

Review of:

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

Isle of Man Department of Health and Social Care

Part 1 – Main Report

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

Report Date: June 2018

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This report presents the findings of the eighth WMQRS review of health services on the Isle of Man that took place between 5th and 8th March 2018. The purpose of the visit was to review compliance with the following standards:

Service	Standards Reviewed
Acute Cardiac Conditions and Coronary Care	WMQRS Generic Quality Standards V1.1 2013 with speciality prompts
Cardiac-Physiology Service	WMQRS Generic Quality Standards V1.1 2013 mapped to IQIP Standards
Respiratory Conditions	WMQRS Generic Quality Standards V1.1 2013 with speciality prompts
Endocrine Service	WMQRS Generic Quality Standards V1.1 2013 with speciality prompts
Anticoagulation Service	WMQRS Enhanced Primary Care Services Quality Standards – amended for use by the IOM
Dermatology Service	WMQRS Generic Quality Standards V1.1 2013 with speciality prompts
Emergency Ambulance Service	WMQRS Urgent Care Quality Standards 2010 - amended for use by IOM
Non-Emergency Ambulance Transport	Not reviewed with Quality Standards
Air Ambulance	IOM Quality Standards for Air Ambulance
Physiotherapy and Occupational Therapy Services (acute and community)	WMQRS Generic Quality Standards V1.1 2013
Podiatry Services	WMQRS Generic Quality Standards V1.1 2013
Speech & Language	Royal College of Speech and Language Therapy Professional Standards - amended for use by IOM
Dietetic Services	WMQRS Generic Quality Standards V1.1 2013
Pharmacy	Royal Pharmaceutical Society Standards for Hospital Pharmacy 2014

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

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

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

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

The text of this report identifies the main issues raised during the course of the visit. Appendix 1 lists the reviewers that took part in Review 8. Appendix 2 contains the details of compliance with each of the standards and the percentage of standards met.

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

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

ACKNOWLEDGMENTS

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

ABOUT WEST MIDLANDS QUALITY REVIEW SERVICE

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

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

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VISIT FINDINGS

PATIENT MEETINGS AND FEEDBACK

Two patient and service user representatives were part of the West Midlands Quality Review Service visiting team to ensure that the patient voice was foremost in the minds of reviewers, and that patients' experiences were understood.

During the visit, reviewers met with patients and users of services individually as part of visits to clinical areas, and through planned meetings.

The visiting team met with patients in a wider group on the first day of the visit, and with a more focused group of patients with experiences of heart conditions. Additionally, reviewers met with a patient group in Speech and Language Therapy. WMQRS are grateful to members of the public who took the time to meet with the review team. Their stories and their experiences were important in shaping the review. Those who took time to join the meeting were representative of the population of many geographical areas, and we recognise the effort of those who travelled longer distances to be at the meetings.

West Midlands Quality Review Service also acknowledge the support from Tynwald, the Parliament of the Isle of Man. At the beginning of the review, senior members of the review team met with Members of the House of Keys, who shared with the reviewers individual and specific experiences from their constituents. These were shared with clinical and patient reviewers and used as the basis for discussion with teams.

Reviewers were impressed by the level of support from the 'third sector' (e.g. British Heart Foundation-Isle of Man and Breathe Easy).

Many of the service users we met had a positive experience and expressed praise for the efforts made by the clinical and support teams in their care. Patients were highly complimentary about the one-to-one care they received. Among the services that had cared for patients present at the meeting were dietetics and cardiac rehabilitation. Their experiences of these services were good.

Patients told us of positive experiences of transfer of care off-island to English NHS trusts for tertiary care. Reviewers heard a few limited examples of where this had broken down and where transfer (usually back home) had failed and patients were left distressed, but in the view of the visiting team, these were the exception. Where problems had arisen and had come to the attention of senior management, they had generally been resolved. Arrangements for transport were described as good. However, there was less confidence in arrangements for transport for carers who were supporting patients travelling to the UK. The biggest challenge appeared to be confusion about who pays for and organises this transport, and when it is required. It was not clear to reviewers that there was a clear policy regarding the need for an escort, the criteria on which this was based, or how the criteria were assessed. Additionally, it was unclear what support was available to carers and how they would access this. A clear set of principles, widely shared and consistently applied, would, in the opinion of the review team, reduce this uncertainty and anxiety.

Patients told us that the podiatry service invited people to give feedback and to talk about their experience, which was a good example of how they engage with and listen to patients. The service provided home-based care and outreach clinics. Patients told us that they felt every effort had been made to involve and support the local community

Interaction with patients was seen as variable in terms of securing patient engagement and patient views. Reviewers were not made aware of any strategic groups or consistent processes for seeking feedback. Reviewers saw isolated examples of good practice where patient satisfaction surveys had been used and processes to seek opinion had been deployed; however, reviewers felt these were occasional, often lacked depth and were not used consistently across the service.

Reviewers were concerned that there did not appear to be a culture of seeking the views of those who use the service in a way that would result in continual service improvement.

Reviewers also saw that processes for reviewing complaints, incidents and comments, and for providing feedback on lessons learned and changes required, were limited. The visiting team were not confident that these messages were

reaching front-line (patient-facing) team members. There was limited assurance that any particular incident would not recur.

ISSUES ACROSS THE HEALTH ECONOMY

Reviewers saw a highly motivated clinical workforce determined to provide good outcomes for their patients. Reviewers saw that patients recognised that and valued their clinical care.

Immediate Risk

1. West Midlands Quality Review Service considered governance as part of our third review. We have not been back to look at progress in this important area. There is a clear theme in many areas of this review about poor communication of incident reports and a lack of learning and feedback to staff, both in the area that raised the concern, but also more widely. There appears to be a failure of communication to staff on the outcome of and learning from incidents. Many staff told us that they did not know what happened or what should be done differently. We were told of a cascade of performance-type information through the divisional senior nurses, but this did not appear to apply formally to incidents. Many staff we spoke with were unable to refer to learning and change following incidents. We are assuming that reports of incidents identified by staff were discussed at the patient safety committee, but we have no evidence of this and it was outside of the remit of this visit. We were unable to see a transparent process of communication and shared learning. We were unable to identify whether trends and themes of incidents were being considered and appropriate lessons learned and shared. The hospital is soon to implement a new incident reporting system; however, whilst this will be a forum for collecting and reporting on incidents and analysing data, it will not in itself provide a system which replaces a robust learning culture across the whole service.¹

¹ **IOM Response:** The dissemination of learning occurs at different levels in and across the organisation. It is accepted, however, that colleagues feel that they are not getting the feedback they need. We welcome the opportunity to revisit our current processes. For acute services, on-line incident reporting is available through the PRISM risk management system. This is an old system and is not user-friendly. A new system (DATIX) will be introduced later in 2018. This will improve our ability to track and oversee information and ensure that it is fed back to individual staff as part of a routine process. PRISM reports are reviewed in real time Monday to Friday, and NHS Improvement never events list and NG tube patient safety alert have been distributed to staff, and colleagues have been reminded to follow the guidance. This risk was discussed at the Patient Safety and Quality Committee (PSQC) in 2017/18 and service leads were identified to undertake a review and assessment of local practice. Upon completion of the review an action plan was developed and implemented to mitigate identified risks and ensure safe practice. The actions required were disseminated via service leads and progress reported to the PSQC regarding implementation. The action plan was discussed by the Medical Director with the Chief Executive Officer to provide assurance. Specific actions included: • Change in NG tube and equipment supplier as a result of local incident review • Dietetics Department undertook audit of practice regarding confirmation of position of NG tubes by x-ray, radiology procedures were amended as a result • Review of the Policy for Confirming Correct Positioning of Fine Bore Nasogastric Feeding Tubes, which included amendment of nursing documentation to ensure correct monitoring • The development and implementation of staff procedure guidelines for the safe insertion and positioning of fine bore NG Tube • Delivery of NG Tube insertion and management training for nursing staff – over 120 nursing staff completed by December 2017 • Development and implementation of eLearning theory module • Formal competency assessment of nursing staff was implemented for the insertion, positioning and management of NG tubes • Inclusion of NG Tube Insertion and management training into FY1 and FY2 induction programme • Presentation to staff at Patient Safety Forum to highlight risks and training requirements

Ongoing training is in place.

WMQRS Response: Revisiting of your current process is acknowledged to ensure that appropriate feedback and learning following incidents is maximised across the organisation. We note that you will be changing to DATIX which will enable real-time reporting on actions. DATIX will allow better communication to staff but will not ensure that learning from incidents has taken place. We note the processes described will allow staff to track incidents that have been reported; however, we believe you would also benefit from a system whereby staff who were not able to attend communication meetings also received active communication of incident learning. The actions will mitigate the risk identified once implemented.

OTHER THEMES

1. Engagement of staff

- a. There appeared to be limited processes for sharing feedback on incidents and investigations with staff. Reviewers heard on multiple occasions from staff that they had reported incidents or near misses but had no feedback. It was not clear to reviewers whether investigations or consideration had been given to the issues as staff told us they had not heard anything, and nothing had changed.
- b. Reviewers heard of plans to restructure the therapies team. The review team heard that this would not be communicated to staff for a few weeks. Reviewers saw that staff understood that change was happening, and felt that the lack of information was creating a destabilising force amongst teams while they speculated on what might happen.
- c. The review team were unable to see a process where effective communication occurred. We were told of a newsletter called 'Nobles News' but we did not see this in wide use. The review team were told of communication to department and ward leads by senior nurses, but the review team understood this focused on performance, not on learning or wider communication.
- d. Reviewers were told, on a number of occasions, of business cases being submitted for service development, but then rejected; however, the reasons for rejection were not clearly communicated to staff. Staff were left unclear as to whether the case was unsupported or the information included in it required more work.

2. Mandatory training

- a. The process for monitoring mandatory compliance was inconsistent across the teams reviewed. Managers did not have access to information on the percentage of their staff who had completed mandatory training, so were unable to monitor compliance for their service. Managers were reliant on staff to confirm that they had completed required training at the time of their appraisal. Other managers said that they did receive data on compliance for their team.
- b. At the time of the visit the Noble's Hospital mandatory training policy (available on the intranet only) covered registered nurses, midwives and health care assistants and had been due for review in February 2017. Managers for services (e.g. cardiac respiratory, therapies) were therefore deciding which mandatory training they thought their staff should complete. Some community services were following the Community Health Service training matrix. Reviewers were told that a new 'e learning' system called 'e-learn Vannin' had not long been introduced, and would mean the overall governance of mandatory training would become more robust.
- c. Several consultants raised the point with us that there did not appear to be a process whereby concerns over patients' clinical management could be raised with the hospital and dealt with under a clear protocol. Clinicians told us they had received direct communications from Members of the House of Keys (MHKs) about individual patients, their appointments and their clinical management. Whilst clinicians recognised the need for MHKs (as elected representatives) to take up matters on behalf of their constituents, they felt this should be a centrally coordinated process with the oversight of senior hospital managers. Clinicians would then be able to offer a formal and consistent response through an agreed position via the hospital director.

3. GP engagement

During this visit the reviewers saw differing levels of GP engagement. A meeting was planned for GPs at the beginning of our visit to allow GPs to inform the review team of their views. However, no-one attended this meeting. At other times GP engagement also appeared low. However, when the visiting team did speak to GPs they were largely positive about the acute and community services offered, positive about communications with clinicians and complimentary about care received. The visiting team felt that this may reflect a communication breakdown and lack of common vision rather than lack of engagement.

4. **Waiting list and performance information**

The reviewers heard of a lack of a common understanding of waiting list and performance information. Data presented by senior management appeared to be different from that understood by clinicians. It is important that the hospital has a single central system through which all clinical activity is recorded and data generated. It is equally important that these data are agreed by both clinicians and managers in a single record. Data seen by the visiting team did not allow a detailed analysis of the waiting time position. The data showed maximum and average wait. Depending on case mix, the interpretation of these data may be confused because of urgent (e.g. for cancer patients) and routine appointments. Within individual specialities, different sub-specialities may have different waiting times, and this was not clear from the data seen by reviewers. The visiting team also saw that four specialities had maximum waiting times of over three years, and one had patients waiting almost 10 years. The visiting team would urge clinicians and managers to validate the waiting list. It is likely that some of these long waiting patients are there in error or no longer require the appointment.

5. **Service measurement and delivery:**

- a. Reviewers saw that, in many services, neither Key Performance Indicators (KPIs) nor methods for collecting data to support them were in place. KPIs are a valuable tool for assuring the service and its managers that the agreed outcomes are being delivered.
- b. The review team saw a limited range of clinical audit and benchmarking in place to assure good quality clinical outcomes. The visiting team saw (for example in anticoagulation) that some outcome measures may be amongst the best when compared to the UK, but there was no formal measurement of this. This meant clinicians were unable to demonstrate whether outcomes for patients were of a high quality, or to understand where to target improvement resources.
- c. Reviewers saw limited assessment of patient satisfaction on an on-going basis. Ad hoc surveys had been undertaken, but unless this is part of an on-going programme, the service is unable to compare progress and improvement.

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ACUTE CARDIAC CONDITIONS AND CORONARY CARE

General Comments and Achievements

Cardiac and coronary care services were part of the Medical Division at Noble's Hospital. The Coronary Care Unit (CCU) was a 5-bedded unit, each bed being in an individual room. Two rooms had en-suite toilets and one shower room was available for all patients to use. There was also a visitor lounge which was capable of offering overnight stay facilities for relatives of critically ill patients.

On occasions the CCU cared for medical patients from intensive care as a stepdown to relieve bed pressures.

The CCU had admitted 474 patients in 2017/18. The most common reasons for admission were NSTEMI (Non-ST-Elevation Myocardial Infarction) which is a type of heart attack, and atrial fibrillation which is a common form of abnormal heart rhythm. These accounted for around 35% of all admissions.

Reviewers saw that the service had set out a clear vision to '*provide exceptional individualised care in a safe welcoming environment delivered by a cardiac specialist team of nurses*'. The review team saw that staff had undertaken additional training to achieve this. The visiting team were told that the training programme had been validated by Manchester Metropolitan University. Student nurses were allocated placements on the unit as part of their nurse training programme.

The cardiac rehabilitation nurse ran an eight-week cardiac rehabilitation programme five times per year. Occupational therapy and physiotherapy staff also provided input to the rehabilitation programme (although this was limited by capacity and staff availability), and there were sessions provided by pharmacists and dieticians. Links with the Isle of Man National Sports Centre in Douglas were well established.

A nurse-led clinic was run by the heart failure nurse, referrals for outpatient review were received from the CCU, and the Specialist Nurse for Heart Failure undertook daily visits to general medical wards and the acute medical unit. Clinic capacity was limited to six slots, and patients were triaged to ensure the service reached those who would benefit most.

The review team saw that the cardiac and coronary care service was provided by committed and enthusiastic staff who were passionate about patient care. Reviewers saw and heard that patients and their relatives were very positive about the service they received and highly complimentary about their care.

Good Practice

1. The senior nurse on the CCU provided good leadership and strong management support to the service. Reviewers were impressed with the organisation and the service provided to meet the needs of the patients.
2. A good process was followed by staff running the cardiac rehabilitation service and the heart failure clinics to ensure that patients were given contact telephone numbers to use for advice and queries, so they did not feel isolated between clinic appointments.
3. A good range of equipment was available in all the cardiology areas; this had been largely funded by charitable donations from the British Heart Foundation (Isle of Man).
4. A good range of staff training programmes and competence frameworks had been developed on the CCU.
 - a. Clinical competences for nursing staff had been developed and validated by Manchester Metropolitan University. For example, staff on the CCU told us they now had competences at levels one, two and three, which is the equivalent of the recognised Coronary Care Course in England.
 - b. A care quality framework was in place alongside job descriptions. Reviewers saw evidence of mandatory training, which staff were now able to complete on-line, and this had helped improve compliance.
 - c. A healthcare assistant core training certification programme was in place.
5. Surgical guidelines had been agreed with Liverpool Heart and Chest Hospital (LHCH) which covered referral and preadmission details prior to attending for surgery.
6. The clinical team had developed good working relationships with the tertiary centre at LHCH.

7. Patients under the care of the cardiac rehabilitation team each had an individualised care plan and appropriate supporting information. There were plans in place for electronic care plans to be implemented in the near future. Pathway-specific patient information was available.
8. The cardiac rehabilitation service was submitting data to the national audit programme. A 'mini-audit' was also carried out with each cardiac rehabilitation group to check whether patients were meeting the appropriate goals and expectations of the programme.

Immediate Risks

1. Temporary (transcutaneous) pacing was available on the Isle of Man during normal working hours. Reviewers heard that the skills within the Isle of Man to deliver this service were limited to one individual who was fully trained. Patients requiring temporary pacing out of hours were stabilised with medication and transferred off-island. Reviewers were concerned that the methods described to them to medically stabilise patients for transfer off-island were suboptimal and could result in a patient's deterioration, so that a patient might not survive to reach their destination. Reviewers heard that there may be staff available with basic core skills who could be trained to provide out of hours cover.²
2. Reviewers were concerned to hear that cardiac services had a backlog of letters waiting to be typed and sent. Reviewers heard that the backlog was between 10 and 16 weeks. Reviewers were most concerned to hear that in some of these letters there were instructions for GPs to start or continue a treatment plan, and that these instructions may not be received by the GP for between two and four months. At the time of the visit the backlog was estimated as 1,070 letters outstanding. Reviewers heard that it was not uncommon for patients to be booked for a clinical review of their treatment only to find they had not yet begun treatment, as the GP had only just received the letter with the treatment plan instruction. Reviewers noted that there was no system in clinic to prioritise urgent letters (e.g. using two dictaphones for urgent and routine) or to ensure other systems were in place to inform GPs responsible for continuing care about clinical care plans.³

Concerns

1. Waiting times

The average wait for a new outpatient appointment at the time of the visit was reported as nine months. Reviewers were concerned that patients waiting for an appointment for this length of time may suffer clinical deterioration of their condition.

2. Drug funding

Reviewers were told that National Institute for Health and Care Excellence (NICE) drugs prescribed for patients during their consultation at the tertiary centre in the UK may not be routinely funded when they return to the

² **IoM response:** Discussion has taken place following the WMQRS visit. No patient has come to harm. It has been agreed that the current arrangements will continue. In the absence of the cardiologist, external temporary pacing and medication to medically stabilise will be offered and the patient will then be transferred off-island. It is not considered appropriate to train a larger number of staff to undertake temporary transcutaneous pacing in order to establish a roster, as the opportunity to maintain a skill-set is at risk due to the low volume of demand.

WMQRS response: The reviewers consider that the actions taken cannot entirely mitigate the risk and the situation on the Isle of Man lies outside of current clinical norms for the UK. Without temporary pacing a patient who does not respond to atropine, isoprenaline and external pacing may come to harm and this could occur prior to or during transfer. We agree that this would be a rare occurrence; but it could happen. We note the issues cannot be fully mitigated without setting up a reasonable and workable rota of suitably skilled clinicians available out of hours. This is a problem of residual risks which occur infrequently. Ultimately a decision will have to be taken whether the risk can be accepted or whether further investment can be found to mitigate the risk.

³ **IoM response:** Five temporary audio-typists have been recruited who will be dedicated to clearing the cardiology backlog and ensuring that a sustainable administration process remains in place. A review with the consultant cardiologist is seeking to understand whether the volume and complexity of letters has contributed to the backlog position. For example, current practice is that all test results are communicated by letter, including those that are NAD. Standard template letters are being considered that can be used for non-events.

WMQRS response: Your actions to address this issue have been noted and we consider the risk will be mitigated once all the actions have been implemented.

Isle of Man. Reviewers heard from clinicians that when they raised this issue, it was suggested they reprioritise their current caseload to free up funding.

3. **Consultant workload**

Reviewers were concerned at the workload of the consultant cardiologist for cardiac and coronary care services. Reviewers were told that the consultant was working 14 programmed activity sessions (PAs) per week, whereas the normal contract for a consultant is ten PAs per week. The consultant was also running urgent access clinics each week which could only be accommodated at the end of a normal working day. The review team were of the opinion that this practice was not sustainable. The visiting team heard that an advert had been placed for an additional consultant, but, with the existing pressure in the service, reviewers were not confident this would significantly reduce the pressure on individual clinicians.

4. **Echocardiogram capacity**

Reviewers were told there was insufficient capacity for echocardiograms to be undertaken on the Isle of Man. In discussion with LHCH, reviewers also heard that the triage and prioritisation of patients for this limited capacity may not be fully effective. The service should be clear on the criteria and process to ensure all appropriate patients have access to this limited resource. Reviewers considered that a service level agreement with LHCH covering criteria for transfer (including out of hours) would also help to clarify arrangements for all consultants at LHCH receiving transfers from the Isle of Man. A business case for an additional cardiac physiologist had been approved and, once operational, would help to address some of the lack of capacity.

5. **Guidelines**

Some key guidelines and evidence used (and upon which the service relied) were out of date. For example, the acute coronary syndrome guidance was out of date in 2003; the heart failure guidance was out of date in 2015; and the percutaneous coronary intervention guidance was out of date in 2013. For some other documentation (for example, the Clexane guidance), publication and review dates were not included. However, the service was able to recognise where there were gaps and would apply NICE guidance when localised guidance was not yet in place.

6. **Data and audit**

There were limited measures of performance within the service, in terms of both access and outcomes. Reviewers saw limited data collected and not mapped to other national audit programmes that would identify whether services were achieving good or poor outcomes. The service did not have a consistent rolling audit programme designed for the routine review of clinical practice and outcomes against agreed standards.

7. **Key Performance Indicators**

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.

Further Consideration

1. Much of the major equipment in the service was funded by charitable donations. Reviewers were impressed by the support for patient care from the community and third sector, but considered that an on-going equipment replacement programme, funded by the hospital, should be implemented for items for cardiac physiology. Staff told reviewers that there was a lack of electronic devices that would improve the accuracy and recording of clinical information such as patient observations and monitoring.
2. The review team noted that the digital strategy for information technology (IT) roll out was showing as 'green' (i.e. that it was complete). However, at the time of the visit the system was not used by the clinical teams for auditing outcome data or performance as navigation and data extraction were difficult. The visiting team were unclear how an assessment of completion had been made for a system that did not fully support practice.
3. Specialist arrangements for disposal of deactivated cardiac devices were not yet in place, which meant that deactivated devices were stored in the cardiac physiology office area.

4. Reviewers noted that the advertisement for an additional cardiologist was placed without consultation with the existing cardiologist. This had resulted in an advert for a post that was unlikely to generate applicants as it asked for both specialist cardiology and general medical experience. In England (where the advert was largely targeted) this model of dual specialist and general medicine training has not been in place for some time. The review team commented that delay in recruitment could have been avoided had there been consultation with the clinical team on development of the job description and advertisement.
5. Reviewers identified that developing a service level agreement with LHCH would improve the service and outcomes for local patients by having agreed referral criteria and preparation for transfer. Currently there were no processes to assure Isle of Man residents that they were getting the level of service required.
6. The cardiac rehabilitation service had 17 hours of physiotherapy input and fewer than 30 hours of occupational therapy input each week. Reviewers considered that this was insufficient to run an effective on-going rehabilitation programme, and would encourage the service to actively review whether this is sufficient, especially once the appointment to additional consultant post has been made.
7. Reviewers noted that all the heart failure nurse's administrative work was done by the heart failure nurse. This amounted to circa 15 hours per week. The visiting team identified that if administrative support was available it would be possible to see an additional 12 patients per week. Reviewers felt this would be a cost-effective solution to increasing activity.
8. There was limited audit activity and data collection in the heart failure clinic, apparently because of the lack of time to undertake this.
9. The review team noted that there was no heart failure community nursing provision and that the whole service for the island was provided through the heart failure clinic. With an ageing population and plans to develop community-based care models, reviewers felt that there were ideal opportunities for service development in heart failure.
10. Reviewers considered that information sent to patients would benefit from a review, and that letters would benefit from greater personalisation, with detail of clinics and contact details. Reviewers observed that review dates on some information had passed and reviews were now overdue.
11. The review team were unable to identify a robust process for seeking regular patient feedback on service quality and satisfaction. Some work had been done in this area, but this was not embedded, and therefore reviewers would encourage the service to seek regular patient engagement on both satisfaction and future service design.
12. The review team felt that more robust forward planning of off-duty rotas would help staff with longer-term planning and allow them to opt in more easily to shifts that needed cover.

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CARDIAC- PHYSIOLOGY SERVICE

General Comments and Achievements

The Cardio-respiratory department provided diagnostic and therapeutic cardiac and respiratory investigations and therapies to the Isle of Man population. The main department was situated at Nobles Hospital, with some outreach clinics provided at Ramsey and District Cottage Hospital (RDCH).

The reviewers saw an enthusiastic team who were providing a good service within their capacity. There was strong leadership from the lead cardiac-respiratory manager.

An answerphone messaging service was available for patients who were unable to contact the team, and for out of hours queries. This was checked during normal working hours of the department.

Mechanisms for feedback along with 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 made: for example, there were domiciliary visits for device checks and a pacing follow-up clinic now took place at RDCH.

Good Practice

1. A good range of equipment was in place, which had been purchased using British Heart Foundation (Isle of Man) charitable funds
2. Staff were proactive in educating and training staff to ensure that there was as much cross cover between cardiac and respiratory physiology services as possible and that competences at all levels were assessed and documented. The lead cardiac-respiratory manager was also a course instructor and examiner for the Society of Cardiological Science and Technology (SCST) diploma, which meant that training places were available for Isle of Man staff to attend.
3. Review of patient complaints and incidents was included as part of each team meeting and learning was shared amongst the team.
4. The team had good links with other MDTs in the hospital. The team had also held some meetings with tertiary centres including Alder Hey Children's NHS Foundation Trust and Liverpool Heart and Chest Hospital.

Immediate Risks: See acute cardiac conditions and coronary care section of the report.

Concerns

1. Staffing of Pacemaker Clinic

Staffing of the cardiac physiology services was insufficient to enable two cardiac physiologists to be present at the clinic, led by the cardiac-physiology service, for follow-up for implantable devices, as recommended by British Heart Rhythm Society (BHRS) guidance. The lead practitioner did ensure that an assistant practitioner was available to provide support when the clinic was in operation, but this gave limited capacity as the assistant practitioner was not trained to the same clinical ability. The service was unable to provide a robust staffing establishment to the clinics that it led, while still maintaining clinical input to other areas. The issue had not been documented on the department risk register.

2. Staffing and workload

The cardiac physiology service was provided by three registered, accredited staff, with support from associate practitioners. Because of the small number of staff there was little flexibility or reserve to deal with staff absence for sickness or annual or other leave. Staff would cross cover where possible, but this option was limited as a result of the specialist competence required to deliver some investigations, as listed below. The team routinely relied on bank staff to cover some sessions.

- a. Cover was not available for the lead cardiac physiologist to cover implantation or follow-up of implantable devices (pacemakers).
- b. Echocardiography was led by two staff and therefore the capacity of the service was reduced by 50% when one member of staff was absent. This restricted the number of echocardiograms undertaken. Reviewers noted the limited capacity for this key examination.
- c. See also Concern 4 on the echocardiography service in the section on acute cardiac conditions and coronary care.
- d. Insufficient staffing meant that the service was unable to support the cardiology pre-assessment clinic on a regular basis. This meant that repeat electrocardiograms (ECGs) were done by other staff and reported later by the cardio-physiology staff.
- e. The reviewers saw that the ability to provide a service to inpatients was severely reduced and, in some areas, was only available on request rather than being a routine service.
- f. The service had only 1.62 WTE administrative support to cover both pre- and post-procedure administration, which 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.
- g. The service had successfully appointed to the vacant cardiac physiologist post, but the post holder was unable to commence until autumn 2018 and the position was being covered by a locum sonographer. At the time of the visit an additional three-month locum position had been agreed but the department had not been able to recruit to this position.

3. Multiple IT systems

A number of issues were raised about the IT governance of the recording of investigations and transfer of data:

- a. A Patient Administration System (PAS) is a core component of a hospital's IT system. It will record all patient admissions and appointments. It will also be key to managing the patient record. A PAS had been established for patient result retrieval and digital copies of historical clinical letters, but the system could not yet link to any electronic equipment in use in the service. This meant that cardiac tests/investigation results were held on a separate local database. Results of investigations would therefore not be accessible to other teams if required.
- b. Patients who attended to have an ECG performed as part of the GP walk-in service were recorded in a book. Reviewers were told it would take too long to log each patient onto the PAS.
- c. A paper waiting list management process was used rather than an electronic one. Staff used a 'bring forward' process for patients who required follow-up appointments. Reviewers were told that this was partly because the PAS was not yet configured to differentiate between the procedures and allocate the appropriate length of time. Capacity was managed in terms of clinic slots available, with patients being allocated to these.
- d. Test data and reports could be stored in digital format, but the process was reliant on manual transfer of files to databases held on the central government servers. Along with an additional time activity in an already pressured system, this gave rise to the risk of transfer and transcription errors.

Reviewers were also told of difficulties with reaching an agreement with the government IT service to install software for medical equipment in a timely manner. New equipment and software installations were classed as 'projects' and were subject to lengthy processes before they could be prioritised and then implemented. For example, 'IECG' was not linked to the Electronic Patient Record (EPR) (which would have allowed ECG data to be shared with referrers), and it had not been possible to install the Lotus Notes version of the National Institute for Cardiovascular Outcomes Research (NICOR) database so that data could be sent to the national audit of Cardiac Rhythm Management.

Further Consideration

1. The mandatory training programme did not specify requirements of training for all health professionals, so the lead manager had to select the training areas which seemed most appropriate for the service. The lead manager was also not able to access data to monitor the compliance for the team, relying on staff to confirm that they had completed all the relevant training at the time of their annual appraisal.
2. There were no KPIs to measure service performance or outcomes. Developing these would help the service understand how it is delivering its service to patients.

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RESPIRATORY CONDITIONS

General Comments and Achievements

Respiratory services were provided by a dedicated and committed team. There was evidence of strong nursing and medical leadership with a clear commitment to try and achieve a high quality of care for patients. The review team also observed good MDT working, with staff working well together within, and across, specialities.

There was a good range of service and condition-specific information, and guidance available to patients. Contact information was also available for patients, but clinical staff were not always able to respond in a timely way because of capacity issues in the service.

The patients who spoke to reviewers about the respiratory services at the patient feedback sessions during the review week were very positive about the care and treatment that they had received. There was also a good service user support network in place which, although being patient-led, was supported by the clinical team.

Good Practice

1. Strong medical and nursing leadership was evident, along with good MDT working.
2. The process for learning within the team to help improve and develop services was good; for example, learning from complaints had led to important changes in processes, and there was good evidence of benchmarking to make further changes in practice.
3. A good range of service and condition-specific information and guidance was available to patients.

Immediate Risks: No immediate risks were identified.

Concerns

1. Consultant workload

Reviewers were concerned about the number of programmed activity sessions (PAs) being worked by the lead clinician. Reviewers were told that the lead consultant was working 14 PAs, because of increasing clinical demands, and that clinical commitments were encroaching into non-clinical PA sessions. Reviewers considered that this workload was not sustainable.

2. Oxygen prescribing

Reviewers were concerned that there were undue demands on all staff with the potential to delay prescribing of oxygen. It was noted that Physiotherapists were not yet legally able to be independent prescribers or able to give oxygen under the equivalent of a Patient Group Direction (PGD).

3. Capacity and staffing

Reviewers were concerned with the overall capacity of clinical and support staff within the team as demand far outstripped capacity (see concern 5 below relating to waiting times). Inpatient and outpatient referrals to the Nurse-led respiratory service had increased by 50% over the last two years. This was impacting on the team's ability to undertake inpatient reviews, domiciliary visits and facilitate education for staff (see also concern 4). This seemed to cause some delays to patients accessing care and treatment as well as putting undue pressure on staff and limiting the time that could be spent on the development of existing services. There was also no cover for planned and unplanned leave.

4. Non-Invasive Ventilation

Reviewers identified a capacity issue with the provision of non-invasive ventilation (NIV)/bilevel positive airway pressure (BiPAP), which was resulting in Intensive Therapy Unit (ITU) staff and beds being used increasingly commonly, and often inappropriately, for patients requiring NIV/BiPAP. Reviewers were of the clear opinion that

NIV alone was not an appropriate reason for admission to ITU. Consideration should be given to training other staff in the acute and community settings to support patients requiring NIV/BiPAP.

5. Waiting times for pulmonary rehabilitation

Reviewers were concerned that, for pulmonary rehabilitation, 13% of patients were seen within six months, while 14% of patients were waiting over two years. Reviewers were also concerned that patients could wait for as long as 92 days for oxygen therapy (see also further consideration 2).

Further Consideration

1. There was no succession planning evident for the staffing within the acute respiratory service. Succession planning would reduce the risk to future service delivery as well as improving resilience within the team.
2. The approach to reconciling the existing pulmonary rehabilitation waiting lists should be reviewed. This would ensure that reconciliation intervals and actions result in the maintenance of an accurate waiting list (including the removal of patients who no longer require a referral to the service).

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ENDOCRINE SERVICE

General Comments and Achievements

Endocrine services were provided by a dedicated, committed and caring team. The staff that the review team met were very welcoming and were enthusiastic about showing the reviewers the service. They were open about what they had achieved, and what they felt to be the challenges that they faced. They demonstrated a clear commitment to achieve a high quality of care for their patients. The team had a strong clinical leader and the reviewers felt that there was good evidence of teamwork and a mutual respect for the clinical leader and other team members.

The review team were not able to speak to any patients on the day of the visit and we were not provided with any patient feedback data. However, reviewers did note the large number of 'Thank you' cards from patients in the staff room

Good Practice

1. The team had good links with off-island tertiary centres. The clinicians used their links effectively, particularly when faced with complex or less common cases.
2. The service provided a wide range of clinics. A weekly endocrine clinic was in place for new and follow-up patients for all endocrine conditions. An additional endocrine clinic was also run each month. A twice-weekly joint antenatal, diabetic and endocrine clinic took place, a young adult clinic was also available for endocrine patients.
3. The service had implemented the use of feedback from visiting clinicians to help improve and develop the service on the Isle of Man. The reviewers saw an example of feedback from a visiting locum.
4. Addison's Disease emergency hydrocortisone injection kits were available for patients and were free of charge. In addition, education and emergency hydrocortisone injection training for patients was available at the centre via the diabetic specialist nursing team.

Immediate Risks⁴

1. Reviewers were told that patients receiving radioactive I¹³¹ (iodine) for thyroid conditions were treated in Liverpool. Patients were travelling back on airlines where the airline was not told about patients who were radioactive. We were told that staff avoided telling the airline about the radioactive nature of patients to avoid problems with them being unable to travel. Standard guidance for patients after I¹³¹ therapy is to avoid close contact with individuals (especially pregnant women and young children) for up to 7 days. Patients travelling on airlines are in close confines with other passengers and the time of each flight (with possible delays) can be longer than expected. Reviewers were clear that this posed a risk to travelling members of the public. Reviewers noted that the number of such patients making the return journey each year would be small and other return journey transport methods would be less hazardous which could include ferry and the island air ambulance transport. Either way, the carrier must be aware of any potential risk to allow them to fully participate in any mitigation.

⁴ **IOM response:** Consultant Endocrinologist, sought guidance from Professor XX Consultant in Nuclear Medicine at Royal Liverpool University Hospital (RLUH). The Professor has advised that RLUH did look at this issue in detail a few years ago and were satisfied with the arrangements made; especially because the flight journey is of the order of 20 to 30 minutes. However, he has requested further advice from the RLUH lead for Medical Physics and the Radiation Protection Adviser. We therefore await further guidance which is due w/c 2 April 2018.

WMQRS response: We note that guidance has been received previously about patients who have received radioactive Iodine¹³¹ and that a flight time of 20 -30 mins poses a minimal risk and that you are seeking further advice from the Royal Liverpool University Hospital on this matter. We would suggest that advice should also be sought to the maximum safe level of time as in our experience flights are often delayed further with people being in close confinement in the boarding areas or on the plane itself for in excess of one hour.

Concerns

1. Access to advice

The advice and contact line were facilitated by the team secretary for used by health care professionals for advice and support regarding patients at risk who may require rapid access. Reviewers were concerned that the secretary was providing clinical advice rather than appointment advice. The type of advice given should be reviewed by the team to ensure that it is appropriate to the skills of the individual.

2. Waiting list

The team were very honest that there was a long backlog of appointments for the service. However, the reviewers were concerned that there appeared to be a lack of clarity regarding the actual length of the list (the longest wait) and also the level of patient risk (if any). Although the use of waiting list initiatives was mentioned by the team as a possible 'solution' to this, there did not appear to be any validation of the list at present to ensure that it did not contain any patients who had subsequently died, or that the initial referrals were still valid. Therefore, reviewers were unsure whether the actual waiting list figures being quoted reflected reality.

3. Access to weight management services

Reviewers were told that the weight management service had been discontinued, which will have an impact on the quality of care for this cohort of patients.

4. Access to imaging

Reviewers were concerned regarding the length of the waiting times for radiology imaging. Reviewers were told that the wait for MRI was six months, although reassurance was given by the clinical lead that urgent imaging could be performed following direct referral to radiologists.

Further Consideration

1. There was no dedicated endocrine nurse on the team. The reviewers felt that this should receive further consideration by the clinical lead. Such an appointment could have a significant impact on the other clinicians' workload and help prioritise and provide more timely care for patients. Other potential benefits could include; patient and healthcare professional education, providing and supporting dynamic function testing, management and treatment of endocrine patients, advising and supporting patients pre and post operatively following tertiary centre referral, liaison between centres and providing clinical support to the advice line.
2. The Society for Endocrinology (UK) had developed a Competency Framework for Adult Endocrine Nursing: <http://www.endocrineconnections.com/content/4/1/W1.full.pdf+html>. This could be reviewed by the team, potentially to upgrade the skills of some of the diabetes nurses in the absence of a dedicated endocrine nurse.
3. The team should consider separating the Addison's guidance for patients between those with primary and those with secondary adrenal insufficiencies.
4. Some of the patient leaflets and other guidance/protocols seen at the time of the visit were out of date. Reviewers suggested that the team may wish to look at the range of leaflets and information available to patients via national patient support groups, for example, the British Thyroid Foundation, the Pituitary Foundation and 'EndoBible™'. The Society for Endocrinology, and other websites such as 'EndoBible' also have protocols and guidance that may be useful.
5. The team should consider ways of involving patients and the public in giving feedback about endocrine services: and implementing a process for patient satisfaction surveys.
6. There was no succession plan in place for staff within the team. This needs to be considered as a priority, to improve the resilience of the existing team and to future proof the delivery of the service should staff leave.

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ANTICOAGULATION SERVICE

General Comments and Achievements

Reviewers were impressed with the enthusiasm and commitment of the team in providing a good quality service. The team were extremely hardworking and were well led by the clinical nurse specialist (CNS).

The nurse-led anticoagulation service provided acute hospital and community care for people treated with oral anticoagulation therapies, from Monday to Friday, 9a.m. to 5p.m. The service managed about 1,800 patients per year in the outpatient setting, with around 70% of patients on warfarin monitoring and 30% on direct oral anticoagulant drugs (DOAC); the service used the 'DAWN AC' anticoagulation software for record keeping and anticoagulation therapy monitoring. A domiciliary service was also provided for people in long-term care and in their own homes. Data showed that an average of about 40 home visits were undertaken monthly. DOAC surveillance clinics were provided in various settings in the community. The team also provided a telephone advice service to GPs and other health professionals. GPs who spoke to the reviewers were very positive and complimentary about the service they received from the anticoagulation team.

Good Practice

1. Patient feedback was very positive about the care and support given by the team. Patients were given anticoagulation therapy booklets (yellow books) and 'alert cards' so they knew their results and doses, and when and how to contact the team for advice.
2. Data submitted to the national database showed that the anticoagulation service was in the top range of performers when benchmarked to similar services in the UK for keeping patients' International Normalised Ratio (INR, which measures patients' blood clotting levels) within the desired and safe therapeutic range.
3. Reviewers saw that links with GPs were very good. GPs commented that the staff were easily contactable, and that updates and information were sent on a regular basis by the Lead CNS.

Immediate Risks: No immediate risks were identified.

Concerns

1. Staffing

- a. Some medical support and oversight of the anticoagulant service was available from the consultant physician with an interest in haematology and oncology, but reviewers were told that time for this was limited because of the consultant's other commitments. The lack of haematologist input meant that the team were unable to meet for regular reviews of patients or multidisciplinary discussion of those patients with complex needs. This issue had been identified and was included on the divisional risk register. Reviewers recognised that the nurse-led service was well managed, but were concerned that the anticoagulation nurse was providing a service with limited medical oversight and was making decisions without formal support, and that there was no multidisciplinary forum to discuss complex cases. Informal arrangements were in place with Roald Dahl Centre, Liverpool, and the CNS had access to a support network for advice.
- b. No shared care arrangements were in place with GPs, so all discharged patients were reliant on the anticoagulant team for on-going management. Reviewers considered that if shared care arrangements were developed, some patients could be managed by GPs, thereby reducing demand on the service.

2. Inpatient and outpatient referral process

The process for receiving referrals from inpatient areas to the anticoagulation team was dependent on staff visiting the ward areas each day and then recording information in a notebook. Staff commented that they were not always made aware when patients commenced warfarin anticoagulant therapy. Reviewers considered that implementing a formal referral process would be more robust, as it would allow medication information to be

recorded by the referrer, and allow checks on medication doses already commenced to be formally documented, rather than the anticoagulant staff checking notes and care records. This would ensure all appropriate referrals were captured and patients were not missed. A formal referral process would also improve the audit mechanism and communication back to referrers on any actions taken or medication changes.

3. Reporting of results and decisions

The interface between the DAWN AC system, Medway and EMIS to enable access to information had not been resourced. The anticoagulant team therefore had to send results and decisions about treatment changes to the GP practice managers, who would then load the results onto EMIS for GPs to action. Reviewers considered that this posed a risk (though not one entirely within the team's control), as incorrect information and decisions could be documented because of the number of systems and personnel involved in the data sharing process. It could also increase the risk of transcription errors.

4. Lack of a Hospital Thrombosis Committee

The service did not have a multidisciplinary process in place to look at the prevention of venous thromboembolism (VTE) in hospitalised patients. Reviewers considered that the implementation of such a process, involving clinical staff from relevant specialities, was important to ensure sufficient safeguards were in place, promote best practice and to be a source of education and training for all staff to help prevent patients from developing VTE.

Further Consideration

1. The process for reporting clinical incidents on the PRISM incident reporting system did not enable staff to receive feedback from specific incidents. Feedback was reliant on the cascade of information via other groups and personnel. Staff who met with the reviewers commented that this process did not always happen. Where learning is not shared with clinical teams, the risk of repeating the error remains high. Learning from errors in other services can also mitigate the risk of repeating an error in one's own service.
2. Development of a 'provoked' and 'unprovoked' Deep Vein Thrombosis (DVT) clinic, whereby patients could be referred to and managed in an outpatient setting, would help reduce the number of attendances at the Emergency Department as well as inpatient admissions.
3. It was not clear from discussions with staff that they had appropriate indemnity insurance for undertaking home and social care establishment visits. Reviewers suggested that the hospital management should check and assure staff that appropriate indemnity insurance is in place.
4. The development and implementation of a workforce plan would help to improve the resilience of the existing team, as well as future proofing the delivery of the service should staff leave.

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DERMATOLOGY SERVICE

General Comments and Achievements

Dermatology services were provided by a small but dedicated and committed team. Some staff in the service had other roles in the hospital and were therefore not able to devote as much time as they would like to provide care for those patients with dermatological conditions. Reviewers saw that the service was under development, with the appointment of a second visiting consultant who would be available within the hospital for longer blocks of time.

Reviewers saw that the service had recognised the need to change and that this was a transition period for it. New clinics in Ramsey were in their infancy (first week) at the time of the review, but clear planning had gone into the medical element of the new model. The new consultant would be available for full alternate weeks at Ramsey and District Cottage Hospital. Reviewers were not clear that the planning for nursing cover for this service development was as robust as the medical workforce model.

There was evidence of strong nursing leadership from the senior outpatient nurse working with the service. Reviewers were impressed by her drive to develop the service.

A range of condition-specific information was available to patients accessing the dermatology service.

Good Practice

1. A new model for providing the service was in its first week of operation. Reviewers noted the significant increase in capacity this would bring.
2. There was strong nursing leadership to the service, although the time that could be devoted to dermatology was limited.
3. Reviewers saw a good phototherapy service being provided to patients, led by a physiotherapy technician with the skills to deliver this.
4. Cryotherapy services were available, with a good range of equipment.
5. The service was well placed to access a wide range of support services in the hospital.
6. Reviewers heard positive comments about the service from patients and a GP. The GP told the review team that the advice they received, often via email, from the visiting dermatology consultant was good, and that treatment guidelines given to GPs were helpful, but noted that an on-island service supported by a CNS would be better.

Immediate Risks: No immediate risks were identified.

Concerns

1. Phototherapy Service

Reviewers were concerned that there was no cover for the phototherapy service while the physiotherapy technician was absent. Reviewers were concerned that, for patients whose phototherapy treatment was disrupted, the outcome could be detrimental to their expected recovery. Reviewers were aware that there were other staff within the service who had the core skills, but no dedicated time, to provide cover for the service. Reviewers would encourage a more robust plan for cover. They also noted that members of staff with the core skills, but no capacity to cover, may become deskilled in this therapy if their skills are not maintained.

2. Waiting times

Reviewers noted that there was a long wait for access to a new dermatology outpatient appointment. Reviewers saw official data from the hospital management that showed that the average wait for a new appointment was over a year; however, data seen by the review team showed that some patients may be waiting in excess of three years. Reviewers were told by the service that waiting times were 27 months for a routine appointment and three months for an urgent appointment. Reviewers would encourage the service clinicians to work with

the hospital management to validate the existing data and agree a single waiting time position that accurately reflects the wait that patients experience. Reviewers were of the opinion that the additional consultant sessions provided in the new plan would reduce this wait and improve timely access to a clinical dermatology opinion. There was no waiting list for patch-testing or phototherapy, although it was recognised that only small numbers of patients were referred for these services.

3. Service capacity

- a. Reviewers were concerned that, for the new additional clinic model, insufficient consideration had been given to the additional nursing capacity required to resource this fully and take advantage of the additional patient activity. The visiting team were therefore concerned that the new model may not be sustainable.
- b. Additionally, the review team identified that the current administrative support to the service consisted of one sixth of a full-time person (0.17 WTE). Reviewers saw a backlog of typing, which indicated that this was currently insufficient. Reviewers were concerned that this backlog would increase as the new model developed. Reviewers were unable to identify additional administrative support in the new model.

Further Consideration

1. A newly developed MDT was in place to ensure that patients with complex conditions could benefit from the input of a range of clinical professionals. However, reviewers noted that the MDT meetings were held off-island. The service may, as it develops, recognise that bringing the MDT meeting onto the island will encourage greater participation and ownership. Reviewers noted that there was no provision for a dermatology MDT on the Isle of Man.
2. Reviewers identified that a business case was under development to sustain the service growth. The visiting team believe that pushing forward with this case will support the sustainability of the service.
3. Reviewers noted that under the new arrangements there was no formally identified clinical lead for the service. The visiting team believe that a clinical lead is important to ensure clinical ownership and progress with the implementation of the new model.
4. As the service develops the team should develop clinical guidelines and consider developing an operational policy with clarity on how the enhanced service will work. Reviewers felt that this would benefit those who refer patients to the service and the professionals who interact with it.
5. Reviewers would encourage the service to explore the opportunity of shared care arrangements for some dermatology patients whose GP was on the island. This would support care closer to home for the patient in a more convenient model and would also allow GPs to develop enhanced skills and interests.

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EMERGENCY AMBULANCE SERVICE

General Comments and Achievements

The Isle of Man ambulance service was based in Cronk Coar on the Noble's Hospital site. This facilitated easy access to the main hospital infrastructure on the Isle of Man.

The ambulance service had recently (1 January 2018) been moved so that it was under the Noble's Hospital management structure. The senior management team described that as being in the 'family of urgent care'. Changes had been made to allow the island's emergency care response to be more seamless and coordinated. The changes were new; reviewers experienced a sense that it would need time for people to become accustomed to them.

The service recognised the limitations of the current model of treating patients at the scene and transporting most patients to hospital. The service described a vision of moving towards an integrated care model on the island in which the ambulance service had a key role. The number of emergency calls made to the 999 number on the island was increasing at around 3.6% per year.

The service maintained four emergency ambulances on duty during the day time and three emergency ambulances at night. Community first responders, in partnership with St John's Ambulance Service, provided an initial response to certain categories of emergency calls. On the Isle of Man, only 11% of patients were discharged at the scene, with the remainder of patients being transferred to hospital. The comparative figure in the UK is around 33% of patients being treated and discharged at the scene, though some UK ambulance services have a level of non-conveyance of nearly 50%.

Reviewers met committed and enthusiastic staff with a clear passion to make the ambulance service one that delivers high quality care to meet patients' needs. Reviewers saw that some staff had taken a personal responsibility for elements of the service, for example IT and the equipment asset register.

Reviewers noted that the service was in transition and that this was a pivotal point, and encouraged staff to maximise the opportunity this presented to ensure the Isle of Man ambulance service achieved its full potential in its new integrated care vision.

Good Practice

1. The service followed Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance and NICE guidelines. This meant that where these were followed the service could evidence best practice. Reviewers noted that not all English standards (e.g. paramedic prescribing) may be covered in Isle of Man legislation.
2. The review team were told that 95% of all ambulance journeys had a paramedic on-board. Reviewers saw this to be good clinical practice, and it was reflected through the discussions with the road crews met during the review.
3. Reviewers saw a good sepsis recognition pathway in place, with supporting documentation to record each patient's condition throughout their journey through the healthcare system.
4. Equipment was well maintained through a formal contract with the hospital.
5. The Ambulance Service had implemented initial management of patients as part of the local integrated stroke pathway. The team described how they assessed stroke patients and commenced treatment in the ambulance, which was pivotal in the onward patient journey
6. The falls pathway for patients was well thought through and included a good referral process and appropriate documentation. An information booklet had also been produced that could be given to patients.
7. The review team also saw that when staff left patients, the information provided on self-care and advice was of a high quality. The self-care checklists were very good as part of the process to ensure safe discharge amongst these patient groups. The visiting team saw that much of the information given to patients was based on NICE evidence-based clinical guidance.
8. The clinical environment in the ambulance was well equipped with a modern mobile clinical facility.

9. The equipment database was very comprehensive. The implementation of the database and monitoring had been championed by one member of staff.
10. A robust vehicle replacement programme was in place, ensuring that an up to date fleet of modern ambulances was available at all times.

Immediate Risks

1. Infection Control ⁵

Infection prevention and control (IPC) processes observed during the visit by reviewers posed a risk to both patients and staff; for example:

- a. Staff were cleaning dirty vehicles (e.g. cleaning bodily fluids) during shift, in their uniform, without wearing any personal protective equipment (PPE), and then attending patient incidents without changing. This concern relates to both staff uniform and footwear from mopping floors.
- b. PPE was not always available to protect staff when cleaning the vehicle, to mitigate splashback risk. For example, on one vehicle we saw that there was a footwell that required cleaning. Using a high-pressure hose in a confined space resulted in splashback of the dirty water to the operator's face. No protective eye or face wear was available.
- c. Clean equipment was observed being piled on the concrete floor in the ambulance station ready to be loaded onto an ambulance. This equipment was at exhaust height and near to vehicle exhausts. This practice appeared to have been normalised by the service.
- d. We saw sterile equipment in open packets (and therefore no longer sterile). For example, reviewers saw a laryngoscope in an open packet in a case. Reviewers were unclear whether this had been opened to facilitated easy access or had been previously used and not removed. Either way this represents the two extremes of poor practice in the IPC spectrum and puts patients at risk. This process was common in every equipment bag opened, both at the Douglas station and on operational vehicles.
- e. In addition to the points made in the immediate risk letter sent to the Department of Health and Social Care following the visit:
 - i. Audit records contained within one vehicle at the Douglas station appeared to show that it had not been cleaned since January (over two months).
 - ii. The Douglas Ambulance Station was generally in a poor state of repair and upkeep.
 - iii. Medical equipment was kept in amongst vehicle maintenance equipment/products within the vehicle garage area and was visibly contaminated by dirt and dust.

Reviewers were concerned that these practices, which failed to protect patients from risk of infection, had become normalised by staff working in the service.

⁵ IOM Response

a and b: Meeting with ambulance personnel have been held and the importance of wearing PPE has been emphasised. New PPE equipment has now been ordered: including items that are easily applied and removed in the event of an emergency call-out. Senior management and Station Officers will undertake random audits for compliance. Our infection control lead nurse is in the process of drafting appropriate guidelines and will then develop a training programme for all ambulance personnel.

c: This practice has been stopped with immediate effect. Compliance will be checked through random audits. Clinical equipment has now been removed and stored in appropriate clinical equipment storage areas.

d. Infection control will intervene and provide appropriate, current guidelines for the safe storage of sterile equipment / packs. All contaminated equipment / items have been removed and sterile replacements issued. New waterproof / wipe-clean equipment bags have been ordered and will be used consistently across the service.

WMQRS Response: We note your infection control lead nurse will be developing guidelines and a training programme for ambulance staff in the use of PPE and the safe storage of sterile equipment and that regular audits will be undertaken to check that the changes in practice of vehicle cleaning and equipment management that have been implemented. Your initial meeting emphasising the concerns with staff will be helpful in sustaining the programme. The actions you outline once implemented and managed will help to address the issue.

2. Staff workload⁶

Reviewers heard that staff were working excessive hours. We heard that some staff worked in excess of 100 hours per week (including on-call). We were particularly concerned because, during these long hours, staff were working in environments where immediate high-impact clinical decisions were made. Making these judgements when tired is likely to reduce their accuracy. Our team were concerned that some staff were visibly 'exhausted'. In addition, the review team identified that outside of working/on-call hours, staff were contacted at home to assist in the answering of 999 calls in close proximity to their homes. The frequency of these calls was unclear, but this concern was highlighted to the team by several staff members.

Concerns

1. Ambulance stations

Reviewers were concerned that the buildings and environment did not reflect the same high quality that the ambulances had reached. Reviewers commented on the poor nature of the infrastructure for the service.

2. Leadership and integration

Reviewers identified a number of concerns relating to the leadership and integration of the ambulance service:

- a. There was insufficient clarity on whether the ambulance service was aligned to the emergency services as part of a divisional team, or whether the service was part of a wider hospital response based in the community. Staff to whom the visiting team spoke were unable to articulate their relationship in the new structure.
- b. There was little clarity on how the ambulance service would maximise its role in the new management structure in the hospital. Some staff seemed less clear than others, and there was a sense of disconnect. The visiting team saw that clarifying this, and joint working, in the vision was a pivotal point in the service's opportunity to grow.
- c. Staff were unable to describe how their voice would be heard by the hospital leadership team, and correspondingly how the communication system would ensure they received information from senior leaders.
- d. Ambulance services need to have good communication and planning with other elements of community-based social care, and with police, fire and similar services. There was a lack of clarity on how these links would continue and who would lead them in the new management structure.

3. Control Room access to clinical advice

The review team noted that there was no clinical advice available to the staff in the control room. Reviewers were concerned that this therefore required the service to dispatch an emergency ambulance to almost every call, regardless of need. Additionally; control room staff were unable to offer bespoke advice to patients during the call as they did not have the training and skills, nor the ability to reference information to support them. Access to clinical advice would ensure a more proportionate response to calls.

4. Confidentiality

It was noted by the review team, that 999 incident details were sent via an 'open channel' message to ambulance crews. Message details included incident address, presenting complaint, and additional information relating to

⁶ **IOM Response:** The Hospitals Directorate Senior Management Team is undertaking a comprehensive review of the working hours and rosters of all ambulance personnel, including the senior ambulance officers. This review will seek to remove legacy working practices, ensure that more personnel participate in the on-call roster - and in so doing ensure that no ambulance service member is working excessive hours.

WMQRS Response: Your plans to undertake a comprehensive review of working hours and rosters by the end of June 2018 are noted. The actions you outline will identify the extent of the issue and, depending on the outcome, will require additional actions to ensure that staff are not working excessive hours. We recognise that there may be a need to change some legacy systems and practices.

the call. This message was an open broadcast message, sent to all radio sets, and; therefore, could be heard by patients and members of the public alike, raising concerns surrounding confidentiality.

5. Lack of audit and outcome monitoring

Reviewers were concerned that there was not an effective audit programme in place. There were no systems for a rolling audit programme. This meant that the service was unable to measure outcomes effectively. Reviewers thought that results for some services such as thrombolysis and cardiac arrest may be providing good outcomes, but this was not understood by the service or its senior management.

6. Care plans

Reviewers noted that care plans were not routinely shared between services. Reviewers identified that this gave a significant potential for silo working and lack of information sharing.

7. Feedback to patients

Reviewers were unable to ascertain a process for providing open and honest feedback to patients, when there had been harm to patients or clinical standards had not been met. There did not appear to be an identifiable process in line with the Duty of Candour

Further Consideration

1. Following the reorganisation, the staff appraisal system in use was now part of the hospital-based system. Staff told reviewers that they were unfamiliar with the system and did not find it easy to use. The review team felt that unless this was addressed quickly, staff may become disengaged from this process.
2. The service had put stickers inside the ambulances seeking patients' feedback via a Facebook page. A survey monkey tool had been used as a one-off. Reviewers heard of a report that detailed the outcome of this survey but were unclear where it had been sent and who had seen it. Reviewers noted that complaints appeared, from the data seen, to represent 0.06% of all activity. Reviewers saw this as a positive indicator for the service and suggested that formal processes to encourage, analyse and report patient feedback on a more regular basis would be advantageous to the service.
3. Reviewers saw that there was a limited process for obtaining patients' views on the service design and for engaging patients in planning for service change to ensure the service met their needs. The visiting team saw that a clear process for patient engagement in planning and design would be highly beneficial to the team and the patients they served.
4. Reviewers noted that calls to the control room 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. Reviewers felt that the service would benefit from reviewing whether more urgent calls in these queues were being inappropriately delayed and whether a priority system may be an advantage.
5. The review team also noted that when responding to incidents, there was no formal arrangement for communication with senior decision makers to ensure effective on-site decisions were made and coordinated. Reviewers thought that there would be benefit from formalising this process.
6. Reviewers saw that all paramedics had different equipment in their personal paramedic bags. This risked staff being unfamiliar with the contents of each case. 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 risk.
7. Reviewers noted that the ambulance service did not utilise mobile data systems to pass 999 incident details and auto-populate SatNav systems with incident locations. It was noted that ambulance crews either used local knowledge or were required to input the location manually into the SatNav system. Reviewers further commented that, on an island where a significant proportion of residences appeared to have house names not numbers, finding a building was not always a logical process. Reviewers noted that the Fire Service automatically

programmed its SatNav systems direct from the call centre. The service may benefit from exploring whether it can access the same system used in the joint control room by the Fire Service.

8. There was limited capacity for additional training. Staff told us they had to do this in their own time if they wanted to do it as they could not be released from shift. This included service critical training such as surgical airway management.
9. An open and collaborative approach to managing risk was not apparent during the review. Reviewers felt that the risk register in use in the service did not work effectively. The risk register was not fully aligned to the governance processes within the hospital. There was no clarity on how the senior management was informed about the operational delivery risks, and how red-rated risks were being considered at board level. Reviewers felt the service would benefit from having a systematic risk register that identified all risks and the actions being taken to mitigate these.
10. The review team felt that the service could improve its analysis of data. Limited detail was available in the data to suggest an understanding of service provision. For example, the team were able to detect that the average response time to a 999 call was two seconds, but there was limited awareness of whether this meant that the service met the standard of 95% of calls being answered within five seconds. An understanding of performance by staff in a service is an important part of ownership of service delivery and change.
11. Staff had access to phrase books to help with treating patients whose first language was not English. Reviewers noted that these were not in use by the staff but, rather, were left in staff lockers; the review team thought the service would benefit from understanding why staff did not value this resource.
12. It was noted that at Douglas Ambulance Station the vehicles were not locked, and keys were left inside the vehicles, posing a potential security risk.
13. The team utilised the Ambulance Headquarters building on several occasions. The team were allowed to enter via the unlocked door and were not challenged, despite encountering staff members who they had not previously met.
14. Paramedics carried their controlled drugs either upon their person or within their personal equipment bags when on duty, despite having safes on each vehicle to store controlled drugs. The storage of controlled drugs when not on shift was not explored during the visit but was considered upon reflection after the visit. A review of the safe storage of controlled drugs was recommended, to ensure that the storage, monitoring and issue of controlled drugs were compliant with both policy and the appropriate legislation.

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NON-EMERGENCY AMBULANCE TRANSPORT (PATIENT TRANSPORT SERVICE)

General Comments and Achievements

The patient transport service (PTS) on the Isle of Man was provided by the British Red Cross (BRC). Reviewers also heard about (but did not meet) a patient transport service based at Ramsey that covered the north part of the island. There was also a service for transport of patients for their renal dialysis, but this was not included in this review.

The BRC service was based on the Isle of Man Business Park on the outskirts of Douglas, but provided an island-wide service.

The service had undertaken 6,757 journeys in 2017. The majority of patients (75%) were self-mobile, requiring transport rather than assistance. Very few patients who required assistance required more than general support.

The emergency ambulance service provided transport for patients in highest need of assistance

The BRC service was most commonly required for appointments for physiotherapy services at Noble's Hospital and outpatient and eye clinics.

Staff who met with the reviewing team were motivated and professional in their approach, and were valued by patients. Patients who met the reviewing team commented on the good care and attention they received from PTS staff.

The service had a good fleet of vehicles that were well maintained. Staff driving the vehicles ensured they were clean and tidy for patients to use.

At the time of the visit the BRC service was undergoing a review and re-tendering exercise, and therefore it was a time of significant uncertainty for the service and staff.

Good Practice

1. The visiting team were impressed with the highly patient-centred approach of those staff with direct patient contact. Patients valued their interaction with those they spoke to and met. This resulted in a high level of patient satisfaction with the service.
2. Reviewers saw good examples of multidisciplinary discussion and learning. An example of this was a change in the practice of transporting patients with a hip replacement following discussion with staff from the occupational therapy department.
3. There was a good provision of appropriate equipment easily available to staff, including bariatric equipment and stair-climbing chairs.
4. Reviewers saw that there was an agreement between the PTS service and the hospital that, where possible, patients using PTS ambulances would be seen on arrival to ensure quick turnaround of the vehicles to transport the next patients.
5. The manager of one of the clinical services we spoke to was very positive about the quality of the service provided by the PTS for their patients.
6. Reviewers saw good cross cover and support from the wider British Red Cross service on the island.

Immediate Risks: No immediate risks were identified

Concerns

1. Service Specification

There was no detailed service specification or service level agreement for the service delivery provided. For this reason, there was nothing upon which to base key performance indicators or other measurements of service output.

2. Lack of Safeguarding Training

Reviewers heard that safeguarding training may not be effective. The visiting team found that there was an awareness amongst staff they spoke to, but a lack of a formal training and assurance programme.

3. Procurement of vehicles

Reviewers were concerned to hear that the service was planning to update its fleet to a different manufacturer based on a government specification. Reviewers heard that there had not yet been consultation with the staff in the PTS who would use the vehicles. Staff told us the planned vehicles were rear wheel drive and would require a loading area higher off the ground to accommodate the rear axle below the vehicle. This would result in restricted access for patients and challenges with use of equipment.

Further Consideration

1. The booking process lacked longer-term robustness. Patients were assessed for suitability and need the first time they used the service. However, following the initial assessment patients were not reassessed before their discharge from the hospital. Reviewers were concerned that a patient's condition or circumstances may improve, and that they may no longer need (or be eligible for) transport services. However, once a patient had been assessed at the beginning, they only had to ring and request transport, and it was booked without question. Reviewers were concerned that this may be using resources that may be better directed to other patient groups. Reviewers would encourage a regular assessment of need and entitlement to ensure the service was provided to those who needed it.
2. The visiting team considered that there was a lack of robust advanced planning for patient transport journeys. This resulted in last minute requests for patient transport by hospital staff, and the BRC feeling obliged to make resources available. The review team saw one occasion where this happened. Reviewers considered that better coordination over discharge planning between hospital wards and departments and the PTS service would enable the PTS service to plan and schedule more effectively. It was of note that on the occasion witnessed by the review team, the BRC was unable to provide an immediate response and the patient made other arrangements, further calling into question the assessment process for a transport requirement.
3. Reviewers heard of an example of a significantly delayed response to a call made about a booking. Reviewers saw that the service was planned and co-ordinated by one BRC manager who took details by telephone and used a terminal remote from the Isle of Man ambulance service to allocate patient journeys to vehicles. Apart from this manager, reviewers saw one receptionist/administrator, a loan equipment technician and the overall manager at the premises. Reviewers concluded that the process for cover for telephone calls when the manager was absent or called away was not robust.
4. Reviewers saw a disparity in the BRC contracted provision and what the hospital needed. An example of this was that the BRC transport service started at 8a.m. but was only contracted to start from 8.30a.m. (i.e. they chose to start earlier to serve the patients).

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AIR AMBULANCE SERVICE

General Comments and Achievements

The Isle of Man operated an air ambulance service to transfer patients to the UK (usually Liverpool but also Manchester, Sheffield, London, and Birmingham). The majority of transfers were carried out on scheduled airline flights (organised by patient transfers), but a contract was in place with an external provider to have 24/7 access to a Piper Chieftain aircraft, which was capable of immediate or medically assisted transfer. This aircraft operated from Ronaldsway Airport and was subject to a 90-minute readiness.

The current air ambulance service had recently started to develop with the introduction of strong clinical leadership, but it remained largely unrecognised by the population and the health board as a discrete service.

At the time of the visit, the aeromedical service was staffed by a skeleton staff of one clinical lead and one operations director. All other operational staff held other substantive roles in the hospital-based healthcare service. This caused difficulties in releasing staff for study and training for their air ambulance work.

Reviewers saw that all staff they encountered were highly motivated and professional, working hard in providing high quality inter-hospital transfers. The visiting team saw that staff had an incredibly positive 'can do' attitude which, despite limited support and funding, had allowed the service to grow to its current position. Reviewers were impressed overall with the approach of the service.

Good Practice

1. Reviewers saw a robust referral assessment. The clinicians staffing the service sought good quality initial information, and this was followed by direct assessment of the patient by the team prior to the tasking being accepted. There was evidence of inappropriate taskings being declined. This resulted in few unexpected cancellations or inflight interventions.
2. The visiting team saw that staff were highly flexible to meet the needs of the staffing rota and service demands. There were great efforts made to fill empty return flights with repatriations, providing a substantial cost saving to the island. The reviewers saw no evidence that these savings were recognised or credited to the service.
3. The aviation and medical staff worked well and had shown ingenuity and resourcefulness in accessing equipment: for example, an old trolley had been adapted for use.
4. Reviewers identified that the clinical frontline team were supported by an equally dedicated and professional administrative team. Reviewers saw that the service worked as a truly multi-professional team.
5. The visiting team found a patient-centred service responding appropriately to clinical priorities.
6. Patient information was available in the service, and additional information was available for non-English speaking patients.

Immediate Risks: No immediate risks were identified.

Concerns

1. **Air Ambulance provision**
 - a. Reviewers heard, on many levels, a discussion about the opportunity to secure a new rotary (helicopter) air ambulance. Whilst reviewers are aware of some of the perceived benefits (direct hospital to hospital transfer and a potential time saving for hyperacute transfers), the view of the visiting team was that hyperacute transfers make up a small overall percentage of the total workload and would limit other functions such as long-range transfers. Reviewers considered that a helicopter service would not replace the current fixed wing aircraft, as the service also made transfers to London, Sheffield and other distant areas that were beyond the range of a standard emergency helicopter. The visiting team considered that this had a danger of becoming a distraction from the more basic development needs that must first be secured by the service.

b. Reviewers were concerned that, when the time was right to discuss which system would best serve the needs of the Isle of Man population, senior clinicians from the air ambulance service should be key in leading that discussion and making the assessment. It was evident that there were other motivations to procuring a rotary service, which would lead to a significant increase in costs (many millions of pounds per annum recurring) and required an assumption that benefactors would support such a service year upon year. There did not seem to be an appreciation of the risk and vulnerability this would bring to the service. Reviewers were unable to see a structured plan that set out cost assessments, funding strategies, risk management and contingencies. Reviewers believed the current fixed wing service was financially far more secure and sustainable at a time when resources were increasingly limited within the Isle of Man health economy.

2. Staffing

Reviewers were concerned that there was not a fully agreed staffing complement for the service. Those working in the service did so voluntarily on a bank contract basis. The reviewers were concerned that this may cause difficulty in ensuring the sustainability of the service.

3. Budget and development

Reviewers saw that, as the service was new in its relationship with the hospital team, there was not yet an identified training budget or an agreed development programme. The visiting team identified that as the service evolves, staff will need their skills and knowledge to grow with it.

4. Future service planning

Reviewers were concerned at the lack of resilience planning for the service. Reviewers noted that it was dependent on a small team and could not see a contingency plan for what would happen if one or more members of the small team became unable to work, for example due to long-term illness. The visiting team felt this made the service vulnerable.

5. Access to appropriate equipment and maintenance of equipment for air transfers

The visiting team were concerned that the service was not resourced with all the equipment it required (see also good practice about ingenuity in modifying equipment). The reviewers heard of the previous need to borrow equipment for inflight monitoring and transfer of patients and the use of an old trolley to transfer patients from ambulances to the aircraft. There should be a clear plan with the hospital of what was reasonably required to maintain the service. This should then be included on the hospital's asset register to ensure it can be appropriately serviced, even if stored off-site, and recorded as part of the hospital's equipment replacement programme.

6. Access to appropriate clothing

The visiting team saw that there was a limited provision of uniform and personal protective equipment, and that this was not appropriate for transferring patients by air transport. For example:

- a. Staff used and shared ill-fitting reflective jackets on the airfield.
- b. Reviewers heard that staff would attend the airfield in winter wearing a hospital nurse's uniform and indoor ward shoes.

Reviewers considered that lack of appropriate clothing posed a risk to staff and did not reflect the professionalism of a quality air transfer service.

Further Consideration

1. There was a lack of robust data collection to understand and measure performance of the service. This will be an important part of the justification for the growth of this service. Reviewers were unable to identify an audit programme. An agreed data set will help clinicians and hospital managers assess the outcomes delivered by the service.

2. There did not appear to be any KPIs against which the service was measured or assessed. The service should be encouraged to agree these with the hospital management. KPIs should reflect the service being provided within the Isle of Man context. This will allow the service to demonstrate its responsiveness.
3. There were no joint MDT meetings where the team was able to reflect on its performance and plan improvements.
4. The review team noted that there was administrative support of two hours per week (0.05 WTE) available to the team. The post holder was currently on leave, with no cover. Once formal KPIs and outcome data are defined and collected, this capacity may require review as it may prove insufficient.
5. Reviewers heard of concerns by the team and the Emergency Department staff that there were frequent delays in the transfer of patients from the hospital to the fixed wing aircraft for onward aeromedical transfer. The existing arrangement was to seek assistance from the Isle of Man ambulance service. However, such calls were prioritised below other urgent and emergency calls, resulting in transfer delays. Reviewers commented that an alternative transfer vehicle could be procured at minimum cost and be based at the hospital as a dedicated aircraft transfer vehicle. If this was the case then the drivers would not require any medical training, as appropriate medical and nursing staff would be in attendance. Development of such a service would reduce delays in transferring patients to the aircraft, making the service more effective.

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PHYSIOTHERAPY AND OCCUPATIONAL THERAPY SERVICES

General Comments and Achievements

The physiotherapy and occupational therapy teams were managed as an integrated team providing a number of different therapy specialities across the hospital and community.

Inpatient services included medical and surgical therapy teams as well as teams covering the musculoskeletal and breast services. Community services included the Community Adult Therapy Service (CATS) and the self-referral service. Some therapy roles also required staff to provide an in-reach service into both Ramsey and Nobles hospitals.

The involvement of therapy services in nearly all of the previous WMQRS quality reviews since 2013 demonstrates the level of engagement of the services across acute and community healthcare.

This review concentrated on the overall provision of therapy services.

The review team did not have a meeting with patients and carers using the physiotherapy and occupational therapy services as part of this review, though reviewers did talk to patients and carers when visiting the facilities.

Reviewers saw that staff were enthusiastic and hard working. The occupational therapy service manager was on a secondment at the time of the review and cover was provided by two senior occupational therapists from the team. There was good leadership from the physiotherapy service manager.

The review team noted that over the past few years there had been a number of changes in senior management who oversaw the therapies services. The current reporting structure saw therapies reporting within primary care. Reviewers saw that this had caused some disruption to services as governance processes were realigned.

As the operational policy covered all the services, compliance with the WMQRS Generic Quality Standards was generally consistent between the therapy teams, resulting in one set of compliance documented by reviewers.

Reviewers were impressed by the progress made within the therapies teams following feedback from the October 2017 review. New systems had already been implemented.

Good Practice

1. The therapy Operational Policy was an extremely comprehensive document and was updated on a regular basis. All services, including dietetics and speech and language therapies, were included. The policy was accessible to all staff on the 'shared drive' and contained links to useful information, hospital and community policies and other documents. The policy was comprehensive enough to be a useful resource for other hospital and community staff. The links in the policy were set so that the lead author would be messaged when the transfer of care documentation was due for review.
2. The transfer of care documentation and process was very good. The documentation was clear and well formatted and provided a succinct record of care and instructions on discharge. Documentation was completed for all inpatients being discharged to community therapy care, and a copy was filed in the patient's notes. Patients were also given a copy of their discharge summary.
3. Reviewers were impressed by the engagement of the therapy teams with the quality and assurance process that the quality reviews had provided. Therapy staff commented that they had found the process useful in improving the quality of care they could deliver. For example, some of the issues raised at the last WMQRS review undertaken in October 2017 had been addressed: the self-referral service had introduced a telephone answering call system that allowed calls to be 'stacked' so that patients were aware that their call would be answered; and patients who were repatriated from hospitals off the island were now seen by the community therapy team rather than the inpatient therapy teams. Other changes included the implementation of a standardised assessment pro forma and plans to improve the delivery of equipment.
4. Staff had access to the electronic information and exercise programme resource 'PhysioTools'. This enabled staff to give any relevant information and print bespoke exercise programmes for patients.

Immediate Risks: No immediate risks were identified.

Concerns

1. Early supported discharge

Early supported discharge or rapid discharge was not yet in place, so patients were being cared for in hospital longer than medically required. Delays in discharging patients are an inefficient use of acute hospital resources and also contribute to poor patient experience. Excessive delays mean patients are prone to contracting healthcare-associated infections to which they may not otherwise be exposed. Reviewers were told that the hospital teams would provide some therapy cover in the community for up to 72 hours to those being discharged.

2. Reablement

Provision of multi-disciplinary reablement was not yet in place across the Isle of Man to help patients who had been discharged or to prevent admission during times of crisis. Access to this service in the Isle of Man would help to maximise the rehabilitation potential of patients and improve outcomes, and is likely to be a cost-effective intervention across health and social care.

3. Access to equipment

- a. Reviewers were told of some delays in obtaining equipment off-island. Hospital staff were spending time sourcing and delivering equipment to patients. Weekend and emergency out of 'core hour' provision was supported by the estates services on an ad hoc agreement. Reviewers heard of plans to integrate the equipment service, and that a delivery and setting up service was due to be in place later in the year.
- b. Leonard Cheshire Disability (IOM) had been commissioned to provide some equipment. However there no formal agreement or agreed key performance indicators in place, including timeframes for standard and rapid equipment delivery, which meant that it was difficult to monitor and audit the provision of equipment.

4. Governance

- a. Reviewers were concerned that staff working across both community and hospital services had to use hospital and community procedures and policies and attend meetings for each service. Staff were also using different patient administration systems: the RiO system in the community and Medway in the hospital. Reviewers were concerned that the lack of cross-communication between systems presented a risk in accessing timely information for care and treatment.
- b. Risk management was not clear across the two service areas. Documented risks had either been moderated and accepted or tolerated; much of the approach to risk had been normalised by the service. Reviewers were unable to see a process for managing risks in terms of the reporting and escalation pathway; for example, actions to address the problem of historic patient records stored in a room at the community hub and the respiratory therapy risks had been on their risk register since 2014. There was no indication of why these risks remained unaddressed after almost four years. Reviewers were concerned that risks rated as red (the highest risk score) were not attracting sufficient governance and management attention to mitigate them.
- c. Some staff who spoke to the reviewing team were unclear whether they should complete the hospital or the community system, or both, for incident reporting. Confusion arose particularly when incidents or near misses were service- rather than location-specific. Confusion in incident reporting leads to staff becoming disengaged with the process and to the risk that there is a failure to learn lessons from incidents and near misses.

5. Service Restructuring

Reviewers were told that therapy services would be restructured on 1st April 2018 but that there had not been any clinical involvement in the planned changes. Reviewers were told that the executive team had no plans to discuss this with staff, and the Therapy Services Manager had not had any contact with her new line manager (who had been in post since January). Staff were understandably concerned about the changes and change process.

Further Consideration

1. Staff were covering a wide range of tasks. Neither the physiotherapy nor the occupational therapy services had dual competence technicians, although this would be more efficient for managing workload and enhancing the service provision.
2. The Therapy Services Manager had nine direct reporting services, including speech and language therapy, dietetics, equipment and wheelchair services. Reviewers were concerned about this level of reporting, especially as it was compounded by the fact that there was no defined occupational therapy service lead (the lead had been on secondment to the equipment service project for over 18 months).
3. The staffing structure in place did not allow for cover between areas or across inpatient and community. Implementing arrangements may help with maintaining service delivery at times of increased workload. Some staff did work across both sites.
4. A legislative framework allowing therapy staff to be independent prescribers was not yet in place. Reviewers were told that there were plans for a framework to be in place by the end of 2018.
5. KPIs were not agreed, and assessments and therapeutic interventions were not reported as part of the monitoring of therapy services. A range of different waiting times and terminology was in use across the teams – for example, *urgent*, *soon 1*, *soon 2* and *routine*. Development of KPIs would therefore enable a more robust framework for the on-going monitoring of service delivery.
6. Data systems/collection were not yet in place across all services to provide comparative data that could be used to improve clinical quality and service efficiency and to commission or develop services in a way that would improve health and reduce inequalities.
7. Inpatient and community therapy teams had different manual handling training programmes, which had the potential to cause confusion between staff groups about the level of competence achieved.
8. Therapy representatives were not yet included in any divisional level meetings, so opportunities would be lost to capture the benefit of therapy and Allied Health Professionals (AHPs) input for operational priorities. Given the breadth of services covered by the therapies teams, representation at meetings would offer valuable insights.

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PODIATRY SERVICES

General Comments and Achievements

The podiatry team provided a comprehensive community podiatry service within the resources that were available to them. Staff who met the reviewing team were hardworking and would 'go the extra mile' for patients and colleagues, with a lot of extra work being undertaken through good will. The staff were passionate about the service, and the reviewers were impressed by the excellent range of information, covering all aspects of the podiatry service, that was presented to them. Reviewers commented that they would be very happy to be cared for themselves by the team.

Staff working in the podiatry service worked collaboratively with GPs and other health care professionals, and with patients and carers. The team also had a role in delivering health education and health promotion.

The team operated a central booking system for all referrals and appointments, and despite the large caseload and increasing demand there was no backlog of letters as clinic and discharge letters were processed quickly by the podiatry administrative team.

The service was based at Crookall House in Douglas but was delivered at a large number of locations around the island and also in patients' homes.

The service had clear referral criteria for patients with potentially serious foot problems including those who were at risk of infection or amputation. The service also offered nail surgery where there was a need for surgical removal, regardless of a patient's medical condition. There was a focus on health education and advice to patients, along with active clinical interventions to support the wider management of long-term conditions.

Good Practice

1. A wide range of patient information was available in a range of formats. Additional resources such as photographs and anatomical models were also available to show to patients, in order to explain the different conditions.
2. Small occupational therapy items such as elastic laces for shoes could be supplied by the podiatry team. Reviewers considered this was an innovative idea that should be shared more widely.
3. Reviewers saw that the 'needs' assessment matrix for patients, based on medical need, was effective, and noted that this had also been shared with care homes for their use when assessing patients, which was good practice.
4. Photographs were taken as part of the assessment process, and patients were given information about early warning signs and what to do if these occurred.
5. Reviewers noted the proactive MDT working with other specialities, for example the wound action group.
6. The podiatry team provided training for carers in nursing homes on self-care for patients, which was seen as good practice in the early management of conditions.

Immediate Risks: No immediate risks were identified.

Concerns

1. Succession planning

There was no succession plan or contingency plan in place for the imminent retirement of the professional lead, who was leaving the service in April 2018. Reviewers saw that this was having a negative impact on the team, who had not been informed of any future plans relating to the service.

2. Secondary care podiatry service

Reviewers were concerned about the provision of podiatry services available to Noble's Hospital for the following reasons:

- a. There was no inpatient podiatry service; reviewers were told the vascular surgeon was therefore also undertaking some podiatry work to help with the increased demand for specialist inpatient podiatry services.
- b. 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 MDT requests. There was no cover for unplanned absences for the podiatrists who supported MDT clinics. Planned absence was covered by community podiatry staff.

3. **Communication of discharge from hospital**

There was no formal discharge communication in place from the hospital to the podiatry service requesting input from the team. Patients were often discharged without the knowledge of the team, resulting in delays to the care pathway.

4. **Data and key performance indicators**

Limited data collection, data analysis and benchmarking were undertaken. KPIs, which could be used for monitoring the effectiveness of the current service and informing any future service developments, had not yet been set. There was an audit programme in place, but this did not reference any audit standards. Although incident and complaints data were reviewed locally by the service to identify learning, this was not communicated outside the podiatry service, and the service did not receive feedback for learning from other services.

5. **IT systems**

Multiple IT systems were in use, which resulted in staff having to undertake duplicate data entry.

6. **Communication**

Staff providing the podiatry service at Noble's Hospital did not have access to the hospital communication and email system, which caused communication delays with other teams.

Further Consideration

1. The team would benefit from more robust data collection and analysis in order to fully understand and articulate the risks facing the service, to determine future developments and to support business cases. Sharing outside the team of lessons learned from incidents and complaints would help to ensure that the service was effective and responsive.
2. Although there was an audit programme in place, reviewers considered that it may be helpful to include any audit criteria from best practice guidance, for example NICE guidelines.
3. The team provided an excellent training programme for care home staff, but reviewers suggested that now may be the right time to evaluate the effectiveness of the training programme to see if there had been a reduction in referrals to the service and whether the continuation of the training programme was appropriate, given the other competing demands on the service.
4. The service could benefit from strengthening the processes for patient and carer involvement and feedback to inform service development
5. The service did not have a formal training and development plan. Reviewers were also told that staff training was often cancelled as a result of workload. The development and implementation of a training needs analysis would help to ensure that the service had the right skill mix, would support existing staff in understanding what development opportunities may be available to them and would improve the resilience of the existing team, as well as future proofing the delivery of the service should staff leave.
6. The service may benefit from completing a stress risk assessment for staff who are facing uncertainty regarding the future of the service because of the imminent retirement of the professional lead.

7. Guidelines were in place, but reviewers felt that they should be strengthened by ensuring more robust document control and ensuring that they reflected current best practice.
8. Reviewers felt that the service may benefit from considering the implementation of a self-referral process for patients. A robust impact assessment should be undertaken to ensure the service can manage this level of activity.
9. A legislative framework allowing podiatry staff to be independent prescribers was not in place. Reviewers were told that there were plans for a framework to be in place by the end of 2018.
10. Reviewers considered that a clear strategy was required to define the on-going service demands, to ensure that the service had the capacity to deliver the full range of inpatient and outpatient services, e.g. services for vascular and rheumatology patients.

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SPEECH & LANGUAGE

General Comments and Achievements

The Speech and Language Therapy team provide an excellent service within the resources that were available to them. The reviewers saw a team who were passionate about the service that they provided and the patients that they cared for. The team were honest about what they had achieved, as well as the challenges that they faced.

Reviewers felt that the team had benefitted from the leadership of the current manager, who had brought an increased robustness to team working as well as more effective care management by adopting new, more efficient, ways of working (e.g. instrumental assessment). Under her leadership, the team capacity had also increased by one third and strong teamwork was observed during the review.

The reviewers heard that two members of the team had won awards in the Isle of Man employer awards for achieving additional competences.

The reviewers saw evidence of good practice and were particularly impressed that Fiberoptic Endoscopic Evaluation of Swallowing (FEES) was in place. They also noted the proactive joint working with other specialities across the hospital. The reviewers also spoke with patients from the Parkinson's Disease group, who were very positive and complimentary regarding the care that they had received from the team.

Good Practice

1. Reviewers were particularly impressed by the leadership of the current team manager and the new ways of working that she had implemented.
2. The implementation of FEES was seen as very proactive by the reviewers.
3. Joint working with other specialities (e.g. Ear Nose & Throat) was effective, and the team attended relevant group meetings across the hospital to promote the team's work and ensure a more seamless pathway of care for patients.
4. The introduction and development of the instrumental assessment service was seen as a positive improvement by reviewers. This was a more objective assessment tool than previously used and recommended as best practice by the Royal College of Speech and Language Therapists (RCSLT).

Immediate Risks: No immediate risks were identified.

Concerns

1. Restructure

There was a concern regarding the planned restructuring of the service, and particularly the lack of communication with the staff regarding the proposals. Reviewers heard that this was a concern for staff as they knew 'something was happening' but had no detail. There was a concern that this may have a negative impact on staff and may destabilise the existing high morale in the service.

2. Patient care pathway

There was no process in place for Early Supported Discharge (ESD) or Augmentative and Alternative Communication (AAC). Both would have a positive impact upon the patient care pathway. As the team were part of an ESD service for stroke patients, an ESD process would pave the way for timelier interdisciplinary intervention and would improve patient outcomes. If the service had access to AAC, this would improve the quality of life for patients with limited ability to communicate and functional communication difficulties.

3. Staffing

Reviewers saw and heard that there was a lack of support services in the team (specifically assistant practitioners and administrative support). The inclusion of these staff on the team would enable qualified staff to provide a

more timely and effective service for patients by reducing the number of administrative and support tasks that they currently had to complete.

4. Documentation

The documentation that the reviewers saw was inconsistent between hospital and community teams. Increased standardisation of documentation and record keeping between these two teams would improve the responsiveness of the service by reducing the amount of duplicate record keeping.

Further Consideration

1. Reviewers noted that there was limited access to the PRISM incident reporting system. As the hospital planned to move to a new system in the near future, improved access to the new system for the team would allow them to investigate their own incidents and also improve learning by analysing themes and trends.
2. The development and implementation of a training needs analysis would help to ensure that the service had the right skill mix, would support existing staff in understanding what development opportunities may be available to them and would improve the resilience of the existing team, as well as future proofing the delivery of the service should staff leave.
3. The team may benefit from reviewing the latest RCLT guidance on best practice regarding prioritisation of patients.
4. Consideration should be given to developing a suite of outcome measures that the team could monitor to understand the impact of the service and that could be shared with other specialities in the hospital and community.
5. The team should consider reinstating services for transgender patients and introducing a resourced service for adult mental health patients.

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DIETETIC SERVICES

NOTE: This review relates to adult services only. Paediatric Dietetics services were covered in Review 5.

General Comments and Achievements

The nutrition and dietetic service accepted referrals from all health care professionals across community and acute care. A dietetic and nutrition service was provided to all the inpatient wards at Noble's Hospital and Ramsey and District Cottage Hospital, to the Hospice-Isle of Man, and to the chemotherapy and renal units. Home visits were undertaken, if required, by the specialist dietitians.

Staff who met with the visiting team were enthusiastic and proud of the service they provided to patients and carers. There was good leadership from the lead dietitian, who was highly regarded by staff and was considered by them to be very proactive. The team were open about what they had achieved, as well as the challenges that they faced. They were very open to change and were forward thinking about how the service could be further improved.

A dietitian specialising in mental health been recruited to the team for a year.

The team had also improved the documentation used to confirm the correct position of nasogastric tubes.

Good Practice

1. Reviewers were impressed by the patient-centred approach of staff that encouraged and empowered patients to manage their care. Patients were given their care plan, which was updated at each visit, and letters detailing any treatment decisions were written to the patient and copied to other health professionals for information.
2. Staff also supported those patients transitioning from paediatric to adult services to enable them to adjust so that they felt more able to attend their appointments.
3. The dietetic team was cohesive and worked well together, had a good appraisal system in place and had good administrative support. The team would cross cover colleagues whenever possible so that patients' treatments and journeys to clinics were not significantly affected by absence.

Immediate Risks

1. **Nasogastric Tube placement**
 - a. Reviewers heard of significant concerns with regard to the placement of nasogastric (NG) tubes. Reviewers heard that the 2016 guidance issued to all UK hospitals by the NPSA (National Patient Safety Agency) had been received in the Isle of Man. This guidance identified a theme of harm and death to patients when nasogastric tubes are misplaced in the pleura or respiratory tract. The NPSA alert was issued following a number of occasions of harm in the UK. The English NHS classes misplaced NG tubes as a Never Event. Never Events are serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
 - b. Reviewers were concerned to hear that staff had raised this with a senior nurse and had been told '... we are the Isle of Man and this doesn't apply to us...'. Reviewers were told that staff had then written to the patient safety committee but had received no reply and no assurance on progress. Reviewers were told that there were not enough nurses trained and competent in NG tube placement, and they were very concerned that failure by the hospital both to recognise the significant risk of misplacement of NG tubes and to mitigate this risk could lead to significant harm to patients.

[NOTE: the placement of NG tubes is a wider clinical technique in hospitals and is not part of the direct remit of dietitians. Nursing and medical staff will also place NG tubes. Dietitians will take a lead role in the nutritional oversight of these patients. This issue was raised with the review team on the dietetics service review. Reviewers

are clear that this was the correct place to identify this risk; however, the responsibility for acting on this risk does not sit entirely with the dietetics service.]⁷

Concerns

1. Care of patients with food allergies

Reviewers were told that different food suppliers were used for inpatients and therefore special 'free from' diets could not be 100% guaranteed. This had the potential to increase the risk of patients suffering an allergic reaction. Reviewers heard that this was being mitigated by asking patients with severe food allergies to bring their own food into hospital, which the Reviewers considered was not acceptable.

2. Nutrition screening

Nutrition screening for early identification of patients who were nutritionally depleted (or likely to become so) was not being followed. A recent audit of inpatients identified that only 6% of patients were being screened. Reviewers heard that this was a Trust-wide issue and that screening was being encouraged and training provided, although uptake of this was poor.

3. Total Parenteral Nutrition (TPN)

The lack of appropriate facilities within the pharmacy aseptic suite meant that TPN could not be prepared specifically for patients on site. Generic TPN preparations were therefore being used which may not provide the optimal intravenous nutritional benefits for patients.

Further Consideration

1. The specialist dietitians for mental health, renal and diabetes had no cover for planned or unplanned absences. Although patient pathways included timescales for assessment and treatment, these timescales were not consistently met when absences occurred. Because of the specialist nature of these services it was difficult for

⁷ **IOM response:** The misplacement of NG tubes is considered to be a never event, following NHS Improvement guidance. The updated (January 2018) NHS Improvement never events list and NG tube patient safety alert have been distributed to staff, and colleagues have been reminded to follow the guidance. This risk was discussed at the Patient Safety and Quality Committee (PSQC) in 2017/18 and service leads were identified to undertake a review and assessment of local practice. Upon completion of the review an action plan was developed and implemented to mitigate identified risks and ensure safe practice. The actions required were disseminated via service leads and progress reported to the PSQC regarding implementation. The action plan was discussed by the Medical Director with the Chief Executive Officer to provide assurance. Specific actions included: • Change in NG tube and equipment supplier as a result of local incident review • Dietetics Department undertook audit of practice regarding confirmation of position of NG tubes by x-ray, radiology procedures were amended as a result • Review of the Policy for Confirming Correct Positioning of Fine Bore Nasogastric Feeding Tubes, which included amendment of nursing documentation to ensure correct monitoring • The development and implementation of staff procedure guidelines for the safe insertion and positioning of fine bore NG Tube • Delivery of NG Tube insertion and management training for nursing staff – over 120 nursing staff completed by December 2017 • Development and implementation of eLearning theory module • Formal competency assessment of nursing staff was implemented for the insertion, positioning and management of NG tubes • Inclusion of NG Tube insertion and management training into F1 and F2 induction programme • Presentation to staff at Patient Safety Forum to highlight risks and training requirements. Ongoing training is in place.

WMQRS Response: We note the action plan developed previously and your plan to provide ongoing training for staff. However, the comments made to reviewers by staff suggest that appropriate monitoring and audit has not been undertaken to ensure that the action plan has been implemented. We note that these steps aim to address the specific issues relating to nasogastric tubes; it is our view that thought should be given to the wider cultural issue that allowed some senior staff to believe that recognising this guidance was not necessary. We consider that once there is assurance that all actions have been implemented including a robust training and education programme for staff, then the actions would mitigate the risk identified.

other staff to maintain competences in these areas to deliver a comprehensive service. Staff were able to provide safe, albeit basic, care in the short term.

2. The nutrition nurse service consisted of only 0.32 WTE, which was insufficient capacity for the service. There were delays in the patients being seen when the nutrition nurse was on leave. The lack of capacity for the service had been highlighted on the divisional risk register, and the risk had been mitigated by the training of other health care professionals.
3. Patients attending outpatients had their weight measured but a Malnutrition Universal Screening Tool (MUST) assessment was not routinely completed. Best practice guidance suggests that all outpatients at their first clinic appointment should be screened, and screening should be repeated weekly for outpatients if there is clinical concern.
4. Reviewers were told of difficulties with communication, particularly from external areas; for example, there had been no communication to the service informing them that the meals on wheels service was stopping.
5. All staff were aware of the incident reporting system, but reviewers were told that staff did not routinely get feedback on the outcome of any investigations or discussions from the patient safety forums. Staff also commented that they had been advised to report incidents to the community health service rather than the hospital system where the team are based.
6. A consequence of improving the level of nutritional screening being undertaken will be an increase in the number of referrals to the dietetic service. Reviewers suggested that any increase in referrals and resulting workload should be monitored to ensure that sufficient and timely dietetic support would be available.
7. The review covered the care of adults, but reviewers were made aware that there was no nutrition nurse available to support children, young people and their families.

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PHARMACY

General Comments and Achievements

The pharmacy team provide an excellent service within the resources that are available to them. The reviewers saw a supportive culture and evidence of a caring team who saw the provision of good patient care as their priority. The team was respected by other Health Care Professionals within the hospital.

The reviewers saw evidence of good practice particularly in the aseptic and oncology units where there were good data quality and assurance processes. The training and advice provided to other Health Care Professionals, including junior doctors, was also seen as proactive by reviewers.

Good Practice

1. The consent screen on EMIS (Egton Medical Information System) used in Primary Care had to be completed by pharmacy staff to ensure that appropriate patient consent was gained before accessing records.
2. Business continuity and contingency plans were in place and worked well, particularly for stock control. Reviewers saw that pharmacy held at least 3 months of anticipated stock requirements (and often more) to ensure a robust supply chain in the event of bad weather causing delays in stock being delivered to the Island.
3. There was evidence of good procedural documentation for internal processes and audit.
4. Publications and audits were comprehensive and well structured.
5. Reviewers were particularly impressed that the aseptic and oncology unit data quality and assurance processes were robust and responsive.
6. There was good engagement from directorate teams who had funded additional pharmacy advice to supplement that which was provided by the central pharmacy team.
7. Reviewers saw that the process and recording of pharmacist interventions (where a pharmacist intervenes in the prescribing or dispensing of medicines either to correct error or to ensure medicines are used appropriately) was robust. Pharmacists had a good understanding of how and when to intervene.
8. Plans were in place for implementation of Electronic Prescribing by the end of the year. However, reviewers noted that the infrastructure and staffing to make this work effectively was crucial to the successful implementation – and therefore needed to be included in the project planning phase.

Immediate Risk

1. Oncology prescribing and transcription errors

Reviewers were told that Pharmacy staff regularly identified prescribing and transcription errors with a visiting Oncology Consultant. Some of these related to faxed prescriptions from the UK. Staff were also of the opinion that off protocol prescribing was a frequent occurrence. Staff told us that they had reported this to senior management on a number of occasions, but no action appeared to have been taken and staff had not received any feedback that this issue had been considered. Staff told us they believed that they identified the problems before patients received treatment. However, staff told us they were extremely concerned that an error may happen.⁸

⁸ **IOM response:** This matter has been discussed and it is considered that the capacity of the visiting service from Clatterbridge Centre for Oncology (CCO) is no longer sufficient to meet increased service demand. A discussion has taken place with the Consultant Oncologist who acknowledges the problem and welcomes a further review of how the service should be resourced. CCO management has also been alerted of the concern and a conference call between Noble's and CCO leads is being arranged for after the Easter holiday.

WMQRS response: We note that you have had further discussion with the relevant Oncologist and that you have a meeting arranged with the relevant senior executive team at Clatterbridge Oncology Centre. We do not consider that the actions you have detailed mitigate the risk of further errors and that the issues do not entirely relate to capacity of the visiting service.

Serious Concern

1. Pharmacy Workforce

Reviewers identified a concern over the robustness of the workforce plan. Ongoing recruitment of staff to the pharmacy team has remained a challenge and several adverts have failed to attract suitably qualified and experienced staff. Reviewers heard that plans were in place for internal (training grade) workforce development, but these would not lead to substantial change in the foreseeable future. Reviewers also heard that skill mix was not well balanced which often resulted in senior staff undertaking more junior roles. Reviewers also identified a lack of robust succession planning. The current head of pharmacy was away on extended personal leave and this role was being delegated to one member of staff in the interim. In addition, two senior members of staff were both leaving the service within the next 3-6 months. Both senior team members will leave a significant gap which will create additional pressure for the rest of the team. In addition, the senior pharmacist with technical responsibilities is a business-critical role in the implementation of the new ePMA system. Reviewers identified that once the head of service returns this will not resolve the staffing problems described. Reviewers felt that whilst the impact of this was not yet fully experienced; this would in the very near future create a 'perfect storm'. Reviewers identified that pharmacy services would benefit from a full workforce review across the whole service and a plan for the future.

Concerns

1. Aseptic Unit capacity

There was a concern regarding the capacity of the aseptic unit in light of the increasing oncology activity on island. Reviewers were told that a business case had been produced but there was a lack of clarity regarding the progress of the business case. Reviewers noted a lack of appropriate facilities for Total Parenteral Nutrition (TPN) which has been fully set out in the dietetics section of this report.

Shared learning from pharmacy data

There was a concern regarding the lack of evidence of wider learning from the systematic collection and analysis of data by the pharmacy team. The pharmacy team had good audit data on their interventions but there was no evidence of this being used across the organisation to fully understand, articulate the actual risks and take action to address prescribing errors and levels of harm.

2. Drug cost modelling

Although agreement had been reached to support the drug formulary (and therefore the associated costings) for cancer treatments used by the Clatterbridge Centre for Oncology and the pan Mersey formulary for other medicines, reviewers were concerned that there was no associated cost modelling and therefore no clarity on the wider financial impact of adopting this strategy.

3. MDT working

Reviewers saw and heard that although pharmacy staff were valued for their skills they were not recognised as senior clinicians by colleagues inside and outside the hospital.

4. Agreement process for drug funding

There was an effective procurement process in place though reviewers did feel 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 requests a non-formulary it was signed by a directorate manager and usually always approved. There was no forum for considering requests across the hospital to allow for a degree of consistency. Reviewers also heard that patients had a high level of direct access to MHKs and therefore decisions were being influenced / made following intervention by the local MHK.

Further Consideration

1. Reviewers noted that there were likely to be further efficiency gains from reviewing the level of medicines wastage that was occurring.
2. Reviewers were told that discharge planning often occurs on the day of discharge and there was therefore no option to plan ahead. Apart from the inevitable delay, pharmacy staff told reviewers that senior pharmacists on the ward found themselves called away from clinical discussions with patients and consultants to arrange discharge medication; this was not best use of their time or clinical competencies. Consideration should be given to working with other Health Care Professionals to ensure that planning occurs earlier, to allow for more effective and timely management of TTOs.

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APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Visiting Team		
Sarah Armer	Specialist Dietitian	South West Yorkshire Partnership NHS Foundation Trust
Dr Philip Brammer	Respiratory Consultant	The Dudley Group NHS Foundation Trust
Bob Colclough	User Representative	
Janet Cooke	Matron	University Hospitals of North Midlands NHS Trust
Dr Nicholas Crombie	Consultant Trauma Anaesthetist	University Hospitals Birmingham NHS Foundation Trust
Helen Dixon	Clinical Lead for Therapy Services / Dietetic Manager	Barnsley Hospital NHS Foundation Trust
Mark Docherty	Director of Clinical Commissioning and Strategic Development / Executive Nurse	West Midlands Ambulance Service NHS Foundation Trust
Jane Freeguard	Head of Medicines Commissioning	NHS South Worcestershire CCG
Jim Hancox	Research, HEMS & Critical Care Paramedic	West Midlands Ambulance Service NHS Foundation Trust
Jessica Harris	Head of Occupational Therapy and Orthotics Contract Manager	Burton Hospitals NHS Foundation Trust
Helen Jackson	Associate Director for Therapy Services & AHP Lead	University Hospitals Birmingham NHS Foundation Trust
Clare Jones	Team Leader, Cannock Community Stroke Services	Walsall Healthcare NHS Trust
Huw Jones	Paramedic Practitioner	West Midlands Ambulance Service NHS Foundation Trust and Care Quality Commission
Margaret Kennedy	Lead for Podiatry	Walsall Healthcare NHS Trust
Helen Lancaster	Director of Operations	South Warwickshire NHS Foundation Trust
Kate Lawson	Operations and Quality Director	Falck Medical Services
Jamie Maxwell	Head of Quality, Safety & Compliance	University Hospitals of North Midlands NHS Trust
Charlotte Mitchell	Speech and Language Therapist	University Hospitals Coventry & Warwickshire NHS Trust
Jane Nolan	Clinical Lead Respiratory	Worcestershire Acute Hospitals NHS Trust
Nicky Norell	Sister	The Royal Wolverhampton NHS Trust

Visiting Team		
Vivien Pettit	Lead Anticoagulation Nurse	Worcestershire Acute Hospitals NHS Trust
Bev Porter	Senior Sister	The Royal Wolverhampton NHS Trust
Andy Rosser	Lead Research Paramedic	West Midlands Ambulance Service NHS Foundation Trust
Alison Rowe	Dermatology Specialist Nurse	Sandwell & West Birmingham Hospitals NHS Trust
Dr Narinder Sahota	General Practitioner	Walsall
Lisa Shepherd	Endocrinology ANP/NMP	Heart of England NHS Foundation Trust
Chris Smith	Head of Ambulance and Clinical Director for Ambulance, Urgent Care and Community Services	Isle of Wight NHS Trust
Belinda Stockton	Podiatry & Orthotics Professional Lead & for Decontamination (Community)	South Warwickshire NHS Foundation Trust
Alison Tennant	Clinical Director of Pharmacy	The Royal Wolverhampton NHS Trust
Gaynor-Kay Travis	Head of Therapy Services	University Hospitals of North Midlands NHS Trust
David Trigger	User Representative	Worcestershire
Mr Matthew Ward	Consultant Paramedic - Emergency Care	West Midlands Ambulance Service NHS Foundation Trust
Sally Woolams	Clinical Manager (Occupational Therapist)	Walsall Healthcare NHS Trust

WMQRS Team		
Tim Cooper	Director	West Midlands Quality Review Service
Rachael Blackburn	Assistant Director	West Midlands Quality Review Service
Sarah Broomhead	Assistant Director	West Midlands Quality Review Service

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APPENDIX 2 COMPLIANCE WITH THE QUALITY STANDARDS

A separate document - Appendix 2 contains the details of compliance with each of the standards and the percentage of standards met.

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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