DHSC – CQC external quality regulation programme

Hailwood Medical Practice

Assessment report

No. 2 Hailwood Court

Governors Hill

Douglas

Isle of Man

IM2 7EA

01624 686949

www.hailwoodmedicalcentre.co.uk

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Our findings

Overall summary

We carried out this announced assessment on 11 August 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

- Safeguarding processes were not always effective, as not all staff were trained to appropriate levels for their roles. Systems to identify vulnerable patients on record were not consistent, and data sharing arrangements did not always allow for the effective sharing of safeguarding information. There was limited engagement in local safeguarding processes.
- Recruitment checks were not always safe, as not all staff received appropriate Disclosure and Barring Service (DBS) checks. Staff qualifications, professional registrations and vaccinations were not always checked.
- Health and safety risk assessments, which included fire, legionella and hazardous substances risk assessments, had not been completed.
- Appropriate standards of cleanliness and hygiene were not met.
- Patient clinical information was not always stored appropriate or securely.
- The practice's system for the appropriate and safe use of medicines, including medicines optimisation, was not effective as patients prescribed high-risk medicines did not always receive all required monitoring. Medication reviews were not always completed when required and documentation regarding completed reviews was limited. Blank prescriptions were not always kept securely. The practice could not demonstrate the prescribing competence of all staff, and there was no direct supervision of all prescribers.
- The practice had some emergency equipment and medicines available, although not all recommended equipment was available. The storage of emergency equipment was not always in line with recommendations.
- The practice did not have effective systems in place to learn and make improvements when things went wrong. This included their system for recording and acting on safety alerts, as several safety alerts had not been actioned or addressed by the practice.
- Patients' needs were not always assessed, and care and treatment were not always delivered in line with current legislation and standards. Patients with long term conditions did not always receive all required monitoring and did not always receive appropriate diagnoses for their condition.
- There was limited monitoring of the outcomes of care and treatment, and the practice did not have an established clinical audit programme in place.
- The practice was not able to demonstrate that all staff had the skills, knowledge and experience to carry out their roles. Training records did not provide an effective oversight of staff training compliance, and not all staff were given dedicated time to complete all required training.

- 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 was unable to demonstrate that it always obtained consent to care and treatment in line with legislation and guidance.
- Staff treated patients with kindness, respect and compassion. Feedback from patients was positive about the way staff treated people. Staff helped patients to be involved in decisions about care and treatment, and respected patients' privacy and dignity.
- The practice organised and delivered services to meet patients' needs. People were able to access care and treatment in a timely way, although telephone access required improvement. Patient complaints were listened and responded to and used to improve the quality of care.
- There was compassionate and inclusive leadership at all levels, however leadership of the practice was not always effective.
- The practice did not have a vision to provide high quality sustainable care.
- The overall governance arrangements were ineffective.
- The practice did not have clear and effective processes for managing risks, issues and performance.

We found the following areas of notable practice:

- The practice proactively reviewed and discussed the care of patients receiving palliative care during each clinical meeting. Where patients had not been contacted or seen by a clinician since the last clinical meeting, clinicians were tasked to review the patient's record to confirm their care needs remained met.

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

- Improve safeguarding processes to ensure all vulnerable children and adults are appropriately identified; all staff are appropriately trained for their role; and there is appropriate engagement in local safeguarding processes
- Improve staff recruitment processes to ensure all staff undergo a Disclosure and Barring Service (DBS) check on recruitment where required; there are effective checks of staff skills and qualifications; there are effective checks of staff professional registrations; and there are effective checks of staff vaccination histories.
- Undertake health and safety risk assessments, which include a fire risk assessment, legionella risk assessment and a hazardous substances risk assessment.
- Improve the cleanliness and maintenance procedures for the practice to ensure all areas meet minimum infection prevention and control standards.
- Improve the security of the storage of confidential patient information to ensure it always remains secured.
- 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 referral processes to ensure all patients are appropriately safety netted.
- Improve the management of medicines, medical equipment and consumables to ensure all expired equipment is removed and disposed of appropriately.
- Improve the security, storage and oversight of blank prescriptions.
- Implement a formalised programme to review clinical staff competencies, including the prescribing competencies of non-medical prescribers.
- Improve the documentation of completed patient medication reviews to ensure there is a clear record of which medications have been reviewed.
- 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.
- Develop effective systems to monitor the prescribing of controlled drugs.
- Improve the storage of emergency medicines and equipment to ensure they are stored in line with recommendations and are clearly signed to staff.
- Improve processes for the checking of emergency medicines and equipment to ensure all expired equipment is promptly removed and there is a clear list of the medicines to be stocked by the practice.
- Improve the checking of medicine fridge temperatures with a secondary independent thermometer.
- Implement a formalised process for any learnings from completed incident investigations to be shared both internally and externally.
- Improve processes for the management and recording of safety alerts, including historic drug safety and medication alerts.
- Develop and implement patient care plans to support the delivery of high quality care and treatment.
- Develop a process to review all requested and completed patient referrals.
- 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 the documentation of patient consultations to ensure all consultation records are comprehensive, provide a contemporaneous record of all care and treatment given, and evidence what safety netting advice has been given.
- Improve childhood immunisation uptake rates.
- Implement a formalised programme of regular and repeat clinical audit.
- Improve the monitoring and oversight of staff mandatory training to ensure there remains effective oversight of the training of all staff roles.
- Improve the uptake of staff mandatory training to ensure all staff have completed training in all required areas, including resuscitation, safeguarding, and infection prevention and control.

- Implement a system that ensures all staff, including both clinical and non-clinical staff, have adequate time to complete all required mandatory training.
- Improve the oversight and management of staff competencies to ensure all staff remain competent in their roles.
- Improve systems to assess and record patient consent to care and treatment.
- Improve the arrangements at reception and waiting areas to ensure patient confidentiality is always maintained, and in all areas.
- Improve disabled access to the practice to ensure all areas of the practice are accessible to all staff and patients.
- Improve patient telephone access to the practice.
- Improve governance and leadership arrangements to ensure all leaders have nominated roles, are aware of their roles and responsibilities, and can hold each other to account in the event of poor performance.
- Develop a leadership succession plan.
- Improve systems for the identification of risks and the management of performance information to ensure all risks are adequately identified, managed and mitigated.
- Develop a practice vision and values that are supported by an effective and credible strategy.
- Develop systems to obtain patient feedback that can be reviewed and used to improve services, such as through a patient participation group.
- Develop a system to work with stakeholders and other healthcare providers to build a shared view of care.
- Develop a proactive system of quality improvement and continuous improvement.

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

- The practice did not always meet the appropriate standards of cleanliness and hygiene, and there was no programme of infection prevention and control audit in place.
- 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 oversight of the monitoring of patients with long term conditions and did not ensure all patients received all required monitoring, assessments, follow-up appointments and medication reviews. Not all patients with a long-term condition had been appropriately identified, diagnosed and coded.
- The practice did not have effective processes for the management of safety alerts, which included historic drug safety and medication alerts.
- The practice’s safeguarding processes were not always effective, as not all staff were evidenced as having completed appropriate training for their roles, systems to identify vulnerable patients on record were not consistent, and data sharing arrangements did not always allow for safeguarding information to be shared between services.

- The practice's recruitment processes were not safe, as there was no effective system in place to check staff qualifications, criminal records, professional registrations and/or vaccinations.
- The practice's storage and oversight of emergency medicines and equipment were not effective, as equipment was not stored in line with recommendations.
- The practice did not have effective processes in place for the supervision and oversight of all staff, including non-medical prescribers.
- The practice did not undertake key health and safety risk assessments, which included fire, legionella and hazardous substances assessments.

Background to assessment

The practice is located at:

- Hailwood Medical Practice, No. 2 Hailwood Court, Governors Hill, Douglas, Isle of Man, IM2 7EA.

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 three GPs, two practice nurses and one physician associate. 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 three patients and six members of staff, which included two GPs. We looked at practice policies and procedures and other records about how the service is managed.

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

Is the service safe?

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

Safety systems and processes

The practice did not have clear systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding

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

Training records did not provide evidence that all partners and staff had completed required safeguarding training for their role. For example, only 16% of staff who were required to complete level two adult and child safeguarding had completed it.

There was limited engagement in local safeguarding processes. Safeguarding remained a recurring agenda item on monthly practice meetings. We found there were no transitional safeguarding arrangements in place, and no regular meetings with health visitors or other healthcare professionals regarding safeguarding.

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 on record were not consistent. The practice did not maintain a child protection register or adult safeguarding register, although they had created a search that identified children with safeguarding concerns. Safeguarding alerts could be placed on patient care records. We found this was not consistent as alerts were not always entered onto the records of siblings or parents of at-risk children. Staff reported they generally did not use alerts for safeguarding but did use them to inform staff of any personal requirements, such as longer appointments.

Disclosure and Barring Service (DBS) checks were not always undertaken when required. Not all staff were evidenced of having received a DBS check. The practice explained DBS checks were generally undertaken for all new staff after they had worked at the practice for six months.

Discussions were not always 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 not carried out in accordance with policy (including for agency staff and locums). The practice did not undertake any checks for GPs, instead relying on the island performers list. There was no process to check staff qualifications upon recruitment, and we saw instances whereby new clinical staff had been appointed with no evidenced check of their skills, qualifications or competencies. Staff professional registrations were not checked, either on recruitment or on an ongoing basis. There was no evidenced check of staff vaccination status upon employment to confirm staff had received all required vaccinations for their role, such as for hepatitis B, tetanus, polio, diphtheria, measles, mumps and rubella vaccinations.

Safety systems and records

Health and safety risk assessments were not carried out. The practice had not carried out a fire risk assessment, a legionella risk assessment or any hazardous substances risk assessments.

There was no fire procedure in place.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not met.

Several areas of the practice were in a poor state of repair, which posed a potential infection risk. This included damaged paintwork and woodwork in clinic rooms and toilets, mould around toilet sinks, and fabric curtains in clinic rooms which were visibly dirty.

Staff did not always receive effective training on infection prevention and control, as training data viewed during our assessment showed several staff had not completed all required and recommended training.

Infection prevention and control audits and hand hygiene audits were not carried out.

The arrangements for managing waste and clinical specimens did not always keep people safe. We found clinical waste was collected and disposed of through arrangements with their local hospital. Staff disposed of clinical waste in the practice through swing lid bins rather than foot pedal operated bins. Staining, and what appeared to be visible dirt, was present on clinical waste bin lids which posed a potential infection risk.

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), although not all staff were suitably trained in emergency procedures. Training data viewed during our assessment showed 10 out of 11 members of staff had completed adult basic life support training, however no staff had completed required training on paediatric and infant basic life support.

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 appropriate, receptionists could book patients an urgent same day appointment. In the event there were no appointments available, receptionists could escalate urgent appointment requests to the GP team for clinical review.

Information to deliver safe care and treatment

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

Individual patient care records, including clinical data, were not always written and managed securely, in line with current guidance or relevant legislation. The practice stored patient care records and clinical information on a secure third-party system, which only authorised staff could access. During our assessment, we found instances of confidential information kept in unlocked drawers and cupboards within unlocked clinic rooms. This included patient medications that contained confidential information on dispensing labels, and a completed mental health assessment form that contained patient information and details on their medical history.

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

There were limited systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. Where data sharing agreements were held, and with the patient's consent, the practice could share information with other healthcare providers such as to out of hours GP services. We found data sharing agreements were not in place for all key healthcare providers, such as with local acute hospital, community and ambulance services, which meant there was a risk key information may not be shared.

Referrals to specialist services were documented and contained the required information. We found there was a limited system to monitor delays in referrals. Referrals were submitted in a timely and appropriate manner, although the practice placed the onus onto the patient to ensure they received all urgent appointments. The provider did not have an effective system and we did not see evidence that appropriate safety netting advice had been given to patients.

There was a documented approach to the management of test results. If the requesting clinician was absent when results were received, managers redistributed these to other clinicians to review.

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. Medicines were stored in stock rooms and cupboards, which only staff had access to.

The practice did not have appropriate processes in place to manage medical consumables and equipment as during our assessment, we identified several items of equipment from across the practice that had exceeded expiry dates. This included the practice's first aid kit, emergency medicine syringes, several boxes of urine analysis test strips, and other medical consumables.

Blank prescriptions were not always kept securely. Bulk prescription boxes were stored securely, but blank prescriptions were found in unlocked printer trays and drawers in unlocked clinic rooms. Records were not maintained as to which prescriptions had been issued to which prescriber.

Documentation demonstrated staff had the appropriate authorisations to administer medicines, including the use of Patient Group Directions (PGDs). The practice did not use Patient Specific Directions (PSDs).

The practice could not demonstrate the prescribing competence of non-medical prescribers, such as nurse prescribers, and there was no regular review of their prescribing. There was no direct supervision of non-medical prescribers, and reviews of each staff member's prescribing was largely completed when patients were subsequently seen by GPs. The practice explained they no longer had access to island-wide prescribing data so could not review each clinician's prescribing but had not implemented any interim arrangements to review prescribing.

There was a process for the safe handling of requests for repeat medicines, although the quality of medication reviews for patients on repeat medicines were variable. As part of our assessment, we reviewed five recently completed medication reviews. A review had been entered into each patient's care record, but did not always contain details 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. The practice held data sharing agreements with some healthcare providers, such as out of hours GP services, which allowed practice staff to review any changes made to a patient's prescription by other services.

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 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 used to treat high blood pressure. Our search identified 1,039 patients who were prescribed this medicine, with 259 patients identified as not having received all recommended monitoring. We undertook a detailed review of five patients' care records and found there was no apparent system in place or recognition of the need for monitoring. Most patients had not received any monitoring for some years, including two patients who were last monitored in 2016 and one patient in 2015. Many patients were evidenced as being at high risk of complications, such as uncontrolled blood pressure or renal and/or electrolyte disturbance. One patient was identified as still being prescribed this medicine by the practice, despite a request from a specialist in 2021 for the medicine to be stopped. No alterations had been made by the practice, which placed the patient at high risk of life-threatening complications.

Another search reviewed the prescribing of a medicine used to treat high blood pressure and heart failure. Our search identified 60 patients who were prescribed this medicine, with 34 patients identified as not having received all recommended monitoring. We undertook a detailed review of five patients' care records and found there was no apparent system in place or recognition of the need for monitoring. Most patients had not received any monitoring for some years, including two patients who were last monitored in 2019 and one patient in 2017. There was no apparent system in place for monitoring potentially serious adverse effects, and no evidence that prescribers had checked the patient's monitoring status prior to prescribing the medicine. One patient was seen to have received a medication review recently, however the lack of monitoring had not been identified by the practice and no actions had been taken as a result. As a result, several patients were being placed at an increased risk of life-threatening complications.

Another search reviewed the prescribing of a medicine used to prevent blood clots. Our search identified 190 patients who were prescribed this medicine, with 78 patients identified as not having received all recommended monitoring. We undertook a detailed review of five patients' care records and saw three patients were being managed through secondary care. We identified two patients who were not receiving appropriate monitoring, including one patient where there was no apparent arrangement in place for monitoring.

The practice did not have effective systems in place to monitor the prescribing of controlled drugs. We conducted a search to review the prescribing of a class of medicines primarily used as a sedative. Our search identified 115 patients who were prescribed more than 10 issues in a 12-month period, and upon reviewing these patients' care records, most patients appeared to be receiving these medicines on repeat prescriptions. We found medication reviews were evidenced in some patients' care records, but few of these reviews commented on the long-term use of these medicines or on any actions made by the practice to reduce their usage.

We conducted another search to review the prescribing of a class of medicines primarily used to treat seizures and nerve pain. Our search identified 55 patients who were prescribed these groups of medicines who had not received a medication review within the last 12 months.

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. Checklists were completed to confirm medicines were available and in date, although did not include a check of the range of medicines or minimum stock levels to be held by the practice.

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 stored emergency medicines and equipment across several locations within the practice. For example, the practice stored their defibrillator along with some emergency equipment in a corridor and stored their emergency medicines and other emergency equipment within lockable cupboards in lockable treatment rooms. Recommended personal protective equipment (PPE) was not stored with their emergency equipment, and this equipment was not effectively signed to indicate its presence. This was not in line with best practice guidelines that recommends for equipment to be stored in a strategic and accessible location and not locked away due to this causing an unacceptable delay in delivering emergency patient care. Emergency medicines were stored across four plastic boxes, which were not tamper-evident. This was not in line with best practice guidelines that recommends for emergency medicines to be stored in suitable, tamper-evident containers.

Vaccines were stored appropriately, monitored and transported in line with appropriate guidance to ensure they remained safe and effective. Staff undertook twice daily temperature checks of all medicine fridges and escalated any anomalous temperatures as appropriate, although the practice did not use a backup thermometer or data logger to confirm the accuracy of the fridge thermometer and allow for temperatures to be recorded in the event of a power or fridge failure.

Track record on safety and lessons learned and improvements made

The practice did not have systems to learn and make 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 incident reporting form, which was reviewed by the practice management team.

There was a limited system in place for recording, investigating and acting on significant events, and limited 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. Reports contained an overview of the incident, but there was limited-to-no evidence of any investigation taking place or of any learnings being identified. For example, we reviewed the three most recently reported incidents which all related to the loss of patient prescriptions by a local pharmacy but saw no evidence of any actions or escalations being taken by the practice despite the clear theme.

Staff understood how to raise concerns and report incidents, both internally and externally. Although we found incidents were discussed and shared locally, there was no formal mechanism in place to share incidents externally.

Safety alerts

Staff did not understand how to deal with alerts, and the system for recording and acting on safety alerts was not 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 a safety alert from 2014 regarding a potential negative interaction between two medicines when prescribed together. Our search identified 22 patients who were still prescribed both medicines. We conducted a detailed review of five patients' care records and did not see any indication or recognition of the safety alert, or that any patients had been informed of this risk. This included one patient who had been prescribed both medicines for over ten years.

Another search reviewed a safety alert from 2018 regarding an increased risk of skin cancer for patients taking a specific medicine. Our search identified 22 who were prescribed this medicine. We conducted a detailed review of five patients' care records and did not see any indication or recognition of the alert, or that any patients had been informed of this risk.

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 not always assessed. We found care and treatment were not always 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. Changes to clinical guidance or care pathways were shared with staff and were discussed in clinical meetings.

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

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

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

Patients' treatment was not regularly reviewed and updated. As part of our assessment, we conducted a series of clinical searches and associated notes review to assess the practice's procedures for the management of patients with long term conditions. We found the practice had ineffective systems in place to monitor patients with long term conditions, and that there was a lack of awareness and understanding of the need for monitoring. The practice did not utilise patient care plans to ensure all their care needs were met.

There were appropriate referral pathways to make sure that patients' needs were addressed. This included referrals to specialists, hospital teams and community services. However, the practice did not have any processes in place to review requested and completed referrals.

Patients were not always told when they needed to seek further help, or what to do if their condition deteriorated. We reviewed consultation records completed by different clinicians at the practice and saw these were completed to a variable standard. Consultations completed by GPs tended to be brief in nature and did not always contain all appropriate red flag exclusions or appropriate safety netting advice.

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 considered 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. This search identified 20 patients who were diabetic but did not have a diagnosis coded. We undertook a detailed review of five patients' care records and saw all patients were diabetic but did not have an appropriate diagnosis coded. This meant these patients were not receiving all required monitoring and were not always invited to recommended services, such as diabetic eye screening. Four patients had not been informed of their diagnosis. Two patients had been identified as having abnormal blood sugar readings on their last two blood tests, but no action had been taken by the practice.

- 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 863 patients who were diagnosed with asthma, of which 17 patients had been prescribed two or more courses of rescue steroids. We conducted a detailed review of five patients' care records and saw no patients had been reviewed within a week of their exacerbation. Three patients were evidenced to have been reviewed after a week, although two patients had not received any review following their exacerbation. This meant these patients may be at increased risk of further exacerbations and may not be receiving effective treatment for their condition.

- Another search reviewed the monitoring of patients with chronic kidney disease (CKD) at stages four and five. This search identified 13 patients who were indicated as not having received a relevant blood test within the last nine months. We undertook a detailed review of five patients' care records and saw all patients were being effectively managed through secondary care.

- Another search reviewed the monitoring of patients with hypothyroidism. This search identified 362 patients with hypothyroidism who were treated with thyroxine. Sixty-six patients were indicated as not having received a thyroid function test within the last 18 months, with 10 patients identified as having abnormal results at their last test. We undertook a detailed review of five patients' care records and saw all patients were overdue monitoring. There did not appear to be effective recognition of the need for monitoring for these patients or an adequate system in place. Three patients were identified as having very high readings at their last test but had not received any review or medication changes from the practice. Two patients had received adjustments to their medication dosages by the practice but did not receive any subsequent tests to check the effectiveness of the change. This meant patients were at a high risk of being over or under treated for their condition.

- Another search reviewed the care and treatment of patients diagnosed with diabetic retinopathy – a complication of diabetes. This search identified 427 patients with diabetes, of which nine patients had both a diagnosis of diabetic retinopathy and a high blood sugar reading recorded at their last test, which suggested poor control of their diabetes. We undertook a detailed review of five patients' care records and saw four patients were being appropriately managed, either by secondary care or by the practice. We identified one patient who was not receiving any monitoring by the practice since being discharged from secondary care in 2021.

Child Immunisation

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

Percentage of eligible patients vaccinated by GP as of 1 January 2022		
Vaccine:	Hailwood Medical Practice	Isle of Man Average:

5-in-1	92.73%	95.77%
Measles, Mumps and Rubella	83.64%	90.68%
Meningitis C	83.64%	90.28%
Pre-school Boosters	87.01%	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	
Hailwood Medical Practice	Isle of Man Average:
75.08%	76.84%

Percentage of persons eligible for bowel cancer screening who have been adequately screened between 1 October 2021 and 31 December 2021	
Hailwood Medical Practice	Isle of Man Average:
63.45%	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 undertook some clinical audits, and staff explained how clinicians held informal discussions on most days, but there was no formalised programme of clinical audit in place. The practice explained how they had undertaken recent searches to review the prescribing of benzodiazepines and pregabalin, but we were unable to evidence any review or actions taken following this. Other audits completed by the practice included an audit to review B12 prescribing, however the practice was unable to provide evidence of this during our assessment.

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

Effective staffing

The practice was not able to demonstrate that all staff had the skills, knowledge and experience to carry out their roles.

The practice could not demonstrate that all 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 that the majority of staff were overdue training. We saw three out of 15 members of staff were at 100% compliance, however 10 out of 15 members of staff were at less than 25% compliance.

Practice training records did not provide a comprehensive overview of completion for all staff groups, such as for GPs, as some staff had conducted training on alternative systems which had not been collated with practice training records.

The practice had a programme of learning and development. The practice had a catalogue of mandatory training courses, which staff were required to complete on a regular basis. This included training on basic life support, safeguarding, and equality and diversity.

Staff did not always have protected time for learning and development. The practice explained training had been a challenge recently due to reduced staffing levels and the COVID-19 pandemic and was focusing on improving this.

There was an induction programme for new staff, although new staff were only required to complete mandatory training after working at the practice for a period of six months. This meant staff may not have completed key mandatory training modules, such as safeguarding or basic life support.

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. At the time of our assessment, the practice reported all appraisals were up to date.

The practice could not demonstrate how they assured the competence of staff employed in advanced clinical practice, such as nurses and physician associates. Each staff member had nominated daily mentors, who oversaw all prescribing and referral requests where these could not be undertaken by the clinician. Outside of this, staff did not have any regular or formalised clinical supervision sessions, and there was no formal assessment of clinical competencies, including for new members of staff. We saw clinical supervision was largely reactive and was undertaken on instances whereby patients had subsequently seen a GP.

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.

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, although we found referrals were generally opportunistic rather than proactive.

Patients in the last 12 months of their lives were supported by the practice. For example, we saw the practice discussed all patients who were receiving palliative care each clinical meeting, and

where patients had not been contacted or seen since the last clinical meeting, clinicians were tasked to review the patient's record and confirm their care needs were being met.

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

Patients had access to appropriate health assessments and checks.

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

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

Consent to care and treatment

The practice was unable to demonstrate that it always obtained consent to care and treatment in line with legislation and guidance.

Clinicians understood the requirements of legislation and guidance when considering consent and decision making, although we found written consent forms were not used for minor surgery and saw consent was not recorded in patient care records for these procedures.

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 clinical 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.

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 408 responses. Of these, 375 respondents rated their overall experience as either 'good' or 'very good', 22 respondents rated their experience as 'poor' or 'very poor', and 11 respondents rated their experience as 'neither good nor poor'. Positive comments largely related to the quality of care received, with comments including how staff are 'always helpful and efficient', how they

feel ‘listened and supported’, and how they receive ‘excellent care’. Negative comments largely related to difficulties contacting the practice by telephone and booking appointments.

Involvement in decisions about care and treatment

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

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

Staff helped patients and their carers find further information and access community and advocacy services. We found the practice was proactive in identifying patients who were carers or had caring responsibilities and maintained a carers register. At the time of our assessment, the practice advised they had 74 patients recorded as carers from a patient list of approximately 7,900 (0.94%).

Interpretation services were available for patients who required them.

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

Information leaflets were available in other languages and formats.

Information about support groups was available on the practice website.

Privacy and dignity

The practice respected patients’ privacy and dignity.

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

Arrangements to ensure confidentiality at the reception desk were ineffective. As a result of COVID-19, a double-glazed window had been installed at the reception desk, which could be opened for the passing of documents and medicines. To allow patients and staff to hear one another, a microphone and speaker system had been installed. We found this loudly amplified the conversation and allowed other patients waiting in reception to hear the conversation and details of what had been discussed. The practice explained this had been installed by the building landlord as the previous shutter screen was not suitable during COVID-19. The practice explained they had raised the confidentiality issue with their landlord but were advised this was the only suitable solution.

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 generally understood the needs of its local population and had developed services in response to those needs. The practice offered patients standard services, which included asthma and diabetes clinics, immunisation appointments, minor surgery and health checks.

The importance of flexibility, informed choice and continuity of care was reflected in the services provided. For example, the practice continued to offer home visits to patients who were unable to attend the practice.

The facilities and premises were not always appropriate for the services being delivered. We found aspects of the building to be in a poor state of repair, which posed potential infection control risks. There was limited disabled access inside the practice, although disabled toilets were available and adequate car parking was immediately available outside the practice building.

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

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

The practice provided information in accessible formats.

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

- Patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice held certain registers of patients living in vulnerable circumstances, including those with a learning disability. Although, registers were not in place for all potentially vulnerable patients.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode, such as homeless people, refugees and Travellers.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability, such as the offering of longer appointments.

Access to the service

People were able to access care and treatment in a timely way. However, telephone access required further improvement.

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 book appointments, order repeat prescriptions and view their medical record.

Patients were generally able to make appointments in a way which met their needs, although patient feedback on the ease of accessing services was mixed. During our assessment, we spoke with three patients who all had experienced difficulties and delays in contacting the practice by telephone and in booking appointments.

Between April 2021 and March 2022, the practice received 408 responses to their friends and family survey. Of these responses, several patients had submitted comments relating to difficulties accessing or booking appointments. One patient explained how they found it ‘very difficult to get through on the phone’, with another patient describing how they ‘struggle to get through on the phone’ with their last call taking ‘17 attempts’, and a third patient reporting of ‘constant issues with the phones’ which causes a ‘direct barrier to receiving basic medical care’. We found other patients reported a positive experience, with one patient explaining how they had their ‘appointment arranged quickly’, with another patient reporting there was ‘not a long wait for

appointments'. This feedback was similar to additional feedback submitted to other online services and social media pages.

The practice explained the biggest challenge around telephone appointments was due to the limited number of incoming telephone lines into the practice. As the practice only had two inbound lines, this meant staff could only answer a maximum of two calls at once. The practice explained how they had tried to mitigate this, such as through ensuring there were always two members of staff taking incoming phone lines. Staff explained how they had opened appointment diaries approximately six months in advance to allow patients to book follow-up appointments whilst in the practice, minimising future telephone contacts.

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.

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

Patients with urgent needs had their care prioritised. Patients could book appointments up to around six months in advance, as well as same day appointments for urgent conditions. Where receptionists had concerns regarding a patient's condition, or if all urgent appointments had been booked, receptionists could escalate any concerns to GPs for urgent review.

The practice had systems to ensure patients were directed to the most appropriate person to respond to their immediate needs. Although the practice did not employ care navigators, staff were proactive in ensuring patients were receiving care from the most appropriate provider or organisation.

Listening and learning from concerns and complaints

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

Information about how to complain was available. Patients could access a copy of the practice's complaints policy and procedure in reception or by speaking with a member of staff. Although some information was available on the practice's website, information on how to raise a complaint was limited, with patients being requested to speak with the practice manager or place their concerns in writing. The practice had a complaints policy in place, although this did not appear to be regularly reviewed as at the time of our assessment, the policy referred to previous GP partners.

There was evidence that complaints were used to drive continuous improvement. In the past year, the practice had received 22 complaints, which primarily related to the practice's telephone system or staffing. We reviewed two completed complaint investigations and saw the practice had acknowledged, investigated and responded to each complaint, with any concerns discussed during clinical meetings.

Is the service well-led?

We found this practice was not always well led in accordance with CQC's assessment framework

Leadership capacity and capability

There was compassionate and inclusive leadership at all levels, however leadership of the practice was not always effective.

Leaders did not always demonstrate they understood the challenges to quality and sustainability. Challenges reported by the practice included the practice premises, lack of confidentiality at reception, and clinical staffing.

Not all actions had been identified to address these challenges. For example, regarding the practice premises and reception arrangements, it was unclear what actions had been taken to address this. Although, we did note the practice had identified a lack of acute appointments and had addressed this by employing a physician associate and nurse prescriber.

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 not a leadership development programme, or a succession plan. For example, one of the GP partners was planning to retire within the next two years, but it was unclear if any planning or actions had been undertaken to prepare for this.

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.

Culture

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

There were arrangements to deal with any inconsistent or poor behaviour. 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 reported managers were ‘good and supportive’ and felt there was an ‘open door policy’ if they needed to raise any questions or concerns.

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

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

The practice encouraged candour, openness and honesty.

The practice had systems in place to allow staff to speak up. Although staff reported they were comfortable to raise concerns to managers or senior clinicians, in the event staff did not feel comfortable raising concerns internally, the practice had an external point of contact within their primary care network.

Not all staff had undertaken equality and diversity training.

Governance arrangements

The overall governance arrangements were ineffective.

The practice had some governance structures and systems in place. All three GP partners had overall responsibility and clinical oversight, with nurses and the practice manager answerable to all partners. Except for safeguarding, none of the GP partners had individual lead roles or areas of responsibility, and it was unclear how each partner was held to account.

Staff were not always clear about their roles and responsibilities.

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

Managing risks, issues and performance

The practice did not have clear and effective processes for managing risks, issues and performance.

There were some assurance systems in place. The partners generally held six-weekly meetings to discuss the operation of the practice, which were mainly attended by the GP partners although nursing and other practice staff occasionally were invited. These meetings followed an agenda with minutes shared with staff who could not attend, although we found meeting minutes were brief, did not contain an overview of all agreed actions, and were not shared in a timely manner following the meeting. For example, during our assessment in August, we found the most recent minutes available were from May's meeting. We noted there was no regular practice meeting in place for other staff roles, such as administration and reception staff. There did not appear to be a regular programme of meetings for other key topics, such as safeguarding.

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 effective, as during our assessment, we identified several significant areas of concern that had not been identified or addressed by the practice. This included concerns relating to safeguarding, recruitment, health and safety, infection prevention and control, staff training, medicines management and the management of patients with long term conditions. Some staff reported that concerns and risks were not always acted upon proactively, with actions instead taken reactively.

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 not always a demonstrated commitment to using data and information proactively to drive and support decision making.

Staff did not always use data to monitor and improve performance. Although the practice monitored the quality of care and treatment through a combination of patient satisfaction survey results, practice meetings and staff appraisals, data was not always used to improve services. For example, the practice did not have a system in place to regularly review data on completed referrals or admission data. The practice did not have access to prescribing data in order to compare its prescribing performance 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

There was limited evidence the practice had involved the public, staff and external partners to sustain high quality and sustainable care.

Patient views were not always acted on to improve services and culture. The practice mainly collected patient feedback through their friends and family test or through feedback shared with staff during consultations.

The practice did not have an active Patient Participation Group (PPG). The practice reported they previously operated a PPG, however found this did not work very well and terminated it and did not have any plans to re-establish the group.

Whilst some changes had been made as a result of patient feedback, such as increasing the number of health promotion displays in waiting areas, there did not appear to be an established process to review and act on feedback provided by patients.

Staff views were reflected in the planning and delivery of services. Staff reported their feedback and concerns were taken seriously, with changes made as a result.

The practice did not always work with stakeholders to build a shared view of challenge and of the needs of the population. For example, we saw the practice had reported several incidents regarding their community pharmacies but did not see any evidence this had been raised or escalated to improve patient care. The practice did not hold routine meetings with other healthcare professionals, such as health visitors, and there was limited-to-no sharing of information with other services, such as social services or ambulance services.

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. The practice reported one of its recent initiatives had been with the recruitment of a physician associate, making them the first practice on the island to recruit such a role. We found the practice did not have a formalised programme of quality improvement, clinical audit or innovation in place.

Learning was not always shared effectively or used to make improvements. For example, although incidents were generally discussed in practice meetings, there were limited processes in place for the sharing of learnings, both internally and externally.