DHSC – CQC external quality regulation programme

Southern Group Practice

Assessment report

Castletown Road

Port Erin

Isle of Man

IM9 6BD

01624 686979

www.southerngp.co.uk

Date of assessment: 16 August 2022

Date of publication: 27 October 2022

Our findings

Overall summary

We carried out this announced assessment on 16 August 2022. The assessment was led by a Care Quality Commission (CQC) inspector who was supported by a CQC national professional adviser.

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

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

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

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

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

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

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

Our key findings were

- Safeguarding processes were not always effective, as not all staff were trained to appropriate levels for their roles, systems to identify vulnerable patients on record were not consistent, and data sharing arrangements did not always allow for the effective sharing of safeguarding information.
- Recruitment checks were carried out in accordance with policy, with Disclosure and Barring Service (DBS) checks undertaken for all staff.
- Health and safety risk assessments carried out did not always include all recommended areas.
- Appropriate standards of cleanliness and hygiene were not met.
- Patient clinical information was stored appropriately and securely.
- The practice's system for the appropriate and safe use of medicines, including medicines optimisation, was not effective as patients prescribed high-risk medicines did not always receive all required monitoring. Medication reviews were not always completed when required and documentation regarding completed reviews was limited. Blank prescriptions were not always kept securely. The practice could not demonstrate the prescribing competence of all staff, and there was no direct supervision of all prescribers.
- Staff had access to emergency equipment and medicines, although the storage of all equipment and medicines was not in line with recommendations.
- The practice had effective systems in place to learn and make improvements when things went wrong.
- Patients' needs were assessed, and care and treatment were delivered in line with current legislation and standards. However, the oversight and management of patients with long term conditions was not always effective.
- The practice had a comprehensive programme of quality improvement activity, which was supported by an established clinical audit programme.
- 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 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, inclusive and effective leadership at all levels.
- The practice had a culture which drove high quality sustainable care.
- Processes for managing risks, issues and performance were effective.

We found the following areas of notable practice:

- The practice was proactive in ensuring patients from all communities had equal access to inclusive and person-centred healthcare, recently focusing on improving the care, treatment and support for patients from the LGBTQ+ community.
- The practice had a strong commitment to quality improvement through regular and repeated clinical audit. There was evidence care and treatment had been improved as a result of clinical audit, with effective systems in place for the findings of audits to be shared with other services and practices.

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

- Improve safeguarding processes to ensure the identification of all vulnerable adults and children is consistent, and that all staff are trained to appropriate levels for their role.
- Improve staff recruitment processes to ensure there is an evidenced check of staff professional registrations and vaccination history.
- Improve health and safety risk assessment processes to ensure all recommended areas are adequately assessed.
- Improve the cleanliness and maintenance procedures for the practice to ensure all areas meet minimum infection prevention and control standards.
- 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 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 the storage of medicines and vaccines to ensure they are stored securely.
- Improve processes for the management and recording of safety alerts, including historic drug safety and medication alerts.
- Improve the management of patients with long term conditions to ensure all patients receive all required monitoring, assessments, diagnoses, follow-up appointments and medication reviews.
- Improve childhood immunisation uptake rates.
- Improve the monitoring and oversight of staff mandatory training to ensure there remains effective oversight of the training of all staff roles.
- 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 for the identification of patients who are carers or have caring responsibilities.
- Improve practice governance systems to ensure they are effective and provide effective oversight of all practice areas.
- Develop a practice vision and values that are supported by an effective and credible strategy.

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

Background to assessment

The practice is located at:

- Southern Group Practice, Castletown Road, Port Erin, Isle of Man, IM9 6BD.

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

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

Is the service safe?

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

Safety systems and processes

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

Safeguarding

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

Training records did not evidence that all partners and staff had completed required safeguarding training for their role. Training on additional topics had been covered, such as domestic violence awareness, which had been delivered by a local police officer.

There was engagement in local safeguarding processes. Safeguarding was discussed internally during regular practice and clinical meetings, and externally during three-monthly meetings with

health visitors. There were no transitional safeguarding arrangements in place, both at a practice or an island level.

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 maintained a child safeguarding register, but did not maintain an equivalent register for potentially vulnerable adult patients. Safeguarding alerts could be placed on patient care records, although this was not consistent.

Disclosure and Barring Service (DBS) checks were undertaken when required. All staff were required to complete an annual check, with the majority of staff having enhanced checks.

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

Recruitment systems

Recruitment checks were carried out in accordance with policy (including for agency staff and locums). This included the obtaining of references, review of ID and completion of an induction programme. Staff professional registrations were not always checked, either on recruitment or on an ongoing basis. 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 tetanus, polio, diphtheria, measles, mumps and rubella vaccinations. Following our assessment, the practice advised they had implemented a process whereby all staff professional registrations would be reviewed and re-checked on an annual basis.

Safety systems and records

Health and safety risk assessments carried out did not always include all recommended areas. The practice had not undertaken a legionella risk assessment and did not conduct water testing for legionella. The practice reported this was the responsibility of the building landlord and understood this was being tested regularly, but a recent issue had been identified whereby legionella was not being tested for during their regular water quality tests. The practice advised this was being investigated at all practices across the island, with testing for legionella due to take place shortly.

There was a fire procedure.

Date of fire risk assessment: March 2022.

Actions from fire risk assessment were identified and completed.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not met.

Some areas of the practice did not meet infection control standards. Several rooms and areas of the practice contained carpeted flooring, and there were no arrangements in place for these to be deep cleaned. The practice advised they had raised this as a concern to their building landlord three years ago and were waiting for these to be replaced, but had not received a date when this would be completed. It was noted the practice had recently had two rooms redeveloped for the

treatment of patients with suspected or confirmed COVID-19, which met infection control standards.

There were no formalised cleaning arrangements in place at the time of our assessment, as the practice advised they were in the process of changing cleaners and all cleaning was currently being completed by practice staff in the interim. Following our assessment, the practice confirmed they had now started their new cleaning arrangements with a third party company, with formal cleaning schedules implemented, which included the regular deep cleaning of all carpeted areas.

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: April 2022

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, with some clinical staff undertaking advanced 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. The practice operated a duty doctor system, to whom receptionists could escalate any patients of concern.

Information to deliver safe care and treatment

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

Individual patient care records and clinical data 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 records were not always written in line with current guidance and legislation. For example, we saw completed consultation records for long term condition reviews did not always contain an adequate record of the patient's relevant medical history or the details and findings of examinations performed.

There was a system for processing information relating to new patients including the summarising of new patient notes. In addition to electronic patient care records, the practice used paper-based notes. The practice reported around 96% of patient records had been effectively summarised, with around 4% still to be completed.

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

There was a documented approach to the management of test results. 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 did not always ensure medicines were stored safely and securely with access restricted to authorised staff. During our assessment, we found instances whereby medicines were stored unsecured in unlocked cupboards or in unlocked medicine fridges.

Blank prescriptions were not always kept securely, as during our assessment, we found instances whereby blank prescription pads had not been stored securely. It was noted staff generally locked treatment rooms when not in use to mitigate this risk. Following our assessment, the practice provided a copy of a new standard operating procedure they had implemented which outlined their new process on how blank prescriptions would be monitored and overseen.

Documentation did not demonstrate that all staff had the appropriate authorisations to administer medicines, including the use of Patient Group Directions (PGDs) and Patient Specific Directions (PSDs). Staff undertook training on the use of PGDs, but there was no record of which PGDs staff were deemed to be competent to operate under and how these had been authorised. PSDs were not in place for all required medicines. The practice advised a PSD was not required for all medicines where a prescription was in place. We reviewed these prescriptions, but saw they did not contain all required and necessary information, such as the name of the person administering the medicine, the route of administration and dosage, or details of the authorising clinician.

The practice could not demonstrate the prescribing competence of non-medical prescribers, such as nurse prescribers, and there was no regular review of their prescribing. The practice did not have access to island-wide prescribing data, so could not review each clinician’s prescribing performance. It was noted the practice was in the process of implementing more regular GP supervision with non-medical prescribers.

The process for the safe handling of requests for repeat medicines was not always effective, and the quality of medication reviews for patients on repeat medicines was variable. As part of our assessment, we reviewed five recently completed medication reviews. Although a review had been coded into each patient’s care record, there was not always evidence that had a review had

taken place. For example, some reviews did not include details of which medications had been reviewed, whether all monitoring was up to date, or whether any concerns had been identified.

We saw several instances whereby patients appeared to be non-compliant with requests for monitoring. Although the practice was largely aware of affected patients, there was limited evidence of steps taken by the practice to address this. Following our assessment, the practice provided a copy of a standardised medication review procedure that outlined how medication reviews should be undertaken, and how non-compliant patients would be managed.

The practice had a process for the management of information about changes to a patient's medicines. We found changes made by other services were not always shared with the practice in a timely manner, which impacted the practice's ability to make timely amendments to patient medications. The practice explained how clinic letters and correspondence from secondary care sometimes took several weeks to be received by the practice.

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

As part of our assessment, we conducted a series of clinical searches and random sample of associated patient care records to review 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 and heart failure. Our search identified 961 patients who were prescribed this medicine, with 38 patients identified as not having received all recommended monitoring. We undertook a detailed review of five patients' care records and found some patients had not received monitoring for several years, including two patients who were last monitored in 2011 and two patients in 2013. Following our assessment, the practice conducted a review of all 38 patients and confirmed 23 patients had either had a blood test completed by secondary care within the last 12 months or had an appointment booked. Of the remaining 15 patients who were overdue monitoring, the practice explained these patients were largely non-compliant with their requests for monitoring and had been contacted on at least one occasion. The practice planned to improve this through the introduction of a new medication review standard operating procedure.

Another search reviewed the prescribing of a high risk medicine used as an immunosuppressant. Our search identified two patients prescribed this medicine, of which both patients were receiving appropriate monitoring through secondary care.

Another search reviewed the prescribing of a medicine used to prevent blood clots. Our search identified 58 patients who had not received all recommended monitoring. We undertook a detailed review of five patients' care records and found several patients had not received any monitoring for some years, including one patient who had not received all monitoring since 2015. The practice explained they were aware of issues regarding the monitoring of these patients, as following a recent clinical audit, they had identified an island-wide issue whereby patients were not always correctly referred to the hospital anticoagulation clinic for ongoing monitoring when first prescribed the medicine. They explained this resulted in around 30% of all patients prescribed this medicine not receiving all required monitoring. Although the practice explained GP surgeries were not commissioned or funded for the monitoring of this medicine, as this should be completed by the hospital anticoagulation clinic, the practice was still responsible for the

prescribing and therefore were responsible for ensuring that all required monitoring was taking place.

Another search reviewed the potential overprescribing of a short acting reliever inhaler used to treat asthma, as the high prescribing or overuse of short acting reliever inhalers is associated with an increased risk of asthma death. Our search identified nine patients who had been prescribed more than 12 reliever inhalers within the last 12 months. We undertook a detailed review of five patients' care records and saw most patients were overdue asthma reviews, including one patient who had not received a review since 2015. The practice did not always take appropriate action when new symptoms were reported by patients, and medication was not always adjusted as appropriate. The practice did not have effective systems to manage the prescribing of this medication, as some patients had continued to receive prescriptions when allocated prescription issue limits had been reached. For example, one patient was showing as 1,000% overuse and the practice had continued to prescribe the medication, with the patient receiving 26 prescriptions issues from a set maximum of six issues. The practice confirmed they were aware of problems regarding overdue asthma reviews, which they attributed to low nurse capacity, and had taken actions to improve this through the recruitment of a new nurse with specialist interest in asthma and the increasing of existing nurse hours.

The practice's systems for the monitoring of prescribing of controlled drugs were not always effective. As part of our review of patient care records, we saw instances whereby patients were continuing to be issued prescriptions of controlled drugs past specified review dates with limited action from the practice. For example, we saw one instance whereby a limit of six prescription issues had been set before a review was required, yet the patient had been able to obtain 96 prescription issues without attending a review. We saw there were limited actions recorded to review and reduce patient usage.

The practice held a small quantity of 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.

The practice produced a medication safety report each month, which reviewed the practice's performance against several medication-related indicators. The report contained information for the previous three months and provided an oversight on the monitoring and prescribing of several topics, which included high risk medications, drug safety alerts, antibiotic prescribing, controlled drug prescribing and outstanding medication reviews. We saw this was still being embedded at the time of our assessment, as we identified several medicine-related concerns that had not been identified or addressed by the practice.

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 weekly to confirm medicines were available and in date, with expiry dates recorded on a digital system that alerted staff to any expiring stock.

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

The practice had emergency medicines and equipment available, but did not store these in line with recommendations. For example, some emergency medicines were stored in locked medicines cabinets within lockable cupboards in lockable treatment rooms, with emergency equipment stored in a separate lockable treatment rooms. This was not in line with guidance from the Resuscitation Council, which recommends for emergency medicines to be stored in tamperproof containers and emergency equipment to be stored together in a strategic and accessible location and not locked away. Following our assessment, the practice advised they planned to conduct a full risk assessment to review their management of emergency medicines, and would now store all emergency equipment in specialised tamperproof containers on a dedicated emergency trolley.

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

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events

The practice monitored and reviewed safety information from a variety of sources. This included safety information shared through Manx Care, as well as other organisations such as the Medicines and Healthcare products Regulatory Agency (MHRA).

Staff knew how to identify and report concerns, safety incidents and near misses. Staff explained how they reported potential incidents and significant events using an online incident reporting form, which was reviewed by the practice management team.

There was a system in place for recording, investigating and acting on significant events, with evidence of learning and dissemination of information. As part of our assessment, we reviewed completed incident reports for incidents reported within the last 12 months. Each incident report contained a score for its severity and likelihood, as well as description of the incident, any learnings identified, and details of how these were shared with other practices and organisations.

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

Safety alerts

Staff understood how to deal with alerts, although the system for recording and acting on safety alerts was inconsistent.

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 2019 regarding the prescribing of a group of medicines to patients of child-bearing age. We reviewed five patients' care records and saw four patients had not been informed of this risk. Two patients were identified to have had a medication review coded, although there was no evidence a review had been completed or that the patient had been informed of the risk. The practice explained they ran a medication safety report each month to review their actioning of drug safety alerts, but during our assessment, we identified two medicines that had not been included on their monthly report. The practice explained this would be rectified and planned to implement an updated safety report by the end of September 2022.

Another search reviewed a safety alert from 2014 regarding a new recommended maximum daily dose. Our search identified one patient who was on a prescription higher than the recommended dose, although this was as per a specialist's request and the patient was seen to be receiving all recommended monitoring.

Is the service effective?

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

Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment were generally delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools. However, the oversight and management of patients with long term conditions was not always effective.

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

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

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

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

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

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

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

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

Effective care for the practice population

- Flu, shingles and pneumonia vaccinations were offered to patients, where relevant.
- Patients had access to appropriate health assessments and checks, when recommended.
- All patients with a learning disability were offered regular health checks.
- Extended length appointments were available, where appropriate.

- End of life care was delivered in a coordinated way, which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder
- Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

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

- Our first search reviewed patients with a potential missed diagnosis of diabetes. This search identified 16 patients who were potentially diabetic but did not have a diagnosis coded. We undertook a detailed review of five patients' care records and saw all patients should have been diagnosed as having diabetes but did not have an appropriate diagnosis coded. With the exception of one patient who was diagnosed on the day of our assessment, most patients had not been informed of their diagnosis of diabetes. The practice explained they conducted a rolling monthly search to identify patients with a potential diagnosis of prediabetes or diabetes, which was supported by a clinical audit conducted in March 2022. To improve the identification of these patients, the practice planned to add this to their monthly medication safety report from September 2022.
- 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 854 patients who were diagnosed with asthma, of which 20 patients had been prescribed two or more courses of rescue steroids in the last 12 months. We conducted a detail review of five patients' care records and saw completed consultations were not always comprehensive and did not always contain details of the patients' history or any examinations or observations undertaken. Patients were not always escalated appropriately, as one patient was seen to have returned on multiple occasions with no improvement in symptoms or response to treatment but was not referred to a GP for further assessment. Not all patients had received an asthma review within the last 12 months, or been issued with a steroid card where appropriate, and some patients were evidenced as being prescribed incorrect dosages and quantities of medication. Following our assessment, the practice confirmed they planned to improve their processes by developing a new treatment protocol, implementing a new template to be used for all asthma exacerbations, and improving the processes for the issuing of steroid cards.
- Another search reviewed the monitoring of patients with chronic kidney disease (CKD) at stages four and five. This search identified 12 patients who were indicated as not having received a relevant blood test within the last nine months. We found the majority of patients were being managed effectively through secondary care. We did identify one

patient who had not received any monitoring since they joined the practice and did not appear to be managed by secondary care.

- Another search reviewed the monitoring of patients with hypothyroidism. This search identified 13 patients who were indicated as not having received a thyroid function test within the last 18 months, with three patients identified as having abnormal results at their last test. We undertook a detailed review of these three patients' care records and saw the practice were aware of each patient and had invited all patients in for monitoring. All three patients appeared to be non-compliant with requests for monitoring, but there was limited evidence the practice had taken steps to address this, such as reducing the amount of medication on each prescription or encouraging the patient to attend their appointment.
- Another search reviewed the care and treatment of patients diagnosed with diabetic retinopathy – a complication of diabetes. We reviewed four patients who had both a diagnosis of diabetic retinopathy and a high blood sugar reading recorded at their last test. Most patients were known to secondary care, but we found the practice did not always review or adjust the medication for patients with high blood sugar readings who were not under the care of the hospital. We saw instances whereby no action had been taken to adjust the medication of patients who displayed symptoms that might be associated with poor diabetic control, and saw that patients were not always escalated to GPs for a further review where they had failed to respond to treatment. Following our assessment, the practice advised they were developing a new treatment protocol that improved the identification and escalation of patients with poor diabetic control to GPs.

Child Immunisation

The below table shows the practice's childhood immunisation performance. The practice performed significantly 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:	Southern Group Practice	Isle of Man Average:
5-in-1	90.00%	95.77%
Measles, Mumps and Rubella	84.00%	90.68%
Meningitis C	84.00%	90.28%
Pre-school Boosters	79.63%	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	
Southern Group Practice	Isle of Man Average:
78.80%	76.84%

Percentage of persons eligible for bowel cancer screening who have been adequately screened between 1 October 2021 and 31 December 2021	
Southern Group Practice	Isle of Man Average:
63.41%	60.74%

The practice worked to improve cancer diagnosis and referral rates. Data provided by the practice showed good performance, with the conversion rate of two week wait referrals, and the detection rate from the two week wait referrals, as being better than the England average.

Monitoring care and treatment

The practice had a comprehensive 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.

The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements. Examples of recent audits completed by the practice included audits to improve cancer diagnosis, antibiotic prescribing, clinical record keeping, drug safety alerts and suspected urinary tract infections.

Audits completed by the practice were of high quality and included details of the background and aims, the clinical standard to be achieved, the methodology, the results, and an action plan. Where relevant, a repeat audit or review date was present to check for any improvement.

For example, we noted the practice had recently identified an issue regarding the prescribing and monitoring of a high risk medicine across the island. Following this audit, the practice had identified several patients who were not being monitored effectively, and had identified the cause of the issue with the prescribing and monitoring being completed by different organisations. Actions taken by the practice following this audit included discussing the audit findings urgently with all practice prescribers, reviewing all patients who were not being monitored effectively, escalating the concerns to other practices through their primary care network and to undertake a repeat audit in three months' time.

The practice had recently focused on improving the identification of patients who may have a missed diagnosis, or who may be prescribed medicines that are no longer in line with clinical recommendations. We found evidence the practice had created several different searches on their patient clinical records system to identify these patients, and had begun taking action to address any potential concerns.

The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.

Effective staffing

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

The practice could not always 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 most staff undertook regular

training in basic life support, infection prevention and control, and safeguarding, as well as additional training as relevant to their role. Whilst training data for some roles was comprehensive, data for other staff, such as GPs, was limited.

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

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

Staff had access to regular appraisals, one to ones, coaching and mentoring. They were supported to meet the requirements of professional revalidation. All staff received annual appraisals with a senior clinician or member of staff. At the time of our assessment, the practice reported all appraisals were up to date.

The practice could not always demonstrate how they assured the competence of staff employed in advanced clinical practice, such as nurses and paramedic practitioners. We saw staff in some roles were effectively supported, and saw instances whereby staff worked alongside a nominated GP who had booked out their diary, allowing staff to raise any queries whilst the patient was in the practice. Other staff roles did not have similar arrangements, with supervision generally undertaken yearly as part of staff appraisals. Following our assessment, the practice confirmed they would implement a new supervision programme, whereby each member of staff would be allocated a nominated named clinical supervisor with whom they would have a minimum of a quarterly supervision meeting, during which completed patient reviews would be discussed and audited.

There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together to deliver effective care and treatment. We found a lack of data sharing arrangements did not always allow staff to work effectively with other organisations.

Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved. We found as data sharing arrangements were not in place for all key services, such as hospital and ambulance services, important care and treatment information was not always shared between services to support the delivery of effective care and treatment.

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

Helping patients to live healthier lives

Staff were consistent in helping patients to live healthier lives.

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

Patients in the last 12 months of their lives were supported by the practice. For example, the practice held quarterly palliative care meetings, which were led by the practice's palliative care lead.

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

Patients had access to appropriate health assessments and checks.

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

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

Consent to care and treatment

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

Clinicians understood the requirements of legislation and guidance when considering consent and decision making.

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

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

As part of our assessment, we undertook a review of three DNACPR decisions processed by the practice. We saw copies of completed DNACPR decision forms had been retained where possible and were easy for staff to view. Patient care records were clear and comprehensive, and included reference to the involvement of the patient's friends, family and relatives, where appropriate.

Is the service caring?

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

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was positive about the way staff treated people.

Staff understood and respected the personal, cultural, social and religious needs of patients. For example, the practice had taken significant steps to improve the care for patients from different communities, such as patients from the LGBTQ+ community. The practice was in the process of implementing the 'Pride in Practice' programme, which aims to ensure all lesbian, gay, bisexual and trans people have access to inclusive and person-centred healthcare. To support this, the practice had developed a dedicated page on its website to provide information to transgender patients, including on how patients can update their medical records to reflect their wishes and preferences.

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 1,119 responses. Of these, 1,062 respondents rated their overall experience as either 'good' or 'very good', 22 rated their experience as 'poor' or 'very poor', and 35 respondents rated their experience as 'neither good nor poor'. Positive comments largely related to the quality of care received, with respondents describing staff as 'amazing', 'fantastic', 'exceptionally helpful' and 'caring'. Negative comments largely related to the practice's appointment and telephone systems.

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 34 patients recorded as carers from a patient list of approximately 7,000 (0.49%).

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

Interpretation services were available for patients who required them.

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

Information leaflets were available in other languages and formats.

Information about support groups was available on the practice website.

Privacy and dignity

The practice respected patients' privacy and dignity.

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

There were arrangements to ensure confidentiality at the reception desk. Receptionists generally answered telephone calls away from the front desk, and closed screens between patients to minimise the risk of confidential information being overheard. The practice explained they were in the process of opening a new window at the reception area to allow patients to speak to staff away from the main waiting area to improve patient confidentiality.

Is the service responsive?

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

Responding to and meeting people's needs

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

The practice understood the needs of its local population and had developed services in response to those needs. This included standard services, such as minor surgery, health checks and

vaccinations, and additional services, such as phlebotomy. The practice explained their phlebotomy service, whereby patients could have blood taken for tests within the practice rather than needing to travel to hospital, was a popular service with the practice undertaking over 500 blood appointments per month. The practice offered blood appointments between 8am to 10.30am daily, but explained they could not offer blood appointments after this due to samples being collected at 11am. The practice explained they had requested a later or additional collection time due to high demand for the service locally, but this had not yet been approved across the island due to cost implications.

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 whereby patients 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 were not compliant with infection control standards, and appropriate mitigating actions had not been taken to address this. For example, several clinical areas contained carpeted floorings, but there were no systems in place for these to be deep cleaned to minimise the infection control risk. The practice was located on the ground floor, with wheelchair access available throughout. 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.

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 able to make appointments in a way which met their needs. The practice regularly reviewed and audited its appointment offering to ensure all patients were able to access care and treatment in a method that they were satisfied with.

Between April 2021 and March 2022, the practice received 1,119 responses to their friends and family survey. Feedback that related to appointment booking systems was mixed. Several patients reported no problems in booking appointments and reported they were able to arrange an appointment when they needed one. Other patients did report issues in booking an appointment, with concerns raised regarding the availability of the appointments and the lead time from booking to the appointment. Most patients reported they were able to arrange emergency and same-day appointments when required. This feedback was similar to additional feedback submitted to other online services and social media pages.

We spoke with five patients during our assessment, with most patients reporting no significant difficulties or concerns in booking appointments.

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. The practice operated a duty doctor system, whereby any urgent appointment requests could be reviewed and seen by a nominated GP.

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 trained and proactive in ensuring patients were receiving care from the most appropriate provider or organisation. Where appropriate, staff could recommend for patients to contact local eye care and minor ailment services.

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, on the practice's website, or by speaking with a member of staff.

There was evidence that complaints were used to drive continuous improvement. During our assessment, we reviewed two completed complaint investigations and saw both had been responded to promptly, investigated thoroughly and any learnings identified. Both responses from the practice included an apology, but did not include details of other organisations complainants could escalate their complaint to if they remained unsatisfied with how their complaint had been handled.

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 maintenance of the practice premises and lack of clinic rooms.

Other challenges that had been addressed by the practice included the recruitment of three new GP partners, a paramedic practitioner and a practice nurse in response to concerns over clinical capacity, and the improvement of the practice team culture following a significant period of challenge and change experienced by the practice.

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

There was a leadership development programme and succession plan in place. The practice had undergone changes within their GP team, with two new GPs being recently recruited.

Vision and strategy

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

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

Culture

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

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 that they ‘feel supported’ by managers and the GP team, and described the door as ‘always open’ if they needed to raise any concerns or queries.

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, however these were not fully embedded at the time of our assessment.

The practice had governance structures and systems in place, but these were not fully embedded or effective at the time of our assessment. We identified several concerns regarding medicines management and the management of patients with long term conditions that had not been identified or addressed by the practice. Following our assessment, the practice had taken swift action to address these concerns, implementing new processes and procedures as appropriate. All GP partners had overall responsibility and clinical oversight, with nurses, the paramedic practitioner and the practice manager answerable to all partners. Each GP partner generally had lead roles, such as for safeguarding, dementia care and learning disability care.

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

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

Managing risks, issues and performance

Processes for managing risks, issues and performance were effective.

There were assurance systems in place, which were regularly reviewed and improved. The partners attended regular practice and clinical meetings to discuss the operation of the practice. Although at the time of our assessment, meetings were not always regular, the practice was in the process of implementing a programme of two weekly practice and clinical meetings. All meetings followed an agenda, with minutes shared with all staff who could not attend. Minutes reviewed as part of our assessment were comprehensive, with details of any actions clearly recorded. Meeting minutes were not always promptly written and shared after each meeting, but the practice advised they were in the process of recruiting a medical secretary who would be taking on this role.

Additional meetings were held with other healthcare providers and organisations, which included weekly wellbeing meetings that were attended by the practice's GPs, along with local occupational therapists, physiotherapists, district nurses and dieticians, as well as regular safeguarding and palliative care meetings.

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, we identified several areas of concern but saw the practice were largely aware of these areas and were in the process of putting appropriate actions in place to address this. For example, we saw the practice were implementing further clinical supervision sessions to improve the oversight of non-medical staff, and had started running medication and drug safety alert searches on their clinical records system to identify potential patients at risk.

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

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

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

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

The practice had adapted how it offered appointments to meet the needs of patients during the pandemic. This included the expansion of remote consultations, including telephone appointments.

The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.

There were systems in place to identify and manage patients who needed a face-to-face appointment.

The practice actively monitored the quality of access and made improvements in response to findings.

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

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

Staff were supported to work remotely where applicable, which included both clinical and non-clinical staff.

Appropriate and accurate information

There was a demonstrated commitment to using data and information proactively to drive and support decision making.

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

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

Governance and oversight of remote services

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

Patient records were held in line with guidance and requirements. The practice primarily used a secure third party clinical records system for the storage and management of confidential patient information.

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

The practice ensured patients were informed how their records were stored and managed.

Patients were made aware of the information sharing protocol before online services were delivered.

Online consultations took place in appropriate environments to ensure confidentiality. For example, all staff completed remote consultations in individual clinic rooms to ensure any confidential information could not be overheard.

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

Engagement with patients, the public, staff and external partners

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

Patient views were 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 received a good uptake to their friends and family test survey, regularly receiving one of the highest response rates across the island.

Changes had been made as a result of patient feedback. For example, the practice had recently invested and installed a new telephony system, as a result of feedback from patients that they previously found it difficult to contact the practice by phone.

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 worked with stakeholders to build a shared view of challenges and of the needs of the population. For example, the practice attended and ran several meetings with stakeholders and other healthcare providers, such as local wellbeing partnership meetings and palliative care meetings.

Continuous improvement and innovation

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

There was strong focus on continuous learning and improvement. GPs were effective in using clinical audit, supported by digital technology, to improve processes, care and treatment.

Learnings were shared effectively and used to make improvements. For example, we saw how the practice had shared the findings of a recent audit regarding the prescribing of a high risk medicine, which led to an island-wide significant event being raised to improve the management of this medicine.