**DHSC – CQC external quality regulation programme**

# Laxey Health Centre

## Assessment report

Laxey Health Centre

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Laxey

Isle of Man

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Date of assessment: 20-21 September 2022

Date of publication: 21 November 2022

# Our findings

## Overall summary

We carried out this announced assessment between 20 and 21 September 2022. The assessment was led by a Care Quality Commission (CQC) inspector who was supported by a GP adviser.

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

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

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

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

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

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

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

## Our key findings were

- The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse. Staff were trained to appropriate levels for their roles, and systems to identify vulnerable patients were consistent.
- Recruitment checks were carried out in accordance with policy, and Disclosure and Barring Service (DBS) checks were undertaken regularly for all staff.
- Appropriate standards of cleanliness and hygiene were met.
- 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 received all required monitoring and medication reviews were completed when required. Staff had access to some emergency equipment and medicines, but the checking and storage of emergency medicines was not always in line with guidance. Vaccines were not always monitored appropriately to ensure they remained safe and effective.
- The practice had effective systems in place to learn and make improvements when things went wrong, but the system for recording and acting on 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.
- The practice had a programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.
- The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles.
- Staff worked together to deliver effective care and treatment. We found a lack of data sharing arrangements did not always allow staff to work effectively with other organisations.
- The practice always obtained consent to care and treatment in line with legislation and guidance.
- Staff treated patients with kindness, respect and compassion. Feedback from patients was positive about the way staff treated people. Staff helped patients to be involved in decisions about care and treatment, and respected patients' privacy and dignity.
- The practice organised and delivered services to meet patients' needs. People were able to access care and treatment in a timely way. Patient complaints were listened and responded to and used to improve the quality of care.

- There was compassionate, inclusive and effective leadership at all levels.
- The practice had a culture which drove high quality sustainable care.
- There were clear responsibilities, roles and systems of accountability to support good governance and management.
- Processes for managing risks, issues and performance were generally effective.

**We found the following areas of notable practice:**

- The practice had developed their own clinical pathways and protocols, which included antibiotic protocols, and used these to improve the quality of care and treatment. Staff utilised care plans to ensure the individual needs of patients with certain conditions or needs, such as patients with poor mental health or who were living with dementia, were met.
- To ensure patients were booked in with the most appropriate clinician, in a timeframe that was appropriate for their condition, the practice had implemented a flowchart that receptionists followed to help determine the severity of the patient's condition. If a patient believed their condition was urgent, the flowchart supported receptionists to categorise it into one of four categories. Depending on the response, receptionists advised patients to call for an emergency ambulance or attend hospital, would book them a same day appointment, or would discuss the patient's condition with a GP for the most appropriate response.

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

- Continue to develop data sharing arrangements with other healthcare providers to ensure safeguarding concerns, information relating to care and treatment delivered by other services, or changes made to patient medications are effectively shared and actioned.
- Improve the quality of patient care records to ensure consultation notes are detailed, contain all red flag exclusions and safety netting advice, and records of any examinations undertaken, and medication reviews contain information on the medications reviewed.
- Improve the oversight and management of patients prescribed controlled drugs to ensure there are evidenced attempts at reducing patients' dependencies where appropriate.
- Improve the storage of emergency medicines and equipment to ensure they are appropriately signed and stored in line with guidance.
- Improve the oversight and checking arrangements of emergency equipment to ensure all recommended emergency equipment is available, and any expired equipment is removed.
- Improve the oversight and management of vaccines to ensure any expired vaccines are removed promptly and appropriately disposed of.
- Improve the oversight and management of medicine fridges to ensure only authorised staff have access to fridge contents and fridge temperatures are checked using a secondary independent thermometer.
- Improve processes for the management and recording of historic safety and medication alerts.

- Improve the management of patients who have had an exacerbation of asthma to ensure they are followed up promptly after their exacerbation.
- Implement a formalised programme of regular and repeat clinical audit.
- Improve systems for the identification of patients who are carers or have caring responsibilities.
- Improve the quality of meeting minutes to ensure they provide a clear and effective oversight of all items discussed.

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

- The practice did not have effective systems in place for the oversight and management of emergency equipment and vaccines.
- The practice did not have effective processes for the management of historic safety and medication alerts.

## Background to assessment

The practice is located at:

- Laxey Health Centre, New Road, Laxey, Isle of Man, IM4 7BF

The practice is a branch site of:

- Village Walk Health Centre, 1 The Village Walk, Onchan, Isle of Man, IM3 4EA.

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

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

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

During our assessment process, we spoke with four patients and six members of staff from across both practices, 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 had clear systems, practices and processes to keep people safe and safeguarded from abuse.**

**Safeguarding**

Safeguarding systems, processes and practices were developed, implemented and communicated to staff. The practice had dedicated policies for safeguarding that outlined key staff responsibilities, the different types of abuse staff should be alert to, and details of the practice's safeguarding lead. In the event staff had a safeguarding query or concern, staff raised this to senior clinicians or to the practice's safeguarding lead, who advised or escalated their concerns accordingly.

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 individual safeguarding cases during practice clinical meetings. The practice hosted quarterly multidisciplinary team safeguarding meetings, which were attended by the practice clinical and management teams, as well as district nurses, long term conditions nurses, and community palliative care teams. The practice did not have any formalised or regular safeguarding meetings with other agencies. There were no transitional safeguarding arrangements in place at an island-level. To mitigate this, the practice had developed their own transitional arrangements, whereby any children on the practice safeguarding register were reviewed and transferred to their vulnerable adults register on transition.

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

The practice explained a lack of island-wide data sharing agreements limited and impacted their ability to effectively safeguard patients. Staff explained how island adult safeguarding teams could not always discuss safeguarding concerns and cases with the practice about one of their patients, with staff needing to raise a safeguarding referral if they had information of concern. Staff explained how they maintained their own safeguarding registers and shared this with local health visiting teams to ensure they were aware of all patients who were vulnerable or at risk, but this was not always shared back with the practice. This meant there was a risk that patients who were vulnerable or at risk were not always effectively shared with the practice.

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

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

Discussions were held between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.

**Recruitment systems**

Recruitment checks were carried out in accordance to policy. The practice obtained references, reviewed the applicant's ID and retained their application documentation. Staff completed an induction programme and checklist. Staff professional registrations were checked on recruitment, but there was not a process for this to be checked on an ongoing basis.

**Safety systems and records**

Health and safety risk assessments were carried out. The practice explained their building landlord was responsible for most health and safety assessments, but they had recently identified some concerns regarding these assessments. The practice explained their landlord undertook regular hot and cold water quality checks to assess for risks such as legionella. However, when the practice requested the test report, they identified that legionella had not been tested for. Managers explained how they had raised this as a significant event, which was under investigation as an island-wide concern at the time of our assessment.

The practice undertook fire-related checks, such as regular fire alarm and emergency lighting checks, and fire evacuation drills. Although the practice had not received an external fire risk assessment, we saw practice staff completed internal fire risk assessments regularly and reviewed these every six months.

**Infection prevention and control**

**Appropriate standards of cleanliness and hygiene were met.**

Staff received effective training on infection prevention and control.

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

Date of last audit: September 2022.

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

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

**Risks to patients**

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

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

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

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

Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients. Where receptionists had concerns over a patient's condition, they could escalate patients to the GP team for review.

**Information to deliver safe care and treatment**

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

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

Patient care records and consultation notes were generally satisfactory and showed appropriate management and prescribing, but the quality of completed consultation reviews was variable. As part of our assessment, we reviewed five completed consultation records. We saw two records did not contain any information of any examinations undertaken, and saw one record did not contain any information regarding the offering of a chaperone for an intimate examination. Follow up information and safety netting information were not always appropriately recorded.

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. Referrals were completed by clinicians directly, and were seen to be appropriate and timely. Patients were given instructions, which were supported by a text message and/or written information, on when to contact the practice if they had not received an appointment.

The practice reported the delays in patients being seen for non-urgent referrals made it difficult to manage and oversee this. Staff explained how some patients were not seen for several months, in some cases years, after the referral was requested which made it difficult to check that patients had attended all requested appointments. The practice explained they previously received an overview of the current delays reported by each speciality, which helped them manage patients' expectations, but had not received this recently.

There was a documented approach to the management of test results and correspondence. The practice had implemented a protocol for the management of test results, and operated a buddy system to ensure any results received when the requesting clinician was absent were 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 generally stored safely and securely with access restricted to authorised staff. Most medicines were stored within locked cupboards or within locked storerooms and treatment rooms. We saw the majority of medicine fridges were kept unlocked, which meant some medicines and vaccines were not always stored securely.

Blank prescriptions were kept securely. The practice maintained electronic logs of the serial numbers of all blank prescriptions, which allowed for the effective reconciliation of all blank stock.

All blank prescriptions were stored securely, with prescriptions removed from printers overnight and when rooms were not in use.

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

The practice could demonstrate the prescribing competence of non-medical prescribers, such as nurse prescribers, and there was regular review of their prescribing. GPs reviewed 10 prescriptions issued by each of the practice's non-medical prescribers on a monthly basis, and discussed their overall prescribing performance during annual appraisals and performance reviews.

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

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

The 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 generally effective.

As part of our assessment, we conducted a series of clinical searches and random sample of associated patient clinical record reviews to assess the practice's procedures on medicines management and prescribing. One search reviewed the prescribing of a high risk medicine used to treat high blood pressure. Our search identified 1,215 patients prescribed this medicine, with five patients identified as not having received all recommended monitoring. We undertook a detailed review of all five patients' care records and saw the practice were aware of all patients and had made evidenced attempts to invite patients in for monitoring appointments.

Another search reviewed the prescribing of a high risk medicine primarily used as a blood thinner. Our search identified 243 patients prescribed this medicine, of which 41 patients were identified as not having received all recommended monitoring. We undertook a detailed review of five patients' care records and saw most patients were being monitored effectively by the hospital anticoagulation clinic. As the hospital did not undertake all recommended monitoring tests, such as regular liver function tests (LFTs) and full blood count tests (FBCs), we saw the practice took on this responsibility and requested all remaining tests to ensure all patients were appropriately monitored.

The practice's systems for the monitoring of prescribing of controlled drugs was not always effective. We conducted a search to review the prescribing of a controlled drug primarily used as a sedative. Our search identified 91 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 saw medication reviews were completed but there were no documented attempts to reduce usage. Only one of the five patient care records reviewed contained information regarding the

risk of addiction. The practice explained the majority of the prescribing of these types of controlled drugs were initiated within secondary care, but there was limited follow-up and support available to support the practice to reduce patients' dependency. Following our assessment, the practice undertook a review of all patients prescribed more than 10 prescription issues within the last 12 months. The practice confirmed 34 of these patients had the medication initiated and were monitored by secondary care. Of the 57 patients that had the medication initiated by the practice, 32 of these prescriptions had been reviewed by the practice within the last 12 months.

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

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

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

The practice held appropriate emergency medicines, which were checked regularly. The practice utilised a checklist to confirm the presence of all required medicines and to ensure all items were in date.

There was medical oxygen and a defibrillator on site, but systems to check these regularly were not always effective. During our assessment, we reviewed the condition of emergency equipment. We saw the practice's primary set of defibrillator pads had passed their expiry dates and saw this had not been identified during the practice's last monthly check. We did note the practice had a spare set of pads that were in date, and saw action was taken during our assessment to rectify this.

The practice had emergency medicines and equipment available, but did not store these in line with guidance. For example, emergency medicines were generally stored in open boxes on a resuscitation trolley. This was not in line with guidance from the Resuscitation Council, which recommends for emergency medicines to be stored in tamperproof containers. The practice stored emergency equipment and medicines within a treatment room, which was kept unlocked at all times. We saw this room was not signed to indicate to staff the presence of the emergency equipment. Some recommended emergency equipment was not available, such as a razor, absorbent towelling, personal protective equipment (PPE) and sharps boxes. All emergency medicines stored in resuscitation trolleys and doctors' bags were stored on an electronic system, which alerted the practice pharmacist when any medicines were approaching their expiry date and required changing.

Vaccines were not always stored appropriately, monitored and/or transported in line with appropriate guidance to ensure they remained safe and effective. During our assessment, we identified several vaccines that had exceeded their expiry dates but had not been removed from the fridges. This included one hepatitis A vaccine that had expired in January 2022 and ten combined diphtheria and tetanus vaccines that had expired in August 2022. Staff undertook daily temperature checks of all medicine fridges and escalated any anomalous temperatures as appropriate. A second thermometer was not in place to allow temperature recordings to continue in the event of a fridge or power failure.

**Track record on safety and lessons learned and improvements made**

**The practice learned and made improvements when things went wrong. However, the oversight and management of 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 by speaking with 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 monthly practice and clinical meetings. For example, we reviewed one incident regarding an error with repeat dispensing and saw the practice had reported this as an incident, had identified several learning and action points, and had implemented these.

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

**Safety alerts**

Staff understood how to deal with safety alerts, but 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 a medicine which may increase a patient's risk of skin cancer. Our search identified 12 patients who were prescribed this medicine, from which we undertook a detailed review of five patients' care records. We saw none of the five patients had been informed of the increased risk, until the week before our assessment whereby the practice had updated all five patients. Prior to this, we saw one patient had been prescribed this medicine for up to eight years with no awareness of the increased risk.

Another search reviewed a safety alert from 2014 regarding a new maximum daily dose for patients aged over 65. Our search identified six patients who were potentially prescribed daily dosages in excess of the recommended limit, from which we undertook a detailed review of five patients' care records. We saw limited awareness of the risk, with documented explanation of the risk present in only two of the five patient care records reviewed. Following our assessment, the practice provided additional information regarding potentially affected patients. The practice confirmed two patients were prescribed dosages less than the maximum daily dose when medication concentrations were taken into account. Of the four patients prescribed dosages in excess of the maximum, two patients had been reviewed by the practice earlier in the year but had declined to reduce their dose, and two patients had not responded to the practice's request to attend a medication review.

The practice explained they were in the process of implementing a new system to manage drug safety alerts, which was overseen by the practice pharmacist. Managers explained how all safety alerts were now recorded onto an electronic register, which relevant staff groups were required to acknowledge receipt of. Additional work was undertaken to review any patients affected by historical safety alerts, with contact made to any affected patients between May and September 2022.

## Is the service effective?

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

**Effective needs assessment, care and treatment**

**Patients' needs were assessed, and care and treatment were generally 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 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 were receiving recommended monitoring, follow-ups and medication reviews, or appropriate diagnoses for their conditions.

There were appropriate referral pathways to make sure that patients' needs were addressed. This included referrals to specialists, hospital teams and community services. The practice had developed their own practice clinical pathways and protocols, which included antibiotic protocols, and used these to improve the quality of care and treatment for patients. We saw evidence the practice utilised care plans to support patients with certain conditions or needs, such as using care plans to effectively meet the needs of patients with poor mental health or who were living with dementia.

Patients were told when they needed to seek further help and what to do if their condition deteriorated, but we saw this was not always effectively recorded within patient clinical records.

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

**Effective care for the practice population**

- Flu, shingles and pneumonia vaccinations were offered to patients, where relevant.
- Patients generally had access to appropriate health assessments and checks, when recommended.
- 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.
- Admiral nurses were available for patients who were living with dementia.
- The practice ran a diabetic clinic, which was staffed by practice nurses and a GP with a special interest in diabetes. The clinic had close links with the consultant endocrinologist to limit the number of referrals required to secondary care.

**Management of people with long term conditions**

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

- Our first search reviewed patients with a potential missed diagnosis of diabetes. This search identified 28 potential patients, from which we undertook a detailed review of five patients' care records. We identified three patients who were diabetic but had not received a diagnosis. We saw the other two patients were appropriately coded and were regularly monitored. The practice explained they had identified a number of patients with a historic missed diagnosis of diabetes and to ensure all patients received all recommended monitoring and reviews, the practice had coded all affected patients as 'prediabetes'. Following our assessment, the practice undertook a detailed review of all patients identified by our search. The practice confirmed four out of the 28 patients reviewed should have had a diagnosis recorded. Of the remaining patients, the practice advised all patients were receiving annual monitoring and were either coded as being 'prediabetic' or had historic raised levels and were coded as 'diabetes in remission'.
- 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 1,017 patients diagnosed with asthma, with 11 patients identified who were prescribed two or more courses of rescue steroids. We conducted a detailed review of five patients' care records and saw most patients were receiving appropriate care, although not all patients were followed up within a week of their exacerbation. We did identify one patient who did not appear to have had an asthma review within the last two years.

- Another search reviewed the monitoring of patients with chronic kidney disease (CKD) at stages four and five. This search identified 17 patients with CKD at stages four and five, with seven patients indicated as not having received a relevant blood test within the last nine months. We saw the majority of patients were being managed effectively through secondary care.
- Another search reviewed the monitoring of patients with hypothyroidism. This search identified 347 patients with hypothyroidism who were treated with thyroxine, of which five patients were indicated as not having received a thyroid function test within the last 18 months. We undertook a detailed review of five patients' care records and saw there was an appropriate system in place for monitoring, with all patients receiving regular blood tests and medication reviews.
- Another search reviewed the care and treatment of patients diagnosed with diabetic retinopathy – a complication of diabetes. Our search identified 470 patients with diabetes, with five patients identified as having 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 all five patients' care records and saw all patients were receiving appropriate management and monitoring.

**Child Immunisation**

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

| Percentage of eligible patients vaccinated by GP as of 1 January 2022 | | |
|---|---|---|
| Vaccine: | Village Walk & Laxey Health Centres | Isle of Man Average: |
| 5-in-1 | 98.85% | 95.77% |
| Measles, Mumps and Rubella | 97.70% | 90.68% |
| Meningitis C | 94.25% | 90.28% |
| Pre-school Boosters | 91.76% | 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 | |
|---|---|
| Village Walk & Laxey Health Centres | Isle of Man Average: |
| 80.27% | 76.84% |

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

| Village Walk & Laxey Health Centres | Isle of Man Average: |
|---|---|
| 64.81% | 60.74% |

**Monitoring care and treatment**

**The practice had a programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.**

Clinicians took part in national and local quality improvement initiatives.

Information about care and treatment was used to make improvements. The practice undertook several clinical audits and used the findings to improve the quality of care and treatment. Recent audits completed by the practice included audits to review pre-diabetes care and diabetic foot screening.

As part of our assessment, we reviewed completed clinical audits and found they were completed to a good standard, identified points of action to improve care and treatment, and included repeat cycles to check for any improvement.

Although the practice completed clinical audits, there did not appear to be a formalised programme of regular clinical audit in place.

The practice did not routinely review referrals, but had recently started reviewing unplanned admissions and readmissions during clinical meetings.

**Effective staffing**

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

The practice could demonstrate 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 reviewed during our assessment showed most staff had achieved 100% compliance.

The practice had a programme of learning and development. Staff had allocated time to complete all required training, and were supported to undertake additional training courses, such as vaccinations and immunisations. Managers explained the practice was a training practice and was passionate about supporting the development of their staff.

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

All staff had access to regular appraisals, one to ones, coaching and mentoring. New staff were supported at three and six monthly performance reviews, with all staff receiving at least annual appraisals. At the time of our assessment, we saw all but one member of staff had received an appraisal within the last 12 months.

The practice generally could demonstrate how they assured the competence of staff employed in advanced clinical practice, such as nurse prescribers. Trainee and newly recruited staff received regular formal supervision, which included a review of their competence. Other clinical staff, such as pharmacists and nurse prescribers, received regular GP supervision and/or six monthly appraisals to assess, discuss and review their work performance.

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. The practice explained how they shared some information with other healthcare services, such as sharing Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions with the ambulance service. 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. The practice worked to deliver care jointly with other local services, such as working with palliative care teams to support patients receiving end of life care. Other healthcare professionals, such as long term conditions nurses, were invited to practice multidisciplinary team meetings.

**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.

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

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

Patients had access to appropriate health assessments and checks.

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

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

**Consent to care and treatment**

**The practice always obtained consent to care and treatment in line with legislation and guidance.**

Clinicians understood the requirements of legislation and guidance when considering consent and decision making. The practice used written consent forms when undertaking minor surgical procedures and contraceptive implants.

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. We

saw clinicians regularly reviewed DNACPR decisions to ensure they were appropriate and reflected the patient's wishes. For example, we saw two instances whereby completed decisions had been reviewed as part of the practice's regular ward rounds at a local nursing home.

## 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 520 responses. Of these, 465 respondents rated their overall experience as either 'good' or 'very good', seven rated their experience as 'poor' or 'very poor', and 48 respondents rated their experience as 'neither good nor poor'. Positive comments largely related the quality of care and treatment and the service received from staff. One respondent commented on how the practice was 'very professional', with another describing the service as 'wonderful'. Other respondents described how they received 'personal treatment from nurses' and how their GP was 'thorough'. Negative comments largely related to long wait times for appointments and difficulties booking a face-to-face GP appointment.

During our assessment, we spoke with four patients and people who use the service. Feedback from all patients was positive, with one patient reporting how they received 'fantastic care', with another describing the doctors and nurses as 'very good'.

**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 not always proactive in identifying patients who were carers or had caring responsibilities. At the time of our assessment, the practice advised they had 47 patients recorded as carers from a patient list of approximately 8,600 (0.55%). The practice was working to improve its systems for the identification of carers and were implementing several improvements, such included the addition of a carers section on chronic disease care plans, the creation of a carers support pack, and the planned sending of text messages to patients to allow patients to easily inform the practice if they were a carer or had caring responsibilities.

Interpretation services were available for patients who required them.

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

Information leaflets were available in other languages and formats.

Information about support groups was available on the practice website.

**Privacy and dignity**

**The practice respected patients' privacy and dignity.**

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

There were arrangements to ensure confidentiality at the reception desk. The practice had installed a plastic screen during the COVID-19 pandemic, which acted as an additional privacy screen that minimised the risk of confidential information being overheard in the waiting area. Receptionists answered telephone calls away from the main reception desk where possible.

## 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. For example, the practice employed different clinical roles, with different skill sets, competencies and training to ensure patients could be seen by the most appropriate clinician. Services provided by the practice included minor surgery, steroid injections, women's health and family planning. Recent service improvements made by the practice to meet the needs of their local community included the running of a diabetes clinic and nursing home ward rounds.

The importance of flexibility, informed choice and continuity of care was reflected in the services provided. Patients were given the choice to choose which clinician they saw, and the practice aimed for patients receiving regular care and treatment for an illness or condition to be seen by the same clinician.

The facilities and premises were appropriate for the services being delivered. The practice was located within a recently converted practice building, which had disabled access throughout. Adequate 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 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**

- 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 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, book appointments and view their medical record.

Patients were able to make appointments in a way which met their needs. Patients could book appointments in advance or on the day.

Between April 2021 and March 2022, the practice received 520 responses to their friends and family test survey. Feedback relating to appointment booking systems was generally positive. Most patients did not report any significant problems with the appointment booking system, with some patients leaving comments about they ‘always get seen quickly’, received their appointment the ‘same day’, and were able to ‘see a doctor quickly’. We did see some feedback was mixed, with some patients reporting it ‘can be difficult to get appointments’, with one patient waiting ‘over two weeks’. This feedback was similar to additional feedback submitted to other online services and social media pages.

During our assessment, we spoke with four patients and people who used both the Laxey and Village Walk health centres. All patients were satisfied with the appointment booking process and did not report any significant delays or challenges in booking their appointment.

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

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

Patients with urgent needs had their care prioritised. To ensure patients were booked in with the most appropriate clinician, in a timeframe that was appropriate for their condition, receptionists followed a triage flowchart that helped determine the severity of the patient’s condition. If a patient believed their condition was urgent, the flowchart supported receptionists to categorise it into one of four categories. Depending on the response, receptionists advised patients to call for an emergency ambulance or attend hospital, would book them a same day appointment, or would discuss the patient’s condition with a GP for the most appropriate response.

The practice had systems to ensure patients were directed to the most appropriate person to respond to their immediate needs.

**Listening and learning from concerns and complaints**

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

Information about how to complain was available. Patients could access a copy of the practice's complaints policy and procedure in reception or by speaking with a member of staff. Patients could raise a complaint using an online form on the practice's website, in writing, by email, by telephone or by speaking with a member of staff.

There was evidence that complaints were used to drive continuous improvement. We reviewed completed complaint investigations and saw the practice acknowledged complaints promptly, provided patients with an apology, and gave them details of organisations they could take their complaint to if they were unhappy with the resolution. Learning from complaints were outlined and recorded, with all complaints discussed during regular practice and clinical meetings, as appropriate.

## 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 the premises at the Village Walk Health Centre, the working relationships between primary and secondary care, and increases in prescribing workloads.

Managers explained how they were working to address these challenges, such as by discussing premises upgrades during regular contract meetings with commissioners, and developing effective working relationships with consultants within secondary care services. To manage increases to prescribing workloads and to ensure the practice's prescribing remained at the required quality, managers explained how they had recruited a practice pharmacist in January 2022 and additional non-medical prescribers to support medicines management and prescribing.

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. Managers explained the practice was a training practice and were passionate about developing their own staff to take on more senior management and clinical roles. Managers explained how they were proactively planning for the upcoming departure of one of their existing GP partners.

**Vision and strategy**

**The practice had an established vision and values, which were supported by a credible strategy.**

The practice had an established vision that was focused around 'providing the best possible and safest care for all our patients'.

Staff knew and understood the vision, values and strategy and their role in achieving them.

Progress against delivery of the strategy was monitored. The practice had outlined clear goals for what they wanted to achieve and outlined some of their recent improvements, such as developing the practice pharmacist role, introducing a patient participation group, and becoming a training practice.

### Culture

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

There were arrangements to deal with any inconsistent or poor behaviour. During staff appraisals, managers discussed each staff member's work performance and behaviours. Where poor behaviours were identified, managers took action to improve this, but we found that not all staff were offered regular annual appraisals.

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 described how they felt 'everyone was approachable at all levels' and described the culture as 'great'.

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

**There were clear responsibilities, roles and systems of accountability to support good governance and management.**

The practice had effective governance structures and systems in place. Each GP partner had different clinical lead roles, such as resuscitation, clinical governance, safeguarding, training and staff liaison. All partners and the practice manager attended quarterly partner meetings, whereby each attendee was held to account.

Staff were clear about their roles and responsibilities. The practice maintained a comprehensive set of policies and procedures that outlined each staff member's duties, including who to contact in the event of any concerns being identified. All staff were informed when policies were updated or changed, enabling staff to keep up to date.

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

### Managing risks, issues and performance

**Processes for managing risks, issues and performance were effective.**

There were assurance systems in place, which were regularly reviewed and improved. Managers held regular practice and clinical meetings to discuss the day-to-day operation of the practice. Topics of these meetings included the outcomes of clinical audits, significant events, complaints, safeguarding cases, unexpected deaths, pharmacy updates and unplanned admissions. We saw

reception and administration staff were not always invited to practice meetings, and separate meetings for reception and administration staff were not held.

Meeting minutes were created following each meeting and shared with all staff who could not attend. We reviewed completed meeting minutes and saw these were brief and did not always contain information of any patients, complaints or incidents discussed.

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

There was a quality improvement programme in place.

Arrangements for identifying, managing and mitigating risks were generally effective. During our assessment, the practice demonstrated how they had identified and managed potential risks that could affect the practice. Examples given by the practice included actions taken following infection prevention and control audits, implementation of a new process to review and act on drug safety alerts including historical alerts, and identification of a concern relating to a lack of legionella water testing by the practice building landlord.

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, patient participation group feedback, practice meetings, staff appraisals and clinical audit.

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

**Governance and oversight of remote services**

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

Electronic 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 care 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.**

Systems to collect feedback from patients and people who use the service was effective and comprehensive. The practice collected and collated patient feedback from several sources, which included their friends and family test survey, their patient participation group, suggestions boxes, and comments from patients and staff. Improvements made as a result of patient feedback included the installation of a new telephone system.

The practice had recently introduced a Patient Participation Group (PPG) and described how they planned to work with their PPG to improve services for patients. For example, staff explained how the practice and their PPG were hoping to launch a carers' coffee morning to improve the support for patients who were carers or had caring responsibilities.

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

The practice worked with stakeholders to build a shared view of challenges and of the needs of the population. For example, the practice gave examples of how they worked with local commissioners to jointly develop their practice transformation plans.

**Continuous improvement and innovation**

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

There was a strong focus on continuous learning and improvement. The practice was a training practice and supported staff to undertake improvement activities, such as clinical audits.

Learnings were shared effectively and used to make improvements. All audits were discussed and reflected upon during practice clinical meetings, with any changes implemented as necessary. The

practice had developed their own set of practice protocols to improve care and treatment, and explained how they were working to develop improvement activity at a network level.