DHSC – CQC external quality regulation programme

Finch Hill Health Centre

Assessment report

Level 2 Chester Street Car Park

Chester Street

Douglas

Isle of Man

IM1 2PG

01624 656050

www.finchhill.im

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Our findings

Overall summary

We carried out this announced assessment on 8 November 2022. The assessment was led by a Care Quality Commission (CQC) inspector who was supported by a GP adviser.

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

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

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

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

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

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

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

Our key findings were

- The 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 not always effective. Patients prescribed high-risk medicines did not always receive all required monitoring and medication reviews were not always 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 learned and made improvements when things went wrong. However, the oversight and management of historic safety alerts was not always effective.
- 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 always able to demonstrate that staff had the skills, knowledge and experience to carry out their roles. However, there were limited clinical supervision arrangements in place.
- 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 not always 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 operated a system whereby a specific code could be added to a patient's care record where staff suspected potential safeguarding concerns. This allowed other practice staff to be aware of any suspicions and allowed patients to be quickly identified and reviewed by the practice.
- 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 and long term conditions coordinators were invited to join the practice GP clinical team to discuss relevant clinical cases. Comprehensive minutes were recorded for each meeting, which included details of any patients discussed and any joint actions agreed.

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

- Implement regular safeguarding meetings to discuss vulnerable children.
- 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 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 guidance.
- Improve the oversight of the checking of medical equipment and consumables to ensure any expired equipment is removed.
- Improve processes for the management and recording of 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 childhood immunisation uptake rates.

- Implement a formalised programme of regular and repeat clinical audit.
- Implement a process to review unplanned admissions, readmissions and referrals.
- Improve the supervision and oversight of clinical staff, including the prescribing competencies of non-medical staff, to ensure all staff remain competent in their roles.
- Improve systems for the identification of patients who are carers or have caring responsibilities.
- Improve systems for the obtaining of interpreters and translators, including translated leaflets and information letters, for patients if required.
- Develop a formalised vision and set of values that is supported by a credible strategy.
- Improve systems for the identification of risks to ensure all risks are adequately identified, managed and mitigated.
- Improve systems to obtain patient feedback, such as through a patient participation group.
- Improve systems and processes for learning, continuous improvement and innovation.

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 and did not ensure all patients received all required monitoring, assessments, follow-up appointments and medication reviews.
- The practice did not have effective processes for the management of historic drug safety and medication alerts.
- The practice did not have systems in place for translators and interpreters to be sourced if required, despite the practice having a significant number of patients who did not speak English as their first language.

Background to assessment

The practice is located at:

- Finch Hill Health Centre, Level 2 Chester Street Car Park, Chester Street, Douglas, Isle of Man, IM1 2PG.

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 one GP partner, several locum GPs, two practice nurses and a pharmacist. The clinical team are supported at the practice by a practice manager who provides managerial oversight, a phlebotomist, 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 three patients and six 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 not always 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 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, but 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 all staff were aware of.

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 discussed safeguarding concerns as part of their two-weekly clinical meetings. Monthly meetings were held with the practice's long term conditions coordinator and health visitor for vulnerable adults to discuss safeguarding concerns. The practice did not have regular external safeguarding meetings to discuss vulnerable children outside of their two-weekly clinical meetings, although explained how they could make contact with the practice's health visiting team if staff had any concerns. Whilst there were no transitional safeguarding arrangements in place at an island level, the practice had informal processes in place to discuss any patients transitioning from children 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 consistent. The practice maintained several safeguarding registers, which included vulnerable adults and children registers. Safeguarding alerts were placed onto patient care records where there were concerns, which the practice could evidence. This included the use of a code in the record when staff had identified potential safeguarding concerns but where they may still be being investigated or reviewed. 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 yearly.

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. The practice explained multiagency safeguarding meetings, such as meetings involving emergency services and social services, did not routinely happen on the island.

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 undertaken a review of the recruitment checks undertaken for all staff employed at the practice, which included staff who had worked at the practice for several years. In the event items were missing from staff files, such as completed references, the practice undertook a risk assessment which involved reviewing the staff member's role and work performance.

The practice had a process in place for staff professional registrations to be checked upon recruitment, and on a yearly 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.

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.

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 June 2022, which had highlighted concerns over a lack of wipeable chairs in clinic rooms and the storage of cleaning products on the floor in storerooms. We saw the practice had addressed this with new chairs installed prior to our visit, and undertook quarterly repeat audits to check for improvement.

Date of last infection prevention and control audit: June 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 satisfactory and showed appropriate management and prescribing. Safety netting and follow-up advice was generally included 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.

Referrals to specialist services were documented, contained the required information and actioned in a timely manner. The practice recorded all requested urgent referrals on a tracker and regularly reviewed this to ensure all referrals were acted on a timely manner. The practice explained they accessed the hospital appointment system to check if an appointment had been booked for the patient, and checked to ensure the patient had attended their appointment. If no appointment had been booked, or the patient had not attended their appointment, the practice took action to address this.

There was a documented approach to the management of test results. All results were returned to the lead GP, who actioned or forwarded to the requesting clinician as appropriate. In the absence

of the lead GP, this role was carried out by an experienced locum GP. During our assessment, we saw all test results and correspondence were up to date and had been actioned promptly.

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

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 that had exceeded use by dates. Out of date products included an oxygen cylinder, saline tubes, speculums, plasters and hand scrubs. Following our assessment, the practice confirmed they planned to improve their processes and undertake additional staff training to reduce the risk of the accumulation of out of date equipment.

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, 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. As part of our assessment, we reviewed five recently completed medication reviews and saw reviews were appropriate and well documented.

The practice had a process for the management of information about changes to a patient's medicines. The practice raised 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. To address this, the practice retained poorly written communications and sent these to their primary care network for review and escalation.

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 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 619 patients prescribed this medicine, with 27 patients indicated as not having received all recommended monitoring. We undertook a detailed review of five patients' care records but did not see the practice had an effective system in place, as two patients we reviewed had not received all monitoring tests for over two years. Following our assessment, the practice reviewed the affected patients and

confirmed 15 of the 27 patients identified had received appropriate monitoring tests, with the results stored on the hospital's pathology system and appropriate reference recorded in each patient's care record.

Another search reviewed the prescribing of a high risk medicine primarily used as a blood thinner. Our search identified 107 patients prescribed this medicine, with 33 patients identified as not having received all recommended monitoring. We undertook a detailed review of five patients' care records and saw all patients were receiving regular renal function tests, but not all patients were 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 until shortly before our assessment, when they had started to request annual LFTs and FBCs for affected patients. 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.

The practice monitored the prescribing of controlled drugs. We conducted a search to review the prescribing of a controlled drug primarily used as a sedative. Our search identified 68 patients who were prescribed more than 10 prescription issues in the last 12 months. We undertook a detailed review of five patients' care records, and although the majority of patients had been started on these medicines by other services such as mental health or pain management teams, we saw there were evidenced attempts taken by the practice to review and reduce patient dependencies.

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. This included a check of the medicine expiry dates and availability.

There was medical oxygen and a defibrillator on site, and systems were in place to ensure these were regularly checked and fit for use. However, we did note one of the practice's oxygen cylinders had passed its expiry date and had not been identified by the practice. Following our assessment, the practice advised they planned on including the expiry date on their checklists to ensure this was not missed.

The practice had emergency medicines and equipment available and generally stored these in line with recommendations. Emergency equipment was stored on a resuscitation trolley, which was stored behind reception and was clearly signed. Emergency medicines were stored within the resuscitation trolley, which all staff could easily access, but were not stored in tamperproof containers as per recommended guidance from the Resuscitation Council.

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. However, the oversight and management of historic 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 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 saw the practice had reported an incident regarding a patient's prescription being stapled to another prescription. We saw the practice had investigated this and had implemented a new process whereby prescriptions were no longer stapled together to prevent this from recurring.

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

Although staff understood how to deal with alerts, the system for recording and acting on historic 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 2018 regarding an increased risk of skin cancer in patients prescribed a particular medicine. Our search identified seven patients who were prescribed this medicine. We undertook a detailed review of five patients' care records but did not see an awareness of the safety alert as none of the patients had been informed of the increased risk. Following our assessment, the practice confirmed they had reviewed and contacted all affected patients and would be undertaking an additional skin check.

Another search reviewed a safety alert from 2014 regarding a potential negative interaction between two medicines when prescribed together. Our search identified seven patients who were prescribed both medicines. We undertook a detailed review of five patients' care records but did not see an awareness of the safety alert as none of the patients had been informed of the increased risk.

The practice advised they were working to improve their management of safety alerts, including through their recent recruitment of a clinical pharmacist.

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 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 through additional training and practice meetings. 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. However, we saw the practice's system for the management of patients with long term conditions was not always effective as not all patients always received all recommended monitoring.

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.
- 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 two patients with a potential missed diagnosis. We undertook a detailed review of both patients' care records and saw one patient was receiving appropriate care and treatment. We noted the other patient had not received any monitoring since 2018 and was therefore likely at increased risk of complications. Following our assessment, the practice confirmed they had reviewed all affected patients.
- 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 567 patients who were diagnosed with asthma, with 14 patients identified as being prescribed two or more courses of rescue steroids. We undertook a detailed review of five patients' care records and saw the practice's management of patients with exacerbation of asthma was effective. All patients reviewed had received an asthma review within the last 12 months and had been reviewed 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 14 patients with CKD at stages four and five, with three patients indicated as not having received a relevant blood test within the last nine months. We undertook a detailed review of all three patients' care records and saw all patients were receiving appropriate care at hospital.
- Another search reviewed the monitoring of patients with hypothyroidism. This search identified 175 patients with hypothyroidism who were treated with thyroxine, with three patients identified as not having received a thyroid function test within the last 18 months. We undertook a detailed review of all three patients' care records and saw the practice did not have an effective system in place for monitoring. We saw the practice requested any required monitoring tests at each patient's annual medication review, but we did not see any actions taken by the practice to check the monitoring tests had been completed or actions taken whereby patients had not attended their follow-up appointment.

Another search reviewed the care and treatment of patients diagnosed with diabetic retinopathy – a complication of diabetes. Our search identified eight patients 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 receiving appropriate monitoring and treatment through secondary care. We did identify two patients who were not being managed by the hospital, and saw the practice had not always taken action to review and manage these patients. This placed both patients at a potential increased risk of further complications. Following our assessment, the practice confirmed they had reviewed all affected patients and had taken additional action where necessary, including the arranging of additional blood tests. 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 three of the four vaccination categories listed below, and had achieved the World Health Organisation's (WHO) target of 95% uptake for one of the four vaccination groups listed below.

The practice explained they had a diverse and transient patient list, with around a quarter of all registered patients originating from outside of the island and the UK. To help improve childhood immunisation uptake rates, the practice undertook new patient screens for all new patients registering at the practice whereby a patient's vaccination history was discussed, and any missing vaccinations or immunisations arranged.

Percentage of eligible patients vaccinated by GP as of 1 January 2022		
Vaccine:	Finch Hill Health Centre	Isle of Man Average:
5-in-1	95.00%	95.77%
Measles, Mumps and Rubella	92.50%	90.68%
Meningitis C	92.50%	90.28%
Pre-school Boosters	90.91%	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	
Finch Hill Health Centre	Isle of Man Average:
73.66%	76.84%

Percentage of persons eligible for bowel cancer screening who have been adequately screened between 1 October 2021 and 31 December 2021	
Finch Hill Health Centre	Isle of Man Average:
51.26%	60.74%

Monitoring care and treatment

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

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

The practice did not have a formal clinical audit programme in place. Reviews completed by the practice largely comprised of electronic patient record searches to review medication prescribing

and long term condition management, but these were not supported by a formal audit programme or repeat searches to check for improvement.

There was no process in place for the practice to review unplanned admissions and readmissions, or to take appropriate action following these admissions.

Following our assessment, the practice confirmed they planned to implement a formal audit programme, with two audit cycles to be undertaken every 12 months, aimed at measuring the practice's performance against defined recognised standards.

Effective staffing

The practice was always able to demonstrate that staff had the skills, knowledge and experience to carry out their roles. However, there were limited clinical supervision arrangements in place.

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 respiratory 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 could not always demonstrate how they assured the competence of staff employed in advanced clinical practice, such as nurse prescribers and pharmacists. Managers explained how staff were encouraged to discuss any queries or concerns with the practice's lead GP, and explained the practice operated an 'open door' policy. With the exception of annual appraisals, we saw there was limited-to-no clinical supervision of clinical staff and their prescribing.

Following our assessment, the practice confirmed they planned on introducing formal quarterly meetings between the GP partner and prescribing clinical staff to provide assurance of prescribing supervision.

The practice used several regular locum GPs, but did not have a process in place to review and assess their competence, largely relying on each GP's annual appraisal.

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, we saw how the practice shared information with social care services upon request.

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 explained how a specialist palliative care nurse attended the practice on a monthly basis to discuss any patients requiring further help or support.

Staff encouraged and supported patients to be involved in monitoring and managing their own health. For example, the practice displayed public health information in waiting areas and clinic rooms to promote key health messages.

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 safeguarding awareness, sepsis care and 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 359 responses. Of these, 356 respondents rated their overall experience as either ‘good’ or ‘very good’, one rated their experience as ‘poor’ or ‘very poor’, and two respondents rated their experience as ‘neither good nor poor’. Positive comments largely related to the quality of care and treatment and the caring nature of staff. One patient commented on how they were ‘always treated with respect’, with another patient describing staff as ‘friendly and helpful’. Other comments included how the practice was ‘perfect’, how they received an ‘excellent service’, and how staff were ‘very professional and caring’. Negative comments largely appeared to be related to specific issues with the respondents’ care.

During our assessment, we spoke with three patients and people who used the service. All patients were satisfied with the care and treatment received, and reported receiving good care 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. 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 on how to meet each patient’s individual needs.

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 43 patients recorded as carers from a patient list of approximately 7,100 (0.61%).

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 did not have a formal process in place to obtain an interpreter for a patient and would usually rely on a patient bringing along a friend or relative.

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 formats, such as large print, but were not available in other languages.

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 they operated services that patients could not usually access on the island, and offered these services to patients registered at other practices where necessary. The practice offered all standard services such as health checks, vaccinations and acute care, as well as additional services such as phlebotomy and injections to treat headaches.

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 converted building, which was owned by the Isle of Man Government. Disabled access was available throughout the practice. The practice building was located within a multi-storey car park, which meant 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 no arrangements in place for people who needed translation services. The practice explained they had a diverse patient list, with approximately a quarter of all registered patients originating from outside of the island and the UK. As a result, staff regularly encountered situations whereby patients could not speak English fluently, or at all. The practice did not have any formal arrangements in place for an independent translator to be sourced, instead relying on mobile phone translation apps or on the patient bringing a bilingual friend or relative. The practice was aware using friends and family members as translators was not recommended due to potential safeguarding concerns or risks of key information being omitted or translated incorrectly.

The practice provided information in accessible formats.

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

- 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 in advance, which allowed patients to be seen by their desired clinician at 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.

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

Patients with urgent needs had their care prioritised. Patients were asked whether they felt their appointment was urgent, and which clinical role they would prefer to see. If patients were unsure, trained receptionists could help guide the patient. A number of urgent appointments were reserved for same day booking, which included both nurse and GP appointments. In the event an urgent appointment was required, and no appointments were available, receptionists could escalate the patient's request to a GP for review. On the day of our assessment, we saw the practice had good availability of both urgent and routine appointments, with appointments available for later that day.

Between April 2021 and March 2022, the practice received 359 responses to their friends and family survey. Feedback that related to appointment booking systems was positive, with respondents describing how they had been 'seen at short notice', how it had been 'quick to see a doctor' and how they were able to get a 'very prompt appointment'. This feedback was similar to additional feedback submitted to other online services and social media pages.

During our assessment, we spoke with three patients and people who use the service. All three patients reported no problems in booking appointments or accessing care and treatment.

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 within a day or two, and provided an apology where appropriate. Complaints were investigated by the practice manager and the lead GP, with a formal response being issued to the complainant usually within a month of their complaint being raised. All complaints were discussed during practice and 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 difficulties recruiting clinical staff, and language and cultural barriers with the practice's patient list.

Managers explained how they were working to address these challenges, such as through the recruitment of additional clinical staff including pharmacists and advanced nurse practitioners.

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.

Vision and strategy

The practice did not have a vision to provide high quality sustainable care.

The practice did not have a vision, set of values or mission statement in place, or a credible strategy for what it wished to achieve.

Managers explained the practice's focus was on the 'provision of excellent patient care' and 'being a great place to work' for all their staff. Managers explained how they were awaiting the outcome of the island's healthcare transformation programme before updating and developing the practice's vision and strategy to align to this.

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 the lead GP, who had overall clinical responsibility, and a second partner who had financial responsibility. The practice manager was responsible for practice policies and procedures, and reported to the lead GP. All clinical staff attended regular practice and clinical meetings, through which staff were held to account for their performance.

Staff were clear about their roles and responsibilities. The practice used a combination of their own policies and procedures, and those created by their primary care network. Policies were stored in a central location, which all staff could access.

There were appropriate governance arrangements with third parties.

Managing risks, issues and performance

Processes for managing risks, issues and performance were not always effective.

There were assurance systems in place, which were regularly reviewed and improved. Managers held several different meetings, which included practice meetings, clinical meetings, and reception meetings. All meetings were regular, followed an agenda, with minutes shared with all staff who could not attend. We reviewed the completed minutes of several meetings and saw these were comprehensive, included details of any patients discussed, and any actions agreed following the meeting.

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

There was a limited quality improvement programme in place.

Arrangements for identifying, managing and mitigating risks were not always effective as during our assessment we identified several areas of concern that had not been identified or addressed

by the practice. This included concerns relating to the management and prescribing of medicines, drug safety alerts, clinical audit processes and the supervision arrangements for clinical staff.

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 and staff appraisals.

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.

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, patient feedback and suggestions. Changes made as a result of patient feedback included changes to the way telephone calls were answered and the layout of the waiting area.

The practice did not have an active Patient Participation Group (PPG). The practice explained under their GP contract, they were required to establish either a PPG or use the friends and family test (FFT) survey, and due to the high responses that they regularly received to their FFT survey, felt this was the better option for seeking patient feedback.

Although the practice received a good response rate to their FFT survey, we saw there were limited other channels whereby the practice could discuss any proposed changes with patients in advance of them being implemented to gain their view and feedback.

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, palliative care nurses and other local healthcare services to discuss the needs of their local community.

Continuous improvement and innovation

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

There was limited focus on continuous learning and improvement. Staff explained how they were given dedicated time for learning and development, and explained how staff regularly shared learnings between each other. We saw there were limited formal training opportunities for clinicians at the practice outside of the island-wide quarterly GP education meetings.

The practice did not have a formal clinical audit or quality improvement programme in place, and there was limited evidence of changes being made to improve services. Staff explained how incidents and any identified learnings were shared with their primary care network, but we did not see any evidence of any participation in quality improvement work within the primary care network.