

Review of:

- Musculo-Skeletal Patient Pathway
- Care of People with Chronic Pain
- Care of People with Drug and Alcohol Problems
- Screening Services
- Transfer from Acute Hospital Care and Intermediate Care and Care of Older People Living with Frailty (Workshop)

Isle of Man Department of Health and Social Care

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INTRODUCTION

This report presents the findings of the seventh review of health services on the Isle of Man that took place on the 3rd to 5th October 2017. The purpose of the visit was to review compliance with the following standards:

Service	Standards Reviewed
Orthopaedics (elective orthopaedics, trauma and orthopaedic therapies)	WMQRS Musculo-skeletal Patient Pathway Quality Standards V1.1 2017
Chronic Pain Team	WMQRS Quality Standards for the Care of People with Chronic Pain V1.3 2014
Drug and Alcohol Team	Community Substance Misuse Services - Quality Standards Framework: The Recovery Partnership 2016
Screening Services	Compliance with Standards was not reviewed in detail but screening services were considered against the UK National Screening Committee standards

A workshop on 'transfer from acute hospital care and intermediate care' and 'care of older people living with frailty' was also held as part of this review visit.

The aim of all WMQRS standards and review programmes is to help to improve clinical outcomes and service users' and carers' experiences by improving the quality of services. The specific aims of the Isle of Man review programme are:

- 1 To provide an assessment to the Manx public and politicians and the Isle of Man Health Service itself of the quality of care provided to Manx patients.
- 2 To identify areas where services are in need of improvement, with special reference to any areas in which there is an unacceptable risk to patient and/or staff safety.
- 3 To comment upon the sustainability, or otherwise, of services currently provided in the Isle of Man.

The report reflects the situation at the time of the visit, and the review teams draw their conclusions from multiple sources (evidence available on the day of the visit, meetings and viewing facilities). Visit reports identify compliance and issues related to the achievement of the Quality Standards. Issues are categorised in the following way:

- **Achievements** made by the service reviewed
- **Good practice** that should be shared with other organisations
- **Immediate risks** to clinical safety and clinical outcomes
- **Concerns** related to the Quality Standards or prerequisites for their achievement. Some concerns may be categorised as 'serious'
- **Further consideration** – areas that may benefit from further attention by the service.

The text of this report identifies the main issues raised during the course of the visit. Appendix 1 lists the reviewers that took part in Review 7. Appendix 2 contains the details of compliance with each of the standards and the percentage of standards met.

During the course of the visit, the visiting team met with members of Tynwald, service users, carers and their representatives and a wide range of staff. Reviewers also looked at a wide range of documentary evidence provided by health services on the Isle of Man.

Most of the issues identified by quality reviews can be resolved by the providers' own governance arrangements, and many can be tackled by the use of appropriate service improvement approaches. Individual organisations are responsible for taking action and monitoring this through their usual governance mechanisms. The Isle of Man Department of Health and Social Care is responsible for ensuring that action plans are in place and for monitoring the implementation of them.

COMMON THEMES

General Comments and Achievements

Throughout the services reviewed there was evidence of caring staff, lovely facilities and vibrant community engagement. Reviewers were impressed by many aspects of the care provided, although this was often achieved despite the systems and processes within which staff were working.

Some common themes emerged strongly during the course of this review and are summarised here.

Concerns

1. Governance

The reviews of the musculo-skeletal pathway, the chronic pain team and screening services all identify governance as a concern. The governance-related issues in the musculo-skeletal and chronic pain sections of this report echo those raised in the review of clinical governance in July 2014 and in most WMQRS Isle of Man service-level reviews. (The only exception to this conclusion is the handling of complaints where arrangements appear to have improved.) The musculo-skeletal pathway report also includes an immediate risk to clinical safety and clinical outcomes which was identified in 2015 and has still not yet been fully addressed. The issues raised at the 'transfer from acute hospital care and intermediate care' workshop and problems with IT systems have also been raised in several previous WMQRS reviews.

There was a significant lack of information and monitoring to provide the Isle of Man Health Service assurance that care was provided in a timely and effective way. Data were not routinely collected, and where data was available there appeared little evidence of systematic review and assessment.

Reviewers concluded therefore that effective governance of health services on the Isle of Man has not been established and that arrangements for monitoring and follow up of issues identified through WMQRS reviews are not robust¹. This conclusion should be of serious concern to those with responsibility for the safety and quality of these services.

2. Management Structures and Relationships

The second common theme from this review was of staff who were not clear how change could be achieved. The barriers between different parts of the health and social care system appeared stronger than ever and the dislocation between management and clinical staff seemed to have grown since review 6. Several staff in the services reviewed were disillusioned, defensive and felt unvalued. Staff were keen to improve services but were not empowered to make the necessary changes.

There did not appear to be effective multi-disciplinary team (MDT) working in operation. We did not see effective coordination of care between teams.

Further Consideration

1. Reviewers did not see mandatory training records for medical staff or for occupational therapists. This review therefore does not provide assurance of competences covered by mandatory training for these groups.

¹ WMQRS is commissioned only to undertake reviews. Responsibility for action planning and follow up of implementation lies with the Isle of Man Department of Health and Social Care.

2. The range of responsibilities of the Isle of Man Department of Health and Social Care and the size of the island's population provide a wonderful opportunity for integrated patient pathways between primary care, hospital, community and mental health services and between health and social care. Reviewers commented that the very traditional management structure of the Department appeared to be promoting the divisions between these services and acting as a barrier to integrated working.

ACKNOWLEDGMENTS

West Midlands Quality Review Service would like to thank the staff and service users and carers for their hard work in preparing for the review and for their kindness and helpfulness during the course of the visit. Thanks are also due to the visiting team and their employing organisations for the time and expertise they contributed to this review.

ABOUT WEST MIDLANDS QUALITY REVIEW SERVICE

WMQRS is a collaborative venture between NHS organisations in the West Midlands to help improve the quality of health services by developing evidence-based Quality Standards, carrying out developmental and supportive quality reviews – often through peer review visits, producing comparative information on the quality of services and providing development and learning for all involved.

Expected outcomes are better quality, safety and clinical outcomes, better patient and carer experience, organisations with better information about the quality of clinical services, and organisations with more confidence and competence in reviewing the quality of clinical services. More detail about the work of WMQRS is available on www.wmqrs.nhs.uk.

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VISIT FINDINGS

TRANSFER FROM ACUTE HOSPITAL CARE AND INTERMEDIATE CARE

CARE OF OLDER PEOPLE LIVING WITH FRAILITY

1. Discussions between the Isle of Man Department of Health and Social Care and WMQRS identified that many of the Standards for 'Transfer from Acute Hospital Care and Intermediate Care' and for 'Care of Older People Living with Frailty' were not yet in place on the Isle of Man. It was agreed that a formal review against these standards was not the most constructive way forward and that a workshop should be held instead with the aim of trying to help staff understand the standards and what needed to be done to implement them. This report summarises the conclusions of the workshop.
2. The half-day workshop was run on 3rd October 2017 with the objectives that participants would:
 - a. Understand the WMQRS Quality Standards for:
 - i. Transfer from acute hospital care and intermediate care
 - ii. Care of older people living with frailty
 - b. Identify whether these Standards were being met on the Isle of Man
 - c. Identify what needed to be done to implement the standards
 - d. Identify barriers to making these changes.
3. The workshop was attended by 23 participants with representatives of service managers, senior nurses, patient flow managers, public health staff, community nurses, social work team, specialist nurses and therapy staff. Unfortunately, only one consultant and no junior doctors were able to attend the workshop. Also, senior managers from the Department of Health and Social Care were involved in another event and so unable to attend. The workshop started with an explanation of the structure of the standards and the expected pathways. The evaluations completed by workshop participants are given in Table 6.

ACHIEVEMENT OF EXPECTED STANDARDS – OCTOBER 2017

4. Tables 1 and 2 summarise participants' conclusions about the extent to which expected timescales for transfer from acute hospital care and the expected processes for the care of older people living with frailty were in place on the Isle of Man.
5. The main finding in relation to transfer from acute hospital care was that the processes would happen eventually but usually not within the expected timescales. Also, expected timescales were not always specified or their implementation monitored. Staff therefore did not have a clear and consistent understanding of the timescales within which others should be responding.
6. This means that the Isle of Man is not using its resources efficiently. The expected processes were all taking place but not as rapidly as expected. Meanwhile, patients were staying in hospital, often for several days longer than necessary. This represents sub-optimal use of resources and will have an adverse effect on patient outcomes.
7. The main finding on care of older people living with frailty was that the expected processes were not in place. Multiple assessments were taking place but with no consistency of approach. The Isle of Man does not have a multi-disciplinary Frailty Team to provide care for the most vulnerable older people living with frailty and to 'drive' improvement in the care pathway for this client group.
8. One overall conclusion related to the lack of intermediate care in people's homes and in care homes. Intermediate care was available at Ramsey Community Hospital, but participants considered that this facility could only be used by Ramsey residents who are patients of Ramsey GPs.

Table 1 - Achievement of Expected Discharge Pathway Timescales – October 2017

Pathway milestone:	Within:	Hours of:	Achieved?	Comments
Expected date of discharge (EDD)	12	Admission	Sometimes	This happened for planned admissions in some areas. The Noble's Hospital Standard is an EDD within 24 hours of admission. The process for achieving this is understood but not consistently applied.
Multi-disciplinary planning of transfer of care	24	Admission	Not usually	The process is understood but not consistently applied. There are particular problems at weekends because staff are not available 7/7. Communication between disciplines, including social workers, is slow. Some staff are not committed to 'board rounds'. Referrals to community nursing cannot be made after 4.30pm for same day home visits.
Social services staff available to undertake social care assessment	24	Request	Not unless urgent	Social care staffing is limited especially at weekends and out of hours. It may be achieved for an emergency discharge. Usual response is not within 24 hours.
Pharmacy services and medication 'To Take Out' (TTOs)	4	Request	Not usually	Requests for drugs 'to take out' (TTOs) have to be at pharmacy at certain times. There are particular problems at weekends. Further discussion highlighted that delays are often due to medical staff not completing the TTO request (rather than pharmacy delays).
Additional health and social care support comprising up to four visits per day for at least 72 hours after return home	4	Request	Not usually	The additional support available is not consistent. It depends on the day and time. Community resources (health and social care) are limited. There are particular problems at weekends and no overnight service.
Patient transport	4	Request	Not usually	Patient transport can only be called during office hours and have set criteria. No patient transport is available at weekends. Stretcher transport is available only in emergency ambulances.
At least 72 hours' supply of dressings and continence aids	4	Request	Not usually	Some participants said that these would be supplied by the hospital until they can be obtained in the community, but others said there were no arrangements for achieving this standard.

Pathway milestone:	Within:	Hours of:	Achieved?	Comments
'Simple' equipment available ²	4	Request	Sometimes	'Simple' equipment is available from Occupational Therapists but not usually within this timescale. There are particular problems at weekends.
All equipment, including beds and hoists, available	24	Request	Not usually	A few days are needed to obtain anything other than 'simple' equipment. Some participants thought that the Isle of Man standard was five days for supply of equipment and that there was no option of a 'rapid response' or faster turnaround. Other participants were aware that there was a rapid discharge policy for those patients who wished to die at home.
'Simple' adaptations available	24	Request	No	The Isle of Man standard was thought to be seven days and achievement of this depended on availability of the technician.
'Simple' assistive technology available	24	Request	Not usually	'Simple' assistive technology was not usually available within this timescale.
Appropriate staff to undertake a home assessment	24	Request	Not usually	Therapy and care assessment staff did not have sufficient capacity to undertake home assessments within this timescale.
Voluntary sector 'settling home' support for up to five days	Next working day	Request	Yes	A new service had been launched by the Red Cross, but some participants were not aware of it.
Informing GP, person taking medical responsibility for the patient and other relevant services that patient has left hospital	4	Transfer of care	No	This does not happen electronically, but patients are given a copy of the discharge letter for their GP.

² Examples of 'simple' equipment are raised toilet seats, chairs, frames and other walking aids. Examples of 'simple' adaptations are fitting of 'grab' handles or key safes. Examples of 'simple' assistive technology include pill dispensers and pendant alarms.

Table 2 - Achievement of Expected Processes for Care of Older People Living with Frailty – October 2017

Appendix 3 gives more detail of the terms used in this table.

Care of Older People Living with Frailty	In place?	Comments
Frailty screening in all health and social care services	Not usually	Some services do falls screening. Some do frailty screening but there is no consistency of approach.
Holistic frailty assessment	Not consistently	All services do assessments but there is no standardised approach. Some patients are assessed many times.
Comprehensive Geriatric Assessment	No	A multi-disciplinary Frailty Team is needed to undertake a Comprehensive Geriatric Assessment.
Care Coordinator	Partial	Frailty-specific care coordinators are not in place although this role may be taken by, for example, a GP or district nurse.
Emergency Care Plan	No	There are no consistent arrangements for creating and storing Emergency Care Plans for older people living with frailty.
Multi-Disciplinary Frailty Team	No	A multi-disciplinary Frailty Team with the membership expected by the Standards is not in place in the Isle of Man.

RECOMMENDED ACTIONS

- The actions recommended by workshop participants are shown in Table 3 and Table 4. (NB. Not in priority order.)

Table 3 - Recommended Actions – Transfer from Acute Hospital Care and Intermediate Care

	Recommended Actions
1	Seven day working: <ul style="list-style-type: none"> Occupational Therapists (or multi-skilled occupational / physio-therapy staff) available at weekends with time for work in the Emergency Department, Acute Medical Unit and wards. Pharmacy open for some time each day. The timing at weekends should be linked to the peak time of requests (probably after morning ward rounds). Integrated community teams Diagnostics Patient transport Wheelchair service
2	Adopt and publicise consistent standards / timescales (including for response from therapies)
3	Admission avoidance: <ul style="list-style-type: none"> Greater triage in the Emergency Department and Acute Medical Unit (supported by Rapid Response) Have AHPs (or others) working with paramedics to help keep patients at home
4	Ensure support for Board Rounds on all wards
5	New and improved patient transport contract
6	Identify ‘trusted assessors’
7	Develop intermediate care <ul style="list-style-type: none"> Rapid response team 24/7 Step up / Step down care – accessible to anyone who needs it Reduced use of respite beds – use for intermediate care Clear criteria for admissions (which are followed)
8	Embed staff training and public engagement so everyone knows what to expect

Table 4 - Recommended Actions – Care of Older People Living with Frailty

	Recommended Actions
1	Develop a Frailty Team to lead the service (and undertake Comprehensive Geriatric Assessments)
2	Get ‘frailty’ into the public domain and make it a priority
3	Identify people as frail (‘frailty screening’)
2	Single assessment process with trusted assessors
3	Integrated care records
4	Integration of community and hospital services (by co-location and co-leadership)
5	Enactment of Health and Social Care Bill

BARRIERS TO CHANGE

10. The barriers to change identified by workshop participants are summarised in Table 5. Each of these themes was identified by more than one group of participants.

Table 5 - Barriers to Change

Barriers to Change	
1	Different IT systems
2	Culture of inconsistent approaches: <ul style="list-style-type: none"> • a lack of resources and willingness to audit, measure and review • some staff unwilling to change practice
3	Too many single person services (i.e. with no cover for absences)
4	Public attitudes and perceptions
5	Political interference
6	Legal framework – inability to move patients due to family objections
7	Strategies and services not ‘joined up’
8	Budgets and staff resources

WORKSHOP EVALUATION

11. The evaluations completed by workshop participants are summarised in Table 6. Twenty-one evaluation forms were returned (one incompletely) giving a 91% response rate. Comments made by several people (number in brackets) were that it was good to understand what was available (4) and the flow-charts were helpful (4). They also commented on the patchy nature of services available and working practices (4). Participants clearly appreciated the chance to work together and discuss the issues (20), especially frailty (3), and were pleased that common themes emerged (9). Some frustration at the barriers and the lack of clarity on next steps was apparent (4). Some people found the session too long (4), would have appreciated more medical and senior management attendance (4) and wanted a bigger room (2). A few people (3) would have liked to have been sent the Quality Standards beforehand although WMQRS experience is that this is not always helpful.

Table 6 - Workshop Evaluations

Objective	Objective Met (No.):		
	Very well	Satisfactorily	Poorly
Understand WMQRS Quality Standards for transfer from acute hospital care and intermediate care	9	12	0
Understand WMQRS Quality Standards for care of older people living with frailty	10	11	0
Identify whether these Quality Standards were being met on the Isle of Man	14	7	0
Identify what needed to be done to implement the standards	8	12	0
Identify barriers to making these changes	10	10	0

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MUSCULO-SKELETAL PATIENT PATHWAY

The musculo-skeletal patient pathway on the Isle of Man involved care of people with trauma in the Emergency Department, the in-patient orthopaedic wards 11 and 12, fracture clinic and consultant out-patient clinics, physiotherapy and occupational therapy services. Four consultant orthopaedic surgeons were in post at the time of the review. Visiting consultants supported the care of people with hand, wrist and elbow problems (from Wrightington), the care of children (from Belfast) and spinal surgery (Liverpool). Each consultant led a team which included an Associate Specialist, speciality doctor and a F1/F2 doctor shared between two teams. Wards 11 and 12 had 16 and 15 beds respectively with four side-rooms on Ward 11 and three on Ward 12. The orthopaedic therapy team provided pre-admission support, care during in-patient stays and post-discharge follow up in the community and in three out-patient settings (Noble's Hospital, The Rosien and Ramsey Cottage Hospital). Self-referral to physiotherapy was available. A hand therapy service was provided. Staffing of this aspect of the service had been reviewed, additional therapy time allocated, and additional staff recruited.

Reviewers did not have the opportunity to talk to staff at the tertiary centre in Liverpool to which Isle of Man patients are referred. The conclusions below therefore do not take account of the perspective from the tertiary centre and are based on the evidence seen and discussions with patients and staff on the Isle of Man.

Reviewers were provided with separate self-assessments and separate evidence for a) Wards 11 and 12 and b) Therapy Services. Reviewers visited the Emergency Department, fracture clinic, Wards 11 and 12, theatres and the gym and rehabilitation areas. The conclusions in this report, and the detailed comments on individual Quality Standards (Appendix 2) are for the musculo-skeletal patient pathway as a whole, on the basis that a coordinated 'patient pathway' approach, rather than working in individual departmental silos, will improve care for patients. Reviewers have tried to identify where the standard is met in one area but not another, but this may not be complete.

General Comments and Achievements

Care for people with musculo-skeletal problems was provided by friendly, caring, open and helpful staff who were clearly committed to improving the service provided. The service fell into four main parts, orthopaedic medical staff, fracture clinic, Wards 11 and 12 nursing staff and therapists. These groups of staff were trying hard to make the patient pathway work for individual patients and were linking well with Emergency Department and theatres staff. The ward sisters on Wards 11 and 12 were pivotal to the coordination of care for patients and should be commended for their achievements.

The service had made progress in a number of areas:

- Good competency documents had been developed for nurses and health care.
- All orthopaedic consultants did a ward round daily (5/7) and generic "Dear Doctor" referrals were being tried.
- Data were being submitted to the National Joint Registry, National Hip Fracture Database and the Trauma Audit and Research Network (TARN).
- Three newly appointed consultants in the Emergency Department had brought new energy and dynamism to the care of patients with trauma
- The service was actively working to develop links with Liverpool

Good Practice

1. Some good information for patients and families was seen, in particular, a 'delirium guide' for families and a 'rapid discharge policy' for patients who wanted to die at home.
2. Links between Wards 11 and 12 were very good. The door between the two wards had been removed, and staff were working flexibly across the two wards.

3. A very good competence framework for advanced orthopaedic nurse competences for registered nurses had been developed and was being used.
4. The therapy services operational document brought together all aspects of the running of the occupational and physiotherapy services in a single document which provided a very useful reference source for staff.
5. A good Health Care Assistant (HCA) development programme was in place. Four competence-based levels of practice had been identified and good support for development and progression was in place, including for the development of special interests. A HCA conference was held every two to three years.

Immediate Risks

1. Lack of Shared Care for Children

The report of the October 2015 WMQRS review visit identified the lack of shared care for children needing surgery as an immediate risk to clinical safety and clinical outcomes.³ In October 2017, reviewers found that no changes had been made, with the possible exception of care of children with diabetes. Children needing orthopaedic surgery were admitted to the paediatric ward under the care of the orthopaedic surgeons. Orthopaedic medical staff were contacted if there were problems and a referral was made to paediatric medical staff if required. If nursing staff were particularly worried about a patient, they would ask a paediatric doctor to review them.

Concerns

1. Medical Input

Reviewers were seriously concerned about the arrangements for medical (rather than surgical) input to the care of patients. The service did not have an orthogeriatrician (or a GP or Associate Specialist with a particular interest) to provide medical input to the care of patients with musculo-skeletal problems, especially those who are elderly or frail. Advice was available from the consultant physicians on the Isle of Man, but reviewers did not find a culture of actively seeking this advice and clear criteria for involvement of medical teams were not evident. Reviewers identified individual patient care at the time of the review where this issue (as well as the lack of a ward-based pharmacist and more sophisticated IT system) could have impacted adversely.

2. Governance

Reviewers were seriously concerned about the governance of the services reviewed. Reviewers were told “we provide good services” but the evidence to support this conclusion was not available. Several aspects of governance were not in place including:

- a. Data about the service (for example, referrals, activity, length of stay, operations and outcomes) were not being collected or reviewed by the service.

³ Extract from October 2015 visit report:

Lack of shared care for surgical patients

Children needing elective surgery and those admitted as emergencies where surgery might be needed were admitted to the paediatric ward but under the care of a consultant surgeon. These children were clerked by surgical junior doctors, and consultant surgeons were called if there were problems. Reviewers considered this was an immediate risk to clinical safety and clinical outcomes because these doctors would not be expected to have training in the care of children, and reviewers saw no evidence of additional training or clear guidelines covering this area of practice. Reviewers’ concerns were compounded by issues relating to the early warning system (see concerns).

- b. Key performance indicators had not been identified and were not being monitored.
- c. Most of the expected patient pathways were not documented and the expected timescales for different steps of the pathways were not clear. Different parts of the service were therefore working separately, without a clear understanding of the expected contribution of others.
- d. Arrangements for multi-disciplinary discussion of patients were not robust, except during 'race weeks'. Therapists and anaesthetic staff attended the Monday morning case review meetings only during 'race weeks'. It was not clear whether imaging representatives attended the meeting at any time.
- e. Arrangements for multi-disciplinary review and learning were not in place. The service as a whole was not considering mortality, morbidity and outcomes and was not learning from audit, incidents and positive feedback. (Divisional governance meetings were held but these did not provide an appropriate forum for service-level multi-disciplinary review and learning.)
- f. Few clinical guidelines were available and most of those that were available were out of date. Those that were had not been localised to show how they would be implemented on the Isle of Man, which is particularly relevant as several of the guidelines could not be implemented without being localised. Reviewers were also concerned about the Clinical Director's lack of commitment to the development and implementation of clinical guidelines.
- g. A rolling programme of audit was not in place. Therapists were starting a quarterly audit programme and some nursing audits had been undertaken. Reviewers saw no evidence of multi-disciplinary audit.
- h. Numbers of operations per surgeon were formally agreed, but only informal monitoring was in place. Some surgeons could therefore be undertaking insufficient numbers of some operations to maintain their competence.

3. Multiple IT Systems

Multiple IT systems were in use, including:

- a. Two electronic patient records, one in the Emergency Department and one for in-patients
- b. Two sets of paper records, one used by doctors and physiotherapists and one by occupational therapists and nurses
- c. Pre-operative assessments recorded on the theatre system
- d. Two operation lists, one printed and one hand-written

Information relating to an individual patient was not brought together and it was very difficult for staff to see the full record for a patient. This carried the risk that information may be missed. This problem was compounded by insufficient IT equipment at ward level, making it more difficult to look at patients' details on the multiple systems. Also, plastering requests were telephoned from the ward to the plaster room with the written confirmation following and sometimes being received after plastering had taken place.

4. Antibiotic Guidelines

Three different elective surgical antibiotic prophylaxis prescribing policies were in use at the time of the review visit, all including the use of Cefuroxime as a first line treatment. Many hospitals try not to use Cefuroxime as a first line treatment due to the evidence linking it to *C. difficile* infection.

5. Long Waiting Times

Waiting times for urgent and routine out-patient appointments, and for surgery, were very long, with waits of well over a year for some patients. Individual consultants had an idea of their waiting times, but this was not aggregated or monitored and data on waiting times was not available to reviewers. Waiting times for some investigations were also very long, for example, patients referred by physiotherapists for MRI scans waited up to a year.

6. Therapy Services

Several issues relating to the musculo-skeletal occupational and physio-therapy services were identified as concerns:

- a. Therapists were not available seven days a week. One physiotherapist was available at weekends, plus one on call, for respiratory conditions and for trauma. Occupational therapists were not available at weekends. This impacted on the active rehabilitation of patients and on the ability to discharge patients at the weekends.
- b. Occupational therapy referrals had to be received by 8.30am for the patient to be seen that day and referrals had to be made on paper (ie. not using any of the available IT systems). This severely affected response times, especially for patients where the need for occupational therapy was identified on a Friday as these patients would not be seen until Monday.
- c. Occupational therapy staffing levels were insufficient with only three occupational therapists for five wards.
- d. Patients with musculo-skeletal problems re-patriated from England were seen by the hospital therapy service even if they had returned home. The therapy service received little advanced notice of these patients. Pre-assessment information was not available and there was no clinical handover to the Isle of Man therapy team. (The Trauma Coordinator was aware of patients with trauma who were returning to the Isle of Man but not about elective patients.)

7. Links with Anaesthetic Services

Links between musculo-skeletal and anaesthetic services were not working well. Reviewers were told that anaesthetists would not all support enhanced recovery. Robust arrangements for agreeing and managing the relationship between orthopaedic and anaesthetic services were not evident. Staff who met reviewers suggested that more collaborative working would improve the patient pathways as there were no structured meetings where all disciplines came together.

8. Discharge from Hospital

Enhanced recovery was not available and the service did not have access to intermediate or 'step down' care (except at Ramsey Hospital for patients of Ramsey GPs). See also 'Transfer from Acute Hospital Care and Intermediate Care' section of this report.

Further Consideration

1. The 'concerns' identified above, in combination, must be impacting on the patient pathways and outcomes for patients. Reviewers recommended that regular audits of achievement of a) NICE Quality Standards for Hip Fracture and b) best practice pathways for total hip and knee replacement would provide baseline data and a mechanism for monitoring progress covering the most significant pathways of care provided by the service. Data from English providers is also available for comparison and benchmarking.
2. All clinical staff commented that they were spending time on administrative tasks which could have been used for clinical work and ward staff were concerned about a shortage of 'housekeepers'. Further work to quantify this could be helpful as a lack of administrative, data collection and house-keeping support may be a) taking staff away from clinical time, b) limiting the ability of the service to develop appropriate governance and c) leading to increased infection risk if standards of cleanliness are not maintained.
3. Neither the orthopaedic, ward or therapy staff could access psychology support or weight management programmes for people with musculo-skeletal problems. This limited the holistic nature of the service provided and would impact on long-term outcomes.
4. Ward-based pharmacy support was not available on Wards 11 and 12. The 'serious concern' (see above) illustrates the value that could have been gained by early involvement of a ward-based pharmacist.

5. The pre-operative assessment pathway had altered to ensure better procedures relating to consent. Rather than simplifying the pathway, this change had added a further step and could involve three or four different attendances prior to surgery. Reviewers suggested that several of the steps could be combined in order to provide a more streamlined experience for patients and to make better use of staff time.
6. The musculo-skeletal patient pathway (orthopaedic, ward and therapy services) did not have arrangements for involving patients in decisions about the organisation of the service. Involvement of patients in the development and agreement of Care Plans was in the early stages of development. A more proactive approach to involving and empowering patients had the potential to improve outcomes and patient experience.
7. Reviewers were told by the Divisional Manager that the governance issues in this report were being addressed by the appointment of four more operational managers. Reviewers considered that additional management posts were not an appropriate response and that existing medical, ward and therapy management should have the responsibility for addressing these issues. Some additional administrative and clerical (or data collection) support may be needed as clinical time was already being spent on administrative tasks.
8. Therapy Services:
 - a. Therapy staffing skill mix appeared high with fewer band 4 and 5 posts than reviewers would have expected for the size of the service.
 - b. The therapy operational document included some patient information, but this was not seen in any of the facilities visited and it was not clear when this information was given to patients.
 - c. Occupational and physiotherapy services were run as separate services, although with an overall manager. Reviewers suggested that greater integration of these services, combined occupational and physiotherapy pathways, shared care plans and multi-skilled assistant staff could improve both quality and efficiency of the service provided.
9. The Theatre Manager attended the Theatre User Group. Other theatre staff who met the visiting team commented that they would appreciate the chance to attend or be more actively involved in the work of the group.
10. Trauma:
 - a. Reviewers suggested that a dedicated weekend trauma list could be trialled, as occurs during 'race weeks'.
 - b. Although the trauma alert call included general surgeons, reviewers were told that they were not usually free enough to respond. Reviewers suggested that this should be audited in order to identify the extent and impact of this problem.
 - c. The service was not involved in any research and development. The visiting team considered that the volume and type of trauma seen on the Isle of Man during 'race weeks' provided a unique opportunity for research and development, possibly undertaken in collaboration with other organisations.
11. Sub-specialty leads were identified but the role they were expected to undertake was not clear. Reviewers suggested that they could be taking a more proactive role in the development of guidelines, data collection and audit for their sub-specialty.
12. Reviewers were told that a shortage of radiographers was sometimes a limiting factor in theatre lists but did not have time to look at this in detail. This issue was also identified in the 2014 WMQRS review of the care of people with cancer and surgical specialties.

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CARE OF PEOPLE WITH CHRONIC PAIN

General Comments and Achievements

Care of people with chronic pain was provided by a committed, caring and motivated team including a consultant (who also had anaesthetic commitments), 1.8 w.t.e. specialist nurses (covering both acute and chronic pain) and a part-time specialist physiotherapist (who was on maternity leave with some cover provided by a senior musculo-skeletal physiotherapist who had been trained by the specialist physiotherapist). Patients could also self-refer to a community physiotherapy service although this was reported as difficult to access via the identified telephone number. Patients who used the service were very appreciative of the service provided (although see comments below in relation to dependence on the service). A second consultant was due to start work in October 2017 and would have sessions allocated to the chronic pain team, including providing cover for absences of the lead consultant. Reviewers were impressed that the service's self-assessment included 'areas for improvement' and staff were clearly aware of changes that could be made to improve the service.

Significant achievements were the establishment of nurse prescribing and the provision of radio-frequency denervation. Training for GPs had been provided with six monthly updates and email communication for advice and urgent assessment.

Good Practice

1. The community pain physiotherapist had implemented a psychosocial model of chronic pain management using the Keele STarT Back programme and comprehensive patient information about self-management.
2. Liaison with the tertiary centre at the Walton Centre was good with appropriate referrals being made and good links to ensure a smooth 'pathway of care' for patients.

Immediate Risks: No immediate risks were identified.

Concerns

1. Staffing

- a. **Clinical psychology or staff with appropriate competences in psychological therapies:** The service had no access to clinical psychology or other staff with appropriate competences in psychological therapies. There was therefore no psychological therapy input to multi-disciplinary assessments and therapies, and no access to a psychologist for suicide risk assessments.
- b. **Physiotherapy:** The service had only a part-time physiotherapist with limited cover for absences (including maternity leave) who did not have sufficient time to attend multi-disciplinary team meetings. Representatives of the community physiotherapy service were also not able to attend multi-disciplinary team meetings.

2. Multi-disciplinary care

Multi-disciplinary assessment and care planning was not in place. The service ran a medical model of out-patient clinics with nurse support but no physiotherapy or clinical psychology input. Therapeutic interventions available 'on island' at the time of the review were mainly drugs and procedures. Patients assessed as needing pain management programmes were referred to tertiary centres due to the lack of multi-disciplinary care available locally. The heavy reliance on drugs and procedures appeared to be perpetuating dependence and disability rather than encouraging self-management and functional restoration. It also contributed to the long waiting list by giving more time to follow-up treatments and less time for new patients.

3. Waiting Times

Waiting time for first out-patient appointment were reported to reviewers variously as two, three and a half, and four and a half years. Some additional clinics were being undertaken but reviewers did not see a clear

plan to reduce waiting times for first outpatient appointment to a reasonable level. This was particularly concerning given the implications on the physical and mental health, employment and well-being of people waiting this length of time in pain.

4. Inappropriate Referrals

Reviewers were told that a high proportion of referrals to the team were inappropriate for a specialist team or had not had appropriate primary care management prior to referral. The service had no pathway showing expected primary care management, no referral criteria and no system for triage or screening referrals (other than for urgency). Inappropriate referrals were generally accepted rather than be returned to general practitioners which resulted in longer waiting times for appropriate referrals.

5. Procedures

Based on the limited information available to reviewers (see comments on 'governance' below), the chronic pain team seemed to be doing a high number of procedures, including facet joint injections, lignocaine infusions, trigger point injections, nerve blocks and cervical root blocks without apparent consideration of latest evidence on the effectiveness of some procedures. There was no auditing structure in place to evaluate the long-term effectiveness of these procedures.

6. Drug Monitoring

Arrangements for controlling entry of new drugs onto the formulary were in place but arrangements for monitoring and control of prescribing thereafter were not robust. Criteria for use of different drugs were not documented or audited and new drugs, such as Qutenza, appeared to be being used without control or challenge. Reviewers commented that this will have workload implications (as patients would need to attend for repeat dressings), as well as significant financial implications.

7. Discharge

Patients were staying with the service for a long time and reviewers were given examples of patients who had been attending every six weeks for five years. The new to follow up ratio for Isle of Man patients in pain clinics was reported as either 4:5 or 2:6, compared with a West Midlands ratio of 6:2. Robust discharge criteria were not documented and reviewers were told that patients who were discharged were just referred back to the service by their GP.

8. Enabling Patient Involvement

Management plans were not documented in an appropriate format for patients to understand. Patients were not routinely given a copy of their GP letter. These were available on request but this was not publicised and patients who met the visiting team were not aware of this facility. Treatment and discharge planning did not appear to involve the patient and there was no 'Stay Well' programme in primary care which patients could access after discharge from the chronic pain service.

9. Governance

Limited data were collected about the care provided. As described above, monitoring of prescribing was not apparent and the number of procedures per patient was not being recorded and monitored. Very few guidelines specific to the Isle of Man were documented and a rolling programme of audit was not in place. The service did not have arrangements for multi-disciplinary review and learning.

Further Consideration

1. Reviewers were told that pain management programmes at tertiary centres cost approximately £10,000 per patient and approximately 15 patients per year were referred. Reviewers suggested that providing this service on the Isle of Man could improve accessibility and improve multi-disciplinary input to the chronic pain team.

2. Reviewers considered that, because of the additional training already undertaken, specialist nurses should consider how functional restoration work could be delivered in conjunction with the specialist and non-specialist physiotherapists for individuals with a medium STaRT score (even without the support of a psychologist – although this would be desirable in the longer term).
3. In general, reviewers considered that the chronic pain team, working with primary care, had the potential to remodel and significantly improve the pathway of care for people with chronic pain. A more timely, responsive and accessible service could be provided within the existing resources and could achieve significant improvement in outcomes for patients.
4. Reviewers were told of problems with supporting the care of patients with cancer-related pain management which had been started in England but could not be supported on the Isle of Man due to pharmacy-related issues. Reviewers did not have time fully to explore this issue and recommended that further work be undertaken locally to investigate and address this problem.

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DRUG AND ALCOHOL TEAM

General Comments and Achievements

The Drug and Alcohol Team (DAT) was working well and providing good care for people with drug and alcohol problems. Team members were highly committed and well-respected. The Team was working towards implementation of the 'Recovery Partnership' Standards. With the exception of the care of children (see below), the Team had appropriate staffing and skill mix including a speciality doctor, social workers, specialist health visitor, Noble's Hospital liaison / older person's nurse, dual diagnosis nurses, criminal justice specialist worker, community support workers, psychologist (post vacant) and administrative support.

Reviewers met a wide range of representatives from services with which DAT liaised, including ambulance, Emergency Department, youth justice, social work, pharmacy, mental health (child and adult), prison and probation representatives. Feedback from these services was positive and all considered DAT was working well and was responsive to client need.

Prescription management processes were robust. Roles and responsibilities were clearly understood and well-managed with good documentation and clear tracking. Pharmacists who met the visiting team had no concerns about DAT's management of medications.

DAT was well-led with clear action plans for addressing issues of concern, good staff supervision and peer support. A good range of audits was undertaken. Multi-disciplinary team meetings were well-attended and were integrated with Motiv-8 (the Isle of Man Tier 2 service). Outcome data seen by the review team showed the service was effective in addressing clients' needs.

Good Practice

1. DAT provided an acute hospital liaison service which provided support for patients and staff and, when appropriate, advice for families.
2. Working arrangements with the Health Services Safeguarding Children Team were good. Arrangements to ensure early prevention and to identify and document risks were in place and appeared to be working well.
3. Liaison with children and young people's social workers about the care of children with drug and alcohol problems was good. Liaison with Looked After Children's services was also working well.
4. The team worked proactively with families with children and took a particularly holistic view of the support required, with the aim of keeping children at home whenever possible.
5. All clients newly accessing the service were offered a health screen which looked at their physical as well as mental health

6. Team members had been trained in recovery and CBT to Masters level (although these skills were not being used at the time of the review visit).

Immediate Risks

1. **Dihydrocodeine prescribing to people in custody**

NB. This immediate risk is not specific to the Drug and Alcohol Team but did relate to the care of people with drug and alcohol problems and involved DAT medical staff.

It was reported that Dihydrocodeine was being prescribed to people in police custody without a drugs test being performed. These services had been advised by the Coroner to ensure everyone in custody had a drugs test before Dihydrocodeine was prescribed but arrangements for this were not yet fully implemented.

2. **Risk Assessments**

Arrangements for recording and accessing risk assessments were not robust. The Rio system provided a range of risk assessment templates, but these related to mental health problems and not the care of people with drug and alcohol problems (for example, safeguarding, risk of overdose and injection-related risks). Separate drug and alcohol-related risk assessments were therefore completed. This resulted in multiple risk assessments without a clear process for staff (including Duty Workers and temporary staff) to access relevant information quickly and easily.

Concerns

1. **Capacity for the Care of Children and Young People**

There was clear evidence that the young person's drug and alcohol worker (a social worker) was providing good care and some good practice was identified. However, she had insufficient capacity for the expected workload and no cover for absences. Over 90 Looked After Children were in care homes, many with drug and alcohol problems. Due to limited capacity, the care provided was becoming reactive rather than proactive, which could have long-term consequences for the children and young people concerned.

2. **Key Performance Indicators**

The Rio IT system did not record some of the work that DAT was undertaking and drug and alcohol-specific key performance indicators for DAT had not been agreed. This had the potential impact of the service being judged unfairly because inappropriate data or inappropriate benchmarks were being used. For example, information on social outcomes (employment, training, housing), the number of detoxifications and whether completed successfully, waiting times or psycho-social interventions provided was not collected. The service was monitored against mental health-specific indicators which were not appropriate for substance misuse services.

3. **Psychology Support**

At the time of the review the psychology post in DAT was vacant and had no cover for absences. DAT service users were only able to access the Community Well-Being Service following discharge from DAT.

4. **Cover for Absences**

DAT had no cover for absences of the Speciality Doctor, including for their work in the prison.

Further Consideration

1. Reviewers commented that provision of psycho-social support and a recovery-focussed service could be developed because of the number of staff trained to Masters level in CBT. This 'offer' would be more robust when the psychologist post was filled but could start with existing staff.
2. The service did not have a 'problem drug and alcohol use' service user group or a peer support group. Although some completed user questionnaires were seen by reviewers, arrangements for service user feedback and for involving service users in decisions about the management of the service were not well-

developed. Strengthening service user and carer involvement mechanisms may help to drive further service improvement and could be used for discussions about any possible changes to the service.

3. Reviewers were told about the recent withdrawal of the acupuncture service which had taken place without consultation with service users, some of whom had completed questionnaires expressing their high regard for this service in helping them manage their condition. Reviewers suggested that it might be worth reconsidering this decision as many drug and alcohol services in England offer acupuncture routinely.
4. DAT was not yet benchmarking activity and outcomes with other services. Reviewers considered that this would be possible through the publicly-available National Treatment Agency for Substance Misuse data profile. This could help the team to justify the work they were doing. Reviewers also suggested that DAT may wish to do more to publicise the good work they were doing.
5. Further development of the psycho-social model and a recovery-focussed service could be achieved through the vibrant and active network of voluntary and community organisations on the Isle of Man. Mapping the available opportunities and potential may be a useful first step. Developing shared care arrangements with GP practices could also help with recovery.
6. In relation to the multiple risk assessments (see immediate risks above), reviewers considered that risk assessments should be together, in one place. The only way to achieve this seemed to be not to complete the Rio risk assessments but to identify on Rio that other risk assessments were available and how to access them.

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SCREENING SERVICES

This review of screening services was based on discussions with the staff providing screening services on the Isle of Man and some telephone discussions with providers of parts of the screening pathway in England. Some aspects of screening had also been considered as part of previous relevant WMQRS review visits on the Isle of Man. The Isle of Man Director of Public Health was not available to meet reviewers during the review visit and so a telephone call took place with reviewers beforehand. This report brings together these findings in relation to screening services on the Isle of Man. It should not be considered as a full quality assurance review of any of the screening programmes.

CERVICAL CYTOLOGY SCREENING

General Comments and Achievements

Cervical cytology screening involved a complex pathway from primary care to colposcopy, with multiple handovers and interdependencies. Overall the service appeared to be working well with good 'fail-safe' follow through. A cohesive team of staff were actively contributing to the development of the service. A new consultant colposcopist (obstetrician and gynaecologist) had started work in the service in September 2016 and was actively driving service quality. Cervical cytology screening on the Isle of Man was mirroring the English National Standards for Cytology. Human papilloma virus screening had been established and new guidelines were being followed.

Good Practice

1. Working relationships with the laboratory in Peterborough were excellent with effective multi-disciplinary team working and good opportunities to learn from staff in the Peterborough service.
2. An open access screening clinic was available.
3. A colposcopy audit programme had been established.

Immediate Risks: No immediate risks were identified.

Concerns

1. Laboratory Service

Reviewers were seriously concerned about the potential impact of NHS England re-procurement of the laboratory service in Peterborough. This had the potential to destabilise cervical cytology laboratory arrangements for Isle of Man residents from December 2017.

2. **Governance:** See the 'Screening Services Overview' section of this report.

Further Consideration

1. Changes to the UK National Screening Committee recommendation for primary human papilloma virus screening will be introduced in the UK in 2019. This will have significant implications for the configuration of laboratories and reviewers suggested that Isle of Man staff should be actively planning for this change.
2. The Isle of Man clinical teams worked well together but the screening pathway was complex and involved multiple handovers. There may be potential to streamline the pathway and improve quality, use of resources and the experience of women being screened.

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BREAST SCREENING

General Comments and Achievements

The Isle of Man breast screening service was aligned to the UK National Screening Committee standards. Women were screened at the Breast Unit at Noble's Hospital. All images were then transferred to Manchester to be read. Between four and six clients were seen at the assessment clinic each week in the Breast Unit. All necessary procedures were also undertaken locally, including vacuum assisted biopsy.

Equipment was of a high standard which enabled more complex procedures to be undertaken and all women needing assessment were seen within two weeks of their mammogram. An accredited breast radiologist was available.

Good Practice

1. Liaison with the Manchester service which read the mammograms was good with the teams meeting on the Isle of Man at least annually.

Immediate Risks: No immediate risks were identified.

Concerns

1. Staffing Levels

The service was having difficulty recruiting breast screening staff with appropriate accredited competences.

2. **Governance:** See the 'Screening Services Overview' section of this report.

Further Consideration

1. Breast screening on the Isle of Man was undertaken two yearly which is more frequent than the UK National Screening Committee standard. Reviewers identified the potential to make the service more cost-effective by increasing the screening interval.
2. There was no identified Director for the breast screening programme. Reviewers recommended that an individual with responsibility for the programme should be identified.

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BOWEL SCREENING

General Comments and Achievements

The Isle of Man bowel screening programme had started in 2011 and the screening age had been extended in line with England. The programme was generally aligned to the UK National Screening Committee standards. The team was unaware of the uptake of the programme but thought this was about average for the UK. Rates of attendance for colonoscopy were good with relatively few patients failing to attend. Clear pathways were in place for the management of patients with more complex conditions. A second bowel screening specialist nurse had been appointed, which had increased the resilience of the programme as cover for absences (expected and unexpected) was now available.

Good Practice

1. A good public awareness campaign aimed at increasing uptake of bowel screening was in place, with material clearly available in several public areas (although it was not clear how the impact of this campaign was being measured).

Immediate Risks: No immediate risks were identified.

Concerns

1. Introduction of 'FIT'

Changes to the English bowel screening programme, including the introduction of the Faecal Immunochemical Test (FIT), will need to be implemented on the Isle of Man if the programme is to continue to be aligned to the UK National Screening Committee standards. This is likely to result in more people needing endoscopy.

2. Endoscopy Capacity

The programme sometimes experienced problems with endoscopy capacity, and with ensuring bowel screening accredited staff were available. Measures to address this were used, including additional lists, but these sometimes had staffing difficulties.

3. **Governance:** See the 'Screening Services Overview' section of this report.

Further Consideration

1. Reports were not available to demonstrate uptake, quality standards and outcomes. Reviewers recommended that these should be produced and reviewed regularly.

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NEW-BORN BLOOD SPOT SCREENING

General Comments and Achievements

This was a well-organised screening programme, run in line with UK National Screening Committee Standards. Communication and liaison with relevant stakeholders, on and off the Isle of Man, was evident.

The programme had a low 'avoidable repeat' rate and was meeting all the expected UK National Screening Committee standards. People moving into the Isle of Man were offered screening and arrangements for screening of babies on the neonatal unit were in place.

Relationships with the regional laboratory and the Isle of Man health visiting service were good and well-established.

Good Practice

1. The Northgate new-born blood spot failsafe system was used by the community midwifery lead and easily identified babies who needed screening.

Immediate Risks: No immediate risks were identified.

Concerns

1. **Governance:** See the 'Screening Services Overview' section of this report.

Further Consideration

1. Access for staff to updates and on-line training modules would help them to keep up to date and to identify any development needs.
2. Reviewers considered that shared learning events involving new-born blood spot screening staff, health visitors and midwifery staff would help to drive improvements to the programme.

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NEW-BORN HEARING SCREENING

General Comments and Achievements

The Isle of Man new-born hearing screening programme had been in place since 1998. A community-based model was used with two part-time members of staff undertaking the screening.

The uptake rate was good (99.3%) with a low rate of parents declining screening. All babies receiving neonatal care were screened while in hospital. Onward referrals were made within appropriate timescales.

Good Practice

1. The programme was run in line with the UK National Screening Committee standards with the exception of an electronic 'failsafe' system (see below).

Immediate Risks No immediate risks were identified.

Concerns

1. **Governance:** See the 'Screening Services Overview' section of this report.

Further Consideration

1. The Northgate electronic 'failsafe' system was not being used. This would bring the programme in line with the UK National Screening Committee standards and would be relatively easy to achieve because it was already in use for new-born blood spot screening.
2. Further work on measuring parental experience of the programme help further to improve the quality of the programme.

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NEW-BORN INFANT PHYSICAL EXAMINATION

General Comments and Achievements

A new-born infant physical examination programme was in place with examinations being carried out by doctors or appropriately training midwives with approximately 10% of midwives having undertaken this training. Six to eight week checks were done by GPs. A paper-based 'failsafe' system was in place.

Good Practice

1. The programme was run in line with the UK National Screening Committee standards with the exception of an electronic 'failsafe' system (see below).

Immediate Risks No immediate risks were identified.

Concerns

1. **Governance:** See the 'Screening Services Overview' section of this report.

Further Consideration

1. The Northgate electronic 'failsafe' system was not being used. This would bring the programme in line with the UK National Screening Committee standards and would be relatively easy to achieve because it was already in use for new-born blood spot screening. The paper-based system relied on health visitors visiting the family in week 3 and asking how the new-born check had gone.

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DIABETIC RETINOPATHY SCREENING

General Comments and Achievements

A formal diabetic retinopathy screening programme was not yet in place. Patients under the care of the Noble's Hospital diabetic service were screened regularly with images graded by a consultant ophthalmologist. Patients whose care was managed in general practice may be screened by a community optician and there was no formal grading process of retinal images for community patients, solely managed in primary care.

Immediate Risks No immediate risks were identified.

Concerns

1. Diabetic retinopathy screening programme

Reviewers were seriously concerned that the arrangements for screening and grading images taken for diabetic patients whose care was managed in primary care were not robust. These patients were not part of a formal screening programme and reviewers were not able to establish whether appropriate equipment was being used. The arrangements governing the hospital-based programme were not clear. Staff who met the visiting team were not aware of the UK National Screening Committee standards and little information about compliance with these could be ascertained.

2. **Governance:** See the 'Screening Services Overview' section of this report.

Further Consideration

1. GPs held a register of all their patients with diabetes and this data was maintained centrally by health services based at Crookall House. This data could be used as a basis for a formal screening programme for the Isle of Man.

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SCREENING SERVICES OVERVIEW

General Comments and Achievements

With the exception of diabetic retinopathy and abdominal aortic aneurysm screening, the Isle of Man had implemented some screening services for its population. From discussion with staff providing services, there was alignment to the UK National Screening Committee standards.

All three cancer screening programmes appeared to have reasonable uptake.

New-born screening programmes were aligned to the UK National Screening Committee standards with the exception of electronic 'failsafe'.

Good Practice

1. New-born blood spot screening had good outcomes with a low overall repeat rate and clear pathways for those screened as positive.
2. The breast screening programme was able to meet applicable standards and had modern, up to date equipment.
3. Multi-disciplinary working was generally good with good arrangements for discussion of results, including good use of modern technology.

Immediate Risks No immediate risks were identified.

Concerns

1. Oversight and Governance of Screening Programmes

Arrangements for oversight and governance of the Isle of Man screening programmes were not in place for any of the programmes reviewed. Uptake (except for cervical, breast and bowel cancer screening), performance, outcomes and impact of the programmes were not, therefore, being monitored. Uptake among vulnerable communities was not being analysed. Oversight of compliance with UK National Screening Committee standards and overall screening pathways was not in place. Responsibility for ensuring oversight and governance of screening programmes was not clear. Some people considered the Director of Public Health had this responsibility, but others were unsure. Reporting arrangements to the Department of Health and Social Care and to Ministers were not clear.

In addition to actions arising from ongoing monitoring of screening programmes, reviewers identified the following issues which required action in the near future:

- a. Liaison with NHS England about arrangements for Isle of Man cervical cytology following the re-procurement being undertaken by NHS England.
- b. Evaluation of the potential impact of changes to the English system for cervical and bowel cancer screening and a proactive approach to the development of these screening programmes.
- c. Implementation of a robust, equitable system of diabetic retinopathy screening

Reviewers were not asked to review the governance of immunisation and vaccination programmes. Reviewers strongly recommended that this should be considered alongside the arrangements for governance of screening programmes to ensure appropriate public health oversight is in place for both.

Further Consideration

1. Responsibility for the 'off island' screening contracts was not clear. Reviewers suggested that these contracts should be reviewed to ensure they are delivering the required standards and providing appropriate reports to support the Isle of Man quality assurance and governance arrangements.
2. Reviewers recommended that the Isle of Man Department of Health and Social Care should consider whether a formal quality assurance review of each screening programme is required in order that compliance with UK National Screening Committee standards is established.

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APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Visiting Team		
Nicola Bengé	Screening & Immunisation Lead	NHS England
Dr Mahesh Chaudhari	Consultant, Pain Management/Anaesthesia	Worcestershire Acute Hospitals NHS Trust
Emily Godfrey	Head of Strategy, Planning and QIPP PMO	NHS South Worcestershire CCG
Helen Jackson	Associate Director for Therapy Services & Allied Health Professional Lead	University Hospitals Birmingham NHS Foundation Trust
Howard King	Head of Operations for Inclusion Services	South Staffordshire and Shropshire NHS Foundation Trust
Catherine Larkin	Clinical Director / Head of Quality and Performance, Inclusion Substance misuse, Mental health and Psychosocial therapies	South Staffordshire and Shropshire NHS Foundation Trust
Dr Gail Parsons	Nurse Consultant, Trauma & Orthopaedics	The Dudley Group NHS Foundation Trust
Dr Adrian Phillips	Director of Public Health	Birmingham City Council
Mr Mathew Revell	Consultant: Trauma & Orthopaedics	The Royal Orthopaedic Hospital NHS Foundation Trust
Dr Narinder Sahota	General Practitioner (previously NHS England Assistant Medical Director)	Walsall
Sandra Smith	Maternity Transformation Early Adopters Programme Lead	NHS England
Gina Stickley	Physiotherapist and Chronic Pain Team Lead Clinician	Birmingham Community Healthcare NHS Trust
Jane Williams	User Representative	

WMQRS Team		
Jane Eminson	Director	West Midlands Quality Review Service
Sarah Broomhead	Assistant Director	West Midlands Quality Review Service

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APPENDIX 2 COMPLIANCE WITH THE QUALITY STANDARDS

Analyses of percentage compliance with the Quality Standards should be viewed with caution as they give the same weight to each of the Quality Standards. Also, the number of Quality Standards applicable to each service varies depending on the nature of the service provided. Percentage compliance also takes no account of ‘working towards’ a particular Quality Standard. Reviewers often comment that it is better to have a ‘No, but’, where there is real commitment to achieving a particular standard, than a ‘Yes, but’ where a ‘box has been ticked’ but the commitment to implementation is lacking. With these caveats, Table 7 summarises the percentage compliance for each of the services reviewed.

Service	Standards Reviewed
Orthopaedics (elective orthopaedics, trauma and orthopaedic therapies)	WMQRS Musculo-skeletal Patient Pathway Quality Standards V1.1 2017
Chronic Pain Team	WMQRS Quality Standards for the Care of People with Chronic Pain V1.3 2014
Drug and Alcohol Team	Community Substance Misuse Services - Quality Standards Framework: The Recovery Partnership 2016

Table 7 - Percentage of Quality Standards met

Details of compliance with individual Quality Standards can be found in a separate document.

Service	Number of Applicable QS	Number of QS Met	% met
Isle of Man Department of Health and Social Care			
Musculo-Skeletal Patient Pathway – Specialist Service	50	14	28
Care of People with Chronic Pain	31	9	29
(Primary Care)	(2)	(1)	(50)
(Chronic Pain Team)	(29)	(8)	(28)
Care of People with Drug and Alcohol Problems - Community Substance Misuse Services - Quality Standards Framework: The Recovery Partnership 2016	75	63	84
Total Health and Social Care for services reviewed with Quality Standards	187	95	51

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APPENDIX 3 KEY TERMS USED IN WMQRS QUALITY STANDARDS FOR THE CARE OF OLDER PEOPLE LIVING WITH FRAILITY

Term	Explanation
Care and Support Plan	A plan summarising the care and support to meet their needs, agreed with a frail older person and their family and carers (where appropriate). Ideally, older people living with frailty will have a single care and support plan.
Care Coordinator	A care coordinator (or key worker) has an overview of the health and social care of an older person living with frailty. Coordinating and maintaining this overview of the care pathway (i.e. 'case management') is central to the care coordinator / key worker role. The care coordinator will normally also be the person responsible for ensuring a review of the older person's Care and Support Plan takes place as planned. The care coordinator will not be expected to answer all queries and will direct queries appropriately. The role may include providing support for personalised budgets.
Comprehensive Geriatric Assessment	A holistic, multi-disciplinary assessment of the needs of a frail older person, undertaken with the older person themselves and their families or carers by the Frailty Team.
Emergency Care Plans	A simple, accessible, portable, easily available summary of what should happen in an emergency, developed and agreed with their frail older person and their main carers.
Frailty	A common long-term condition related to age, but not directly associated with it, which is characterised by a gradual loss of inbuilt reserves resulting in vulnerability to sudden deterioration as a result of relatively mild stressors.
Frailty screening	A systematic approach to identifying if an older person is frail.
Frailty screening tool	A systematic approach to undertaking frailty screening. A common frailty screening tool should, ideally, be used across each health and social care economy. Frailty screening should not cause delay in treatment and care. Depending on the severity and complexity of needs, frailty screening may lead to an older person being offered: <ul style="list-style-type: none"> a. Information and 'signposting' to available services and support b. Holistic frailty assessment (within the service or by referral) c. Referral to the Frailty Team for comprehensive geriatric assessment
Frailty Team (Care of Older People Service)	A multi-disciplinary team providing comprehensive (multidisciplinary) geriatric assessments and overseeing the care of the frailest older people, as well as providing specialist advice and guidance to other services. The Frailty Team is expected to provide care for these older people living with frailty in the community and if they are admitted to hospital. Models with separate community and hospital teams are unlikely to be an efficient way of meeting the Quality Standards, except in geographical areas which refer to several acute hospitals with no main acute provider. One Frailty Team for each health and social care 'economy' is therefore expected to be the norm. The Frailty Team will need a hospital base as well as working in the community. The Team may not be called a 'Frailty Team' and may have another name, such as 'Care of Older People' service.

Term	Explanation
Health and social care economy	A health and social care 'economy' is the statutory and voluntary sector providers and commissioners of care for older people living with frailty for a defined area. This area will normally be the catchment area for an acute hospital taking acute medical admissions, although special arrangements may be needed in geographical areas which refer to several acute hospitals with no main provider of acute care.
Holistic frailty assessment	A holistic assessment of the needs of a frail older person, undertaken with the older person themselves and their families or carers. This assessment may be uni-disciplinary but with more detailed assessments available as required. Holistic frailty assessments may be undertaken by a range of services and settings, for example, general practice, social services teams, admission avoidance teams, community nursing teams, admission wards, long-term conditions teams and mental health services. Responsibility for a holistic frailty assessment lies with a registered health or social care professional, although aspects of the assessment may be undertaken by non-registered staff, including voluntary sector organisations, on their behalf.

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