed appointment.

Percentage of eligible patients vaccinated by GP as of 1 January 2022		
Vaccine:	Castletown Medical Centre	Isle of Man Average:
5-in-1	100.00%	95.77%
Measles, Mumps and Rubella	94.29%	90.68%
Meningitis C	94.29%	90.28%
Pre-school Boosters	94.74%	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	
Castletown Medical Centre	Isle of Man Average:
78.66%	76.84%

Percentage of persons eligible for bowel cancer screening who have been adequately screened between 1 October 2021 and 31 December 2021	
Castletown Medical Centre	Isle of Man Average:
57.14%	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. The practice undertook several clinical audits and used the findings to improve the quality of care and treatment. Recent

audits completed by the practice included audits to review osteoporosis and diabetes care. Although the practice completed clinical audits, there did not appear to be a formalised programme of regular clinical audit that included repeat cycles to check for sustained improvement.

The practice did not regularly review unplanned admissions and readmissions, but did review patients who had contacted out of hours GP services each day.

The practice no longer had access to island-wide prescribing data, so was unable to easily compare its prescribing performance with other services and practices. To mitigate this, staff explained they followed external prescribing formulary tools and other services to improve the quality of prescribing.

Effective staffing

The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles.

The practice demonstrated that 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 all staff undertook regular training in basic life support, data protection, safeguarding, infection prevention and control, and fire safety, with the majority of staff seen to be at 100% compliance for all training courses.

The practice had a programme of learning and development, and staff had protected time for learning and development. Staff explained how they were supported to undertake additional training, such as diabetes care and prescribing training courses.

There was an induction, training and mentoring 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 demonstrated how they assured the competence of staff employed in advanced clinical practice, such as practice nurses. All new staff undertook competency training, which was followed by clinical supervision with senior colleagues. Formal supervision and teaching sessions took place on a weekly basis between GPs and the practice nursing team, during which any learnings from cases were discussed and shared. Further informal supervision was in place for GPs, which included locum GPs, whereby any difficulties or barriers could be discussed.

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, the practice hosted six monthly multidisciplinary team clinical meetings, where local health visitors, hospice nurses and school nurses were invited to join

the practice GP clinical team to discuss any patients of concern. We reviewed the minutes of their last meeting and saw these were comprehensive, contained a clear overview of each patient and an overview of any concerns identified. We saw during the meeting health visitors initially discussed any new safeguarding incidents, followed by hospice teams who discussed any patients receiving end of life or palliative care, ending with the practice GPs discussing any relevant clinical cases. The practice reported these meetings were very helpful and were in the process of increasing the frequency to quarterly.

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. This included signposting patients to local wellbeing services, hospice teams, long term condition coordinators and voluntary services.

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. For example, the practice had installed a digital screen in the waiting area that the practice used to share public health information, such as bowel cancer screening awareness.

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 was always 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 used for more invasive procedures, such as steroid injections and minor surgical procedures. Completed consent forms were appropriately scanned and retained within patient clinical records.

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 three 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 care records were clear and comprehensive, and included reference to the involvement of the patient's friends, family and relatives, where appropriate.

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.

Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition. The practice was proactive in sharing public health information and support groups that patients could access. This included information on domestic violence support services, safeguarding awareness, sepsis care and bowel cancer screening awareness.

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 212 responses. Of these, 200 respondents rated their overall experience as either 'good' or 'very good', eight rated their experience as 'poor' or 'very poor', and four respondents rated their experience as 'neither good nor poor'. Positive comments largely related to the quality of care and treatment, the caring nature of staff, and the helpfulness of receptionists. One patient described the staff as 'fantastic', the doctors as 'so friendly and knowledgeable' and receptionists as 'very calming and reassuring'. Another patient commented on how staff were 'highly professional', with doctors showing 'genuine concern'. One patient described their GP as 'exceptional', with another reporting they 'have nothing but praise for the work' of staff at the practice. Negative comments largely appeared to be related to specific issues with the respondents' care.

During our assessment, we spoke with four patients and people who used the service. All patients were satisfied with the care and treatment received, with people describing the practice as 'absolutely brilliant' and 'really lovely', and receptionists as 'fantastic'.

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. The practice explained how alerts were placed onto patients' care records to inform staff of any additional patient needs or requirements. For example, if a patient was visually impaired or deaf, appropriate alerts would be added to instruct staff to collect the patient from the waiting area rather than calling them through on the usual display screens.

The practice worked to ensure they supported all patients who had additional needs. For example, the practice explained how they could seat patients in quieter areas of the waiting area if they found busier areas unsettling.

Staff helped patients and their carers find further information and access community and advocacy services. We found the practice was not always proactive in identifying patients who were carers or had caring responsibilities. At the time of our assessment, the practice advised they had 27 patients recorded as carers from a patient list of 4,150 (0.65%).

The practice was proactive in improving the care for patients who were potentially vulnerable.

Interpretation services were not always available for patients who required them. The practice explained they were located near to a local police station and could arrange interpreters and translators through them, but did not have a formalised process in place. The practice explained they could use a patient's friend or family member as a translator if no other options were available, but were aware this was not recommended.

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 waiting area was adequately spaced from the main reception area, and receptionists generally answered telephone calls away from the desk, to minimise the risk of confidential information from 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. Managers explained how the practice was a small, rural practice and was focused on meeting the needs of their local community. The practice offered all standard services such as health checks, vaccinations and acute care, as well as additional services such as phlebotomy.

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

The facilities and premises were appropriate for the services being delivered. The practice was located within a purpose built building, which was owned by the Isle of Man Government. Disabled access was available throughout the ground floor where all clinic rooms and patient-facing areas were located. There was no lift to the first floor of the practice, where some staff areas and meeting rooms were located. The practice explained this had been raised as a concern to their landlord, who was exploring options to improve this. Ample car parking was available immediately outside the practice.

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 limited arrangements in place for people who need translation services. The practice explained they were located near to a local police station and could arrange interpreters and translators through them, but did not have a formalised process in place. The practice explained they could use a patient's friend or family member as a translator if no other options were available, but were aware this was not recommended.

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.
- 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 always 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, view their medical record and book appointments.

Patients were able to make appointments in a way which met their needs. Staff explained how routine appointments could be booked up to two months in advance, which allowed patients to be seen by their desired clinician and a convenient time and day. Patients were able to book appointments by telephone, online or by visiting the practice.

The practice offered a range of appointment types to suit different needs, which included face-to-face appointments and telephone consultations. The practice supported patients to access care and treatment in a way that met their needs, such as through offering flexible and longer appointments. Patients were generally given the option of whether they would like a face-to-face or a telephone appointment, and staff could move any booked face-to-face appointment to a telephone appointment if a patient was no longer able to visit the practice in person.

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

Patients with urgent needs had their care prioritised. The practice reserved a number of appointments each day, which could only be booked as an emergency appointment on the day. This included appointments with both GPs and other practice staff, such as practice nurses. A dedicated child appointment slot was kept available at the end of each clinical session, which allowed receptionists to directly book any poorly children or babies into who needed urgent care and treatment. In the event an urgent appointment was required, and no appointments were available, receptionists could escalate patients to the GP team for review. If the patient was calling towards the end of the day, receptionists either recommended patients to contact the out of hours service, or could book them an urgent appointment for the next day. This included patients who had tried to book an appointment for several consecutive days but had been unsuccessful, or who were unable to contact the practice first thing in the morning.

Between April 2021 and March 2022, the practice received 212 responses to their friends and family survey. Feedback that related to appointment booking systems was positive, with respondents describing how they had ‘no problems seeing a doctor’, how there was a ‘timely appointment system’ in place that allowed them to ‘get seen quickly’, and how they ‘always managed to get an appointment’. 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 four patients reported no problems in booking appointments or accessing care and treatment. Patients described how it was ‘easy’ to get through on the phone and book appointments, and described receptionists as ‘absolutely fantastic’.

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 complaint policy and procedure by speaking with a member of staff. Staff explained how patients could raise complaints verbally, in writing, by telephone, by email or through an online complaints and feedback form on the practice’s website.

There was evidence that complaints were used to drive continuous improvement. We reviewed completed complaint investigations and saw the practice acknowledged all complaints promptly, usually the same day, and provided an apology where appropriate. Complaints were investigated by the practice manager and GP partners, with a formal response being issued to the complainant within 28 days of their complaint. All complaints were discussed during relevant practice meetings, such as business or clinical meetings, with information stored on an electronic system that all staff could access. All patient feedback, including informal complaints and comments, were discussed by staff during staff meetings and huddles.

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 maintaining high levels of care and the safe prescribing of medicines following increases in patient demand and difficulties recruiting GPs.

Managers explained how they were working to address these challenges, such as through the recruitment of additional GPs to allow all GPs more time to focus on improving prescribing and care indicators.

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. At the time of our assessment, the practice was in the process of recruiting an additional GP and had started planning for the expected retirement of an existing GP partner within the next two years.

Vision and strategy

The practice had a vision for what it wanted to achieve, but this was not formalised or supported by a credible strategy.

The practice explained their vision was focused around ‘patient care and innovation’, with staff expected to demonstrate the values of ‘being transparent, open and honest’.

However, we found the practice’s vision was not formalised or supported by a credible strategy, and staff did not always know or understand the practice’s aims.

Culture

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

Arrangements to deal with inconsistent or poor behaviour were effective. All staff received annual appraisals, 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.

There was a strong emphasis on the safety and well-being of staff. Staff spoke positively about working for the practice, and described how they felt supported by colleagues and managers.

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 effective.

The practice had effective governance structures and systems in place. The partnership of the practice comprised of three GPs partners, who all had their own clinical lead roles and areas of

responsibility, such as safeguarding. All partners attended regular business meetings, through which each partner was held to account for their performance.

Staff were clear about their roles and responsibilities. The practice maintained their own set of policies and procedures that outlined each staff member's duties. We reviewed several policies and saw they were clear, comprehensive and contained links to external guidance and legislation. For key policies such as safeguarding, the practice had extracted the most important contact details and information and had summarised this in a quick reference section at the beginning of the policy. This allowed staff to quickly refer to critical information in the event of an incident occurring.

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 business meetings, clinical meetings, multidisciplinary team meetings, staff meetings and nurse meetings. All meetings were regular, followed an agenda, with minutes shared with all staff who could not attend.

There were processes to manage performance. Staff performance was monitored and assessed through each staff member's annual appraisal.

There was a quality improvement programme in place.

Arrangements for identifying, managing and mitigating risks were effective. During our assessment, we identified some potential areas of concern but saw the practice were largely aware of all these areas and had taken appropriate action to mitigate any risks. For example, we saw how the practice had implemented a 'red list' to safely manage the prescribing of high risk medicines whereby patients were not compliant with the practice's attempts at monitoring.

A major incident plan was in place, and staff were trained in preparation for major incidents.

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 used information from external prescribing formulary tools and other prescribing services to improve the quality of prescribing. The practice explained they no longer had access to island-wide prescribing data so was unable to compare the prescribing performance of practice clinicians with other services. To mitigate this, the practice used information from external prescribing formulary tools and other prescribing services to improve and monitor the quality of prescribing.

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 involved the public, staff and external partners to sustain high quality and sustainable care.

Patient views were acted on to improve services and culture. The practice collected feedback through their friends and family test, their GP assessment questionnaire and patient suggestions. Changes made as a result of patient feedback included a change of the layout of the waiting room and the installation of microphones at reception desks.

The practice did not have an active Patient Participation Group (PPG). The practice explained they wished to form a PPG, and had made repeated attempts over several years to achieve this, but had not been successful in finding enough members to form an effective group. We saw the practice had compiled a comprehensive page on their website that advertised the function and

benefits of the PPG, including how patients could express an interest to join and the expected commitments.

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 held regular multidisciplinary clinical meetings with health visitors, school nurses and other local healthcare services to discuss the needs of their local community.

Continuous improvement and innovation

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

There was a strong focus on continuous learning and improvement. We saw how staff were encouraged and supported to improve care and treatment, such as through clinical audit. Managers explained how all staff were constantly working to improve services, with the practice being the first on the island to introduce several new initiatives, such as automatic check-in screens and drug formularies.

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. Managers explained how they regularly shared learnings, both formally and informally, with other staff and clinicians to improve the quality of care.