WM QRS West Midlands Quality Review Service

Isle of Man Government
Reiltys Ellan Vannin

Review of:

- **Acute Cardiac Conditions and Coronary Care**
- **Respiratory Conditions**
- **Anticoagulation Service**
- **Emergency Ambulance Service**
- **Air Ambulance**
- **Speech & Language**
- **Pharmacy**
- **Cardiac – physiology Service**
- **Endocrine Service**
- **Dermatology Service**
- **Non-Emergency Ambulance Transport**
- **Podiatry Services**
- **Dietetic Services**
- **Physiotherapy and Occupational Therapy Services (acute and community)**

Isle of Man Department of Health and Social Care

Part 2 – Appendix 2

Visit Date: 5th, 6th, 7th & 8th March 2018 Report Date: June 2018

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APPENDIX 2 COMPLIANCE WITH THE QUALITY STANDARDS

This document only contains compliance with the Quality Standards. The reports for each of the services reviewed can be found in the main report.

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 1 summarises the percentage compliance for each of the services reviewed.

Table 1 - 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
Acute Cardiac Conditions and Coronary Care	35	16	46%
Cardiac - respiratory Service	25	12	48%
Respiratory Conditions	39	27	69%
Endocrine Service	29	13	45%
Anticoagulation Service	23	14	61%
Dermatology Service	40	14	35%
Emergency Ambulance Service	41	21	51%
Air Ambulance	21	10	48%
Physiotherapy and Occupational Therapy Services (acute and community)	31	20	65%
Podiatry Services	29	18	62%
Speech & Language	57	49	86%
Dietetic Services	32	22	69%
Pharmacy	123	53	43%
Total Health and Social Care for services reviewed with Quality Standards	**525**	**289**	**55%**

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ACUTE CARDIAC CONDITIONS AND CORONARY CARE

Ref	Quality Standards	Met?	Reviewers' Comments
XX-101	**Service Information** Each service should offer patients and their carers written information covering: a. Organisation of the service, such as opening hours and clinic times b. Staff and facilities available c. How to contact the service for help and advice, including out of hours d. Range of other services available locally	Y	Clinic times were not clear in the evidence seen, but otherwise all information was available. Appointment letters sent to patients were not signed (i.e. sent by an identifiable person). There was a number to ring if patients could not attend, but this was not for general queries. Patients were given a telephone number to contact the nurses for help and advice.
XX-102	**Condition-Specific Information** Information for patients and their carers should be available covering, at least: a. Brief description of their condition and its impact b. Self-care c. Possible complications and how to prevent these d. Pharmacological and non-pharmacological therapeutic and rehabilitation interventions offered by the service e. Possible side-effects of therapeutic and rehabilitation interventions f. Symptoms and action to take if unwell g. DVLA regulations and driving advice (if applicable) h. Health promotion, including smoking cessation, health eating, weight management, exercise, alcohol use, sexual and reproductive health, and mental and emotional health and well-being i. For frail older people: Pain, depression, skin integrity, falls and mobility, continence, safeguarding issues, delirium and dementia, nutrition and hydration, sensory loss, activities of daily living, vital signs and end of life issues j. Sources of further advice and information k. Self care	Y	Limited information was available on pharmacological interventions. Some information seen by reviewers had exceeded its documented review dates.
XX-102H	**Condition-Specific Information - Cardiac** Information should cover: a. Cardiac presentations and conditions b. Investigations and interventions	Y	Information was displayed on information boards and a range of leaflets was available in the ward areas.

Ref	Quality Standards	Met?	Reviewers' Comments
XX-103	**Care Plan** Each patient and, where appropriate, their carer should discuss and agree their Care Plan, and should be offered a written record covering at least: a. Agreed goals, including life-style goals b. Self-management c. Planned assessments ,therapeutic and/or rehabilitation interventions d. Early warning signs of problems, including acute exacerbations, and what to do if these occur e. Planned review date and how to access a review more quickly, if necessary f. Who to contact with queries or for advice The Care Plan should be communicated to the patient's GP and to relevant other services involved in their care.	Y	Care planning was in place and reviewers were told that there were plans to implement an electronic care planning system in the future.
XX-104	**Review of Care Plan** A formal review of the patient's Care Plan should take place as planned and, at least, six monthly. This review should involve the patient, where appropriate, their carer, and appropriate members of the multi-disciplinary team. The outcome of the review should be communicated in writing to the patient and their GP.	N/A	This QS was not applicable due to the short duration of admissions.
XX-105	**Contact for Queries and Advice** Each patient and, where appropriate, their carer should have a contact point within the service for queries and advice. If advice and support is not immediately available, then the timescales for a response should be clear. Response times should be no longer than the end of the next working day. All contacts for advice and a sample of actual response time should be documented.	Y	Admission leaflets included a contact number for patients and carers to phone with queries. A discharge pro forma was faxed to GPs and a copy given to patients. Patients were given a contact number if they required any advice after discharge. The ward team also kept a diary log which recorded patient calls and the advice given.
XX-106	**School Health Care Plan (Services caring for children and young people only)** A School Care Plan should be agreed with each child or young person covering, at least: a. School attended b. Care required while at school including medication c. Responsibilities of carers and of school staff d. Likely problems and what to do if these occur, including what to do in an emergency e. Arrangements for liaison with the school f. Review date and review arrangements	N/A	This standard is N/A as this is an adult service; however, reviewers did note that an occasional patient under 18 years of age might be admitted. The service may wish to reconsider how they would meet this standard should under 18-year-old admissions become more than 'exceptionally rare'.

Ref	Quality Standards	Met?	Reviewers' Comments
XX-195	**Transition to Adult Services** Young people approaching the time when their care will transfer to adult services should be offered: a. The opportunity to discuss the transfer of care with paediatric and adult services b. A named coordinator for the transfer of care c. A preparation period prior to transfer d. Written information about the transfer of care including arrangements for monitoring during the time immediately afterwards	Y	Transition of young people to adult services was led by the paediatric cardiac service at Alder Hey Hospital NHS Trust. A general hospital document covering transition to adult services was in place.
XX-196	**Discharge Information** On discharge from the service, patients and their carers should be offered written information covering at least: a. Care after discharge b. Return to normal activities c. Ongoing self-management of their condition d. Possible complications and what to do if these occur e. Who to contact with queries or concerns	Y	Reviewers saw examples of an admission leaflet, a cardioversion leaflet and a transoesophageal echocardiogram (TOE) leaflet. They also saw a cardiac rehabilitation nurse contact card. Patient information was available covering 'c' and 'd'.
XX-197	**General Support for Patients and Carers** Patients and carers should have easy access to the following services and information about these services should be easily available: a. Interpreter services, including British Sign Language b. Independent advocacy services c. Complaints procedures d. Social workers e. Benefits advice f. Spiritual support g. HealthWatch or equivalent organisation h. Relevant voluntary organisations providing support and advice i. Self-care	N	'b' was not met. Information about how to complain, and how to access a social worker and the chaplaincy was displayed in the ward and clinic areas. Social workers were available to give benefits advice to patients. An on-call chaplain service was available 24/7. Patient support groups were in place. A quality and safety group considered all complaints received.
XX-198	**Carers' Needs** Carers should be offered information on: a. How to access an assessment of their own needs b. What to do in an emergency c. Services available to provide support	Y	All information was provided in the welcome letter given to patients.
XX-199	**Involving Patients and Carers** The service should have: a. Mechanisms for receiving regular feedback from patients and carers about treatment and care they receive b. Mechanisms for involving patients and carers in decisions about the organisation of the service c. Examples of changes made as a result of feedback and involvement of patients and carers	Y	However, reviewers considered that the team should formalise mechanisms for receiving regular feedback. The patient audits in 2016 and 2017 had limited responses. A hot board and suggestions box were in place in the ward area.

Ref	Quality Standards	Met?	Reviewers' Comments
XX-201	**Lead Clinician** A nominated lead clinician should have responsibility for staffing, training, guidelines and protocols, service organisation, governance and for liaison with other services. The lead clinician should be a registered healthcare professional with appropriate specialist competences in this role and should undertake regular clinical work within the service.	Y	
XX-202	**Staffing Levels and Skill Mix** Sufficient staff with appropriate competences should be available for the: a. Number of patients usually cared for by the service and the usual case mix of patients b. Service's role in the patient pathway and expected timescales c. Assessments and therapeutic and/or rehabilitation interventions offered by the service d. Use of equipment required for these assessments, therapeutic and/or rehabilitation interventions e. Urgent review within agreed timescales An appropriate skill mix of staff should be available including medical, nursing, allied health professionals, social care professionals, support workers and other staff required to deliver the range of assessments and therapeutic and/or rehabilitation interventions offered by the service. Cover for absences should be available so that the patient pathway is not unreasonably delayed, and patient outcomes and experience are not adversely affected, when individual members of staff are away.	N	Insufficient staff were available to provide temporary pacing for patients out of hours. See immediate risk section of the main report for detail. Nurse staffing was generally at appropriate levels and there was access to bank nurses; however, availability was often limited if needed to cover sickness. Overtime was supported if other avenues had been explored.
XX-203	**Service Competences and Training Plan** The competences expected for each role in the service should be identified. A training and development plan for achieving and maintaining competences should be in place.	Y	A care quality framework was in place alongside job descriptions. Reviewers saw evidence of mandatory training. Staff were able to complete mandatory training on-line, which helped improve compliance. A healthcare assistant core certificate was in place. Level one, two and three nurse competences were assessed.

Ref	Quality Standards	Met?	Reviewers' Comments
XX-203H	**Service Competences and Training Plan – Cardiac** Staff with competences in the investigations and interventions appropriate to the usual case mix of patients should be available.	N	Reviewers were particularly concerned that staff were not available out of hours with competences to provide temporary pacing. Out of hours patients were stabilised and flown off-island. Reviewers were concerned that this method was sub-optimal care and could lead to significant deterioration. Reviewers felt this arrangement posed a serious risk to this patient group. Nursing level one and two competences were completed in-house. Nursing level three competences were supported by Manchester Metropolitan University.
XX-298	**Competences – All Health and Social Care Professionals** All health and social care professionals working in the service should have competences appropriate to their role in: a. Safeguarding children and/or vulnerable adults b. Recognising and meeting the needs of vulnerable children and/or adults c. Dealing with challenging behaviour, violence and aggression d. Mental Capacity Act and Deprivation of Liberty Safeguards e. Resuscitation	Y	Reviewers identified that staff were aware of and able to identify vulnerable children.
XX-299	**Administrative, Clerical and Data Collection Support** Administrative, clerical and data collection support should be available.	N	Specialist nurses were undertaking their own administration, which limited their availability for direct patient contact. Reviewers noted there was a significant backlog of clinical letters (reviewers were aware of a backlog between 10 and 16 weeks). Reviewers were concerned that these letters sometimes contained instructions to GPs to commence treatment for patients. See main report for details. Reviewers saw that there was limited data collection to measure both the backlog and the impact of the backlog on patient care.

Ref	Quality Standards	Met?	Reviewers' Comments
XX-301	**Support Services** Timely access to an appropriate range of support services should be available.	N	Access to echocardiograms on the ward was on request only. Issues were also identified in obtaining echo studies. Patients were also referred to Liverpool with the results of these studies. Given the capacity issues, the visiting team were unable to identify that the prioritisation of patients for echo studies ensured that the limited resources were being maximised appropriately. Reviewers were told that access to occupational therapists took approximately five days. Physiotherapy was available within 24 hours. Good pharmacy support by the Isle of Man team was identified; however, it was noted that this was limited at weekends. The crisis team was available for patients with mental health issues and support for mental capacity assessments was available via the Department of Health and Social Care (DHSC) intranet. There was daily support for patients with dementia.
XX-303H	**Investigations and Interventions** Investigations and interventions appropriate to the case mix of patients should be available.	N	The service understood the limitations of the provision they were able to make, and when to refer off-island for tertiary interventions. Please see comment in Standard XX-203H. Reviewers were particularly concerned that there was no out of hours cover for temporary pacing. Out of hours, patients were stabilised and flown off-island. Reviewers were concerned that this method was sub-optimal care and could lead to significant deterioration. Reviewers felt this arrangement posed a serious risk to this patient group. There was clear evidence of the use of referral forms.

Ref	Quality Standards	Met?	Reviewers' Comments
XX-401	**Facilities** Facilities available should be appropriate for the assessments, therapeutic and/or rehabilitation interventions offered by the service for the usual number and case mix of patients.	Y	
XX-402	**Equipment** Timely access to equipment appropriate for the service provided should be available. Equipment should be appropriately maintained.	Y	Reviewers saw a good range of specialist equipment but a lack of more basic equipment. Staff reported that they were short of tablets to record patient observations and automatic devices recording patient observations such as blood pressure. Reviewers were concerned about the reliance on charitable funding rather than there being a structured plan for replacement. Equipment was not covered by a capital replacement programme and there was limited evidence of a plan for replacing equipment that had reached the end of its working life.
XX-499	**IT System** IT systems for storage, retrieval and transmission of patient information should be in use for patient administration, clinical records, outcome information and other data to support service improvement, audit and revalidation.	N	The IT system in use appeared difficult to navigate and not entirely intuitive. It was not able to generate outcome and activity data that would allow service planning and delivery modelling. Electronic patient records were in place; where paper records were used they were scanned in as part of the record. The current system was not used by the clinical teams for auditing outcome data or performance, as navigating it and extracting data were difficult. Reviewers noted that the digital IT strategy was showing as green (i.e. completed), which is at odds with the challenges in its use identified above.

Ref	Quality Standards	Met?	Reviewers' Comments
XX-501H	**Diagnosis and Assessment Guidelines** Guidelines on diagnosis and assessment should be in use covering the usual case mix of patients referred to the service. Guidelines should cover: a. Common presentations b. Investigations appropriate to the usual case mix of patients.	N	Reviewers saw that a significant number of the guidelines and evidence used (and upon which the service relied) were out of date. For example, Acute coronary syndrome (ACS) was out of date in 2003; Heart Failure in 2015; Percutaneous Coronary Intervention (PCI) in 2013 Reviewers saw that there were some guidelines in place. The service was able to recognise where there were gaps in the guidelines available and in such cases, they followed NICE guidelines.
XX-502H	**Clinical Guidelines – Cardiac** Guidelines should cover cardiac conditions relevant to the usual case mix of patients should be in use covering, at least: a. Therapeutic and/or rehabilitation interventions offered by the service b. Monitoring and follow up	N	As QS XX-501H.
XX-503H	**Additional Guidelines – Cardiac** Guidelines should be in use covering: a. Assessment of patients with cardio-vascular disease prior to non-cardiac surgery b. Assessment of patients prior to cardiac surgery c. Care of patients following cardiac surgery d. Management of critically ill patients with haemodynamic disturbances e. Heart disease in pregnancy	Y	Guidelines for heart disease in pregnancy were in place. Surgical guidelines were in place with Liverpool Heart and Chest Hospital. However, some of the evidence seen, for example guidance on the use of Clexane, did not include publication or review dates.
XX-595	**Transition** Guidelines on transition of young people from paediatric to adult services should be in use covering, at least: a. Involvement of the young person and, where appropriate, their carer in planning the transfer of care b. Involvement of the young person's general practitioner in planning the transfer c. Joint meeting between paediatric and adult services in order to plan the transfer d. Allocation of a named coordinator for the transfer of care e. A preparation period prior to transfer f. Arrangements for monitoring during the time immediately after transfer	N/A	It was rare for there to be young people transitioning to adult services. If required, informal mechanisms were in place with local and tertiary services.

Ref	Quality Standards	Met?	Reviewers' Comments
XX-596	**Discharge Guidelines** Guidelines on discharge from the service should be in use.	N	Guidelines covering discharge from the service were not yet in place. Hospital discharge guidelines were in place.
XX-599	**Care of Vulnerable People** Guidelines for the care of vulnerable children, young people and adults should be in use, in particular: a. Identification of vulnerable people b. Individualised care plans for people identified as being particularly vulnerable c. Restraint and sedation d. Missing patients e. Mental Capacity Act and the Deprivation of Liberty Safeguards f. Safeguarding g. Information sharing h. Palliative care i. End of life care	N	The guidance for 'a' that was accessible on the intranet was from 1999. Guidelines for 'h and 'i' were available in hard copy but were not accessible on the Noble's Hospital intranet.
XX-601	**Operational Policy** The service should have an operational policy describing the organisation of the service including, at least: a. Expected timescales for the patient pathway, including initial assessment, start of therapeutic and/or rehabilitation interventions and urgent review, and arrangements for achieving and monitoring these timescales b. Responsibility for giving patient and carer information at each stage of the patient journey c. Arrangements for responding to patients' queries or requests for advice by the end of the next working day d. Arrangements for follow up of patients who 'do not attend' e. Arrangements for multi-disciplinary discussion of appropriate patients f. Arrangements for liaison with key support services (QS XX-301) g. Arrangements for maintenance of equipment (QS XX-402) h. Responsibilities for IT systems (QS XX-499)	Y	However, there was neither a formal MDT with Liverpool Heart and Chest Hospital nor a service level agreement covering referral and service delivery.

Ref	Quality Standards	Met?	Reviewers' Comments
XX-601H	**Operational Policy – Cardiac** The operational policy should include: a. Responding to requests for assessment by the Emergency Department or acute medical and surgical units within one hour of request b. Ensuring all patients are admitted within one hour of the decision to admit and are on an appropriate specialty ward within 24 hours of the decision to admit c. Arrangements for multi-disciplinary discussion with: i. Staff undertaking investigations and interventions ii. Critical care iii. Cardiac surgery	N	Evidence of much of this was seen; however, reviewers again noted that there was neither a formal MDT with Liverpool Heart and Chest Hospital nor an SLA to manage referral and service delivery. There was an ITU transfer form to support these patients.
XX-602	**Liaison with Other Services** Review meetings should be held at least annually with key support services to consider liaison arrangements and address any problems identified.	N	There was neither a formal MDT with Liverpool Heart and Chest Hospital nor an SLA to manage referral and service delivery. Electronic referral forms were in place to support the rapid and accurate transfer of information. Reviewers noted that there was no formal data collection or analysis to help the service understand its level of provision or outcomes for those patients receiving care off-island.
XX-701	**Data Collection** Regular collection and monitoring of data should be in place, including: a. Referrals to the service, including source of appropriateness of referrals b. Number or assessments, urgent reviews and therapeutic and /or rehabilitation interventions undertaken by the service c. Outcome of assessments and therapeutic and /or rehabilitation interventions d. Number of discharges from the service and type of care after discharge e. Key performance indicators	N	Limited data collection was in place. There was no process of benchmarking data against other providers; for example, if there were Myocardial Ischaemia National Audit Project (MINAP) data these could be used to benchmark against English hospitals' provision. Key performance indicators (KPIs) had not been agreed to enable any analysis of service outcomes. The average wait at the time of the visit for a new outpatient appointment was nine months.
XX-702	**Audit** The services should have a rolling programme of audit of compliance with: a. Evidence-based clinical guidelines (QS XX-500s) b. Standards of record keeping c. Timescales for key milestones on the patient pathway	N	As QS XX-701: there was no audit programme in place. Reviewers noted that in some areas (e.g. cardiac rehabilitation) some 'mini-audits' were undertaken.

Ref	Quality Standards	Met?	Reviewers' Comments
XX-702H	**Audits – Cardiac** The service should participate in all relevant national audits, including submitting data and consideration of results and comparative data.	N	Data were not routinely collected or analysed to help understand or benchmark outcomes.
XX-703	**Key Performance Indicators** Key performance indicators (QS XX-701) should be reviewed regularly with Trust (or equivalent) management and with commissioners.	N	Reviewers were unable to identify any formal KPIs that were collected or measured. The service did not have formal delivery standards that were seen by the review team.
XX-798	**Multi-disciplinary Review and Learning** The service should have multi-disciplinary arrangements for a. Review of and implementing learning from positive feedback, complaints, outcomes, incidents and 'near misses' b. Review of and implementing learning from published scientific research and guidance c. Ongoing review and improvement of service quality, safety and efficiency	N	Weekly morbidity and mortality meetings were in place (held on a Wednesday), but the cardiologist was unable to attend these meetings. Reviewers questioned how effective these meetings were without the input of the cardiologist. Reviewers identified that the incident reporting system (PRISM) did not alert the ward sister to incidents in order that timely action could be taken. The hospital was planning to implement the DATIX incident system in the future.
XX-799	**Document Control** All policies, procedures and guidelines should comply with Trust (or equivalent) document control procedures.	N	Some information provided was either out of date or undated. The quality of information was variable, although the team had plans to review all information.

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CARDIAC - RESPIRATORY SERVICE

Ref	Quality Standards	Met?	Reviewers' Comments
XX-101	**Service Information** Each service should offer patients and their carers written information covering: a. Organisation of the service, such as opening hours and clinic times b. Staff and facilities available c. How to contact the service for help and advice, including out of hours d. Range of other services available locally	Y	The DHSC website had some information about types of investigations and opening times of the department. A telephone number was included in the patient letter to enable patients to change their appointment time. In the department there was information about other local services, and a board that explained which staff were on duty.
XX-102	**Condition-Specific Information** Information for patients and their carers should be available covering, at least: a. Brief description of the procedure and its impact b. Who will be present at the procedure c. Possible complications and how to prevent these d. Consent e. Sources of further advice and information	Y	A wide range of British Heart Foundation and local information was displayed in the clinic areas. Staff working in the department were also listed. However, appointment letters to patients explaining the procedure would benefit from review to make it clear that patients could ring the telephone number for advice as well as changing their appointment time, and to add a named contact/valediction.
XX-105	**Contact for Queries and Advice** Each patient and, where appropriate, their carer should have a contact point within the service for queries and advice. If advice and support is not immediately available, then the timescales for a response should be clear. Response times should be no longer than the end of the next working day. All contacts for advice and a sample of actual response time should be documented.	Y	An answerphone messaging service was available and checked during normal working hours of the department.
XX-196	**Discharge Information** On discharge from the service, patients and their carers should be offered written information covering at least: a. Care after discharge b. Return to normal activities c. Ongoing self-management of their condition d. Possible complications and what to do if these occur e. Who to contact with queries or concerns	N/A	However, post-procedure advice was given to patients.

Ref	Quality Standards	Met?	Reviewers' Comments
XX-197	**General Support for Patients and Carers** Patients and carers should have easy access to the following services and information about these services should be easily available: a. Interpreter services, including British Sign Language b. Independent advocacy services c. Complaints procedures d. Social workers e. Benefits advice f. Spiritual support g. HealthWatch or equivalent organisation h. Relevant voluntary organisations providing support and advice	N	'b' was not met. For some services the team would refer back to the GP or medical team responsible for the patient's care.
XX-198	**Carers' Needs** Carers should be offered information on: a. How to access an assessment of their own needs b. What to do in an emergency c. Services available to provide support	N/A	
XX-199	**Involving Patients and Carers** The service should have: a. Mechanisms for receiving regular feedback from patients and carers about treatment and care they receive b. Mechanisms for involving patients and carers in decisions about the organisation of the service c. Examples of changes made as a result of feedback and involvement of patients and carers	N	Mechanisms for feedback and involving patients and carers in decisions about the organisation of the service were not formalised. However, changes as a result of feedback from patients had been actioned; for example, domiciliary visits for device checks and a pacing follow-up clinic at Ramsey now took place.
XX-201	**Lead Clinician** A nominated lead clinician should have responsibility for staffing, training, guidelines and protocols, service organisation, governance and for liaison with other services. The lead clinician should be a registered healthcare professional with appropriate specialist competences in this role and should undertake regular clinical work within the service.	Y	

Ref	Quality Standards	Met?	Reviewers' Comments
XX-202	**Staffing Levels and Skill Mix** Sufficient staff with appropriate competences should be available for the: a. Number of patients usually cared for by the service and the usual case mix of patients b. Service's role in the patient pathway and expected timescales c. Assessments and therapeutic and/or rehabilitation interventions offered by the service d. Use of equipment required for these assessments, therapeutic and/or rehabilitation interventions e. Urgent review within agreed timescales An appropriate skill mix of staff should be available including medical, nursing, allied health professionals, social care professionals, support workers and other staff required to deliver the range of assessments and therapeutic and/or rehabilitation interventions offered by the service. Cover for absences should be available so that the patient pathway is not unreasonably delayed, and patient outcomes and experience are not adversely affected, when individual members of staff are away.	N	Because of the small number of staff there was no cover for staff absence. Staff would cross cover where possible, but this option was limited due to the specialist competence required to deliver some investigations. The team routinely relied on bank staff to cover some sessions. There was one WTE vacancy for a cardiac physiologist, and although the team had appointed to the post, the post holder was unable to commence before the autumn of 2018. The service had not been able to cover with a locum physiologist. There was only one pacing physiologist available for the pacing clinic (national recommendation is that two qualified pacing physiologists should be available), although the team ensured that an associated practitioner was always present.
XX-203	**Service Competences and Training Plan** The competences expected for each role in the service should be identified. A training and development plan for achieving and maintaining competences should be in place.	Y	Because the team was small, competences had been defined for each team member rather than the service as a whole.
XX-204	**Competences – All Health and Social Care Professionals** All health and social care professionals working in the service should have competences appropriate to their role in: a. Safeguarding children and/or vulnerable adults b. Recognising and meeting the needs of vulnerable children and/or adults c. Dealing with challenging behaviour, violence and aggression d. Mental Capacity Act and Deprivation of Liberty Safeguards e. Resuscitation	Y	However, the mandatory training programme was not specified by the hospital, and therefore the lead selected the areas which were deemed appropriate. The lead manager was not able to access data to monitor the compliance of the team, and relied on staff confirming that they had completed all the relevant training at the time of their annual appraisal.

Ref	Quality Standards	Met?	Reviewers' Comments
XX-299	**Administrative, Clerical and Data Collection Support** Administrative, clerical and data collection support should be available.	N	The service had only 1.62 WTE admin support to cover the pre- and post-procedure administration. This included co-ordinating and booking any elective admissions for transoesophageal echocardiogram (TOE), pacemaker implants and direct current cardioversion (DCCV). There was no administrative support for data collection.
XX-301	**Support Services** Timely access to the following services should be available: a. IT support b. Porters c. Patient transport d. Security e. Cleaning f. Linen supplies g. CSSD h. Pharmacy, covering advice and supply of drugs and medical gas testing i. Infection control advice j. Medical records	N	Clinic schedules were often disrupted by the late arrival of patients who required non-emergency patient transport to attend investigations.
XX-401	**Facilities** Facilities available should be appropriate for the assessments, therapeutic and/or rehabilitation interventions offered by the service for the usual number and case mix of patients, including: a. Privacy, dignity and security for patients b. Control of infection c. Storage of drugs and contrast media	Y	
XX-402	**Equipment** Timely access to equipment appropriate for the service provided should be available. Equipment should be appropriately maintained.	Y	The service had a wide range of equipment which had been purchased using charitable donations by the British Heart Foundation (IOM). Staff reported that they had a good service from external and in-house engineers.

Ref	Quality Standards	Met?	Reviewers' Comments
XX-499	**IT System** IT systems for storage, retrieval and transmission of patient information should be in use for patient administration, clinical records, outcome information and other data to support service improvement, audit and revalidation.	N	Multiple systems were in use. Staff could record test data and reports in digital format but there was heavy reliance on the manual transfer of files. Staff reported that there were difficulties in the installing software required by some medical equipment as each piece of software was classed as a project and then often delayed by the agreement process put in place by the IOM government IT service. Storage of cardiac tests on the Medway hospital system was not yet possible.
XX-502	**Clinical /Procedural Guidelines** Guidelines on management of the usual case mix of patients referred to the service should be in use covering, at least: a. all diagnostic tests offered by the service b. Referral Guidelines for referring GPs and referring hospital clinicians. c. Consent d. Monitoring and follow up e. Medicines management	Y	However, the hospital consent procedure was due for review in June 2017.
XX-503	**Procedural Policies** Policies for the service should be in use covering, at least: a. Infection Control b. Management of hazardous substances and materials c. Moving and handling d. Use of protective equipment e. Decontamination of equipment and environment f. Risk Management including reporting and management of adverse healthcare events (incidents and errors) g. Management of Clinical Records	N	Hospital policies accessible on the intranet for 'e' and 'g' did not cover all areas. The decontamination policy was for haemodialysis services, and the management of clinical records only covered maternity services.
XX-504	**Reporting Guidelines** Reporting guidelines should be in use covering: a. Roles and responsibilities b. Agreed reporting formats c. System to assure quality, accuracy and verification of reports d. System to ensure amendments are issued within specified timescales (when required)	Y	

Ref	Quality Standards	Met?	Reviewers' Comments
XX-599	**Care of Vulnerable People** Guidelines for the care of vulnerable children, young people and adults should be in use, in particular: a. Identification of vulnerable people b. Individualised care plans for people identified as being particularly vulnerable c. Violence and aggression d. Missing patients e. Mental Capacity Act and the Deprivation of Liberty Safeguards f. Safeguarding g. Information sharing h. Palliative care i. End of life care	N	'a': the only policy that could be located on the hospital intranet was from 1999. 'e', DHSC policy: information about capacity was in place. 'h' and 'i' were not applicable to the cardiac physiology department.
XX-601	**Operational Policy** The service should have an operational policy describing the organisation of the service from referral to discharge including, at least: a. Expected timescales for the patient pathway b. Responsibility for giving patient and carer information at each stage of the patient journey c. Arrangements for how, when and by whom results/reports will be communicated. d. Arrangements for responding to patients' queries or requests for advice by the end of the next working day e. Arrangements for follow up of patients who 'do not attend' f. Arrangements for multi-disciplinary discussion of appropriate patients g. Arrangements for liaison with key support services (QS XX-301) h. Arrangements for maintenance of equipment (QS XX-402) i. Arrangements for out of hours provision j. Responsibilities for IT systems (QS XX-499)	N	An operational policy was in the process of being developed.
XX-602	**Liaison with Other Services** Review meetings should be held at least annually with key support services to consider liaison arrangements and address any problems identified.	Y	Some meetings had been held with Alder Hey and Liverpool Heart and Chest Hospital but in practice staff would contact the tertiary services if there were any problems. There were good links with other MDTs in the hospital.

Ref	Quality Standards	Met?	Reviewers' Comments
XX-701	**Data Collection** Regular collection and monitoring of data should be in place, including: a. Referrals to the service, including source of appropriateness of referrals b. Number or assessments, urgent reviews and therapeutic and /or rehabilitation interventions undertaken by the service c. Outcome of assessments and therapeutic and /or rehabilitation interventions d. Number of discharges from the service and type of care after discharge e. Key performance indicators	N	Some data were collected on echo and pulmonary function. Data on capacity was not collected, although the service did use appointment usage as a gauge. DNA rates were around 1%.
XX-702	**Audit** The services should have a rolling programme of audit of compliance with: a. Evidence-based clinical guidelines (QS XX-500s) b. Standards of record keeping c. Timescales for key milestones on the patient pathway	N	An audit programme as specified in the QS was not yet in place.
XX-703	**Key Performance Indicators** Key performance indicators (QS XX-701) should be reviewed regularly with Trust (or equivalent) management and with commissioners.	N	KPIs had not yet been defined to support service monitoring and development.
XX-798	**Multi-disciplinary Review and Learning** The service should have multi-disciplinary arrangements for a. Review of and implementing learning from positive feedback, complaints, outcomes, incidents and 'near misses' b. Review of and implementing learning from published scientific research and guidance c. Ongoing review and improvement of service quality, safety and efficiency	Y	Review and learning was included as part of each team meeting.
XX-799	**Document Control** All policies, procedures and guidelines should comply with Hospital (or equivalent) document control procedures.	N	The service was in the process of reviewing documentation. As part of this process documentation would be standardised and controlled in line with the local policy.

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RESPIRATORY CONDITIONS

Ref	Quality Standards	Met?	Reviewers' Comments
XX-101	**Service Information** Each service should offer patients and their carers written information covering: a. Organisation of the service, such as opening hours and clinic times b. Staff and facilities available c. How to contact the service for help and advice, including out of hours d. Range of other services available locally	Y	A range of written information was available for patients. Information was also available on the DHSC website.
XX-102	**Condition-Specific Information** Information for patients and their carers should be available covering, at least: a. Brief description of their condition and its impact b. Self-care c. Possible complications and how to prevent these d. Pharmacological and non-pharmacological therapeutic and rehabilitation interventions offered by the service e. Possible side-effects of therapeutic and rehabilitation interventions f. Symptoms and action to take if unwell g. DVLA regulations and driving advice (if applicable) h. Health promotion, including smoking cessation, health eating, weight management, exercise, alcohol use, sexual and reproductive health, and mental and emotional health and well-being i. For frail older people: Pain, depression, skin integrity, falls and mobility, continence, safeguarding issues, delirium and dementia, nutrition and hydration, sensory loss, activities of daily living, vital signs and end of life issues j. Sources of further advice and information k. Self care	Y	
XX-102R	**Condition-Specific Information – Respiratory** Information should cover: a. Common presentations b. Respiratory conditions c. Investigations and interventions	Y	

Ref	Quality Standards	Met?	Reviewers' Comments
XX-103	**Care Plan** Each patient and, where appropriate, their carer should discuss and agree their Care Plan, and should be offered a written record covering at least: a. Agreed goals, including life-style goals b. Self-management c. Planned assessments ,therapeutic and/or rehabilitation interventions d. Early warning signs of problems, including acute exacerbations, and what to do if these occur e. Planned review date and how to access a review more quickly, if necessary f. Who to contact with queries or for advice The Care Plan should be communicated to the patient's GP and to relevant other services involved in their care.	Y	Care plans were detailed; however, the care plans seen did not always include 'e'.
XX-104	**Review of Care Plan** A formal review of the patient's Care Plan should take place as planned and, at least, six monthly. This review should involve the patient, where appropriate, their carer, and appropriate members of the multi-disciplinary team. The outcome of the review should be communicated in writing to the patient and their GP.	Y	Treatment plans were reviewed if patients were still under the care of the team.
XX-105	**Contact for Queries and Advice** Each patient and, where appropriate, their carer should have a contact point within the service for queries and advice. If advice and support is not immediately available, then the timescales for a response should be clear. Response times should be no longer than the end of the next working day. All contacts for advice and a sample of actual response time should be documented.	Y	However, it was not always possible to respond as defined by the QS because of capacity issues.
XX-106	**School Health Care Plan (Services caring for children and young people only)** A School Care Plan should be agreed with each child or young person covering, at least: a. School attended b. Care required while at school including medication c. Responsibilities of carers and of school staff d. Likely problems and what to do if these occur, including what to do in an emergency e. Arrangements for liaison with the school f. Review date and review arrangements	N/A	

Ref	Quality Standards	Met?	Reviewers' Comments
XX-195	**Transition to Adult Services** Young people approaching the time when their care will transfer to adult services should be offered: a. The opportunity to discuss the transfer of care with paediatric and adult services b. A named coordinator for the transfer of care c. A preparation period prior to transfer d. Written information about the transfer of care including arrangements for monitoring during the time immediately afterwards	Y	A general document covering transition to adult services was in place.
XX-196	**Discharge Information** On discharge from the service, patients and their carers should be offered written information covering at least: a. Care after discharge b. Return to normal activities c. Ongoing self-management of their condition d. Possible complications and what to do if these occur e. Who to contact with queries or concerns	Y	A good information / discharge leaflet was in place, but reviewers queried the capacity of the team to respond to patients after discharge.
XX-197	**General Support for Patients and Carers** Patients and carers should have easy access to the following services and information about these services should be easily available: a. Interpreter services, including British Sign Language b. Independent advocacy services c. Complaints procedures d. Social workers e. Benefits advice f. Spiritual support g. HealthWatch or equivalent organisation h. Relevant voluntary organisations providing support and advice i. Self-care	N	'b' was not met. All other support was in place.
XX-198	**Carers' Needs** Carers should be offered information on: a. How to access an assessment of their own needs b. What to do in an emergency c. Services available to provide support	Y	
XX-199	**Involving Patients and Carers** The service should have: a. Mechanisms for receiving regular feedback from patients and carers about treatment and care they receive b. Mechanisms for involving patients and carers in decisions about the organisation of the service c. Examples of changes made as a result of feedback and involvement of patients and carers	Y	

Ref	Quality Standards	Met?	Reviewers' Comments
XX-201	**Lead Clinician** A nominated lead clinician should have responsibility for staffing, training, guidelines and protocols, service organisation, governance and for liaison with other services. The lead clinician should be a registered healthcare professional with appropriate specialist competences in this role and should undertake regular clinical work within the service.	Y	
XX-202	**Staffing Levels and Skill Mix** Sufficient staff with appropriate competences should be available for the: a. Number of patients usually cared for by the service and the usual case mix of patients b. Service's role in the patient pathway and expected timescales c. Assessments and therapeutic and/or rehabilitation interventions offered by the service d. Use of equipment required for these assessments, therapeutic and/or rehabilitation interventions e. Urgent review within agreed timescales An appropriate skill mix of staff should be available including medical, nursing, allied health professionals, social care professionals, support workers and other staff required to deliver the range of assessments and therapeutic and/or rehabilitation interventions offered by the service. Cover for absences should be available so that the patient pathway is not unreasonably delayed, and patient outcomes and experience are not adversely affected, when individual members of staff are away.	N	Reviewers felt that this was a dedicated and committed team working extremely hard. However because of the limited capacity, there were concerns (as stated by the team themselves in the self-assessment) regarding cover and resilience within the team for key clinical staff. The respiratory clinicians' time was focused on day to day delivery of care, with limited capacity for future planning of potential service development. Workload for the Nurse – led respiratory team had also increased by 50% over the last two years and there was no cover for absences (See Concern 2 for more detail in the report). The team was unable to meet waiting times despite working extremely hard, which suggests that the establishment at the time of the visit was not always adequate for the demand.
XX-202R	**Staffing Levels and Skill Mix – Respiratory** Staffing levels should include the following staff with time allocated for work with the respiratory service: a. Physiotherapist b. Palliative care	N	There was little development of the potential for physiotherapy to manage non-invasive ventilation (NIV or other aspects of respiratory care.

Ref	Quality Standards	Met?	Reviewers' Comments
XX-203	**Service Competences and Training Plan** The competences expected for each role in the service should be identified. A training and development plan for achieving and maintaining competences should be in place.	N	There was some evidence of accredited training plans for nursing and of past training. There was a bespoke rolling education programme in place, but staff constraints meant this could not be implemented, with the potential of loss of skills and competences for nurses and physiotherapists. There was no evidence of the maintenance of competences. There was limited funding for study leave.
XX-203R	**Service Competences and Training Plan – Respiratory** Staff with competences in the investigations and interventions appropriate to the usual case mix of patients should be available.	N	Competences were not defined for all staff groups.
XX-298	**Competences – All Health and Social Care Professionals** All health and social care professionals working in the service should have competences appropriate to their role in: a. Safeguarding children and/or vulnerable adults b. Recognising and meeting the needs of vulnerable children and/or adults c. Dealing with challenging behaviour, violence and aggression d. Mental Capacity Act and Deprivation of Liberty Safeguards e. Resuscitation	Y	
XX-299	**Administrative, Clerical and Data Collection Support** Administrative, clerical and data collection support should be available.	N	There was insufficient respiratory service administrative support for discharge summaries, referral letters and data collection. The waiting time from the dictation to the typing of clinical letters had risen progressively. Reviewers were told that urgent letters were typed within 24-48hrs but that the waiting time for typing of routine letters was around one month.
XX-301	**Support Services** Timely access to an appropriate range of support services should be available.	N	There was access to support services, but this was not always timely.

Ref	Quality Standards	Met?	Reviewers' Comments
XX-302R	**Imaging** Access to imaging services should be available including: a. Plain chest x-rays b. CT scans (anatomical, CT pulmonary angiography and high resolution CT) c. MRI d. PET-CT e. Thoracic ultrasound f. Ventilation perfusion (VQ) scans g. Bone scans	Y	
XX-303R	**Investigations and Interventions** Investigations and interventions appropriate to the case mix of patients should be available.	Y	
XX-401	**Facilities** Facilities available should be appropriate for the assessments, therapeutic and/or rehabilitation interventions offered by the service for the usual number and case mix of patients.	Y	
XX-402	**Equipment** Timely access to equipment appropriate for the service provided should be available. Equipment should be appropriately maintained.	Y	
XX-499	**IT System** IT systems for storage, retrieval and transmission of patient information should be in use for patient administration, clinical records, outcome information and other data to support service improvement, audit and revalidation.	Y	
XX-501	**Diagnosis and Assessment Guidelines** Guidelines on diagnosis and assessment should be in use covering the usual case mix of patients referred to the service.	Y	
XX-501R	**Diagnosis and Assessment Guidelines – Respiratory** Guidelines should cover: a. Common presentations b. Investigations appropriate to the usual case mix of patients	Y	
XX-502	**Clinical Guidelines** Guidelines on management of the usual case mix of patients referred to the service should be in use covering, at least: a. Therapeutic and/or rehabilitation interventions offered by the service b. Monitoring and follow up	Y	
XX-502R	**Clinical Guidelines – Respiratory** Guidelines should cover respiratory conditions relevant to the usual case mix of patients.	Y	

Ref	Quality Standards	Met?	Reviewers' Comments
XX-595	**Transition** Guidelines on transition of young people from paediatric to adult services should be in use covering, at least: a. Involvement of the young person and, where appropriate, their carer in planning the transfer of care b. Involvement of the young person's general practitioner in planning the transfer c. Joint meeting between paediatric and adult services in order to plan the transfer d. Allocation of a named coordinator for the transfer of care e. A preparation period prior to transfer f. Arrangements for monitoring during the time immediately after transfer	N/A	It was rare for there to be young people transitioning to adult services. If required, informal mechanisms were in place with local and tertiary services.
XX-596	**Discharge Guidelines** Guidelines on discharge from the service should be in use.	Y	
XX-599	**Care of Vulnerable People** Guidelines for the care of vulnerable children, young people and adults should be in use, in particular: a. Identification of vulnerable people b. Individualised care plans for people identified as being particularly vulnerable c. Restraint and sedation d. Missing patients e. Mental Capacity Act and the Deprivation of Liberty Safeguards f. Safeguarding g. Information sharing h. Palliative care i. End of life care	Y	Guidelines for 'h' and 'i' were not accessible on the Noble's intranet but were found via the local respiratory shared folder.
XX-601	**Operational Policy** The service should have an operational policy describing the organisation of the service including, at least: a. Expected timescales for the patient pathway, including initial assessment, start of therapeutic and/or rehabilitation interventions and urgent review, and arrangements for achieving and monitoring these timescales b. Responsibility for giving patient and carer information at each stage of the patient journey c. Arrangements for responding to patients' queries or requests for advice by the end of the next working day d. Arrangements for follow up of patients who 'do not attend' e. Arrangements for multi-disciplinary discussion of appropriate patients f. Arrangements for liaison with key support services (QS XX-301) g. Arrangements for maintenance of equipment (QS XX-402) h. Responsibilities for IT systems (QS XX-499)	N	There was a respiratory support service framework in place, but this did not meet all the requirements as defined by this QS.

Ref	Quality Standards	Met?	Reviewers' Comments
XX-601R	**Operational Policy – Respiratory** The operational policy should include: a. Responding to requests for assessment by the Emergency Department or acute medical and surgical units within one hour of request b. Ensuring all patients are admitted within one hour of the decision to admit and are on an appropriate specialty ward within 24 hours of the decision to admit c. Arrangements for multi-disciplinary discussion with: i. Imaging ii. Staff undertaking investigations and interventions iii. Critical care iv. Specialist palliative care services	N	See QS XX-601
XX-602	**Liaison with Other Services** Review meetings should be held at least annually with key support services to consider liaison arrangements and address any problems identified.	Y	Review meetings with local support services (radiology), and a quarterly Interstitial Lung Disease (ILD) MDT via video link with the tertiary centre, were in place.
XX-701	**Data Collection** Regular collection and monitoring of data should be in place, including: a. Referrals to the service, including source of appropriateness of referrals b. Number or assessments, urgent reviews and therapeutic and /or rehabilitation interventions undertaken by the service c. Outcome of assessments and therapeutic and /or rehabilitation interventions d. Number of discharges from the service and type of care after discharge e. Key performance indicators	N	The service was collecting data for point 'a', and information about the time it took to be seen. However, no data about priority / outcomes were seen. KPIs had not yet been agreed for the service.
XX-702	**Audit** The services should have a rolling programme of audit of compliance with: a. Evidence-based clinical guidelines (QS XX-500s) b. Standards of record keeping c. Timescales for key milestones on the patient pathway	N	The review team agreed that there was evidence of audits, but not all of the requirements as identified in the QS were in place.
XX-702R	**Audits – Respiratory** The service should participate in all relevant national audits, including submitting data and consideration of results and comparative data.	Y	
XX-703	**Key Performance Indicators** Key performance indicators (QS XX-701) should be reviewed regularly with Trust (or equivalent) management and with commissioners.	Y	

Ref	Quality Standards	Met?	Reviewers' Comments
XX-798	**Multi-disciplinary Review and Learning** The service should have multi-disciplinary arrangements for a. Review of and implementing learning from positive feedback, complaints, outcomes, incidents and 'near misses' b. Review of and implementing learning from published scientific research and guidance c. Ongoing review and improvement of service quality, safety and efficiency	Y	
XX-799	**Document Control** All policies, procedures and guidelines should comply with Trust (or equivalent) document control procedures.	N	Based on the evidence seen.

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ENDOCRINE SERVICE

Ref	Quality Standards	Met?	Reviewers' Comments
XX-101	**Service Information** Each service should offer patients and their carers written information covering: a. Organisation of the service, such as opening hours and clinic times b. Staff and facilities available c. How to contact the service for help and advice, including out of hours	N	Information on the DHSC website contained contact details for diabetes but not for endocrine services.
XX-102	**Condition-Specific Information** Information for patients and their carers should be available covering, at least: a. Brief description of their condition and its impact b. Possible complications and how to prevent these c. Pharmacological and non-pharmacological therapeutic and rehabilitation interventions offered by the service d. Possible side-effects of therapeutic and rehabilitation interventions e. Symptoms and action to take if unwell f. DVLA regulations and driving advice (if applicable) g. Health promotion, including smoking cessation, health eating, weight management, exercise, alcohol use, sexual and reproductive health, and mental and emotional health and well-being h. For frail older people: Pain, depression, skin integrity, falls and mobility, continence, safeguarding issues, delirium and dementia, nutrition and hydration, sensory loss, activities of daily living, vital signs and end of life issues i. Sources of further advice and information	Y	However, guidance covering 'f' was not available at the time of the visit. Some evidence provided in the folder was out of date. See also 'further consideration' section of the report about utilising other websites that have good patient leaflets, e.g. British Thyroid Foundation and the Pituitary Foundation.
XX-103	**Care Plan** Each patient and, where appropriate, their carer should discuss and agree their Care Plan, and should be offered a written record covering at least: a. Agreed goals, including life-style goals b. Self-management c. Planned therapeutic and/or rehabilitation interventions d. Early warning signs of problems, including acute exacerbations, and what to do if these occur e. Planned review date and how to access a review more quickly, if necessary f. Who to contact with queries or for advice	Y	Clinic letters viewed contained all expected / relevant information.

Ref	Quality Standards	Met?	Reviewers' Comments
XX-104	**Review of Care Plan** A formal review of the patient's Care Plan should take place as planned and, at least, six monthly. This review should involve the patient, where appropriate, their carer, and appropriate members of the multi-disciplinary team. The outcome of the review should be communicated in writing to the patient and their GP.	Y	As above.
XX-105	**Contact for Queries and Advice** Each patient and, where appropriate, their carer should have a contact point within the service for queries and advice. If advice and support is not immediately available, then the timescales for a response should be clear. Response times should be no longer than the end of the next working day. All contacts for advice and a sample of actual response time should be documented.	Y	However, contact cards were only available for diabetes patients (not endocrine patients), and the main contact was the team secretary. Reviewers were concerned that the team secretary was giving clinical advice or dealing with clinical queries (see 'concerns' section).
XX-106	**School Health Care Plan (Services caring for children and young people only)** A School Care Plan should be agreed for each child or young person covering, at least: a. School attended b. Care required while at school including medication c. Responsibilities of carers and of school staff d. Likely problems and what to do if these occur, including what to do in an emergency e. Arrangements for liaison with the school f. Review date and review arrangements	N/A	
XX-195	**Transition to Adult Services** Young people approaching the time when their care will transfer to adult services should be offered: a. The opportunity to discuss the transfer of care with paediatric and adult services b. A named coordinator for the transfer of care c. A preparation period prior to transfer d. Written information about the transfer of care including arrangements for monitoring during the time immediately afterwards	N/A	Very few young people were transitioning to the team and they were dealt with on a case by case basis.
XX-196	**Discharge Information** On discharge from the service, patients and their carers should be offered written information covering at least: a. Care after discharge b. Return to normal activities c. Ongoing self-management of their condition d. Possible complications and what to do if these occur e. Who to contact with queries or concerns	N	Evidence was not available covering all aspects of the QS.

Ref	Quality Standards	Met?	Reviewers' Comments
XX-197	**General Support for Patients and Carers** Patients and carers should have easy access to the following services and information about these services should be easily available: a. Interpreter services, including British Sign Language b. Independent advocacy services c. Complaints procedures d. Social workers e. Benefits advice f. Spiritual support g. HealthWatch or equivalent organisation h. Relevant voluntary organisations providing support and advice	N	'b' was not met. All other support was in place.
XX-198	**Carers' Needs** Carers should be offered information on: a. How to access an assessment of their own needs b. What to do in an emergency c. Services available to provide support	N	Information for carers was not yet in place.
XX-199	**Involving Patients and Carers** The service should have: a. Mechanisms for receiving regular feedback from patients and carers about treatment and care they receive b. Mechanisms for involving patients and carers in decisions about the organisation of the service c. Examples of changes made as a result of feedback and involvement of patients and carers	N	Team self-assessment confirmed that patient feedback collection activities were not in place.
XX-201	**Lead Clinician** A nominated lead clinician should have responsibility for staffing, training, guidelines and protocols, service organisation, governance and for liaison with other services. The lead clinician should be a registered healthcare professional with appropriate specialist competences in this role and should undertake regular clinical work within the service.	Y	

Ref	Quality Standards	Met?	Reviewers' Comments
XX-202	**Staffing Levels and Skill Mix** Sufficient staff with appropriate competences should be available for the: a. Number of patients usually cared for by the service and the usual case mix of patients b. Service's role in the patient pathway and expected timescales c. Assessments and therapeutic and/or rehabilitation interventions offered by the service d. Use of equipment required for these assessments, therapeutic and/or rehabilitation interventions e. Urgent review within agreed timescales An appropriate skill mix of staff should be available including medical, nursing, allied health professionals, social care professionals, support workers and other staff required to deliver the range of assessments and therapeutic and/or rehabilitation interventions offered by the service. Cover for absences should be available so that the patient pathway is not unreasonably delayed, and patient outcomes and experience are not adversely affected, when individual members of staff are away.	Y	However there did not appear to be resilience within the team in terms of cover arrangements. Improved skill mix in the teams would release medical staff to undertake purely clinical activities and would have a positive impact upon the waiting list position.
XX-203	**Service Competences and Training Plan** The competences expected for each role in the service should be identified. A training and development plan for achieving and maintaining competences should be in place.	N	No written training plan or competency assessment was in place for all team members. Staff training was agreed as part of personal development reviews and the appraisals process. Reviewers considered that the team might find the Society for Endocrinology (UK) competences for nurses helpful.
XX-204	**Competences – All Health and Social Care Professionals** All health and social care professionals working in the service should have competences appropriate to their role in: a. Safeguarding children and/or vulnerable adults b. Recognising and meeting the needs of vulnerable children and/or adults c. Dealing with challenging behaviour, violence and aggression d. Mental Capacity Act and Deprivation of Liberty Safeguards e. Resuscitation	Y	
XX-299	**Administrative, Clerical and Data Collection Support** Administrative, clerical and data collection support should be available.	Y	However, more cover would allow the team secretary to take on other tasks, including more robust and meaningful data collection, KPI monitoring, waiting list management etc.

Ref	Quality Standards	Met?	Reviewers' Comments
XX-301	**Support Services** Timely access to an appropriate range of support services should be available.	Y	
XX-401	**Facilities** Facilities available should be appropriate for the assessments, therapeutic and/or rehabilitation interventions offered by the service for the usual number and case mix of patients.	Y	
XX-402	**Equipment** Timely access to equipment appropriate for the service provided should be available. Equipment should be appropriately maintained.	Y	
XX-499	**IT System** IT systems for storage, retrieval and transmission of patient information should be in use for patient administration, clinical records, outcome information and other data to support service improvement, audit and revalidation.	N	A range of IT systems and paper-based processes was in place. Reviewers considered that the use of manual data recording systems could lead to error and an inaccurate data status position.
XX-501	**Diagnosis and Assessment Guidelines** Guidelines on diagnosis and assessment should be in use covering the usual case mix of patients referred to the service.	N	Guidelines would benefit from being reviewed to include up to date evidence-based practice protocols.
XX-502	**Clinical Guidelines** Guidelines on management of the usual case mix of patients referred to the service should be in use covering, at least: a. Therapeutic and/or rehabilitation interventions offered by the service b. Monitoring and follow up	Y	However, reviewers felt that guidelines were missing for rare conditions, e.g. thyrotoxic storm, myxoedema coma.
XX-595	**Transition** Guidelines on transition of young people from paediatric to adult services should be in use covering, at least: a. Involvement of the young person and, where appropriate, their carer in planning the transfer of care b. Involvement of the young person's general practitioner in planning the transfer c. Joint meeting between paediatric and adult services in order to plan the transfer d. Allocation of a named coordinator for the transfer of care e. A preparation period prior to transfer f. Arrangements for monitoring during the time immediately after transfer	N/A	It was rare for there to be young people transitioning to adult services. If required, informal mechanisms were in place.

Ref	Quality Standards	Met?	Reviewers' Comments
XX-596	**Discharge Guidelines** Guidelines on discharge from the service should be in use.	N	Guidelines covering discharge from the service were not yet in place. Hospital-wide discharge guidance was in place.
XX-599	**Care of Vulnerable People** Guidelines for the care of vulnerable children, young people and adults should be in use, in particular: a. Identification of vulnerable people b. Individualised care plans for people identified as being particularly vulnerable c. Restraint and sedation d. Missing patients e. Mental Capacity Act and the Deprivation of Liberty Safeguards f. Safeguarding g. Information sharing h. Palliative care i. End of life care	N	Although safeguarding training was provided, there was no evidence seen of any local procedures or whether the safeguarding training provided included all aspects of the standard. Guidelines for 'h' and 'i' were not accessible on the Noble's intranet.
XX-601	**Operational Policy** The service should have an operational policy describing the organisation of the service including, at least: a. Expected timescales for the patient pathway, including initial assessment, start of therapeutic and/or rehabilitation interventions and urgent review, and arrangements for achieving and monitoring these timescales b. Responsibility for giving patient and carer information at each stage of the patient journey c. Arrangements for responding to patients' queries or requests for advice by the end of the next working day d. Arrangements for follow up of patients who 'do not attend' e. Arrangements for multi-disciplinary discussion of appropriate patients f. Arrangements for liaison with key support services (QS XX-301) g. Arrangements for maintenance of equipment (QS XX-402) h. Responsibilities for IT systems (QS XX-499)	N	A documented operational policy was not yet in place, although the self -assessment suggested that arrangements were in place covering some aspects of the QS. Contact cards were only in place for diabetes patients. Arrangements for MDT discussion appeared to be on a 1:1 basis rather than a full MDT. It was unclear what arrangements were in place for adverse reactions to drugs.
XX-602	**Liaison with Other Services** Review meetings should be held at least annually with key support services to consider liaison arrangements and address any problems identified.	N	Review meetings with other services such as those off-island were not yet in place.

Ref	Quality Standards	Met?	Reviewers' Comments
XX-701	**Data Collection** Regular collection and monitoring of data should be in place, including: a. Referrals to the service, including source of appropriateness of referrals b. Number or assessments, urgent reviews and therapeutic and /or rehabilitation interventions undertaken by the service c. Outcome of assessments and therapeutic and /or rehabilitation interventions d. Number of discharges from the service and type of care after discharge e. Key performance indicators	N	Reviewers were not provided with any data at the time of the visit. It was also not clear from discussions with staff that the waiting list length and content was known. There was no evidence of regular review within the team of any data provided by the management information system.
XX-702	**Audit** The services should have a rolling programme of audit of compliance with: a. Evidence-based clinical guidelines (QS XX-500s) b. Standards of record keeping c. Timescales for key milestones on the patient pathway	N	The team commented that there was little time available for audits, and no written evidence was provided, although the team were keen to undertake audits in the future.
XX-703	**Key Performance Indicators** Key performance indicators (QS XX-701) should be reviewed regularly with Trust (or equivalent) management and with commissioners.	N	Key performance indicators for the service were not yet agreed.
XX-798	**Multi-disciplinary Review and Learning** The service should have multi-disciplinary arrangements for a. Review of and implementing learning from positive feedback, complaints, outcomes, incidents and 'near misses' b. Review of and implementing learning from published scientific research and guidance c. Ongoing review and improvement of service quality, safety and efficiency	N	Although PRISM was used to report incidents, the reviewers heard that 'nothing came back' so learning from incident trends was not yet in place. The team confirmed that there was insufficient time to stay up to date with all the latest guidance and research. Reviewers were told that there was a risk register in place but could not see any evidence of it being regularly reviewed to drive service improvements. A lack of regular feedback from patients also limited the ability for patient-driven service improvements.
XX-799	**Document Control** All policies, procedures and guidelines should comply with Trust (or equivalent) document control procedures.	Y	

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ANTICOAGULATION SERVICE

Ref	Quality Standards	Met?	Reviewers' Comments
NM-101	**Service Information** Each practice should offer patients and their carers written information covering: a. Organisation of the clinic- based service, such as opening hours and clinic times b. Arrangements for patients who are housebound c. Staff available d. How to contact the service for help and advice e. How to complain about the service, including details of where complaints should be directed	Y	
NM-102	**Condition-Specific Information** Patients and their carers should be offered up to date, written information about their condition and its impact. A note of the information given should be made available in the patient's medical record.	Y	A wide range of information was available. The team also recorded the information and education given to patients on the electronic patient record system (DAWN AC).
NM-103	**Management Plan** Each patient and, where appropriate, their carer should discuss and agree their Management Plan, and should be offered a written record covering at least: a. Agreed goals, including life-style goals b. Self-management c. Importance of complying with the monitoring regime d. Planned therapeutic interventions e. Early warning signs of problems, and what to do if these occur f. Planned review date and how to access a review more quickly, if necessary g. Who to contact with queries or for advice	Y	Patients were given a copy of their treatment and management plans. The plans were all recorded on the DAWN AC anticoagulation software.
NM-104	**Review of Management Plan** A formal review of the patient's Management Plan should take place at least annually: a. Anticoagulation service: INR checked at least every eight weeks and more often if indicated by test results b. Near patient testing: As specified in clinical guidelines (QS NM-501) This review should involve the patient, where appropriate, their carer, and appropriate members of the multi-disciplinary team (if required).	Y	

Ref	Quality Standards	Met?	Reviewers' Comments
NM-196	**Discharge Information** Patients for whom the service is no longer appropriate should discuss and agree: a. Arrangements for their future care b. Ongoing self-management of their condition c. Possible complications and what to do if these occur This discussion should be documented in the patient's notes.	Y	Patients were given information if discharged from the service. The lead nurse also had a process of contacting patients who did not attend clinic appointments.
NM-199	**Involving Patients and Carers** The service should have: a. Mechanisms for receiving regular feedback from patients and carers about the treatment and care they receive from the service b. Examples of changes made as a result of feedback and involvement of patients and carers	N	Reviewers were not made aware of any examples of changes made as a result of feedback or the involvement of patients and carers. Mechanisms for patient feedback were in place and reviewers were told that feedback was positive about the service provided.
NM-201	**Lead Clinician** A nominated lead clinician should have responsibility for the effective delivery of the service, including staffing, training, guidelines and protocols, service organisation, governance and liaison with other services. The lead clinician should be a registered healthcare professional with appropriate specialist competences in this role and should undertake regular clinical work within the service.	Y	
NM-202	**Staffing Levels and Skill Mix** Sufficient staff with appropriate competences should be available for: a. The number of patients usually cared for by the service and the usual case mix of patients b. The service's role in the patient pathway and expected timescales c. The assessments and therapeutic interventions offered by the service d. Urgent review if clinically indicated Cover for absences should be available so that the patient pathway is not unreasonably delayed, and patient outcomes and experience are not adversely affected, when individual members of staff are away.	N	There was no medical clinical lead with time to lead and support the anticoagulant service. Urgent review, if clinically indicated, was achieved by the anticoagulant nursing team who would liaise with the consultant physician covering haematology, a consultant haematologist based in Liverpool, the referring consultant or the patient's GP. All qualified nursing staff were non-medical prescribers and had attended a relevant course in anticoagulation.

Ref	Quality Standards	Met?	Reviewers' Comments
NM-203	**Service Competences and Training Plan** The competences expected for each role in the service should be identified, including: a. Clinical competences for the service provided b. Development and maintenance of a practice register of patients c. Running the call and recall system d. Adverse events reporting A training and development plan for achieving and maintaining competences should be in place.	Y	
NM-203A	**Service Competences and Training Plan – Anticoagulation Service** Staff providing an anticoagulation service should have competences appropriate to their role in: a. Anticoagulation monitoring b. Use of appropriate anticoagulation Near Patient Testing equipment c. Use of Computer Software Decision Support (CSDS) to assist in dose calculation and running audits (QS NM-499A) d. Dose decisions: A registered healthcare professional who, if not medically qualified, has completed an accredited course in anticoagulation management	Y	
NM-299	**Administrative, Clerical and Data Collection Support** Administrative, clerical and data collection support should be available.	N	Clinical staff were spending time on data collection.
NM-301	**Services providing Support and Advice to Practices** Timely access to an appropriate range of support services should be available, including: a. Consultant-led haematology service (anticoagulation service only) b. Consultant-led stroke service (anticoagulation service only) c. Consultant-led service for each drug or condition (near patient testing only) d. Consultant specialising in the care of frail older people	N	There was insufficient access to support for the anticoagulant service. Some support was available from the on-island consultant physician who covered haematology and oncology, and from the stroke and cardiac teams. In practice the team would seek advice from whoever was available and liaise with the patient's GP. The team did have good links with other providers in the community and social care.

Ref	Quality Standards	Met?	Reviewers' Comments
NM-401	**Facilities** Facilities available should be appropriate for the assessment and therapeutic interventions offered by the service for the usual number and case mix of patients, including appropriate arrangements for: a. Infection prevention b. Management of sharps c. Storage, including refrigerated storage when required	Y	
NM-402A	**Equipment – Anticoagulation Service** Timely access to appropriate equipment should be available including: a. Near Patient Testing equipment plus an additional monitor for any branch surgery b. Appropriate Diagnostics consumables c. Quality assurance of equipment by an external provider (four surveys of two samples per machine per annum)	Y	
NM-499	**IT System** IT systems for storage, retrieval and transmission of patient information should be in use for patient administration, clinical records, outcome information and other data to support service improvement, audit and revalidation.	N	Multiple IT systems were in use as well as paper records.
NM-499A	**IT System – Anticoagulation** Practices should use the Computer Software Decision System (CSDS) made available by commissioners (QS NZ-499A) for developing and maintaining an up to date register of patients, call and recall of patients, indication and duration of treatment, target INR and dose calculations, and audits.	N	The anticoagulant service used the DAWN AC software system, but this system was not integrated with other hospital systems. The system had not been resourced to link to EMIS (which was used by GPs). The team had to email GP practice managers with reports of relevant blood test results and instructions.
NM-501	**Clinical Guidelines** Up to date locally agreed clinical guidelines should be in use covering: a. Diagnosis and assessment b. Interventions offered by the service c. Monitoring and follow-up d. Anticoagulation service only: Action to take if INR, with or without symptoms, is: i. Between 5.0 and 7.9 ii. 8.0 or above e. Indications for contacting the relevant consultant-led service (QS NM-301) f. Discharge from the service	Y	Guidelines had been developed by the lead nurse, but the ratification process was not clear on the versions seen by the reviewers.

Ref	Quality Standards	Met?	Reviewers' Comments
NM-601	**Operational Policy** The service should have an operational policy describing the organisation of the service including at least: a. Responsibility for giving patient and / or carer information at each stage of the patient journey b. Arrangements for care of people who are housebound or resident in a care home c. Arrangements for care of working age adults who are not easily able to access the practice during the core contract hours of 8:00am to 6:30pm, Monday to Friday d. Arrangements for follow-up of patients who 'do not attend' e. Arrangements for multi-disciplinary discussion of appropriate patients f. Arrangements for liaison with key services providing support and advice (QS NM-301) g. Arrangements for maintenance of equipment (QS NM-402A) h. Responsibilities for IT systems (QS NM-499) i. Call and recall system arrangements and responsibilities for these j. Recording and reporting incidents as per local policy k. Anticoagulation service only: i. Quality assurance of equipment by an external provider (four surveys of two samples per machine) ii. Arrangements for ordering testing strips.	Y	
NM-602	**Participation in Local Review and Learning Meetings** A representative of the service should attend each Local Review and Learning Meeting (QS NZ-602).	Y	
NM-701	**Data Collection** Regular collection and monitoring of data should be in place, including: a. Referrals to the service, including source and appropriateness of referrals b. Number of patients seen by the service c. Number of annual reviews undertaken d. Number of patients who 'do not attend' and number who 'do not attend' for more than four weeks e. Number of discharges from the service and type of care after discharge f. Number of incidents reported to the DHSC g. Key performance indicators h. Uploading of external quality assurance results to Computer Software Decision Support (CSDS) (anticoagulation service only)	N	There was no formal in-patient referral document to enable all aspects of data collection to be collated. A new GP referral form was in the process of being implemented, which would allow better data collection. Acuity data were collected. The DAWN AC system would allow for benchmarking and budget reporting, but this information was not utilised. 'c' was only known for those patients on direct oral anticoagulant drugs DOAC.

Ref	Quality Standards	Met?	Reviewers' Comments
NM-702	**Audit** The service should have a rolling programme of audit of compliance with: a. Evidence-based clinical guidelines (QS NM-501) b. Annual audit of proportion of patients who have had an annual review c. Anticoagulation services: Ongoing audit of Key Performance Indicators (QS NM-701) made available. d. Near patient testing services: i. Patients have documented drug monitoring within the recommended time frames ii. Appropriate parameters are monitored for each drug iii. Blood monitoring results are within the recommended range iv. Patients have a documented indication for high-risk drugs	N	Audits were not yet in place covering all aspects of the QS. The DAWN AC system could provide audits of activity, which could be used as a basis for an audit. However, data that were collected did show that the service performed highly in ensuring that patient treatment was within the approved INR range.
NM-703	**Audit Information** The service should comply with requests for: a. Announced and unannounced visits b. Reasonable additional audit information	N/A	No external assurance visits were undertaken.
NM-798	**Multi-disciplinary Review and Learning** The service should have multi-disciplinary arrangements for: a. Review of and implementation of learning from positive feedback, complaints, outcomes, incidents and 'near misses' b. Ongoing review and improvement of service quality, safety and efficiency	Y	
NM-799	**Document Control** All policies, procedures and guidelines should comply with reasonable document control standards.	N	Although reviewers were told that a process for ratification was undertaken, it was not clear that this was the case from the documentation seen at the time of the visit.

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DERMATOLOGY SERVICE

Ref	Quality Standards	Met?	Reviewers' Comments
XX-101	**Service Information** Each service should offer patients and their carers written information covering: a. Organisation of the service, such as opening hours and clinic times b. Staff and facilities available c. How to contact the service for help and advice, including out of hours d. Range of other services available locally	N	Little service-specific information was available. Information that was seen was out of date (2014), with no review date or plan to review. Some skin condition specific leaflets included aftercare i.e. cryotherapy and other skin conditions. The dermatology secretary was the contact from the service for patient queries.
XX-102	**Condition-Specific Information** Information for patients and their carers should be available covering, at least: a. Brief description of their condition and its impact b. Self-care c. Possible complications and how to prevent these d. Pharmacological and non-pharmacological therapeutic and rehabilitation interventions offered by the service e. Possible side-effects of therapeutic and rehabilitation interventions f. Symptoms and action to take if unwell g. DVLA regulations and driving advice (if applicable) h. Health promotion, including smoking cessation, health eating, weight management, exercise, alcohol use, sexual and reproductive health, and mental and emotional health and well-being i. For frail older people: Pain, depression, skin integrity, falls and mobility, continence, safeguarding issues, delirium and dementia, nutrition and hydration, sensory loss, activities of daily living, vital signs and end of life issues j. Sources of further advice and information k. Self care	N	Condition-specific leaflets were available, but these were in a generic format and did not include advice on side effects or further sources of advice. Specifically, there was limited or no evidence of information for 'e' to 'k'.
XX-102S	**Condition-Specific Information – Dermatology** Information should cover: a. Skin presentations and conditions b. Investigations and interventions	Y	Leaflets were available.

Ref	Quality Standards	Met?	Reviewers' Comments
XX-103	**Care Plan** Each patient and, where appropriate, their carer should discuss and agree their Care Plan, and should be offered a written record covering at least: a. Agreed goals, including life-style goals b. Self-management c. Planned assessments ,therapeutic and/or rehabilitation interventions d. Early warning signs of problems, including acute exacerbations, and what to do if these occur e. Planned review date and how to access a review more quickly, if necessary f. Who to contact with queries or for advice The Care Plan should be communicated to the patient's GP and to relevant other services involved in their care.	N	Patients were not routinely offered written records of their plans of care, although reviewers were told that information for patients was included in letters to GPs. Copies of GP letters were not available for review so reviewers did not have the opportunity to review this directly. Planned patient review dates were in place.
XX-104	**Review of Care Plan** A formal review of the patient's Care Plan should take place as planned and, at least, six monthly. This review should involve the patient, where appropriate, their carer, and appropriate members of the multi-disciplinary team. The outcome of the review should be communicated in writing to the patient and their GP.	N	As QS XX-103. Evidence was not available to show that formal reviews of patients' plans of care were undertaken.
XX-105	**Contact for Queries and Advice** Each patient and, where appropriate, their carer should have a contact point within the service for queries and advice. If advice and support is not immediately available, then the timescales for a response should be clear. Response times should be no longer than the end of the next working day. All contacts for advice and a sample of actual response time should be documented.	Y	A point of contact for patients and carers was provided for each patient. Reviewers considered that the service should review the robustness of the process, given the size of the service and the dependence on the dermatology secretary.
XX-106	**School Health Care Plan (Services caring for children and young people only)** A School Care Plan should be agreed with each child or young person covering, at least: a. School attended b. Care required while at school including medication c. Responsibilities of carers and of school staff d. Likely problems and what to do if these occur, including what to do in an emergency e. Arrangements for liaison with the school f. Review date and review arrangements	N	It was unclear to the reviewers who had responsibility for the management of paediatric patients with dermatological conditions who may require a school care plan. The reviewers were unsure whether the visiting dermatologist had training in the management of paediatric dermatology and, therefore, of the arrangements for shared care and advice with the paediatric team.

Ref	Quality Standards	Met?	Reviewers' Comments
XX-195	**Transition to Adult Services** Young people approaching the time when their care will transfer to adult services should be offered: a. The opportunity to discuss the transfer of care with paediatric and adult services b. A named coordinator for the transfer of care c. A preparation period prior to transfer d. Written information about the transfer of care including arrangements for monitoring during the time immediately afterwards	N	A general document covering transition to adult services was in place. There was no paediatric dermatology service.
XX-196	**Discharge Information** On discharge from the service, patients and their carers should be offered written information covering at least: a. Care after discharge b. Return to normal activities c. Ongoing self-management of their condition d. Possible complications and what to do if these occur e. Who to contact with queries or concerns	N	There was no evidence provided by the service of dermatology-specific discharge information for patients. Patients were admitted to hospital under the direct care not of a dermatologist but of other medical teams.
XX-197	**General Support for Patients and Carers** Patients and carers should have easy access to the following services and information about these services should be easily available: a. Interpreter services, including British Sign Language b. Independent advocacy services c. Complaints procedures d. Social workers e. Benefits advice f. Spiritual support g. HealthWatch or equivalent organisation h. Relevant voluntary organisations providing support and advice i. Self-care	N	'b' was not met. All other support was in place. General information was available for patients and information on 'a', 'c' and 'h'. However, there was no information regarding general support or the other areas listed in the QS.
XX-198	**Carers' Needs** Carers should be offered information on: a. How to access an assessment of their own needs b. What to do in an emergency c. Services available to provide support	N	No information was available that dealt directly or specifically with the needs of carers.
XX-199	**Involving Patients and Carers** The service should have: a. Mechanisms for receiving regular feedback from patients and carers about treatment and care they receive b. Mechanisms for involving patients and carers in decisions about the organisation of the service c. Examples of changes made as a result of feedback and involvement of patients and carers	N	There was no proactive process for obtaining feedback from patients and carers. The service was unable to provide evidence of change in practice following comments from patients and carers.

Ref	Quality Standards	Met?	Reviewers' Comments
XX-201	**Lead Clinician** A nominated lead clinician should have responsibility for staffing, training, guidelines and protocols, service organisation, governance and for liaison with other services. The lead clinician should be a registered healthcare professional with appropriate specialist competences in this role and should undertake regular clinical work within the service.	N	There was no lead clinician for dermatology on the Isle of Man. Dermatology services were provided by a visiting consultant dermatologist.
XX-202	**Staffing Levels and Skill Mix** Sufficient staff with appropriate competences should be available for the: a. Number of patients usually cared for by the service and the usual case mix of patients b. Service's role in the patient pathway and expected timescales c. Assessments and therapeutic and/or rehabilitation interventions offered by the service d. Use of equipment required for these assessments, therapeutic and/or rehabilitation interventions e. Urgent review within agreed timescales An appropriate skill mix of staff should be available including medical, nursing, allied health professionals, social care professionals, support workers and other staff required to deliver the range of assessments and therapeutic and/or rehabilitation interventions offered by the service. Cover for absences should be available so that the patient pathway is not unreasonably delayed, and patient outcomes and experience are not adversely affected, when individual members of staff are away.	N	Reviewers noted that a new (additional) visiting clinician had just started at Ramsey Hospital (during the two weeks before the review visit). This should reduce waiting times, which, at the time of the visit, were 27 months for a routine appointment and three months for an urgent appointment. Reviewers noted that, while the clinician time had increased, it was not clear that additional nursing and administrative time had been identified for the service. Reviewers identified the need for senior managers to assess the impact of the new service after it had been running for a few months. The phototherapy service had recently been reinstated, but there was only one dedicated member of staff. One other person did have competences in phototherapy, but there was no programmed cover time in their job plan, and therefore the service could not operate when the designated person was not available.
XX-203	**Service Competences and Training Plan** The competences expected for each role in the service should be identified. A training and development plan for achieving and maintaining competences should be in place.	Y	

Ref	Quality Standards	Met?	Reviewers' Comments
XX-203S	**Service Competences and Training Plan – Dermatology** Staff with competences in the investigations and interventions appropriate to the usual case mix of patients should be available.	Y	However, see comment above about cover for the phototherapy service. If the additionally trained member of staff does not use these skills regularly, competences will diminish.
XX-298	**Competences – All Health and Social Care Professionals** All health and social care professionals working in the service should have competences appropriate to their role in: a. Safeguarding children and/or vulnerable adults b. Recognising and meeting the needs of vulnerable children and/or adults c. Dealing with challenging behaviour, violence and aggression d. Mental Capacity Act and Deprivation of Liberty Safeguards e. Resuscitation	N	It was not clear from discussions whether all staff caring for dermatological patients had competence for 'c', 'd', and 'e'.
XX-299	**Administrative, Clerical and Data Collection Support** Administrative, clerical and data collection support should be available.	N	The medical secretary designated for this role had only 0.17 WTE (1/6th) time identified for dermatology. Reviewers were told of a backlog of clinic letters.
XX-301	**Support Services** Timely access to an appropriate range of support services should be available.	Y	X-ray, phlebotomy, pathology and portering services were amongst those available to the dermatology team.
XX-302S	**Pathology** Access to pathology services should be available including: a. Special stains b. Immunohistochemistry c. Immunoflourescence microscopy d. Electron microscopy e. Molecular techniques	Y	
XX-303S	**Investigations and Interventions** Investigations and interventions appropriate to the case mix of patients should be available.	Y	A newly developed MDT was held off-island. However, it was noted that this was for complex lesions (e.g. skin cancers). There was no MDT in the Isle of Man for those with routine or complex skin conditions.
XX-401	**Facilities** Facilities available should be appropriate for the assessments, therapeutic and/or rehabilitation interventions offered by the service for the usual number and case mix of patients.	Y	Reviewers reviewed the facilities at Noble's Hospital, although additional clinics were to be held at Ramsey and District Cottage Hospital.

Ref	Quality Standards	Met?	Reviewers' Comments
XX-402	**Equipment** Timely access to equipment appropriate for the service provided should be available. Equipment should be appropriately maintained.	Y	Cryotherapy services with suitable equipment were available.
XX-499	**IT System** IT systems for storage, retrieval and transmission of patient information should be in use for patient administration, clinical records, outcome information and other data to support service improvement, audit and revalidation.	Y	The Medway patient administration system (PAS) system was in use, although there was no remote access to this system for the visiting clinicians.
XX-501	**Diagnosis and Assessment Guidelines** Guidelines on diagnosis and assessment should be in use covering the usual case mix of patients referred to the service.	Y	
XX-501S	**Diagnosis and Assessment Guidelines – Dermatology** Guidelines should cover: a. Common presentations b. Investigations appropriate to the usual case mix of patients	Y	The guidelines and operational policy were based on NICE guidelines and British Association of Dermatology standards, which had been modified for use on the Isle of Man.
XX-502	**Clinical Guidelines** Guidelines on management of the usual case mix of patients referred to the service should be in use covering, at least: a. Therapeutic and/or rehabilitation interventions offered by the service b. Monitoring and follow up	Y	The guidelines and operational policy were based on NICE guidelines and British Association of Dermatology standards, which had been modified for use on the Isle of Man.
XX-502S	**Clinical Guidelines – Dermatology** Guidelines should cover skin conditions relevant to the usual case mix of patients.	Y	The guidelines and operational policy were based on NICE guidelines and British Association of Dermatology standards, which had been modified for use on the Isle of Man.
XX-595	**Transition** Guidelines on transition of young people from paediatric to adult services should be in use covering, at least: a. Involvement of the young person and, where appropriate, their carer in planning the transfer of care b. Involvement of the young person's general practitioner in planning the transfer c. Joint meeting between paediatric and adult services in order to plan the transfer d. Allocation of a named coordinator for the transfer of care e. A preparation period prior to transfer f. Arrangements for monitoring during the time immediately after transfer	N /A	It was rare for there to be young people transitioning to adult services. If required, informal mechanisms were in place.

Ref	Quality Standards	Met?	Reviewers' Comments
XX-596	**Discharge Guidelines** Guidelines on discharge from the service should be in use.	N	Guidelines covering discharge from the service were not yet in place.
XX-599	**Care of Vulnerable People** Guidelines for the care of vulnerable children, young people and adults should be in use, in particular: a. Identification of vulnerable people b. Individualised care plans for people identified as being particularly vulnerable c. Restraint and sedation d. Missing patients e. Mental Capacity Act and the Deprivation of Liberty Safeguards f. Safeguarding g. Information sharing h. Palliative care i. End of life care	N	The guidance for 'a' that was accessible on the intranet was from 1999. Guidelines for 'h' and 'i' were not accessible on the Noble's intranet.
XX-601	**Operational Policy** The service should have an operational policy describing the organisation of the service including, at least: a. Expected timescales for the patient pathway, including initial assessment, start of therapeutic and/or rehabilitation interventions and urgent review, and arrangements for achieving and monitoring these timescales b. Responsibility for giving patient and carer information at each stage of the patient journey c. Arrangements for responding to patients' queries or requests for advice by the end of the next working day d. Arrangements for follow up of patients who 'do not attend' e. Arrangements for multi-disciplinary discussion of appropriate patients f. Arrangements for liaison with key support services (QS XX-301) g. Arrangements for maintenance of equipment (QS XX-402) h. Responsibilities for IT systems (QS XX-499)	N	The service handbook seen by reviewers was a guide to the services and treatments available. Reviewers noted that there was guidance available for the service, but the dermatology pathway was not specifically documented. The MDT only discussed complex care cases and was held off-island.
XX-601S	**Operational Policy – Dermatology** Arrangements for multi-disciplinary discussion (e) should include arrangements for discussion with: a. Pathology services b. Staff undertaking investigations and interventions c. Mental health services d. Genito-urinary medicine services	N	Reviewers could not identify an agreed operational policy for the service.
XX-602	**Liaison with Other Services** Review meetings should be held at least annually with key support services to consider liaison arrangements and address any problems identified.	N	Reviewers identified a review for phototherapy services only.

Ref	Quality Standards	Met?	Reviewers' Comments
XX-701	**Data Collection** Regular collection and monitoring of data should be in place, including: a. Referrals to the service, including source of appropriateness of referrals b. Number or assessments, urgent reviews and therapeutic and /or rehabilitation interventions undertaken by the service c. Outcome of assessments and therapeutic and /or rehabilitation interventions d. Number of discharges from the service and type of care after discharge e. Key performance indicators	N	Reviewers did not see any information on data and service delivery monitoring that was collected by the service and available for its use.
XX-702S	**Audits – Dermatology** The service should participate in all relevant British Association of Dermatologists national audits, including submitting data and consideration of results and comparative data.	N	The service did not collect comparative data, nor benchmark against national UK (or other service) data. It was noted that some areas of a visiting consultant's practice would be considered off-island.
XX-702	**Audit** The services should have a rolling programme of audit of compliance with: a. Evidence-based clinical guidelines (QS XX-500s) b. Standards of record keeping c. Timescales for key milestones on the patient pathway	N	Reviewers were not able to identify any audit activity in progress, or reports of any audits undertaken. There was no comprehensive programme of audit in place in the service.
XX-703	**Key Performance Indicators** Key performance indicators (QS XX-701) should be reviewed regularly with Trust (or equivalent) management and with commissioners.	N	There were no agreed KPIs for this service.
XX-798	**Multi-disciplinary Review and Learning** The service should have multi-disciplinary arrangements for a. Review of and implementing learning from positive feedback, complaints, outcomes, incidents and 'near misses' b. Review of and implementing learning from published scientific research and guidance c. Ongoing review and improvement of service quality, safety and efficiency	N	Reviewers were unable to identify evidence of governance meetings to discuss incidents, complaints or other useful governance indicators.
XX-798S	**Multi-disciplinary Review and Learning – Dermatology** All dermatologists should participate actively in: a. Regular review of their own biopsy specimens with a histopathologist b. Departmental clinicopathological review	N	Reviewers were unable to see evidence that MDT review was occurring on the island. Off-island reviews were identified for complex cases only.

Ref	Quality Standards	Met?	Reviewers' Comments
XX-799	**Document Control** All policies, procedures and guidelines should comply with Trust (or equivalent) document control procedures.	N	Reviewers saw a handbook dated 2014. This did not have a review date.

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EMERGENCY AMBULANCE SERVICE

Ref	Quality Standards	Met?	Reviewers' Comments
AB 101	The patient or caller should be reassured that the correct help or advice will be given to them over the telephone using the Advanced Medical Priority Dispatch System and where appropriate assessment by a suitably qualified professional either over the telephone or face to face.	N	Written information was not available, although scripted advice was given. Reviewers were concerned that there was no clinical advice available to call handling staff in the control room, which resulted in an emergency ambulance being sent to each call. Any clinical advice required was received via the on-call officer, but this appeared to be governed by an ad hoc relationship. There was no access to 'LanguageLine' or another translation and interpreting service.
AB 102	Self-care advice on a range of conditions should be given to patients and recorded on the Patient Report Form or printed from the Electronic Care System.	Y	Reviewers saw good information that was based on NICE guidelines. Excellent checklists were available on the rear of the Patient Report Form (PRF), which allowed for documentation of red-flag considerations and advice / instructions given. Staff did not know the non-conveyance rates when they were questioned.
AB 103	Patients and, with the patient's agreement, relatives and carers should have the information, encouragement and support to enable them fully to participate in decisions about their care.	N	Reviewers identified a lack of staff training to assess patients' mental capacity. There was no formal link with a GP (or alternative provider) to discuss care issues or clinical history fully. Reviewers noted that the Isle of Man did not have a mental capacity Act, but that UK practices were treated as common law and were followed and used for training.

Ref	Quality Standards	Met?	Reviewers' Comments
AB 104	Staff with patient contact should have a handbook of useful phrases in sign and a variety of other languages, and access to interpreter services.	N	Phrase books were in place, but discussions with staff revealed that these were not used in operational practice.
AB 199A	a. Mechanisms for receiving feedback from patients and carers about the treatment and care they received.	Y	Posters and stickers on the inside of ambulances encouraged patients to use Facebook for feedback. A one-off 'survey monkey' tool had been used. A report from patient feedback had been prepared, but it was unclear whether this had been shared with the hospital senior management. Reviewers noted that complaints occurred in 0.06% of all clinical activity, which was a positive indicator. There were no formal arrangements for fulfilling the Duty of Candour or its equivalent in cases where harm by the ambulance service was identified.
AB 199B	Mechanisms for involving patients and carers in decisions about the organisation of the services.	N	There was no focus group or forum for patients to allow them to be involved in making decisions about the service delivery. Reviewers identified that one of the managers did meet with patients, but it was unclear whether any follow-up activity resulted from these meetings.
AB199 C	b. A rolling programme of audit of a random sample of patients' experiences of the service.	N	Reviewers noted that there did not appear to be any evidence of action following patient feedback. Reviewers were not clear that a rolling programme of audit was in place or whether an audit was just an occasional occurrence.

Ref	Quality Standards	Met?	Reviewers' Comments
AB 201	Sufficient staff with competences in giving telephone advice and using the validated assessment system should be available at all times to ensure 95% off 999 calls are answered within 5 seconds.	N	Average response time was two seconds; however, reviewers were unclear whether this was the mean or the median. Reviewers were also unable, from the data, to assess compliance with the 95% standard. Reviewers noted that service managers had not attempted to do this analysis for their own information. Reviewers had concerns around the utilisation of the joint control room – they were unsure which calls received priority, and felt that little existed to support a surge of calls. Reviewers heard that some paramedics had trouble getting through to the service, which suggested that patients might also be experiencing the same problem at times. Reviewers were also concerned to hear that the service did not measure service pressure at busy periods.
AB 202	Two Health Professions Council Registered Paramedics should be available for all emergency responses. If this is not possible, an Institute of Health Care Development Qualified Technician should accompany a registered paramedic on a double-manned ambulance.	Y	Reviewers noted that 95% of all ambulance journeys had a paramedic on board. Reviewers identified a good level of skills mix. The senior management team was utilised to bolster the paramedic workforce and fill any gaps in the rota.
AB 203	All healthcare professionals should have training appropriate to their role in: Protection of vulnerable adults, Recognition of the needs of vulnerable groups including young people, people with mental health problems, dementia, alcohol and substance misuse problems, learning disabilities and older people. Mental Capacity Act and Deprivation of Liberty Safeguards.	Y	Three days' mandatory training annually were compulsory for operational staff. The training content was decided by the senior clinical managers and included changes in care pathways, emerging clinical events, complaints, etc.

Ref	Quality Standards	Met?	Reviewers' Comments
AB 204	There should be a training and development plan for all staff. The competences expected of each role should be identified and the plan for achieving and maintaining these competences described.	Y	However, reviewers noted that there was no capacity for additional training, as staff could not be released. Other (additional) training was offered (e.g. training in surgical airway management), but staff were expected to undertake this in their own time.
AB 301	A list of support services which the ambulance service can offer to patients should be available within the Emergency Operations Centre (EOC).	N	There was a limited range of other support services that could be offered to patients and so there was no list in the control room. Reviewers were unable to identify how GPs were engaged in this service in or out of hours.
AB 303	The Ambulance Service should have achieved full HART (Hazardous Area Response Team) Status	N	There was no emergency resilience capacity available. The Isle of Man did not have a HART or equivalent service.

Ref	Quality Standards	Met?	Reviewers' Comments
AB 401	A double-manned ambulance (DMA) and rapid response vehicle (RRV) should be available for all emergency responses. All facilities in which care is delivered should be designed and maintained to ensure a clean environment.	N	The service had an excellent fleet of ambulances available which were of a modern design and appeared to be relatively new. There were RRVs in the fleet, but the one that was seen at Douglas Station appeared to be an older vehicle that was described as being of a poor design, meaning that some equipment had to be stored on the back seat; this created a risk of moving objects should the vehicle be in a collision. However, reviewers were specifically concerned about the infection prevention and control risks in the service which were not well managed (see main report). It was noted at Douglas Station that a vehicle was not locked and keys were left inside the vehicle, posing a potential security risk.
AB 402	Portable diagnostic equipment required for a full assessment of sick or injured patients should be available for all emergency responses.	Y	A good range of equipment was available, which was maintained by the hospital's Electro-Biomedical Engineering (EBME) service under contract. Reviewers were impressed by the equipment database that a member of staff had taken time to develop.

Ref	Quality Standards	Met?	Reviewers' Comments
AB 403	Appropriate drugs and portable equipment for the treatment of patients should be available for all emergency responses. Drugs and equipment should be checked in accordance with trust (or equivalent) policy.	Y	Reviewers noted that technically this standard was met; however, all paramedics had different equipment in their portable case. This risked staff being unfamiliar with the case contents. In an emergency situation, a paramedic may not always have immediate access to their own bag, but, rather, may be required to rely on the closest bag, which may therefore not contain what they expect it to. Reviewers felt that a more standardised approach to contents would reduce this risk. A good system was in place to manage equipment maintenance; however, this was heavily reliant upon one member of staff (an operational paramedic) in a voluntary role, leading to a risk of future unsustainability.
AB 404	All emergency response ambulances should have IT systems for electronic communication of patient details to Emergency Departments.	N	Reviewers noted that there was no simple way to navigate to a location using existing SatNav systems. Reviewers noted that the Fire Service system automatically programmed the SatNav direct from the call centre whereas the ambulance service was required to input this information manually. Reviewers further commented that on an island where the majority of residences appeared to have names rather than numbers, finding a building was not always a logical process.

Ref	Quality Standards	Met?	Reviewers' Comments
AB 501	A policy for prioritisation of calls should be in use identifying: Patients who can be directed to support services including NHS Direct (or equivalent). Patients who can be assessed over the telephone, Patients who require a rapid response, Action when patients who have been assessed by a health care professional as requiring an urgent response.	N	Calls were answered in the order they were made. There was no system for determining priority. In busy periods, calls were stacked and answered in order.
AB 502	A system of priority dispatch should be in use to ensure that responses are prioritised according to the clinical need of the patient. This system should ensure that response times are within the following timescales: A Category = 8 mins B Category = 19 mins C category = 30 mins Healthcare referral (case defined) within 4 hours.	N	The service was in the process of introducing a new standard, but there was not currently a response standard in place.
AB 503	A validated telephone assessment system should be in use which ensures a definitive assessment of urgent calls is commenced within 30 minutes of the call being received.	N	Reviewers noted that in the current system this was not possible. The service was not designed to deliver this standard.
AB 504	Guidelines on initial (face to face) clinical assessment should be in use.	Y	The service followed JRCALC (Joint Royal Colleges Ambulance Liaison Committee) guidelines and NICE guidance.
AB 505	Access to evidence-based clinical guidelines should be easily available to staff undertaking telephone assessment and advice and to staff on emergency responses.	Y	The service followed JRCALC guidelines and NICE guidance.
AB 506	Guidelines on the diagnosis, treatment and management of patients suffering from exposure to a wide range of pharmaceuticals chemicals (agricultural, household and industrial), plants and animals should be easily available to staff undertaking telephone assessment and advice and to staff on emergency responses.	Y	The service should, however, check whether staff have individual log-in codes for TOXBASE.
AB-507	Guidelines should be in use which ensure that patients are treated, transferred or referred to the most appropriate service, according to the health economy matrix of services at which different patient groups and conditions should be treated	N/A	This QS is not applicable because of the configuration of healthcare on the island.
AB 508	Clinical guidelines should be in use covering: a. Resuscitation, b. Do not attempt resuscitation (DNAR), c. Recognition of Life Extinct, d. Management of birth.	Y	Reviewers were informed that the service uses the JRCALC guidelines.
AB 509	Arrangements for identifying people with advance care plans (QS AZ-705) and accessing the patient's latest care plan should be in use.	N	There were no care plans shared between services. Reviewers identified the potential for silo working.

Ref	Quality Standards	Met?	Reviewers' Comments
AB 510	A policy on the protection of vulnerable adults should be in use	Y	Reviewers identified that there was a policy in place. However, reviewers were unable to see how ambulance service staff would be involved in its review.
AB 511	A policy on non – conveyance of patients to a treatment centre should be in use to ensure that patients discharged at the scene have been clinically assessed and given appropriate advice	Y	The reviewers noted that the service conveyed a large majority of patients to a hospital, and discharged few patients at the scene.
AB 601	All staff under-taking emergency responses should have details of 'senior decision-makers' in acute services who they can contact for advice (QS AC-306).	N	There were no formal contact arrangements with anyone when staff required advice. There was no Bronze/Silver/Gold (or equivalent) command structure. Joint Emergency Services Interoperability Programme (JESIP) principles were not in place.
AB 602	A protocol should be in use to ensure that an electronic or paper-based patient record meeting Trust (or equivalent) clinical record keeping standards is completed at the end of each patient contact and submitted to the receiving health care professional and to the Ambulance Service.	N	Reviewers were told that records were completed, but there was limited knowledge of what happened to the completed records. Reviewers noted that there was no audit programme. Reviewers were unable to see how completed PRFs were mapped to calls, to review and learn from outcomes.
AB 603	The IoM Ambulance Service should have plans to provide emergency response and medical management of major incidents.	Y	However, reviewers were told that MAJAX training was voluntary.
AB 604	The IoM Ambulance Service should have plans to manage surge and sustained increases in demand.	Y	Reviewers considered that this may not be sustainable as the majority of the plan relied on voluntary participation and goodwill.
AB 605	The IoM Ambulance Service should monitor the need for ambulance transfer of bariatric patients and ensure that appropriate vehicles are available.	Y	Reviewers saw good provision of bariatric equipment.

Ref	Quality Standards	Met?	Reviewers' Comments
AB 607	The IoM Ambulance Service should actively participate in the health economy groups within the area for which services are commissioned.	Y	However, reviewers were unable to see how this would continue with the new management structure (with ambulance services as part of the hospital). Reviewers would suggest developing clear plans to include the continued engagement of ambulance staff in these meetings.
AB 608	Representatives of the service should meet at least annually with individual local urgent care services to review links between the services and address any problems identified.	N	Ambulance services had moved into the management structure of the hospital on 1 January 2018. Reviewers believed that these links would be available through this new chain of command, but at the time of the visit they were not yet formally in place.
AB 609	The service should have arrangements for liaison with falls prevention services, with the police on prevention of violence and with initiatives to reduce harm from alcohol or substance misuse.	Y	However, reviewers noted that this was in place because of the co-location of the call centre, rather than by formal design. The service may benefit from formalising this.
AB 701	There should be regular collection of data and monitoring of response times and turnaround times at each hospital.	N	Reviewers noted that no data on response or turnaround times were regularly collected or analysed.

Ref	Quality Standards	Met?	Reviewers' Comments
AB-702	The service should have a rolling programme of audit of: a. compliance with evidence-based guidelines (QS AB-504 to 508) b. compliance with national standards on clinical documentation.	N	A regular or rolling audit programme was not yet in place. Reviewers were told that senior management had not asked for this. Reviewers noted that some services (e.g. thrombolysis and cardiac arrest) may be getting very good outcomes because of the nature of the service and its geography, but these outcomes may be unrecorded. It was noted that whilst there was no formalised clinical audit programme, the anecdotal feedback was that the ambulance service performed very well in areas such as cardiac arrest survival, and that it could be comparable with high performing health services in both the UK and the rest of Europe.
AB-703	The service should have a complaints procedure that is consistent with the principles of the-DHSC complaints procedure.	Y	However, reviewers noted that this was a generic system and not specific to the ambulance service.
AB-704	The IoM Ambulance Service should have a system for reporting anonymised details of each complaint, including the way in which it has been handled, to the contracting body	Y	However, reviewers noted that this was a generic system and not specific to the ambulance service.
AB-705	The IoM Ambulance Service should have appropriate arrangements for reporting and investigating adverse incidents and 'near misses'.	Y	The service used the hospital-based system. However, staff in the service told reviewers that they submitted 'a lot of forms' but did not receive feedback on incidents and were therefore unable to implement any lessons learned.
AB-799	All policies, procedures and guidelines should comply with the IoM Ambulance Service 's document control procedures.	N	Reviewers were unable to identify a document control system in use.

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AIR AMBULANCE

Ref	Quality Standards	Met?	Reviewers' Comments
AT-101	**Service Information** The Transport service should offer patients and their carers written information covering: a. Organisation of the service b. Transport options c. Staff and facilities available d. How to contact the service for help and advice, including out of hours e. Financial advice for patients and carers.	Y	
AT-199	**Involving Patients and Carers** The Transport Service should have: a. Mechanisms for receiving regular feedback from patients and carers about the service b. Mechanisms for involving patients and carers in decisions about the organisation of the service c. Examples of changes made as a result of feedback and involvement of patients and carers	Y	
AT-201	**Lead Clinician** A nominated lead clinician should have responsibility for staffing, training, guidelines and protocols, service organisation, governance and for liaison with other services. The lead clinician should be a registered healthcare professional with appropriate specialist competences in this role and should undertake regular clinical work within the service.	Y	
AT-202	**Staff Authorised to Undertake Emergency Transfers** The nominated lead consultant and lead nurse for the Transport Service should specify which staff are appropriately trained and experienced to carry out emergency transfers.	N	Staff were in post, but these posts were not substantive roles within the air ambulance service but instead were 'borrowed' from other areas. Reviewers were concerned that this left the service vulnerable to external influences beyond its control. Reviewers were of the clear opinion that there should be a formal agreement to avoid potential service failure.

Ref	Quality Standards	Met?	Reviewers' Comments
AT-203	**Service Competences and Training Plan** The competences expected for each role in the Transport Service should be identified. Staff should have competences in providing Level 3 adult and Level 3 paediatric critical care and appropriate competences in emergency transfer. A training and development plan for achieving and maintaining competences should be in place. All staff working on the Transport Service should be undertaking Continuing Professional Development of relevance to their work within the Specialist Transport Service.	N	Reviewers were unable to see a structured design for the service that defined competences and how they would be maintained. The review team were clear that staff involved in the service had the skills and competences in their existing roles that made them best placed to work in this service, but could not see any formal assessment of this that gave appropriate assurance. Reviewers were unable to see that training for staff was funded.
AT-204	**Staffing Levels and Skill Mix** Sufficient number of crew with appropriate competences should be available for the: a. Number of patients usually cared for by the transport service and the usual case mix of patients b. Transport Service's role in the patient pathway and expected timescales c. Assessments and therapeutic interventions offered by the service d. Use of equipment required e. Practitioners should be rostered in sufficient numbers to meet service need. f. The following staff should be available 24/7: i. Transfer Practitioner; ii. Critical Care Transfer Practitioner iii. Paediatric Transfer Practitioner iv. Neonatal Transfer Practitioner v. Doctor for critical care transfers vi. Doctor for paediatric transfers vii. Doctor for neonatal transfers. g. Cover for absences should be available so that the patient pathway is not unreasonably delayed, and patient outcomes and experience are not adversely affected, when individual members of staff are away.	N	The service was at the beginning of a formal process to be recognised as a professional service within the Isle of Man. There was no formal calculation of the staff required, and neither was there a formal agreement that staff working in the service (who had substantive roles elsewhere) would be released when required to meet the needs of the air ambulance service. Reviewers saw that the service was beginning to take steps to formalise the arrangements. Reviewers identified that lack of substantive staffing for this service remained a clear risk to its delivery.
AT-205	**Indemnity** Staff working on the Transport Service must be: a. Indemnified for their practice in all environments in which they work b. Insured for personal injury sustained in the course of their professional work	Y	

Ref	Quality Standards	Met?	Reviewers' Comments
AT--210	**New Starters and Agency, Bank and Locum Staff** Before starting work in the service, local induction and a review of competence for the expected role in assessments and procedures should be completed for all new starters and agency, bank and locum staff.	N	See comments at QS AT-204. Staff held substantive roles in other parts of the emergency and critical care areas. There was no formal plan for induction or review of competences.
AT-299	**Administrative, Clerical and Data Collection Support** Administrative, clerical and data collection support should be available.	N	At the time of the review there was no administrative support to the service, as the post holder was on maternity leave. Reviewers were concerned that 2 hours per week (0.05WTE) of administrative support was not sufficient. There was not sufficient support for data collection (see AT-703).
AT-301	**Support Services** Timely access to an appropriate range of support services should be available.	Y	Reviewers saw that access to support services and transfer was in place. However, transfer by land ambulance to the airfield from the Emergency Department (ED) was given a lower priority than some other calls, and ward-based transfers were given a lower priority than GP urgent admissions. Agreed criteria with the ambulance service covering prioritising of transfer were not yet in place.

Ref	Quality Standards	Met?	Reviewers' Comments
AT-402	**Equipment** Timely access to equipment appropriate for the service provided should be available. For example: - 1. Critical care transfer monitors should allow clear display of the physiological parameters. 2. Monitor alarms should be both audible and visible. The monitor should be adequately charged and also have a backup battery pack. 3. Portable ventilators must have disconnection and high-pressure alarms and the facility for PEEP, the ability to allow manipulation of oxygen concentration, inspiratory, expiratory ratios, respiratory rate and tidal volume as a minimum specification. In addition, the ability to provide pressure-controlled ventilation and CPAP is desirable. 4. Infusion pumps should be sufficient in number and should be fully charged before departure. 5. Stretchers should be appropriate and maintained. 6. Loading systems should be appropriate and maintained. 7. Transfer staff should have access to appropriate clothing. Equipment should be appropriately maintained and a process for equipment replacement in place.	N	Reviewers saw a lack of PPE and suitable uniform. Reviewers were told that staff had borrowed reflective jackets (of the wrong size) in order to deliver the service. Equipment to deliver the service had been sourced from other areas. It was unclear to the reviewers whether a sustainable equipment provision and replacement programme had been developed. There was no assurance that the equipment currently used by the service formed part of the hospital's equipment asset register or replacement programme. Reviewers were concerned that the resilience of the service was at risk without a clear equipment programme.
AT-499	**IT System** IT systems for storage, retrieval and transmission of patient information should be in use for patient administration, clinical records, outcome information and other data to support service improvement, audit and revalidation.	N	Reviewers saw a paper-based system with multiple files. Reviewers noted that with 0.05 WTE administrative support, retrieval of information was a challenge to the clinical staff.

Ref	Quality Standards	Met?	Reviewers' Comments
AT-601	**Operational Procedure – Aeromedical Transport (1)** Procedures for the management of the usual case mix of patients referred to the service should be in use, including: a. Access to the duty coordinator by a single telephone call 24 hours a day. b. Arrangements to ensure rapid mobilisation of staff once an urgent transfer is requested c. Expected timescales for the patient pathway d. Responsibility for giving patient and carer information at each stage of the patient journey e. Arrangements for multi-disciplinary discussion of patients requiring transfer f. Arrangements for liaison with key support services (QS AT-301) g. Equipment and medicines to be included on all flight including arrangements for maintenance of equipment (QS AT-402) h. Arrangements for providing all necessary information to the transfer practitioner and pilot including destination, weights, numbers, altitude restriction i. Process for recording observations of patients being transported j. Processes for cleaning and infection control Process for management of obese patients k. Authorisation of staff to undertake emergency transfers l. Roles within the emergency transfer team m. Risk assessment of each journey n. Staff rostering to minimise fatigue and unplanned overtime. o. Duty status during illness and pregnancy p. 'Surge' plan for days when the Transport Service is not available or local capacity is exceeded q. Aircraft breakdown r. Incident reporting	Y	However, please see earlier comments about the resilience of the service and a structured service delivery plan.

Ref	Quality Standards	Met?	Reviewers' Comments
AT-602	**Operational Procedure – Aeromedical Transport (2)** In addition to the requirements of QS AT-601, the Operational Procedure for aeromedical transport should cover: a. Pre flight procedures to include notification of the caller and communications with other parties including ambulance operators. b. Multi-crew operation for all flights by pilots with competences in multi-crew operation c. Separation between clinical and aviation decision-making. d. In flight procedures - including communication between the transport team and destination coordinator or crew access to clinical or operational advice e. How information for referring hospitals will be communicated and updated (phone numbers and clinical information expected) f. Carriage and use of hazardous materials in all types of flying conditions. g. Agreements should be in place with other ambulance and transport services covering arrangements for 24/7 access and patient transfer.	Y	
AT-603	**Liaison with Other Services** Review meetings should be held at least annually with key support services to consider liaison arrangements and address any problems identified. For example: a. North West Transport Service b. North West Critical Care and Major Trauma Network	Y	
AT-701	**Data Collection** The Specialist Transport Service should be collecting at least the following data for road and air (if provided) transfers: a. Referrals, including: i. those to which it is not able to respond (e.g. weather, airport operating times, infection control issues) b. Pre-transfer patient condition and management c. Untoward clinical incidents d. Mortality and morbidity e. Utilisation data	Y	
AT-702	**Audit** The services should have a rolling programme of audit of compliance with: a. Evidence-based clinical guidelines (QS AT-500s) b. Standards of record keeping c. Timescales for key milestones on the patient pathway	N	A rolling programme of audit was not yet in place.

Ref	Quality Standards	Met?	Reviewers' Comments
AT-703	**Key Performance Indicators** Key performance indicators (QS AT-701) should be reviewed regularly with the Trust (or equivalent) management, relevant stakeholders and the IoM Department Health and Social Care.	N	The IOM team self-assessed this QS as not applicable. Reviewers felt that this standard was applicable and that KPIs should be developed for the service and should be routinely measured.
AT-704	**Research** The service should actively participate in relevant research	N	Reviewers were unable to see evidence of the service undertaking any structured research or similar programmes.
AT-798	**Multi-disciplinary Review and Learning** The service should have multi-disciplinary arrangements for: a. Review of and implementing learning from positive feedback, complaints, outcomes, incidents and 'near misses' b. Review of and implementing learning from published scientific research and guidance c. Ongoing review and improvement of service quality, safety and efficiency.	N	Reviewers noted that the development of this service was in its infancy, but that there were currently no MDT meetings at which management and clinical staff could jointly review clinical delivery and learn from previous experience.
AT-799	**Document Control** All policies, procedures and guidelines should comply with Hospital (or equivalent) document control procedures.	Y	

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PHYSIOTHERAPY AND OCCUPATIONAL THERAPY SERVICES (ACUTE AND COMMUNITY)

Ref	Quality Standards	Met?	Reviewers' Comments
XX-101	**Service Information** Each service should offer patients and their carers written information covering: a. Organisation of the service, such as opening hours and clinic times b. Staff and facilities available c. How to contact the service for help and advice, including out of hours	Y	The IOM government therapies website was easy to navigate, and information for patients was clearly written. The website also had links to other relevant services.
XX-102	**Condition-Specific Information** Information for patients and their carers should be available covering, at least: a. Brief description of their condition and its impact b. Possible complications and how to prevent these c. Pharmacological and non-pharmacological therapeutic and rehabilitation interventions offered by the service d. Possible side-effects of therapeutic and rehabilitation interventions e. Symptoms and action to take if unwell f. DVLA regulations and driving advice (if applicable) g. Health promotion, including smoking cessation, health eating, weight management, exercise, alcohol use, sexual and reproductive health, and mental and emotional health and well-being h. For frail older people: Pain, depression, skin integrity, falls and mobility, continence, safeguarding issues, delirium and dementia, nutrition and hydration, sensory loss, activities of daily living, vital signs and end of life issues i. Sources of further advice and information	Y	Information was available from the physiotherapy and occupational therapy services. The occupational therapy information would benefit from being reviewed so that it was in the same format as the physiotherapy information. Staff would also print any relevant information and exercise programmes for patients via the 'PhysioTools' information system.
XX-103	**Care Plan** Each patient and, where appropriate, their carer should discuss and agree their Care Plan, and should be offered a written record covering at least: a. Agreed goals, including life-style goals b. Self-management c. Planned therapeutic and/or rehabilitation interventions d. Early warning signs of problems, including acute exacerbations, and what to do if these occur e. Planned review date and how to access a review more quickly, if necessary f. Who to contact with queries or for advice	N	Patients were not offered a written record of their care plan that covered all aspects of the QS. Care plans / goals were discussed with patients and documented using a standardised template in either inpatient medical records or, for those accessing care from community services, on the Rio electronic record system.

Ref	Quality Standards	Met?	Reviewers' Comments
XX-104	**Review of Care Plan** A formal review of the patient's Care Plan should take place as planned and, at least, six monthly. This review should involve the patient, where appropriate, their carer, and appropriate members of the multi-disciplinary team. The outcome of the review should be communicated in writing to the patient and their GP.	Y	Review of treatment plans took place prior to discharge and the outcome of the review was communicated to the GP. However, a copy was not given to patients. For community services patients could self-refer should their condition change.
XX-105	**Contact for Queries and Advice** Each patient and, where appropriate, their carer should have a contact point within the service for queries and advice. If advice and support is not immediately available then the timescales for a response should be clear. Response times should be no longer than the end of the next working day. All contacts for advice and a sample of actual response time should be documented.	Y	Information about who to contact with queries or for advice was given to patients or accessible on the website.
XX-106	**School Health Care Plan (Services caring for children and young people only)** A School Care Plan should be agreed for each child or young person covering, at least: a. School attended b. Care required while at school including medication c. Responsibilities of carers and of school staff d. Likely problems and what to do if these occur, including what to do in an emergency e. Arrangements for liaison with the school f. Review date and review arrangements	N/A	The self-referral service would see children over 12 years of age, but developing any school health care plans would be the responsibility of the patient's medical team.
XX-195	**Transition to Adult Services** Young people approaching the time when their care will transfer to adult services should be offered: a. The opportunity to discuss the transfer of care with paediatric and adult services b. A named coordinator for the transfer of care c. A preparation period prior to transfer d. Written information about the transfer of care including arrangements for monitoring during the time immediately afterwards	Y	It was rare for there to be young people transitioning to adult services; however, appropriate mechanisms were in place if required for both inpatient and community services.

Ref	Quality Standards	Met?	Reviewers' Comments
XX-196	**Discharge Information** On discharge from the service, patients and their carers should be offered written information covering at least: a. Care after discharge b. Return to normal activities c. Ongoing self-management of their condition d. Possible complications and what to do if these occur e. Who to contact with queries or concerns	Y	Inpatient services offered patients a copy of their discharge plan. The self-referral service would give patients a copy of their 'goal' sheet, which included some information on care after discharge. For patients being discharged from the Community Adult Therapy Service (CATS) verbal information was given, and occasionally this was supported by written information. A good transfer of therapy document was completed for all patients who were discharged to community therapy care.
XX-197	**General Support for Patients and Carers** Patients and carers should have easy access to the following services and information about these services should be easily available: a. Interpreter services, including British Sign Language b. Independent advocacy services c. Complaints procedures d. Social workers e. Benefits advice f. Spiritual support g. HealthWatch or equivalent organisation h. Relevant voluntary organisations providing support and advice	N	'b' was not met. Support to patients was generally good. There was also an iPad available for those with hearing loss.
XX-198	**Carers' Needs** Carers should be offered information on: a. How to access an assessment of their own needs b. What to do in an emergency c. Services available to provide support	Y	

Ref	Quality Standards	Met?	Reviewers' Comments
XX-199	**Involving Patients and Carers** The service should have: a. Mechanisms for receiving regular feedback from patients and carers about treatment and care they receive b. Mechanisms for involving patients and carers in decisions about the organisation of the service c. Examples of changes made as a result of feedback and involvement of patients and carers	Y	Friends and Family feedback was in place; however, response levels were low. The IOM government website had a 'how did we do' feedback link for physiotherapy and occupational therapy services. Comment boxes were visible in some areas, and reviewers considered that making comment boxes available in more areas may help increase the level of feedback about the service.
XX-201	**Lead Clinician** A nominated lead clinician should have responsibility for staffing, training, guidelines and protocols, service organisation, governance and for liaison with other services. The lead clinician should be a registered healthcare professional with appropriate specialist competences in this role and should undertake regular clinical work within the service.	Y	

Ref	Quality Standards	Met?	Reviewers' Comments
XX-202	**Staffing Levels and Skill Mix** Sufficient staff with appropriate competences should be available for the: a. Number of patients usually cared for by the service and the usual case mix of patients b. Service's role in the patient pathway and expected timescales c. Assessments and therapeutic and/or rehabilitation interventions offered by the service d. Use of equipment required for these assessments, therapeutic and/or rehabilitation interventions e. Urgent review within agreed timescales An appropriate skill mix of staff should be available including medical, nursing, allied health professionals, social care professionals, support workers and other staff required to deliver the range of assessments and therapeutic and/or rehabilitation interventions offered by the service. Cover for absences should be available so that the patient pathway is not unreasonably delayed, and patient outcomes and experience are not adversely affected, when individual members of staff are away.	N	Although the physiotherapy and occupational therapy services were integrated in terms of management, there was no flexibility between the services to cover any other team members. The occupational therapy lead was on secondment and there was no cover. Neither service had dual competence technicians (which would help with managing workload). In-patients: Urgent referrals could be seen within an hour, but otherwise the waiting time was 24 hours for physiotherapy and 48 hours for occupational therapy. Out of hours and at weekends, cover was only available for respiratory and elective orthopaedic patients. There was no cover for absences for any of the single specialist physiotherapists. Reviewers were told that staff would try and get patient pre-operative assessment work completed before their leave. Community: A recent audit showed that waiting times were not consistently met (*urgent* 86%, *soon 1* 67%, *soon 2* 70%, and *routine* 80%). Some work had taken place across the two disciplines to improve the resilience of the service.

Ref	Quality Standards	Met?	Reviewers' Comments
XX-203	**Service Competences and Training Plan** The competences expected for each role in the service should be identified. A training and development plan for achieving and maintaining competences should be in place.	N	Defined competences were in place for Band 5, 6 & 7 physiotherapists but not for occupational therapists or other roles within the teams. Training plans were in place.
XX-204	**Competences – All Health and Social Care Professionals** All health and social care professionals working in the service should have competences appropriate to their role in: a. Safeguarding children and/or vulnerable adults b. Recognising and meeting the needs of vulnerable children and/or adults c. Dealing with challenging behaviour, violence and aggression d. Mental Capacity Act and Deprivation of Liberty Safeguards e. Resuscitation	N	Reviewers were told that mandatory training compliance was checked during appraisals, but this was not documented as having been completed in any of the records or lists seen at the time of the visit. A CAT service audit showed that only 76% of mandatory training had been completed.
XX-299	**Administrative, Clerical and Data Collection Support** Administrative, clerical and data collection support should be available.	N	Staff were spending time on administrative duties and there was no administrative support for data collection.
XX-301	**Support Services** Timely access to an appropriate range of support services should be available.	Y	However, the self-referral service commented on patients experiencing long waiting times to access imaging.
XX-401	**Facilities** Facilities available should be appropriate for the assessments, therapeutic and/or rehabilitation interventions offered by the service for the usual number and case mix of patients.	Y	Services at the Central Community Health Centre were spacious and well equipped.
XX-402	**Equipment** Timely access to equipment appropriate for the service provided should be available. Equipment should be appropriately maintained.	N	Reviewers were told that timely delivery of equipment was always not always possible. Therapy staff were spending time sourcing and delivering equipment.
XX-499	**IT System** IT systems for storage, retrieval and transmission of patient information should be in use for patient administration, clinical records, outcome information and other data to support service improvement, audit and revalidation.	N	Across the therapy services, multiple IT systems were in use. When working at Noble's Hospital the teams used the Medway system, and in the community, they used the Rio system. Other community services accessed EMIS.

Ref	Quality Standards	Met?	Reviewers' Comments
XX-501	**Diagnosis and Assessment Guidelines** Guidelines on diagnosis and assessment should be in use covering the usual case mix of patients referred to the service.	Y	A standardised pro forma for assessments was in place.
XX-502	**Clinical Guidelines** Guidelines on management of the usual case mix of patients referred to the service should be in use covering, at least: a. Therapeutic and/or rehabilitation interventions offered by the service b. Monitoring and follow up	Y	
XX-595	**Transition** Guidelines on transition of young people from paediatric to adult services should be in use covering, at least: a. Involvement of the young person and, where appropriate, their carer in planning the transfer of care b. Involvement of the young person's general practitioner in planning the transfer c. Joint meeting between paediatric and adult services in order to plan the transfer d. Allocation of a named coordinator for the transfer of care e. A preparation period prior to transfer f. Arrangements for monitoring during the time immediately after transfer	Y	The process was documented, but in practice any transition of young people to adult services was led by the paediatric teams.
XX-596	**Discharge Guidelines** Guidelines on discharge from the service should be in use.	Y	A discharge and transfer of care document was in place across the services.
XX-599	**Care of Vulnerable People** Guidelines for the care of vulnerable children, young people and adults should be in use, in particular: a. Identification of vulnerable people b. Individualised care plans for people identified as being particularly vulnerable c. Restraint and sedation d. Missing patients e. Mental Capacity Act and the Deprivation of Liberty Safeguards f. Safeguarding g. Information sharing h. Palliative care i. End of life care	N	Hospital- and community-based staff had to access two different systems. The link in the operational policy for identifying vulnerable people was to a document from 1999 which was out of date. 'c' and 'd' were not applicable to the therapies teams. 'e': DHSC capacity policy and guidance (ref. PC48) 'h' and 'i': guidelines were not available on the hospital website, but 'h' and 'i' were not applicable to therapies teams.

Ref	Quality Standards	Met?	Reviewers' Comments
XX-601	**Operational Policy** The service should have an operational policy describing the organisation of the service including, at least: a. Expected timescales for the patient pathway, including initial assessment, start of therapeutic and/or rehabilitation interventions and urgent review, and arrangements for achieving and monitoring these timescales b. Responsibility for giving patient and carer information at each stage of the patient journey c. Arrangements for responding to patients' queries or requests for advice by the end of the next working day d. Arrangements for follow up of patients who 'do not attend' e. Arrangements for multi-disciplinary discussion of appropriate patients f. Arrangements for liaison with key support services (QS XX-301) g. Arrangements for maintenance of equipment (QS XX-402) h. Responsibilities for IT systems (QS XX-499)	Y	See good practice section of the report.
XX-602	**Liaison with Other Services** Review meetings should be held at least annually with key support services to consider liaison arrangements and address any problems identified.	Y	
XX-701	**Data Collection** Regular collection and monitoring of data should be in place, including: a. Referrals to the service, including source of appropriateness of referrals b. Number or assessments, urgent reviews and therapeutic and /or rehabilitation interventions undertaken by the service c. Outcome of assessments and therapeutic and /or rehabilitation interventions d. Number of discharges from the service and type of care after discharge e. Key performance indicators	N	Some data were collected on referral and timeframes, but not as required by the QS. Data were not summarised in a format that could be used for monitoring or service development purposes. The breast service collected data on the number of discharges from the service and the type of care after discharge.
XX-702	**Audit** The services should have a rolling programme of audit of compliance with: a. Evidence-based clinical guidelines (QS XX-500s) b. Standards of record keeping c. Timescales for key milestones on the patient pathway	Y	Each service undertook three audits per year which were sent to the hospital and/or community-led audit committee.
XX-703	**Key Performance Indicators** Key performance indicators (QS XX-701) should be reviewed regularly with Hospital (or equivalent) management and with commissioners.	N	KPIs that could be used to demonstrate clinical quality and service efficiency were not yet agreed.

Ref	Quality Standards	Met?	Reviewers' Comments
XX-798	**Multi-disciplinary Review and Learning** The service should have multi-disciplinary arrangements for a. Review of and implementing learning from positive feedback, complaints, outcomes, incidents and 'near misses' b. Review of and implementing learning from published scientific research and guidance c. Ongoing review and improvement of service quality, safety and efficiency	Y	Team meetings were held with staff. The inpatient team also invited ward representatives to attend, and was linked to MDTs of other services.
XX-799	**Document Control** All policies, procedures and guidelines should comply with Hospital (or equivalent) document control procedures.	Y	

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PODIATRY SERVICES

Ref	Quality Standards	Met?	Reviewers' Comments
XX-101 POD QS1	**Service Information** Each service should offer patients and their carers written information covering: a. Organisation of the service, such as opening hours and clinic times b. Staff and facilities available c. How to contact the service for help and advice, including out of hours d. Range of other services available locally	Y	A wide range of information was available. The information was very clear and easy to read.
XX-102 POD QS2	**Condition-Specific Information** Information for patients and their carers should be available covering, at least: a. Brief description of their condition and its impact b. Self-care c. Possible complications and how to prevent these d. Pharmacological and non-pharmacological therapeutic and rehabilitation interventions offered by the service e. Possible side-effects of therapeutic and rehabilitation interventions f. Symptoms and action to take if unwell g. DVLA regulations and driving advice (if applicable) h. Health promotion, including smoking cessation, health eating, weight management, exercise, alcohol use, sexual and reproductive health, and mental and emotional health and well-being i. For frail older people: Pain, depression, skin integrity, falls and mobility, continence, safeguarding issues, delirium and dementia, nutrition and hydration, sensory loss, activities of daily living, vital signs and end of life issues j. Sources of further advice and information	Y	As XX-101. In addition, patients were given leaflets from The Society of Chiropodists and Podiatrists and were directed to NHS resources and the IOM government website.

Ref	Quality Standards	Met?	Reviewers' Comments
XX-103 POD QS3	**Care Plan** Each patient and, where appropriate, their carer should discuss and agree their Care Plan, and should be offered a written record covering at least: a. Agreed goals, including life-style goals b. Self-management c. Planned assessments ,therapeutic and/or rehabilitation interventions d. Early warning signs of problems, including acute exacerbations, and what to do if these occur e. Planned review date and how to access a review more quickly, if necessary f. Who to contact with queries or for advice The Care Plan should be communicated to the patient's GP and to relevant other services involved in their care.	Y	Each patient was assessed using a needs assessment. Only patients with diabetes had a copy of their care plan, although treatment letters were given to other patients. For patients with diabetes a community diabetic foot assessment was used. Photographs were taken as part of the assessment and patients were given information about early warning signs and what to do if these occurred. Mobility plans were also completed.
XX-104 POD QS4	**Review of Care Plan** A formal review of the patient's Care Plan should take place as planned and, at least, six monthly. This review should involve the patient, where appropriate, their carer, and appropriate members of the multi-disciplinary team. The outcome of the review should be communicated in writing to the patient and their GP.	Y	The service was in the process of transferring to an electronic records system.
XX-105 POD QS5	**Contact for Queries and Advice** Each patient and, where appropriate, their carer should have a contact point within the service for queries and advice. If advice and support is not immediately available, then the timescales for a response should be clear. Response times should be no longer than the end of the next working day. All contacts for advice and a sample of actual response time should be documented.	N	Patients and carers could contact the service and could also leave a message that would be dealt with the following day. However, if a message was left on a Friday, this would not be dealt with until Monday. Under NICE guidelines, there should be 24-hour access to a multidisciplinary team, and this was not available at weekends. This is a risk as the patient should be directed to A&E if the condition is acute.
XX-196 POD QS6	**Discharge Information** On discharge from the service, patients and their carers should be offered written information covering at least: a. Care after discharge b. Return to normal activities c. Ongoing self-management of their condition d. Possible complications and what to do if these occur e. Who to contact with queries or concerns	Y	Staff would also contact the patient's key worker / district nurse if appointments were missed.

Ref	Quality Standards	Met?	Reviewers' Comments
XX-197 POD QS7	**General Support for Patients and Carers** Patients and carers should have easy access to the following services and information about these services should be easily available: a. Interpreter services, including British Sign Language. b. Independent advocacy services c. Complaints proceduresd. d. Social workerse. e. Benefits advice f. Spiritual supportg. g. Health Watch or equivalent organisation. h. Relevant voluntary organisations providing support and advice	N	'b' was not met. All other support was in place, and staff would also refer to the falls service if required.
XX-198 POD QS8	**Carers' Needs** Carers should be offered information on: a. How to access an assessment of their own needs b. What to do in an emergency c. Services available to provide support	Y	A podiatrist would signpost to the appropriate information. Leaflets were available about support services in place. Staff also provided training for carers in their own homes.
XX-199 POD QS9	**Involving Patients and Carers** The service should have: a. Mechanisms for receiving regular feedback from patients and carers about treatment and care they receive b. Mechanisms for involving patients and carers in decisions about the organisation of the service c. Examples of changes made as a result of feedback and involvement of patients and carers	Y	The service encouraged patients to give feedback about their treatment via a comments form and via the IOM government website. The Community Executive Team also had a programme of 'patient safety walkabouts', but the 'walkabouts' did not always include meetings with patients. Changes made as a result of feedback included better signage in the waiting areas, disabled parking, and communication boards. Reviewers considered that holding a patient focus group may enhance the level of feedback about the service.

Ref	Quality Standards	Met?	Reviewers' Comments
XX-201 POD QS10	**Lead Clinician** A nominated lead clinician should have responsibility for staffing, training, guidelines and protocols, service organisation, governance and for liaison with other services. The lead clinician should be a registered healthcare professional with appropriate specialist competences in this role and should undertake regular clinical work within the service.	N	There was a nominated lead clinician. However, the lead professional did not undertake regular clinical sessions. The lead only covered staff sickness absence or if there was no other available cover. In addition, the professional lead was retiring at the end of April 2018. No leadership replacement had been agreed at the time of the report.

Ref	Quality Standards	Met?	Reviewers' Comments
XX-202 POD Q11	**Staffing Levels and Skill Mix** Sufficient staff with appropriate competences should be available for the: a. Number of patients usually cared for by the service and the usual case mix of patients b. Service's role in the patient pathway and expected timescales c. Assessments and therapeutic and/or rehabilitation interventions offered by the service d. Use of equipment required for these assessments, therapeutic and/or rehabilitation interventions e. Urgent review within agreed timescales An appropriate skill mix of staff should be available including medical, nursing, allied health professionals, social care professionals, support workers and other staff required to deliver the range of assessments and therapeutic and/or rehabilitation interventions offered by the service. Cover for absences should be available so that the patient pathway is not unreasonably delayed, and patient outcomes and experience are not adversely affected, when individual members of staff are away.	N	Development of specialist areas within secondary care had increased the workload of the team, and reviewers were told that there was insufficient time for staff to in-reach to the hospital and cover all the acute clinics and MDTs. The vascular surgeon was therefore also undertaking some podiatry work to help with the increased demand for specialist podiatry services. A business case to increase the staffing levels to cover the acute hospital service had been submitted but not agreed. There was insufficient time for clinical supervision and peer review for staff. Historically the service had been set up to provide community-based podiatry and therefore all residents of the 22 care homes received domiciliary care rather than attending a community clinic. This placed an increasing demand on the service. There was a lack of cover for staff sickness, the biomechanics service needed development, there was no paediatric service, there was no peripheral arterial disease service, and there was very little public health involvement. In addition, there was little time available for the Band 8A professional to develop the service strategically as she only had one administrative session per week. Training was also cancelled to cover sickness absence.

Ref	Quality Standards	Met?	Reviewers' Comments
XX-203 POD QS12	**Service Competences and Training Plan** The competences expected for each role in the service should be identified. A training and development plan for achieving and maintaining competences should be in place.	N	There was no overarching training and development plan for the service. Reviewers were also told that training was often cancelled due to staff shortages. Mandatory training was completed and competences for the Band 3, 5, 6, 7 and 8 roles were assessed on an annual basis as part of the teams' appraisal process.
XX-204 POD QS13	**Competences – All Health and Social Care Professionals** All health and social care professionals working in the service should have competences appropriate to their role in: a. Safeguarding children and/or vulnerable adults b. Recognising and meeting the needs of vulnerable children and/or adults c. Dealing with challenging behaviour, violence and aggression d. Mental Capacity Act and Deprivation of Liberty Safeguards e. Resuscitation	Y	However, staff who spoke to the reviewers were not always clear on their responsibilities for the equivalent process on the IOM for managing Deprivation of Liberty Safeguards.
XX-299 POD QS14	**Administrative, Clerical and Data Collection Support** Administrative, clerical and data collection support should be available.	N	Clinical staff were spending time on administrative tasks and there was no support for data collection.
XX-301 POD QS15	**Support Services** Timely access to an appropriate range of support services should be available for example: a. Community nursing staff b. Diabetes service c. Imaging d. Pathology e. Plaster service f. Patient transport services	N	In the south of the island there was no community patient transport service, and therefore patient access to appointments was poor.
XX-401 POD QS16	**Facilities** Facilities available should be appropriate for the assessments, therapeutic and/or rehabilitation interventions offered by the service for the usual number and case mix of patients.	Y	
XX-402 POD Q17	**Equipment** Timely access to equipment appropriate for the service provided should be available. Equipment should be appropriately maintained.	Y	

Ref	Quality Standards	Met?	Reviewers' Comments
XX-499 POD Q18	**IT System** IT systems for storage, retrieval and transmission of patient information should be in use for patient administration, clinical records, outcome information and other data to support service improvement, audit and revalidation.	N	Multiple systems were in use across the services. Community staff used the Rio information system, but this system did not yet allow for recording of patients' progress and therefore paper records were kept. EMIS was in the process of being implemented for the podiatry service. When attending the hospital staff had to use both the Diamond information database for the diabetes service and Medi-viewer electronic document management system
XX-501 POD Q19	**Diagnosis and Assessment Guidelines** Guidelines on diagnosis and assessment should be in use covering the usual case mix of patients referred to the service.	Y	The guidelines for assessment were very good and were based on eligibility and the needs matrix.
XX-502 POD Q20	**Clinical Guidelines** Guidelines on management of the usual case mix of patients referred to the service should be in use covering, at least: a. Therapeutic and/or rehabilitation interventions offered by the service b. Monitoring and follow up	Y	A good range of guidelines / protocols was in place for the therapeutic intervention provided by the service.
XX-596 POD Q21	**Discharge Guidelines** Guidelines on discharge from the service should be in use.	Y	
XX-599 POD Q22	**Care of Vulnerable People** Guidelines for the care of vulnerable children, young people and adults should be in use, in particular: a. Identification of vulnerable people b. Individualised care plans for people identified as being particularly vulnerable c. Restraint and sedation d. Missing patients e. Mental Capacity Act and the Deprivation of Liberty Safeguards f. Safeguarding g. Information sharing g. Palliative care h. End of life care	Y	DHSC guidelines were in place covering: Adult protection policy Managing patients at end of life Raising concerns over patient care, safety and wellbeing Guidance for managers regarding advance directives/living wills Standard operating procedure (SOP) dealing with advance directions/ living wills DHSC capacity policy and guidance (ref. PC48).

Ref	Quality Standards	Met?	Reviewers' Comments
XX-601 POD Q23	**Operational Policy** The service should have an operational policy describing the organisation of the service including, at least: a. Expected timescales for the patient pathway, including initial assessment, start of therapeutic and/or rehabilitation interventions and urgent review, and arrangements for achieving and monitoring these timescales b. Responsibility for giving patient and carer information at each stage of the patient journey c. Arrangements for responding to patients' queries or requests for advice by the end of the next working day d. Arrangements for follow up of patients who 'do not attend' e. Arrangements for multi-disciplinary discussion of appropriate patients f. Arrangements for liaison with key support services (QS XX-301) g. Arrangements for maintenance of equipment (QS XX-402) h. Responsibilities for IT systems (QS XX-499)	N	Expected timescales for the patient pathways were not yet formalised and monitored, although data on the number of referrals and interventions were collected. Arrangements for multidisciplinary discussion of patients with complex needs were not yet in place and staff could not always attend hospital MDT meetings. The service specification covered access criteria, and other standard operating procedures covered 'c', 'd', 'f', 'g' and 'h'.
XX-602 POD Q24	**Liaison with Other Services** Review meetings should be held at least annually with key support services to consider liaison arrangements and address any problems identified.	Y	The team would raise any operational issues with the relevant support service rather than holding an annual meeting.
XX-701 POD Q25	**Data Collection** Regular collection and monitoring of data should be in place, including:a. Referrals to the service, including source of appropriateness of referralsb. Number or assessments, urgent reviews and therapeutic and /or rehabilitation interventions undertaken by the servicec. Outcome of assessments and therapeutic and /or rehabilitation interventionsd. Number of discharges from the service and type of care after dischargee. Key performance indicators	N	Data for 'c' were not collected and no KPIs had been agreed. Data were collected covering 'a', 'b' and 'd'.
XX-702 POD Q26	**Audit** The services should have a rolling programme of audit of compliance with: a. Evidence-based clinical guidelines (QS XX-500s) b. Standards of record keeping c. Timescales for key milestones on the patient pathway	Y	A range of audits was undertaken, and action plans developed.
XX-703 POD Q27	**Key Performance Indicators** Key performance indicators (QS XX-701) should be reviewed regularly with management and with commissioners.	N	KPIs for monitoring and service development had not yet been set. The team did collate a three-monthly summary of performance which was used as the basis of discussion with managers.

Ref	Quality Standards	Met?	Reviewers' Comments
XX-798 POD Q28	**Multi-disciplinary Review and Learning** The service should have multi-disciplinary arrangements for a. Review of and implementing learning from positive feedback, complaints, outcomes, incidents and 'near misses' b. Review of and implementing learning from published scientific research and guidance c. Ongoing review and improvement of service quality, safety and efficiency	Y	
XX-799 POD Q29	**Document Control** All policies, procedures and guidelines should comply with Trust (or equivalent) document control procedures.	Y	

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SPEECH & LANGUAGE

Ref	Quality Standards	MET?	Reviewers' Comments
1	The service audits its performance against the RCSLT minimum service standards as part of a regular process of service review.	N	An audit programme was in progress but not fully embedded. The service was compliant with mandatory training and infection control.
2	Policies are reviewed at least once every three years	Y	SharePoint sent notifications when policies were out of date
3	The service has a system for monitoring SLT's HPC registration status	Y	
4	Exit interviews are conducted with all staff leaving the service.	Y	However, no staff have left the service in the last five years.
5	All staff have a clear and up-to-date contract of employment.	Y	
6	All staff have a clear and up-to-date job description.	N	Due to the recent changes / restructuring not all staff had up-to-date job descriptions.
7	The service has a system for monitoring staff absence.	Y	
8	The service provides a planned orientation, induction and support programme for all new staff, including locum staff, and returners to practice.	Y	
9	The service has an up-to-date organisation and service profile showing clear lines of responsibility and accountability within the organisation.	Y	
10	All staff have an annual performance review supported by a systematic approach to training and development including a PDP and appropriate CPD opportunities.	Y	
11	The service has a system for reviewing the requirements of a post in terms of knowledge and skills.	Y	
12	The service has agreed mechanisms in place to support practitioners working within external agencies.	Y	
13	The service has an up-to-date policy and system of clinical supervision for all clinical staff.	Y	
14	All SLTs access an appropriate form of clinical supervision at least once every 12 weeks.	Y	
15	The service has a system for accessing clinical advice or second opinions.	Y	
16	The service uses the competency-based framework to structure the learning of the newly-qualified practitioner during the initial twelve-month period and as evidence of readiness to transfer to full RCSLT membership.	Y	

Ref	Quality Standards	MET?	Reviewers' Comments
17	The service supports the monitoring of clinical practice through managerial and clinical supervision, staff development review and personal development plans.	Y	
18	The service has a clear and up-to-date policy for dealing with staff concerns about clinical care, including a confidential procedure for staff to follow.	Y	
19	As appropriate, service managers are involved in influencing and defining the objectives of the wider organisation.	Y	
20	All staff have the opportunity to participate in the planning, decision making and formulating of policies that affect service provision	Y	
21	The service has clear and up-to-date administrative policies that relate to speech and language therapy working practices. These are written by or in consultation with a registered SLT.	Y	
22	RCSLT's professional standards and guidelines inform the development of policy and practice.	Y	
23	The service has a strategic and systematic approach within each clinical team to establish an evidence-based resource as the basis for provision of clinical care, organisation of services and service development.	Y	
24	The service has a system to collect information for service management purposes and to meet contractual obligations. Information is collected on a consistent and regular basis.	Y	
25	The design of service documents includes a code to allow for audit trails and identification of source.	Y	
26	All staff maintain personal learning portfolios and reflect on learning gained through practice, both individually and in teams.	Y	
27	All staff have access to a personal development review at least once every twelve months.	Y	
28	The service has a clear and up-to-date staff training and development policy.	Y	
29	The service has sufficient and appropriate resources to support the principal functions of the service.	N	See 'concerns' section of report in relation to lack of support services and assistant practitioners.
30	The financial resources of the service are planned, managed and controlled.	Y	
31	Equipment used in therapy is non-hazardous to the client and conforms with health and safety standards. This includes regular cleaning of equipment in accordance with infection control guidance.	Y	

Ref	Quality Standards	MET?	Reviewers' Comments
32	The service has a range of relevant and up-to-date literature available to support the client and/or carer in understanding the nature and extent of any given swallowing or communication disorder.	N	Although some leaflets were in place, there were no information leaflets covering aphasia and apraxia. Information leaflets were not available for people whose first language was not English.
33	The service has a written statement of philosophy, core purpose and operational policy	Y	
34	All staff (including those in remote areas) are aware of available resources and are able to access them as appropriate.	Y	
35	The service has a mechanism for ongoing monitoring of staff workloads.	Y	
36	The urgency or priority of referrals is determined in a systematic and equitable manner. Prioritisation systems are evidence-based as far as possible and clearly documented.	Y	
37	Written records are kept of each individual's care.	Y	
38	The service has clear standards of record keeping in line with Data Protection Act (1998) principles and RCSLT guidance that are reviewed and audited on a regular, at least annual, basis.	Y	
39	The service has a clear and up-to-date policy on the confidentiality, use, security and disclosure of health information.	Y	
40	The service has a clear and up-to-date policy detailing the process through which individuals (or their advocates) have access to their records in line with the Data Protection Act (1998).	Y	
41	The service has a clear and up-to-date policy relating to the length of retention and ultimate disposal of clinical records which complies with legislation and RCSLT guidance.	Y	
42	The service has a clear and up-to-date policy relating to storage and disposal of audio and visual recordings.	Y	
43	The service has clear and up-to-date risk-management policy and guidelines.	Y	
44	The service a clear and up-to-date local policy and procedures for handling complaints.	Y	
45	The service has a clear and up-to-date policy related to health, safety and protection of staff and clients.	Y	
46	The service involves service users in the evaluation and development of services.	Y	
47	The service has a clear and up-to-date policy for dealing with media enquiries.	Y	
48	The service has a clear and up-to-date policy on the management of student placements.	Y	

Ref	Quality Standards	MET?	Reviewers' Comments
49	Where the service head is not a qualified speech and language therapist, there is a system of professional representation to the service manager on matters relating to clinical issues.	Y	
50	Where there are gaps or shortfalls against standards in the service, there is clear evidence that the service is taking steps to develop and improve the service.	Y	
51	The service has a strategy in relation to health inequalities and is able to demonstrate actions taken to reduce these inequalities.	N	No services were in place for Augmentative & Alternative Communication (AAC), transgender patients or outpatient mental health services.
52	There are clear and up-to-date written policies on admission to and discharge from speech and language therapy services for referred individuals (level 3 services).	N	There was no clear policy, though some detail was included in the care pathway for discharge.
53	The service has links with voluntary organisations vocational/employment agencies, and local support groups to complement the work of the service.	Y	
54	There are clear written care pathways for each speech and language therapy care group that reflect and anticipate the needs of clients, many of whom have enduring, complex and multiple health and social needs.	N	No services were in place for Augmentative & Alternative Communication (AAC), transgender patients or outpatient mental health services.
55	Where specialist services are not available within the immediate service or local district there is a pathway and clear procedures for individuals to access these outwith the region.	N	See comment at standard 54.
56	Clinical care standards are linked to the published research evidence-base and consensus views on best practice.	Y	
57	Service evaluation as the basis of a service development bid involves consultation with commissioners, service users, referral agents, and other services or agencies that are co-providers of services.	Y	

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DIETETIC SERVICES

Ref	Quality Standards	Met?	Reviewers' Comments
XX-101	**Service Information** Each service should offer patients and their carers written information covering: a. Organisation of the service, such as opening hours and clinic times b. Staff and facilities available c. How to contact the service for help and advice, including out of hours	Y	Service information was available on paper and electronically. Large print and audio information was also available. The website and patient letters included a link for feedback about the service.
XX-102	**Condition-Specific Information** Information for patients and their carers should be available covering, at least: a. Brief description of their condition and its impact b. Possible complications and how to prevent these c. Pharmacological and non-pharmacological therapeutic and rehabilitation interventions offered by the service d. Possible side-effects of therapeutic and rehabilitation interventions e. Symptoms and action to take if unwell f. DVLA regulations and driving advice (if applicable) g. Health promotion, including smoking cessation, health eating, weight management, exercise, alcohol use, sexual and reproductive health, and mental and emotional health and well-being h. For frail older people: Pain, depression, skin integrity, falls and mobility, continence, safeguarding issues, delirium and dementia, nutrition and hydration, sensory loss, activities of daily living, vital signs and end of life issues i. Sources of further advice and information	Y	An extensive range of leaflets covering condition-specific information and generic dietary advice was available. A resource list of available condition-specific information was also available.
XX-103	**Care Plan** Each patient and, where appropriate, their carer should discuss and agree their Care Plan, and should be offered a written record covering at least: a. Agreed goals, including life-style goals b. Self-management c. Planned therapeutic and/or rehabilitation interventions d. Early warning signs of problems, including acute exacerbations, and what to do if these occur e. Planned review date and how to access a review more quickly, if necessary f. Who to contact with queries or for advice	Y	Care plans were discussed and agreed with patients. Patients were also given a copy of their care plan and encouraged to bring it with them to follow-up appointments, although this did not always happen. Letters about treatment decisions were written to the patient, and other health professionals were copied in.

Ref	Quality Standards	Met?	Reviewers' Comments
XX-104	**Review of Care Plan** A formal review of the patient's Care Plan should take place as planned and, at least, six monthly. This review should involve the patient, where appropriate, their carer, and appropriate members of the multi-disciplinary team. The outcome of the review should be communicated in writing to the patient and their GP.	Y	Patients who required on-going follow up had care plans reviewed.
XX-105	**Contact for Queries and Advice** Each patient and, where appropriate, their carer should have a contact point within the service for queries and advice. If advice and support is not immediately available, then the timescales for a response should be clear. Response times should be no longer than the end of the next working day. All contacts for advice and a sample of actual response time should be documented.	Y	Contact numbers were included in the care plans. Answer machine messages were actioned on a daily basis and the team could also be contacted via a generic email address. When the specialist dietitian was away then arrangements were in place for staff to contact the tertiary centre for advice if required.
XX-106	**School Health Care Plan (Services caring for children and young people only)** A School Care Plan should be agreed for each child or young person covering, at least: a. School attended b. Care required while at school including medication c. Responsibilities of carers and of school staff d. Likely problems and what to do if these occur, including what to do in an emergency e. Arrangements for liaison with the school f. Review date and review arrangements	Y	Dietetic staff would liaise with paediatric teams.
XX-195	**Transition to Adult Services** Young people approaching the time when their care will transfer to adult services should be offered: a. The opportunity to discuss the transfer of care with paediatric and adult services b. A named coordinator for the transfer of care c. A preparation period prior to transfer d. Written information about the transfer of care including arrangements for monitoring during the time immediately afterwards	Y	Staff were involved with any patient transition to adult services. The hospital had also appointed a complex care coordinator who provided the key link between paediatric and adult services.

Ref	Quality Standards	Met?	Reviewers' Comments
XX-196	**Discharge Information** On discharge from the service, patients and their carers should be offered written information covering at least: a. Care after discharge b. Return to normal activities c. Ongoing self-management of their condition d. Possible complications and what to do if these occur e. Who to contact with queries or concerns	Y	The care plan booklet also included information on discharge. Patient goals/expectations were documented on discharge, though the team were not following up whether expectations were met. The team also had a process for following up those patients who did not attend appointment and who were under the care of mental health, paediatric or long-term care services
XX-197	**General Support for Patients and Carers** Patients and carers should have easy access to the following services and information about these services should be easily available: a. Interpreter services, including British Sign Language b. Independent advocacy services c. Complaints procedures d. Social workers e. Benefits advice f. Spiritual support g. HealthWatch or equivalent organisation h. Relevant voluntary organisations providing support and advice	N	'b' was not met but support to patients was generally good.
XX-198	**Carers' Needs** Carers should be offered information on: a. How to access an assessment of their own needs b. What to do in an emergency c. Services available to provide support	Y	Dietetics would contact or refer to GP, community nurses, social workers or voluntary organisations if required. All patients and carers who were enterally fed at home were provided with written information which included emergency contact details and a number for 24 hour contact.
XX-199	**Involving Patients and Carers** The service should have: a. Mechanisms for receiving regular feedback from patients and carers about treatment and care they receive b. Mechanisms for involving patients and carers in decisions about the organisation of the service c. Examples of changes made as a result of feedback and involvement of patients and carers	Y	A range of feedback mechanisms was in place for patients.

Ref	Quality Standards	Met?	Reviewers' Comments
XX-201	**Lead Clinician** A nominated lead clinician should have responsibility for staffing, training, guidelines and protocols, service organisation, governance and for liaison with other services. The lead clinician should be a registered healthcare professional with appropriate specialist competences in this role and should undertake regular clinical work within the service.	Y	The lead clinician also had a clinic caseload with no cover for absences.
XX-202	**Staffing Levels and Skill Mix** Sufficient staff with appropriate competences should be available for the: a. Number of patients usually cared for by the service and the usual case mix of patients b. Service's role in the patient pathway and expected timescales c. Assessments and therapeutic and/or rehabilitation interventions offered by the service d. Use of equipment required for these assessments, therapeutic and/or rehabilitation interventions e. Urgent review within agreed timescales An appropriate skill mix of staff should be available including medical, nursing, allied health professionals, social care professionals, support workers and other staff required to deliver the range of assessments and therapeutic and/or rehabilitation interventions offered by the service. Cover for absences should be available so that the patient pathway is not unreasonably delayed, and patient outcomes and experience are not adversely affected, when individual members of staff are away.	N	Specialist dietitians for mental health, renal and diabetes services did not have cover for absences. Seven-day working was not in place though there were arrangements for out of hours support. The dietetic team did not run late clinics as this was not seen as a priority for the service. The nutrition nurse service consisted of 0.32 WTE and there was no cover for absences. The issue had been highlighted on the divisional risk register and a mitigation plan put in place to train other health care professionals. The adult dietetic team consisted of 5.99 WTE clinical posts plus 1.00 WTE temporary post and 1.3 WTE administrative staff. Staffing levels had been determined using British Dietetic Association caseload guidance as a guide and were monitored using KPIs and audits to ascertain whether department standards were being fulfilled.
XX-203	**Service Competences and Training Plan** The competences expected for each role in the service should be identified. A training and development plan for achieving and maintaining competences should be in place.	N	Competences expected for each role in the service had not yet been defined. Staff were assessed for competence as part of their annual appraisal process.

Ref	Quality Standards	Met?	Reviewers' Comments
XX-204	**Competences – All Health and Social Care Professionals** All health and social care professionals working in the service should have competences appropriate to their role in: a. Safeguarding children and/or vulnerable adults b. Recognising and meeting the needs of vulnerable children and/or adults c. Dealing with challenging behaviour, violence and aggression d. Mental Capacity Act and Deprivation of Liberty Safeguards e. Resuscitation	Y	The manager would also email staff when training was due for review.
XX-299	**Administrative, Clerical and Data Collection Support** Administrative, clerical and data collection support should be available.	Y	
XX-301	**Support Services** Timely access to an appropriate range of support services should be available.	Y	The dietetics team had good links with radiology, catering, food stores and pharmacy, as well as hospital transport and, externally, Abbott Nutrition.
XX-401	**Facilities** Facilities available should be appropriate for the assessments, therapeutic and/or rehabilitation interventions offered by the service for the usual number and case mix of patients.	N	The clinic room did not support personal safety as the room was very small which meant that the patient sat by the door.
XX-402	**Equipment** Timely access to equipment appropriate for the service provided should be available. Equipment should be appropriately maintained.	N	There were no 'stand on' scales in the outpatient department, and patients therefore had to use the chair scales, which was not conducive to maintaining their dignity. Hoist scales were shared between wards.
XX-499	**IT System** IT systems for storage, retrieval and transmission of patient information should be in use for patient administration, clinical records, outcome information and other data to support service improvement, audit and revalidation.	N	Multiple systems were in use across mental health, acute hospital and community services. Staff were concerned that information could be missed as patients transferred between services.
XX-501	**Diagnosis and Assessment Guidelines** Guidelines on diagnosis and assessment should be in use covering the usual case mix of patients referred to the service.	Y	Care pathways had been developed which were based on national guidance but had been adapted for use locally.

Ref	Quality Standards	Met?	Reviewers' Comments
XX-502	**Clinical Guidelines** Guidelines on management of the usual case mix of patients referred to the service should be in use covering, at least: a. Therapeutic and/or rehabilitation interventions offered by the service b. Monitoring and follow up	Y	
XX-595	**Transition** Guidelines on transition of young people from paediatric to adult services should be in use covering, at least: a. Involvement of the young person and, where appropriate, their carer in planning the transfer of care b. Involvement of the young person's general practitioner in planning the transfer c. Joint meeting between paediatric and adult services in order to plan the transfer d. Allocation of a named coordinator for the transfer of care e. A preparation period prior to transfer f. Arrangements for monitoring during the time immediately after transfer	Y	
XX-596	**Discharge Guidelines** Guidelines on discharge from the service should be in use.	Y	However, staff reported that patients cared for by tertiary centres may not always be linked back for follow up locally.
XX-599	**Care of Vulnerable People** Guidelines for the care of vulnerable children, young people and adults should be in use, in particular: a. Identification of vulnerable people b. Individualised care plans for people identified as being particularly vulnerable c. Restraint and sedation d. Missing patients e. Mental Capacity Act and the Deprivation of Liberty Safeguards f. Safeguarding g. Information sharing h. Palliative care i. End of life care	N	The guidance for 'a' that was accessible on the intranet was from 1999. Guidelines for 'h' and 'i' were not accessible on the Noble's intranet.

Ref	Quality Standards	Met?	Reviewers' Comments
XX-601	**Operational Policy** The service should have an operational policy describing the organisation of the service including, at least: a. Expected timescales for the patient pathway, including initial assessment, start of therapeutic and/or rehabilitation interventions and urgent review, and arrangements for achieving and monitoring these timescales b. Responsibility for giving patient and carer information at each stage of the patient journey c. Arrangements for responding to patients' queries or requests for advice by the end of the next working day d. Arrangements for follow up of patients who 'do not attend' e. Arrangements for multi-disciplinary discussion of appropriate patients f. Arrangements for liaison with key support services (QS XX-301) g. Arrangements for maintenance of equipment (QS XX-402) h. Responsibilities for IT systems (QS XX-499)	Y	Patient pathways included timescales.
XX-602	**Liaison with Other Services** Review meetings should be held at least annually with key support services to consider liaison arrangements and address any problems identified.	Y	Meetings were held with catering and pharmacy services as well Abbott Nutrition.
XX-701	**Data Collection** Regular collection and monitoring of data should be in place, including: a. Referrals to the service, including source of appropriateness of referrals b. Number or assessments, urgent reviews and therapeutic and /or rehabilitation interventions undertaken by the service c. Outcome of assessments and therapeutic and /or rehabilitation interventions d. Number of discharges from the service and type of care after discharge e. Key performance indicators	N	KPIs and specific outcome measures were not yet formalised. Issues with the IT system meant that data could not be obtained from the clinic records. Data on DNA rates were identified but not analysed for each clinic day. Data on 'a' – 'd' were collected.

Ref	Quality Standards	Met?	Reviewers' Comments
XX-702	**Audit** The services should have a rolling programme of audit of compliance with: a. Evidence-based clinical guidelines (QS XX-500s) b. Standards of record keeping c. Timescales for key milestones on the patient pathway	N	A record keeping audit had not been undertaken but was planned for 2018. A nutritional screening audit showed that only 6% of records viewed had a completed screening assessment documented. Other audits had been completed (for example, the Malnutrition Universal Screening Tool (MUST) audit showed that 97% of inpatients were seen within 72 hours).
XX-703	**Key Performance Indicators** Key performance indicators (QS XX-701) should be reviewed regularly with Hospital (or equivalent) management and with commissioners.	N	KPI's were not routinely measured but reviewers were told that the issue may be addressed once the IT systems can upload the new dietetic outcome template.
XX-798	**Multi-disciplinary Review and Learning** The service should have multi-disciplinary arrangements for a. Review of and implementing learning from positive feedback, complaints, outcomes, incidents and 'near misses' b. Review of and implementing learning from published scientific research and guidance c. Ongoing review and improvement of service quality, safety and efficiency	Y	The service had arrangements in place for multidisciplinary review and learning. However, see main report about the hospital and community processes for feedback following incidents.
XX-799	**Document Control** All policies, procedures and guidelines should comply with Hospital (or equivalent) document control procedures.	Y	

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PHARMACY

Note: The Royal Pharmaceutical Society: Standards for Hospital Pharmacy 2014 are written with 'supporting statements' against each of the Standards ('Dimensions' column) and are included below along with the compliance and reviewers' comments.

Dimension	Supporting statements	Met?	Reviewers' Comments
Standard 1.0	**Putting Patients First: Patients and their carers are supported in their decision-making about medicines**		
1.1 Patient focus **Communication with and the involvement of patients and carers is an integral component of safe, effective pharmacy services**	Patients and their carers are treated with compassion, dignity and respect by pharmacy staff	Y	
	The views of patients and carers are actively sought to inform the development and delivery of pharmacy services enabling patients to have direct input into the services that they receive	N	The views of patients and carers were not actively sought at the time of the visit, though any feedback through bodies such as the Patient Safety and Quality Committee was considered.
1.2 Information about medicines **Patients and their carers have access to information and support in order to make informed choices about the use of medicines or the implications of choosing not to take them*** ***When patients lack capacity appropriate procedures should be followed**	The pharmacy team provides the leadership, systems support and expertise to enable the organisation to: Provide patients with information about medicines and their unwanted effects, in a form that they can understand Give patients the opportunity to discuss medicines with an appropriate healthcare professional	N	Information for patients was not always available. Written information was seen for oncology, cardiac, rehabilitation and mental health.
	Pharmacists support the provision of clear, understandable information about medicines throughout the organisation	N	The reviewers saw examples in practice, but pharmacy support was not available across all areas due to capacity constraints.
	Patients and their carers can ask to see a pharmacy team member or call a help line to discuss their medicines, or how pharmacy services can support them to improve health and well-being through public health services and activities (see also RPS Professional standards for Public Health Practice for Pharmacy)	N	The reviewers were unclear as to whether patients actually knew that they could speak directly to the pharmacist or that the other options highlighted here were available. No evidence was available to support this standard at the time of the review.

Dimension	Supporting statements	Met?	Reviewers' Comments
1.3 Adherence to medicines ***For England, See also Medicines Optimisation: Helping patients to make the most of medicines.*** **Systems are in place to identify patients who may need adherence support, or to allow patients to request support**	Patients' beliefs about, and experiences of taking, their medicines are routinely explored by health professionals to assess the impact on adherence. Where difficulties are identified further specialist input is provided by the pharmacy team	N	Medicine reviews were not always recorded, as evidenced on the charts that were seen by the reviewers.
	Medicines regimes are simplified as far as possible and/or appropriate aids and charts are made available to support patients	N	Evidence was not seen for all specialities. This part of the standard was met for mental health patients.
	Liaison with other healthcare professions or agencies outside the organisation is undertaken where ongoing support is needed	N	There was no evidence of liaison with other care providers such as GPs, care homes or district nursing teams to ensure that issues such as compliance or monitoring were identified and addressed.
	When care is transferred to another setting, patients are referred or signposted to appropriate follow-up. For example, if high-risk medicines are changed during admission or new medicines are started. (Examples of country-specific national community pharmacy services include: Targeted Medicines Use Reviews; the Chronic Medication Service; the Discharge Medicines Review Service; and the New Medicine Service. Other local support may be available e.g. through intermediate care or community service.	N	No active referral mechanism was in place, though signposting was evident.
Standard 2.0	**Episode of care: Patients' medicines requirements are regularly assessed and responded to in order to keep them safe and optimise their outcomes from medicines**		

Dimension	Supporting statements	Met?	Reviewers' Comments
2.1 On admission or at first contact **Patients' medicines are reviewed; to ensure an accurate medication history, for clinical appropriateness and to identify patients in need of further pharmacy support.**	The pharmacy team provides the leadership, systems support and expertise that enables a multidisciplinary team to: - Reconcile patients' medicines as soon as possible, ideally within 24 hours of hospital admission to avoid unintentional changes to medication. - Effectively document patients' medication histories as part of the admission process. - Give patients access to the medicines that they need from the time that their next dose is needed. - Identify patients in need of pharmacy support and pharmaceutical care planning. - Identify potential medicines problems affecting discharge (or transfer to another care setting) so that they can be accommodated to avoid extending patients' stays in hospital	N	There was leadership displayed in part where capacity allowed. However, pressure on dispensing services prevented effective use of pharmacists' skills in undertaking medicine reconciliation across all wards or participating in ward rounds unless specifically resourced to do so. There was good delivery of medicine reviews, where capacity allowed. Medicine reconciliation using EMIS with patient consent was documented on every occasion.
2.2 Care as an inpatient **Patients have their medicines reviewed by a clinical pharmacist to ensure that their medicines are clinically appropriate, and to optimise[3] their outcomes from their medicines.**	Pharmacists regularly clinically review patients and their prescriptions to optimise outcomes from medicines (timing and level of reviews adjusted according to patient need and should include newly prescribed medicines out of hours) and take steps to minimise omitted and delayed medicine doses in hospitals. .	N	This was partially undertaken and only where capacity allowed. There was limited provision, and this provision was reducing, due to staffing capacity within the team.
	Patients targeted for clinical pharmacy support have their medicines' needs assessed and documented in a care plan which forms part of the patient record.	N	Staffing was insufficient to allow pharmacists to provide this level of support on the wards.
	Pharmacists attend relevant multidisciplinary ward rounds, case reviews and/or clinics.	N	Pharmacists did attend some MDTs, but only where their input had been directly resourced.
	Patients, medical and nursing teams have access to pharmacy expertise when needed.	Y	The website and intranet page for medicines was very good.
	The pharmacy team provides the leadership, systems support and expertise that enables patients to: - Bring their own medicines into hospital with them and self-administer one or more of these wherever possible. - Have their own medicines returned at discharge where appropriate.	N	This was allowed in the policy but was not operational at the time of the visit.

Dimension	Supporting statements	Met?	Reviewers' Comments
2.3 Monitoring patient's outcomes **Patients' outcomes from and experiences of treatment with medicines are documented, monitored and reviewed.**	As part of a multidisciplinary team, pharmacy team members monitor: - Patients' responses to their medicines. - Unwanted effects of medicines	N	This was not possible because of staff shortages.
	Appropriate action is taken where problems (potential and actual) are identified	Y	Pharmacy staff did highlight issues identified. Feedback on interventions was given on an ad hoc basis. There was no systematic process in place.
	The pharmacy team provides the leadership, systems support and expertise that enables healthcare professionals to: - Help patients to avoid adverse events resulting from their medicines -Document, report* and manage any adverse events that do rise *adverse events should be reported to the Medicines and Healthcare products Regulatory Agency (MHRA) via the Yellow Card Scheme	N	Adverse Drug Reporting forms were completed where adverse events were identified. Allergies were routinely recorded. Insufficient leadership was in place to ensure recording of all adverse drug events and interactions.
2.4 Continuity of care for patients not admitted *(e.g. outpatients, outreach, homecare) - see also RPS Professional standards for Homecare Services in England*Patients who are taking medicines at home or in non-acute care settings, have access to continuing supplies of medicines and to pharmacy services and support appropriate to their care	Systems are in place to ensure patients whose care does not involve admission can access medicines when they need them.	Y	
	Patients (and/or their healthcare professionals) have access to the pharmacy expertise that they need to optimise their medicines.	N	This was met in part but was very limited. See above – reviewers were unclear whether patients were aware that they could actually access this expertise.
Standard 3.0	**Integrated transfer of care: Patients experience an uninterrupted supply of medicines when they move care settings and the health and (where relevant) social care teams taking over their care receive accurate and timely information about the patient's medicines**		

Dimension	Supporting statements	Met?	Reviewers' Comments
3.1 Patient needs **Patients and their carers are given information about their medicines and have their expressed needs for information met**	The pharmacy team provides the leadership, systems support and expertise to enable the organisation to support continuity of care and: -Give patients and their carers information about their medicines in a form that they can understand before discharge or transfer to another service. - Advise patients and their carers who to contact if they need more information about their medicines, who will prescribe continuing treatment and how to access further supplies. - Identify and put in place measures to support patients at high risk of experiencing problems with their medicines or on transfer to another care setting. Help patients find pharmacy support to improve health and well-being through public health services and activities when appropriate (see also RPS Professional Standards for Public Health Practice for Pharmacy)	N	The process for giving patients information was ad hoc and therefore inconsistent.
3.2 Professional responsibilities **Accurate information about the patient's medicines is transferred to the healthcare professional(s) taking over care of the patient at the time of transfer [5].** **Arrangements are in place to ensure a safe supply of medicines for the patient and ongoing support where necessary. [5] This also has relevance when patients move setting within organisation**	The pharmacy team provides the leadership, systems support and expertise to enable the organisation to: - Transfer information about patients' medicines to the healthcare professional(s) taking over care of the patient (e.g. general practitioner, community pharmacist or care home or domiciliary care agency staff).(see also Keeping patients safe when they transfer between care providers- getting the medicines right) - Monitor the accuracy, legibility and timeliness of information transfer. - Ensure that patients have access to an ongoing supply of their medicines (based on local agreement and individual patient need) - Monitor, identify and minimise delays to patient discharge or transfer caused by waiting for medicines to be supplied - Signpost or refer patients and carers to sources of support for medicines use once they have been transferred to another setting	N	All drugs to take out (TTOs) were checked by the pharmacist. However, only limited information was recorded on electronic records and reviewers were unclear as to where the audits and incident information etc. were reported internally.
Standard 4.0	**Effective use of medicines: Medicines used in the organisation are chosen to maximise, safety, effectiveness and adherence to treatment**		

Dimension	Supporting statements	Met?	Reviewers' Comments
4.1 Medicines policy **The pharmacy team supports an integrated approach to the choice of safe, clinically-effective medicines for patients.**	A multidisciplinary medicines management group provides a focal point for the development of medicines policy, procedures and guidance within the organisation, and is appropriately resourced with pharmacist leadership and support.	N	The medicines policy was in the process of being reviewed. At the time of the visit there was a lack of senior pharmacy support (see main report). A Drugs and Therapeutics Committee was in place, chaired by a member of the hospital medical staff.
	The pharmacy team leads the development and operation of processes that ensure prescribing is evidence-based, consistent with local, regional and/or national commissioning/purchasing arrangements, and linked to treatment guidelines, protocols and local patient pathways. This is achieved, for example, through horizon scanning, formulary systems and area prescribing committee membership.	N	The pharmacy team did not lead on the development and operational process for prescribing as required by the standard. Support was available from pharmacists.
	Horizon scanning processes enable early discussions with clinicians, local partners and commissioners/purchasers about the financial and service implications of the introduction of new medicines, or new therapeutic practices.	N	Reviewers did not see any evidence of proactive horizon scanning. There was a good range of guidelines available, although this was more reactive.
	The pharmacy team works with healthcare professionals throughout the local health economy to provide seamless pharmaceutical care for patients.	N	At the time of the visit, working with health professionals was reactive rather than proactive due to staff shortages.
	Opportunities for collaboration and sharing best practice across healthcare organisations are identified and exploited, e.g. through joint posts for 'regional' activities, meetings between senior pharmacy team members in different organisations, and safety and quality improvement networks	Y	All pharmacists had access to clinical networks (North West).
	Governance arrangements are in place for management of all medicines, including licensed medicines, off-label use of licensed medicines, unlicensed medicines and Investigational Medicinal Products (IMPs, Clinical Trial medicines).	Y	

Dimension	Supporting statements	Met?	Reviewers' Comments
	Governance arrangements are consistent with MHRA position on unlicensed medicines: - Medicines are used in accordance with their marketing authorisations wherever possible. Selection between different licensed options for individual patients is guided by considerations of safe use, effectiveness, tolerability and value.- If individual clinical need cannot be addressed safely or appropriately by a licensed option, the off-label use of a licensed medicine is the first alternative. Unlicensed medicines are used only where licensed or off-label medicines are inappropriate for an individual patient's needs.- Pharmacists work closely with patients and carers, and other healthcare professionals to reach a joint decision on which treatment option best suits an individual patient's needs. This is based on the risks and benefits of each option and supported by high quality information that includes the licensed status of the chosen treatment.	Y	Documentation seen by the reviewers for compliance with this standard was very good.
4.2 Medicines procurement **Medicines procurement is managed by pharmacy in a transparent and professional way. Quality assured medicines are procured through robust and appropriate processes.**	Procurement decisions are informed by clinical practice and formulary systems to ensure that medicines meet the needs of the patients and the healthcare staff prescribing and administering them.	N	There was an effective procurement process in place though reviewers considered that the processes for agreeing individual funding requests and purchase of non-formulary drugs were not as robust or consistent as they should be. Reviewers heard that if a clinician requested a non-formulary drug it was signed by a directorate manager and was almost always approved. There was no forum for considering requests across the hospital to allow for a degree of consistency. See section in the report about direct influence by MHKs.
	Medicines procurement takes into account nationally or locally negotiated contracts and the quality and safety of the products.	Y	
	Contingency plans are in place to manage product recalls and shortages of medicines.	Y	

Dimension	Supporting statements	Met?	Reviewers' Comments
	All medicines (licensed and unlicensed) are assessed and assured to be of appropriate quality before supply to patients.	Y	
	Medicines procured are safely and securely received and stored in pharmacy, in accordance with relevant professional guidance and legislation.	Y	
4.3 Custom-made medicinesAny medicines custom-made by, or for, the organisation are quality assured and appropriate for their intended use	Use of compounded, extemporaneously prepared, aseptically prepared, repacked and over-labelled medicines is consistent with the principles of risk reduction and using licensed medicines wherever possible.	Y	
	Aseptic preparation facilities (internal or outsourced) are subject to routine internal and external audit.	Y	
	Robust operator and patient safety systems are in place for the production of high-risk medicines, for example, chemotherapy, radiopharmaceuticals, parenteral nutrition.	Y	
	Appropriate quality assurance and control systems support selection, management and use of all custom-made medicines whether produced internally or outsourced.	Y	
Standard 5.0	**Medicines expertise: The pharmacy team provides expertise and advice to support the safe and effective use of medicines by patients (where necessary seven days a week)**		
5.1 Expertise for healthcare professionals **Healthcare professionals prescribing, administering and monitoring the effects of medicines have relevant, up-to-date, evidence-based information and pharmaceutical expertise available to them at the point of care.**	The pharmacy team supports induction, and ongoing training and education in the best practice use of medicines for relevant clinical and support staff across the organisation.	N	This standard was nearly met but the reviewers did not feel that the pharmacists were as much involved or recognised as professional leaders as they should be.
	Pharmacists are accessible in (or to) clinical areas to provide advice for other healthcare professionals on the choice and use of medicines.	N	Access to pharmacists in clinical areas was limited due to the capacity within the team.
	A pharmacist-led medicines information and query-answering service is available to healthcare teams, working to national standards for medicine information.	Y	
	The pharmacy team works to ensure that prescribers are supported in their everyday activities by readily-accessible information and guidance. (See also 4.1 Medicines Policy)	Y	

Dimension	Supporting statements	Met?	Reviewers' Comments
5.2 Expertise for patient care *(see also Domain 1 The patient experience*) **Pharmacists are integrated into clinical teams across the organisation and provide safe and appropriate clinical care directly to patients**	Pharmacists are integrated into multidisciplinary clinical teams and contribute to multidisciplinary clinics where appropriate.	N	There was limited provision, and this provision was reducing, due to staffing capacity within the team.
	Specialist / advanced practitioners work in clinical specialties as part of the multidisciplinary team.	N	In part, and where funded, specialist pharmacists had completed additional training, but this was not across all areas.
	Pharmacist prescribers are integrated into relevant care pathways across the organisation, e.g. in accident and emergency, on admissions wards, in specialist clinics and outreach services	N	There was only 1.4 WTE to cover oncology.
	Pharmacists support optimisation of treatment, especially with identified high-risk medicines.	N	This was not evident in all specialities – as referenced in the team's self-assessment.
Standard 6.0	**Safe use of medicines: The pharmacy team encourages and supports a multidisciplinary approach to safe medication practices and a culture of continuous learning in the organisation (including contracted or directly outsourced services and third-party providers)**		
6.1 Safe systems of care **The chief pharmacist* leads in ensuring that all aspects of medicines use within the organisation are safe.**	Pharmacists are involved in the design and updating of prescription and administration documentation and systems (paper or electronic).	Y	
	A named senior pharmacist is directly involved in the planning and development of electronic (or other) prescribing systems and relevant patient information systems	Y	
	Pharmacists visibly record when they have seen a prescription and assessed it as clinically appropriate for the patient (in the context in which they are working)	Y	
	Omitted and delayed doses are monitored and where necessary investigated as potential medication errors.	N	As confirmed by the team's self-assessment this was met only in part and was not a consistent process.
	The pharmacy team supports the timely implementation of relevant national therapeutic guidance and national patient safety alerts.	N	There were processes in place for communicating alerts etc. but reviewers felt that the process was not consistent.
	Systems are in place to ensure appropriate and timely responses to MHRA and supplier led defective medicines alerts and recalls within specified timescales.	Y	

Dimension	Supporting statements	Met?	Reviewers' Comments
6.2 Safety culture **The chief pharmacist ensures that medication safety has a high profile, both within the organisation and with partner organisations.**	The Chief Pharmacist has overall responsibility for and/or is closely linked to the board to support medicines safety in the organisation	N	Appropriate cover and arrangements for delegated authority arrangements for the Chief Pharmacist were not in place to ensure direct engagement between the hospital senior management team and the pharmacy department.
	The chief pharmacist has representation on all high-level medicines safety and governance groups.	Y	
	Senior pharmacists must be party to or lead on Serious Incidents (SIs) involving medicines. Systems and processes are in place to ensure other medication errors are identified, recorded, monitored, appropriately reported and investigated	N	Reviewers did not see any evidence that this was being led by senior pharmacists.
	Pharmacists intervene with prescribers, patients and other healthcare professionals to ensure medicines are safe and effective.	N	This only occurred where services allowed it.
	Systems are in place to ensure patients who have experienced a medication error are informed, apologised to, and appraised of any action being taken to rectify the error	N	Evidence was not available at the time of the visit.
	Learning from medication errors and systems failures related to medicines is shared with the multidisciplinary team and the whole organisation if appropriate and acted upon to improve practice and safety.	N	Evidence was not available at the time of the visit.
	Shared learning is reviewed, reported at board level on a regular basis, and shared within professional networks	N	Evidence was not available at the time of the visit.
Standard 7.0	**Supply of medicines: Medicines are supplied, distributed, stored and if required disposed of in a safe, legal and timely way where necessary seven days a week**		
7.1 Dispensing **Medicines are clinically appropriate, dispensed or prepared accurately, and available when needed**	Before dispensing or preparation, prescriptions are reviewed for clinical appropriateness by a pharmacist.	Y	
	Systems are in place to prioritise dispensing in order to minimise the risks of omitted and delayed doses of critical medicines or of delayed discharge.	Y	

Dimension	Supporting statements	Met?	Reviewers' Comments
	Dispensing processes make appropriate use of technology, efficient ways of working and skill mix, e.g., automated systems, near patient dispensing, accuracy checking pharmacy technicians.	Y	
	Systems are in place to identify and review the causes of dispensing errors, to minimise the future risk of them reoccurring.	Y	
7.2 Labelling **Medicines dispensed or prepared are labelled for safety in line with legal requirements.**	Dispensaries have standards for labelling that ensure consistency and safe labelling practice.	Y	
	Labelling (and packaging) takes into account the diversity of patients accessing medicines, e.g. age and disability.	Y	
7.3 Distribution, storage and unused medicines **Medicines are safely and securely distributed from a pharmacy and stored in a secure and suitable environment prior to administration.**	Supply systems ensure that clinical areas have timely access to medicines needed routinely. Where necessary, medicines needed urgently outside core pharmacy service hours can be obtained.	Y	
	Standard Operating Procedures (SOPs) and systems, informed and monitored by the pharmacy team, underpin the legal, secure and appropriate handling of medicines wherever they are located (wards, outpatient clinics, patients' lockers, theatres, emergency drugs cupboard etc).	N	This standard was met in part but there did not appear to be any oversight or assurance processes to the management or to wards and departments.
	Audit trails and governance processes are in place to underpin the supply and storage of medicines.	N	Reviewers did not feel that these processes were consistent across all areas.
	SOPs are in place to ensure the appropriate management of waste and returned medicines.	Y	
Standard 8.0	**Leadership: Pharmacy has strong professional leadership, a clear strategic vision and the governance and controls assurance necessary to ensure patients are safe and get the best from their medicines (see also RPS leadership competency framework for pharmacy professionals)**		
8.1 Professional leadership (see also the right culture for patient safety and professional empowerment) The pharmacy team recognises that they have a duty of care to patients and act in the patients' best interests	The Chief Pharmacist leads by example through commitment, encouragement, compassion and continued learning approach	N	Compliance could not be assessed at the time of the visit as the Chief Pharmacist was on leave.
	The Chief Pharmacist promotes a just, open and transparent culture	N	Compliance could not be assessed at the time of the visit as the Chief Pharmacist was on leave.
	Professional leadership at all levels is encouraged and developed	Y	

Dimension	Supporting statements	Met?	Reviewers' Comments
	The pharmacy team behave in a candid, open and transparent way	Y	
	Peer review is an integral part of workforce development	N	Although the self-assessment confirmed that a peer review had been completed, this was not seen by the reviewers at the time of the review.
	All members of the pharmacy team are encouraged to raise any professional concerns they may have both from within the pharmacy service and from other parts of the organisation	Y	
	Professional concerns are investigated and, if substantiated dealt with at an appropriate level in the organisation	N	Although the self-assessment confirmed that investigations had taken place, these were not seen by the reviewers at the time of the review.
8.2 Strategic leadership **The chief pharmacist ensures that the organisation maintains a clear vision for pharmacy services and optimal use of medicines across the organisation.**	The chief pharmacist is held accountable for the quality of medicines used and the standard of pharmacy services across the organisation.	Y	
	The Chief Pharmacist is, or reports to, a designated Executive Board member.	Y	
	The Chief Pharmacist provides assurance to the Board about the safe and secure handling of medicines within the organisation, on a regular basis.	N	The review team did not see any evidence that monthly information was routinely taken to the hospital management team.
	The organisation has a strategy for optimising patient outcomes from medicines that has Board approval and support and is regularly reviewed.	N	Although there was a medicines policy in place, there was no evidence provided of a strategy to address the requirements of the standard.
	The chief pharmacist encourages improvement and innovation in service delivery to better meet patients' needs, including the adoption of national initiatives and guidance, and encouraging the active involvement of patients.	N	Evidence was not available at the time of the visit.
	The chief pharmacist engages with the health community to develop a whole system approach to medicines and public health, including emergency preparedness, resilience and response	N	Evidence was not available at the time of the visit.

Dimension	Supporting statements	Met?	Reviewers' Comments
8.3 Operational leadership **Pharmacy services are safe, put patients first, and are aligned with organisational priorities and the range and level of healthcare commissioned/purchased.**	The type and level of resources required to deliver safe and effective pharmacy services and to support the safe and secure use of medicines are identified and available to the chief pharmacist.	N	See 'immediate risk' and 'serious concern' sections of the report.
	The pharmacy services are delivered within appropriate allocated resources.	N	Evidence provided showed insufficient staff capacity.
	Agreed key performance indicators (KPIs) are in place to enable internal and external assessment of the operational and financial performance of pharmacy services.	N	Agreed KPIs were not yet in place.
	All outsourced pharmacy services (including homecare) are performance managed through Service Level Agreements (SLA) and/or contract quality monitoring. Immediate action is taken if services fail to meet contracted standards.	N	The team had been unable to sign a full Service Level Agreement with 'hospital at home'. However, outsourced chemotherapy was managed well.
	The pharmacy service structure has clear lines of professional and organisational responsibility established and is regularly reviewed.	Y	There was a clear internal structure for the pharmacy service. However, the escalation process outside the pharmacy service was not robust.
	Feedback from patients, service users and colleagues inform the development of services.	N	Patient involvement in development and planning of the service was not yet in place.
	Operational performance is benchmarked against other relevant organisations.	N	There was no external benchmarking for processes such as error reporting. Reviewers considered that this was a challenge for the service as they were not part of the National Reporting and Learning Service (NRLS) or similar system. Benchmarking for staffing against Northern Irish organisations had been included when possible. There was a formal benchmarking process in place for aseptic services.

Dimension	Supporting statements	Met?	Reviewers' Comments
8.4 Clinical leadership **The pharmacy team is recognised as leading on medicines issues in the organisation at all levels.**	The pharmacy team provides leadership, advice, support and education to other clinicians and support staff about safe, effective medicines usage.	N	Individuals provided good advice and support but, due to staff absence, there was limited leadership at a senior level.
	Pharmacy team input is an integral part of the design of any services involving medicines.	N	The only evidence seen was based on individuals and not on organisational expectations that pharmacy was involved.
	The pharmacy team supports the development of integrated care pathways which involve medicines as a treatment option.	N	The pharmacy team were not involved in the development of any integrated care pathways that involved medicines as a treatment option.
	The pharmacy team participates in relevant research and clinical audit activities within the organisation.	Y	
Standard 9.0	**Governance and financial management: Safe systems of work are established, and pharmacy services have sound financial management**		
9.1 Systems governance *(see also Domain 2 Safe and effective use of medicines domain*) **Systems of work are established that are safe, productive, support continuous quality improvement, are regularly audited and comply with relevant regulations.**	Care contributions are documented and audited to demonstrate the impact of the service on patient outcomes and to help target resources.	N	The team's self-assessment commented that: *Drug budgets are held out with Pharmacy and such resource and targeting work is devolved to them.*
	Controlled Drugs are managed in line with the requirements of the Misuse of Drugs legislation and governance requirements.	Y	
	Pharmacy services have effective complaints systems for patients and staff to use that are aligned to organisational systems encouraging patient safety, continuous learning and service improvements	Y	
	Information governance processes in line with legislation are in place to safeguard patient identifiable information about care / medicines supplied.	Y	
	Governance systems are in place for working with the pharmaceutical industry.	N	Evidence was not available at the time of the visit.
	Technical and IT capabilities are progressive and fit for purpose.	Y	

Dimension	Supporting statements	Met?	Reviewers' Comments
	Working environments are planned and maintained in line with Health and Safety requirements, regulatory and professional best practice standards.	Y	
	Equipment is maintained and operated only by appropriately trained members of the team or external contractors.	Y	The records of equipment in the aseptic unit were comprehensive.
	Standard operating procedures (SOPs) are in place for the delivery of all medicines management and pharmacy services across the organisation.	Y	
	SOPs are controlled, regularly reviewed and updated.	N	The team confirmed that a number of SOPs were overdue. Therefore the process was not consistent.
	The continuous improvement and development of systems is informed by a programme of audit and/or other improvement techniques/methodologies.	Y	
9.2 Financial governance **Robust business planning, financial planning and reporting are undertaken.**	A business plan for pharmacy services, incorporating finance, service and workforce plans, linked to the organisation's corporate plan is devised, implemented and monitored through agreed KPIs.	N	Although reviewers saw many business plans from previous years, there had been no progress.
	National initiatives and guidance relating to medicines and pharmacy are incorporated into business and financial planning activities.	N	The team were utilising the resources in their internal pharmacy, but this was not escalated / replicated at an organisational level.
	Medicines utilisation reports are produced that support budget management and monitoring of clinical practice. Pharmacists discuss these. The pharmacy team supports the development of integrated care pathways which involve medicines as a treatment option.	N	No evidence was seen relating to actions following discussions.
	Pharmacists engage with commissioners/purchasers and primary care clinicians to ensure prescribing delivers value from the investment in medicines across the health community.	N	However, there were emerging opportunities through collaboration with the pharmaceutical advisor for the DHSC and the hospital team.
Standard 10.0	**Workforce: The pharmacy team have the right skill mix and the capability and capacity to develop and provide safe, quality services to patients**		

Dimension	Supporting statements	Met?	Reviewers' Comments
10.1 Workforce planning **The pharmacy workforce is planned and appropriately resourced in order to support service quality, productivity and safety.**	There is a plan for reviewing, developing, supporting and funding a pharmacy workforce that optimises skill mix and meets the needs of patients and the changing needs of the service.	N	The workforce plan had been developed, but recommendations had not yet been actioned by the hospital.
	Where deficiencies or shortfalls in workforce are identified a corrective plan is put in place.	Y	Services had been reconfigured to maintain safety. Business cases were in place.
	Succession planning arrangements are in place and are linked to workforce training and personal development plans.	N	See serious concern about imminent loss of staff.
	Numbers of pre-qualification trainees are planned and agreed on an annual basis.	N	The service could not plan on an annual basis because it did not have adequate funding to do so.
	There is pharmacy engagement with workforce planners and education commissioners at local level.	N	There was no evidence of strategic engagement with education commissioners and planners to actively agree trainee numbers. Staff did attend career fairs and other relevant meetings.
	The pharmacy service benchmarks its workforce and skill mix against other relevant organisations.	Y	The department was using the Northern Irish clinical staffing assessment.
10.2 Workforce developmentPharmacy has an effective performance management and personal development planning process linked to workforce planning.	The pharmacy team has roles and responsibilities clearly defined in job descriptions and are performance managed through appraisal and other regular means of engagement.	N	As reflected in the team's self-assessment this was in place for some roles but not all.
	All members of the pharmacy team are aware of their own level of competency and see how they can develop in their roles and careers for example through RPS faculty and foundation support where appropriate.	Y	
	Processes are in place to identify and manage team members who fail to reach minimum competency or performance standards.	Y	
	Where they exist, recognised clinical, leadership and managerial development frameworks and assessment tools are used for all grades of staff.	N	

Dimension	Supporting statements	Met?	Reviewers' Comments
	Planning is in place to ensure that competency is maintained and developed to meet changing service needs, patient expectations and the introduction of new technologies.	Y	In-house training was undertaken, but there was no evidence that staff had any external development or training.
10.3 Education and Training **Induction and continued learning and development are provided for all members of the pharmacy team.**	All training programmes used are reviewed regularly and adapted to ensure that they remain fit for purpose.	Y	
	Training records are maintained for mandatory and role related training. Regular competency assessment is in place, revalidation and refresher training provided if necessary.	N	No spreadsheet was seen by reviewers.
	Trainees receive support, facilitation and supervision from appropriate educational and practice supervisors.	Y	
	The pharmacy team has the opportunity to undertake further learning and development that delivers service improvements and improvements in patient care.	Y	

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