

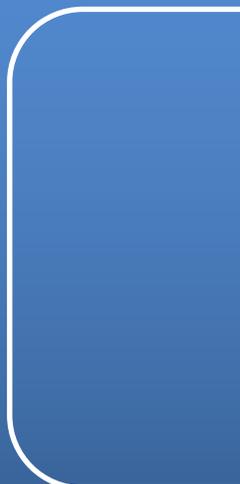
Acute Medical Admissions and the Care of People with Long-Term Conditions

Isle of Man Health Services Version 2

Visit Date: 12th March 2014

Report Date: November 2014

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NOTES TO VERSION 2

Page 6	Primary Care Section	This section has been updated and can be found in the following report: ‘WMQRS IoM Acute Medicine and Long-Term Conditions Report Addendum to Primary Care V1 20141105’
Pages 10 & 11	Amendment	Reference to the British Heart Foundation corrected to the ‘British Heart Foundation (Isle of Man)’

INTRODUCTION

This report presents the findings of the review of: Acute Medical Admissions, Care of People with Long-Term Conditions, in particular, those with Diabetes, Heart Failure, Chronic Obstructive Pulmonary Disease (COPD) and Chronic Neurological Conditions, and Cardiac Rehabilitation which took place on 12th March 2014. The purpose of the visit was to review compliance with:

- West Midlands Quality Review Service (WMQRS) Quality Standards for:
 - Acute Medical Admissions, D4 20131219
 - Care of People with Long-Term Conditions, Version 1.1, August 2012

and the following UK standards:

- British Association of Cardiovascular Prevention and Rehabilitation, Standards and Core Components for Cardiovascular Disease Prevention and Rehabilitation, March 2012

These Quality Standards are based on latest English guidance on effective healthcare and form the basis of the external quality assurance of Isle of Man health services commissioned by the Isle of Man Department of Health.

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, 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 conclusion from multiple sources (evidence available on the day of the visit, meetings and viewing facilities). Visit reports will identify compliance and issues related to the achievement of the Quality Standards. Issues are categorised in the following way:

- **Achievements** made by the service reviewed
- **Good practice** which 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 which 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 visiting team which reviewed the services on 12th March 2014. 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 patients and a wide range of staff. The visiting team also looked at the responses to 62 patient and carer questionnaires (acute medical admissions: 19; diabetes: 18; heart disease: 9 and chronic neurological conditions: 16), other written feedback from patients and members of Tynwald and a range of written evidence provided by the services being reviewed.

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 is responsible for ensuring action plans are in place and monitoring their implementation.

ABOUT WEST MIDLANDS QUALITY REVIEW SERVICE

WMQRS was set up as a collaborative venture by 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

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.

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ACUTE MEDICAL ADMISSIONS – NOBLE’S HOSPITAL

At the time of the review, the Acute Medical Unit (AMU) was a 21 bedded unit caring for approximately 4,900 patients per annum of which approximately 45% were GP referrals and 55% admitted through the Emergency Department. An average of 13.5 patients per day were admitted. Medical cover for the unit was provided by the on-call consultant which changed every 24 hours in the week but covered the whole weekend. At the time of the review, consultants did not have time allocated to working on the unit. A speciality doctor was available 24/7 with time allocated for work on the AMU. A business case for additional acute physicians had been submitted in November 2013.

General Comments and Achievements

The AMU was staffed by a cohesive team who were clearly committed to the care of their patients and keen to improve the service offered. Quality improvement work during the months before the visit included implementation of some guidelines and introduction of ward-based teams. All consultants were accessible and prepared to provide support whether they were on call or not.

Patients were also admitted acutely to other medical wards. A full assessment of these wards against the Quality Standards for acute admissions was not undertaken but, on the basis of the evidence seen during the review visit, reviewers considered that these conclusions would also apply to other medical wards accepting acute admissions.

Immediate Risks: See acute hospital-wide section of this report.

Concerns

- 1 Co-ordination of care for individual patients: See systemic issues section of this report.
- 2 Hospital admission process: See systemic issues section of this report.
- 3 Discharge from hospital process: See systemic issues section of this report.

4 **Nursing competences**

Nursing staff did not have the range of competences expected for work on an acute medical unit, including monitoring, resuscitation and male catheterisation. A training plan was in place but much of the mandatory training was out of date.

5 **Medical leadership and availability of senior decision-makers**

The nominated lead consultant for the AMU was also lead for the diabetes service and did not have time in his job plan for the development of the AMU.

Senior decision-makers from the AMU were not usually involved in decisions on whether patients should be admitted. A full management plan, including review by a senior decision-maker, was not usually completed within four hours of admission. The organisation of consultant ward rounds did not enable reasonable continuity of care.

6 **Therapy services**

The AMU had no occupational therapy service and physiotherapy provided only discharge mobility assessments and chest physiotherapy. Dietetic and speech and language therapy services were available by referral only and the timeliness with which these services would attend to see a patient was not clear.

7 **Monitoring facilities**

The AMU did not have a dedicated area or facility for monitoring the expected number, dependency and case mix of patients. A bedside cardiac monitor was in use but was not always easily visible. Evidence that nursing staff had appropriate competences in rhythm recognition (for example, Immediate Life Support ILS) training was not available. Patients needing monitoring could be admitted to the coronary care unit (CCU)

or telemetry from CCU was available. The hospital was considering purchasing a 'track and trigger' system to enhance monitoring arrangements.

8 Nurse staffing levels

Reviewers considered that nurse staffing was insufficient for the number and potential dependency of patients, even taking account of the relatively low admission threshold (see systemic issues section of this report). Information from the self-assessment, review of rotas and discussion with staff showed that the ward was usually staffed by three registered nurses and two health care assistants (HCAs) on early and late shifts and two registered nurses and two HCAs Monday, Friday and Saturday nights with two registered nurses and one HCA on other nights. The staffing ratio was therefore 1:6 registered nurses in the daytime and 1:10 or 1:11 at night.

A review of nurse staffing had been conducted which suggested that staffing levels were adequate and provided good value for money. Staffing levels had, however, been calculated on an average occupancy of 13.6 beds whereas 21 beds were open at the time of the review. Reviewers considered that staffing levels should be sufficient for the number of open beds. The apparent discrepancy between the WMQRS findings and the review of nurse staffing is explained by this difference in bed numbers. The difference between average occupancy and open beds is likely to have been higher in the Isle of Man than in the other Medical Admission Units against which comparisons were made.

Further Consideration

- 1 Both medical leadership and availability of senior decision-makers would be improved by the appointment of two consultant acute physicians as proposed in a business case for strengthening medical staffing of the unit. Additional senior medical staff with time dedicated to work on the AMU would also help to move the service from twice daily ward rounds to a system of rolling review of patients.
- 2 More formal arrangements for multi-disciplinary review and learning within the AMU may be helpful. Links with other services may also be improved by being included in these arrangements.
- 3 The AMU did not have a defibrillator with an external pacing facility. Improved links with the coronary care unit for the care of people with acute coronary syndromes may also be helpful. Reviewers saw evidence of links with the critical care outreach service but not of similar links with coronary care. Clear guidelines on when to contact critical care services, especially out of hours when the Outreach Team is not available, may also be helpful.
- 4 Support at home: See systemic issues section of this report.

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CARE OF PEOPLE WITH LONG-TERM CONDITIONS

PRIMARY CARE

A self-assessment against the Quality Standards expected for primary care was not completed. Data on achievement of the Quality and Outcomes Framework were also not available, which would have helped to give an indication of the quality of primary care services. Reviewers met a group of general practitioners and the information from this meeting contributed to the conclusions in this report. Due to the lack of relevant information, reviewers were not able to comment on the quality of arrangements for the care of people with long-term conditions in primary care, including early identification, case finding and risk stratification. Particular issues which arose were:

Concerns

1 Quality assured diagnostic spirometry

Robust arrangements for quality assurance of diagnostic spirometry undertaken in primary care were not apparent. See also the Chronic Obstructive Pulmonary Disorder (COPD) section of this report in relation to liaison with specialist respiratory team.

2 Arrangements for diabetic retinopathy screening

Arrangements for annual retinal screening for people with diabetes did not appear to be robust, especially those who had never been under the care of the specialist diabetes team. Reviewers were told that these patients were directed to community optometry but may not receive the annual retinal check that was provided for patients cared for by the specialist team. Audit of annual retinal check was not available.

Further Consideration

- 1 Primary care and hospital-based services did not appear to be using the same guidelines for the care of people with long-term conditions. Reviewers were told by some hospital managers that integrated pathways of care were in place but these were not mentioned by GPs and clinical staff in the hospital, with the exception of a diabetes pathway covering screening, assessment, diagnosis, initial treatment and initial referral criteria. Some COPD guidelines were in use in the hospital but GPs said that they followed *Map of Medicine* guidelines rather than a local pathway.
- 2 Reviewers suggested that an ongoing programme of education and development for GPs and practice staff would help to support improving care for people with long-term conditions and would provide a forum for addressing several of the issues in this report. Reviewers were told of a quarterly half day education session for GPs but it was not clear how other services could influence the programme for these sessions. The heart failure team had set up a specific training session for GPs but this had been poorly attended.
- 3 Visiting consultant neurologists commented that they were receiving many referrals of patients who could more appropriately be managed in primary care. These consultants would be interested in discussion of this patient pathway, referral criteria and headache-related training for GPs. This could result in more appropriate referrals and more effective use of visiting consultants' time.

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COMMUNITY LONG-TERM CONDITION SERVICES

The district nursing service on the Isle of Man provided care for people with long-term conditions and reviewers met representatives of this service. The Isle of Man did not have services supporting general practices and other primary care services in providing community-based care for people with long-term conditions, especially those who have multiple long-term conditions or who are particularly frail and so no review of community long-term condition services was undertaken. (Examples of these services include virtual wards, community matrons or admission avoidance services, ideally with integrated health and social care support.) This issue is covered further in the systemic issues section of this report.

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ACUTE HOSPITAL-WIDE

Immediate Risks

1 24/7 Temporary Pacing

The arrangements for 24/7 access to temporary pacing were not robust. Reviewers were told that staff would ring round relevant staff, whether or not they were on duty. A clear process to be followed, including indications for transfer of the patient 'off island', was not evident.¹

Concerns

1 Ward pharmacy support

Reviewers were seriously concerned that only one of the wards at Noble's Hospital had dedicated time from a pharmacist to support medicines reconciliation, medicines management issues and advice to ward staff. Both safety and quality of in-patient care would be expected to improve as a result of ward-based pharmacy input and length of stay may be reduced. The hospital pharmacy service had developed a proposal for providing ward-based support but reviewers were told that this had not been supported because it increased the 'headcount' of the service.

Further Consideration

- 1 Several ward nursing staff commented that they were often asked to work additional hours or additional shifts, that they felt under pressure and that this sometimes impacted on their ability to undertake training. Particularly worrying for reviewers was that some staff said they "sometimes went home thinking that they had not done a good job".
- 2 Access to off-island training necessary to maintain competence and to keep up to date was mentioned to reviewers as variable. This issue will be explored further during the clinical governance review.

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DIABETES

At the time of the review, the Isle of Man specialist diabetes team provided care for 1736 of the 3480 people with diabetes on the island. Approximately 500 patients had been discharged back to the care of their GP over the previous year. The specialist diabetes team comprised one consultant, one speciality doctor, 1.8 wte diabetes specialist nurses, 1.6 wte diabetes support nurses, 1.0 wte senior healthcare assistant, 0.4 wte dietician, 0.4 wte podiatry from community health service and administrative support.

General Comments and Achievements

The team providing specialist care for people with diabetes was enthusiastic, committed and working hard to provide good care within the resources available. Significant improvements had been made to the service over the past 10 years. In particular, the Diabetes Centre at Noble's Hospital had opened, a specialist diabetes team had been recruited and a multi-disciplinary antenatal service for pregnant women with diabetes involving obstetricians and midwives with a special interest had been established. The diabetes service had worked with local care homes to try and improve the quality of care for people with diabetes. The community-based podiatry service was also in the process of rolling out a foot screening service to all patients with diabetes referred to the team.

¹ Immediate Risk response: Temporary Pacing; A formal rota has been devised and will be introduced by the 31st March 2014.

WMQRS response: The actions taken by Nobles Hospital in relation to formalising the rota for Temporary Pacing as described in the response will address the issue identified.

Good Practice

- 1 Patients had access to free blood pressure machines and a range of glucometers.
- 2 Nursing staff of the team were well organised with good nursing documentation and good opportunities for personal development. This approach also ensured good cover for absences and succession planning.
- 3 A good 'one stop' antenatal clinic was provided for pregnant women with diabetes, thereby avoiding the need for multiple hospital visits.
- 4 The team had good links with off-island specialists for the discussion of patients with more complex needs.

Immediate Risks: No immediate risks were identified.

Concerns

1 Co-ordination of care, care planning and annual reviews for individual patients

None of the patient records seen by reviewers included a personalised care plan for patients and none of the completed patient questionnaires indicated that patients had received a personalised care plan. Annual reviews were being undertaken but reviewers noted some instances of incomplete recording of the annual review and some delays in communication with other services. More robust arrangements for personalised care planning should be introduced as part of improving the quality of the service.

See also systemic issues section of this report.

2 Structured education programmes

Structured education programmes were not offered to people with diabetes and there were no opportunities for group education. Reviewers were told that education was offered on an individual basis but there was no structured framework to ensure all relevant issues had been addressed and nearly all the patient feedback questionnaires said that education had not been provided. A business case to implement structured education programmes had been submitted but at the time of the visit had not been agreed.

There was also no formalised programme of training for ward staff in the care of people with diabetes, although the introduction 'Think Glucose' training was being considered.

3 Waiting times for podiatry and orthotic services

At the time of the review, waiting times for podiatry patients referred to orthotic services were up to five months. Waiting times for routine referrals to orthotic services were approximately 18 months to two years.

4 Integration with primary care

Although reviewers were told that an integrated diabetes pathway covering screening, assessment, diagnosis, initial treatment and initial referral criteria had been developed, this did not appear to be working well in practice. Reviewers saw little evidence of communication between primary care and the specialist service or of effective shared care.

5 Arrangements for diabetic retinopathy screening: See primary care section of this report

6 Hospital admission process: See systemic issues section of this report.

7 Discharge from hospital process: See systemic issues section of this report.

Further Consideration

- 1 The diabetes service worked closely with podiatry services on the care of people with diabetes and foot problems but links with the vascular service were not as well developed. Reviewers suggested that the establishment of a multi-disciplinary forum involving diabetes, podiatry and vascular services would be helpful.

- 2 Guidelines on the care of people with diabetes were in the process of being updated and several were out of date at the time of the review. Reviewers were particularly concerned that guidelines for the management of diabetic ketoacidosis and hypoglycaemia were out of date.
- 3 Specialist advice at weekends: See systemic issues section of this report.
- 4 Support at home: See systemic issues section of this report.

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HEART FAILURE

Specialist care for people with heart failure was provided by a team comprising one consultant and one staff grade doctor (who also provided acute general medicine services), and one specialist heart failure nurse.

General Comments and Achievements

The specialist heart failure nurse had been in post for only six weeks before the review visit (although there had been a previous post-holder). Much of the work to achieve compliance with the expected Quality Standards was in progress at the time of the review. Reviewers were impressed by the commitment of the team and considered that many of the issues identified would be addressed if this progress continued. Good links with the British Heart Foundation (Isle of Man) were in place

The cardiac physiology service was strong with a good overall vision for the development of the service and good links with hospitals in England. The service was, however, limited by a lack of access to robust image storage.

Good Practice

- 1 The service had a good 'one stop' diagnostic clinic at which investigations were carried out, the diagnosis was given by the consultant and the specialist nurse was available to provide support. This process also ensured that good use was made of the specialist nurse's time as she saw people who had been given a diagnosis and had an agreed management plan.
- 2 The cardiac physiologist was actively working to improve the service offered and undertook a monthly clinical session in Liverpool in order to ensure that her competences were maintained.
- 3 A good patient support group was running.

Immediate Risks: See acute hospital-wide section of this report.

Concerns

- 1 Co-ordination of care for individual patients: See systemic issues section of this report.
- 2 Hospital admission process: See systemic issues section of this report.
- 3 Discharge from hospital process: See systemic issues section of this report.

4 Echocardiography

Several issues relating to echocardiography services were identified:

- a. Echocardiography was not available within the expected time of two weeks of referral. At the time of the review, waiting times for echocardiography for people with suspected heart failure and a previous myocardial infarction or high levels of serum natriuretic peptides were approximately five weeks.
- b. Previous echocardiogram results were not easily available, especially if the echocardiography machine was in use. Electronic transfer of results was not possible and communication of echocardiograms to and from specialist services in Liverpool was via a CD.

- c. The lead cardiologist did not have British Society of Echocardiography accreditation and arrangements for review and moderation with another service were not apparent. The number of pacemaker implants and trans-oesophageal echocardiograms being undertaken were not clear but appeared to be low. These numbers should be reviewed to ensure they are sufficient to maintain competence and consideration should be given to collaboration with another service for ongoing moderation of work undertaken on the Isle of Man (ie. not just for referral) and audit of complication rates.

5 Cover for Specialist Nurse

There was no cover for absences of the specialist nurse.

- 6 Ward pharmacy support: See acute hospital-wide section of this report.

Further Consideration

- 1 Specialist advice at weekends: See systemic issues section of this report.
- 2 Support at home: See systemic issues section of this report.
- 3 Cover for specialist teams: See systemic issues section of this report.
- 4 GP training: See primary care section of this report.
- 5 CD transmission of echocardiograms should be checked to ensure this provides appropriate security of patient-identifiable information. The British Heart Foundation (Isle of Man) had been asked financially to support a project to improve access to echocardiograms and reviewers were told that this project had been agreed.
- 6 Some patients who met the visiting team talked about 'information overload' when they first came into contact with the service. Others said that they would have appreciated more information about local services. Reviewers suggested that further work with user and carer support groups on this issue may be helpful.

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CARDIAC REHABILITATION

The cardiac rehabilitation service for the Isle of Man was provided for patients with coronary heart disease including all acute coronary syndromes, stable angina and following revascularisation procedures. The service was provided by a multi-disciplinary team of a lead cardiology consultant plus three lead practitioners (nurse, physiotherapist and occupational therapist), supported by a dietician and a pharmacist. Good links with the Manx Support Group were in place.

General Comments and Achievements

The cardiac rehabilitation team offered a high quality rehabilitation service, evidenced by good localised patient records. The team worked well with other services for people with heart disease. This teamwork was helped by the cardiac services being co-located.

Good Practice

- 1 The occupational therapist had additional competences in psychological therapies which helped to bring this perspective to the work of the team.

Immediate Risks: No immediate risks were identified.

Concerns: No concerns were identified.

Further Consideration

- 1 Stable patients with heart failure were offered cardiac rehabilitation when places were available. The possibility of extending the service to this group of patients was being considered. Reviewers suggested that capacity and demand work may be helpful in order to identify any service shortfall for this group of patients.
- 2 Members of the cardiac rehabilitation team each provided good input to the service from their professional background. Reviewers considered cover from within the team may be feasible through the development of enhanced skills.

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CHRONIC OBSTRUCTIVE PULMONARY DISORDER (COPD)

The Respiratory Team at Noble's Hospital provided care for patients with all respiratory diseases and care of people with COPD was part of their work. Specialist care for people with respiratory disease was provided by a team comprising one consultant and one staff grade doctor (who also provided acute general medicine services), one speciality doctor, one specialist respiratory nurse and 0.8 wte respiratory specialist physiotherapist. The respiratory laboratory was staffed by two clinical physiologists (one of whom was a locum) and an associate physiologist. The team was unable to identify how many patients with COPD were provided with specialist care or how many patients were admitted acutely with COPD. At the time of the review, 1332 people on the Isle of Man were diagnosed with COPD, with an estimated further 2600 people having the disease but not yet having a COPD diagnosis. 'Pathways' had been developed for out-patient referrals, in-patient referrals and management and for self-referral.

General Comments and Achievements

The specialist respiratory team worked well together and provided care 'over and above' that which could reasonably be expected. Links with community nursing services appeared to work well with some district nurses keen to take on more advanced roles in relation to the care of people with COPD and interested in undertaking training for these roles. Study days for primary care were run regularly and were well attended by practice nurses.

Good Practice

- 1 Good leadership was provided by the respiratory specialist nurse who had developed additional knowledge and skills for this role.
- 2 A good range of pulmonary physiology services was available, including a sleep apnoea service and a 'body box'.

Immediate Risks: No immediate risks were identified.

Concerns

- 1 **Co-ordination of care for individual patients:** See systemic issues section of this report.
- 2 **Integration with GPs**

There was no clear pathway covering integration between primary and secondary care. Referral pathways were in place but coordination of care beyond referral was not evident. Some guidelines were in use in the hospital but GPs said that they followed *Map of Medicine* guidelines rather than a local pathway. British Lung Foundation COPD self-management packs were in use in the hospital service but patients in primary care did not have access to these.

Different views on the COPD diagnostic process were also apparent. Reviewers were told by hospital-based staff that diagnostic spirometry was undertaken in the hospital service with high rates of referral for simple spirometry and reversibility. GPs commented that most diagnostic spirometry was undertaken in primary

care because all practices have spirometers (see primary care section of this report in relation to quality assurance of these spirometers).

This issue was considered particularly important because most patients with COPD were cared for by their GP without specialist team input. Limited home support was available from the respiratory team for patients who were unable to attend the hospital.

3 Pulmonary rehabilitation

At the time of the review, only limited pulmonary rehabilitation was available to people with COPD due to staff sickness.

4 Hospital admission process: See systemic issues section of this report.

5 Discharge from hospital process: See systemic issues section of this report.

6 Non-invasive ventilation guidelines

Reviewers were given examples of patients being started on non-invasive ventilation by non-respiratory specialist staff and, when seen by the respiratory team this was considered inappropriate. Some guidelines on non-invasive ventilation were in place but these did not appear to be being fully implemented by all staff within the hospital.

7 Cover for Specialist Nurse

There was no cover for absences of the specialist nurse.

Further Consideration

1 Follow-up arrangements may benefit from review and discussion with general practitioners. It appeared to reviewers that some follow up was being undertaken by the specialist team which may more appropriately have taken place in primary care. This may free up some respiratory specialist nurse time which could be used for visiting the AMU daily and for training and education and improving links with primary care.

2 Multi-Disciplinary Review and Learning: The team did not meet together to review and implement learning from positive feedback, complaints, incidents and 'near misses' and outcomes.

3 The respiratory team ran training days for ward staff but a competence framework and competence assessment for these were not apparent. It may be helpful to develop a clear competence framework and assessment approach.

4 Specialist advice at weekends: See systemic issues section of this report.

5 Support at home: See systemic issues section of this report.

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CHRONIC NEUROLOGICAL CONDITIONS

Specialist care for people with chronic neurological conditions was provided by two visiting consultant neurologists who came to the Isle of Man for one day on alternate weeks and two locally-based specialist nurses, one for people with multiple sclerosis or motor neurone disease (0.7 wte) and one for people with Parkinson's disease (0.8 wte). Support services including neuro-physiotherapy and other therapies were available, especially for people with multiple sclerosis.

General Comments and Achievements

Specialist care for people with multiple sclerosis or motor neurone disease was well organised and the care for people with Parkinson's disease was actively being developed. Visiting consultant neurologists were highly committed to supporting patients on the Isle of Man.

Good Practice

- 1 Policies on the care of people with multiple sclerosis or motor neurone disease were clear and well-presented.
- 2 A clear and comprehensive information booklet was available for people with multiple sclerosis or Motor Neurone Disease.
- 3 Good patient-held records were used.
- 4 Voluntary sector support for people with chronic neurological conditions was very good and linked well with the services provided by the specialist team.

Immediate Risks: No immediate risks were identified.

Concerns

- 1 **Co-ordination of care for individual patients:** See systemic issues section of this report. (NB. This did not apply to patients with motor neurone disease whose care was well-coordinated.)
- 2 **Support for people with epilepsy and other neurological conditions**
No on-island support was available for people with epilepsy and other chronic neurological conditions (apart from multiple sclerosis, motor neurone disease, acquired brain injury and Parkinson's disease). Improvements to the care of these people will be difficult to achieve without local specialist support.
- 3 **Lead clinician**
No-one had overall clinical leadership responsibility for the care of people with chronic neurological conditions. Reviewers considered that local clinical leadership was particularly important given that consultant neurologists visited the island one day each week.
- 4 **Community-based support**
Community-based support for people with chronic neurological conditions was limited. Reviewers were told of one specialist neuro-physiotherapist and limited occupational therapy support. These staff were working hard to meet the increasing needs of local patients but were not available at weekends. This limited the ability of hospital services to discharge patients at weekends.
- 5 **Hospital admission process:** See systemic issues section of this report.
- 6 **Discharge from hospital process:** See systemic issues section of this report.

Further Consideration

- 1 Specialist advice at weekends: See systemic issues section of this report.
- 2 Support at home: See systemic issues section of this report.
- 3 On-island clinical leadership for the care of people with chronic neurological conditions could be provided by someone from a variety of backgrounds, including a general practitioner, specialist nurse, allied health professional or non-consultant grade doctor with particular interest in this area. The lead clinician would need to have appropriate support to liaise with visiting neurologists and relevant locally based staff to ensure services for people with all chronic neurological conditions were improved.
- 4 Visiting consultant neurologists did not have access to patients' imaging results when they were not 'on island'. This resulted in delayed discharges from hospital for some patients.
- 5 Prior to the review there had been several changes in nursing leadership on the rehabilitation ward. A newly appointed nurse was in post at the time of the review and may need support to ensure the ward improves multi-disciplinary goal setting and reduce length of hospital stays.

- 6 Multi-Disciplinary Review and Learning: The team did not meet together to review and implement learning from positive feedback, complaints, incidents and 'near misses' and outcomes.
- 7 A strategy for the development of services for people with chronic neurological conditions was not apparent. If the services are to achieve compliance with National Institute for Health and Clinical Excellence (NICE) guidance then an overall strategy and agreed implementation plan will be needed. This strategy should also address ensuring appropriate cover for absences of the specialist nurses is available.
- 8 Reviewers were told of a number of difficulties and delays in access to housing adaptations and appropriately modified housing stock. Supportive housing opportunities appeared limited and difficulties in communication with the 14 housing departments did not appear to be functioning effectively.
- 9 See primary care section of this report: Visiting consultant neurologists commented that they were receiving many referrals of patients who could more appropriately be managed in primary care. These consultants would be interested in discussion of this patient pathway, referral criteria and headache-related training for GPs. This could result in more appropriate referrals and more effective use of visiting consultants' time.
- 10 The 'Hub and Spoke' approach with visiting neurologists appeared to be working well and could perhaps be used as an example for other specialties.

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SYSTEMIC ISSUES

Reviewers found that care in the Acute Medical Unit (AMU) and for people with long-term conditions was provided by caring, committed staff who were keen to provide the best possible service for their patients. Some issues were common across the services reviewed and are described in full in this 'systemic issues' section of the report:

Concerns

1 Co-ordination of care for individual patients

Reviewers were seriously concerned that it was often not clear what was happening in relation to the care of an individual patient. General practice and hospital IT systems did not communicate with each other although reviewers were told of plans for GPs to be able to access the hospital system. With a few exceptions, patients were not routinely given a copy of their care plan and reviewers were told from several sources about delays in sending clinical letters and discharge summaries. Specialist nurses were not routinely copied into GP communications. Most patients did not have a 'care coordinator' and when the specialist nurse took this role it was not clear that access to all relevant information was available. Clinics were rescheduled apparently without anyone checking that the resulting delay did not compromise patients' clinical care. Systems for following up imaging and pathology results and ensuring appropriate action was taken did not appear to be robust. Feedback from the patients who met the visiting team provided several examples of difficulties which had arisen as a result of delays in communication and a lack of coordination of care. Specialist nurses generally did not have access to secretarial support and were typing their own letters which may also add to delays in communication.

2 Hospital admission process

Reviewers considered that the process of admission to hospital resulted in many patients being admitted to Noble's Hospital who could have been cared for at home. Staff from the Emergency Department decided whether patients needed admission, usually with no input from the AMU or specialist teams. Patients therefore appeared to be being admitted for an assessment rather than senior decision-makers from the AMU or specialist team being called and undertaking an initial assessment within 30 minutes.

Reviewers considered that between 25 and 30% of admissions could have been avoided if the following were in place:

- a. AMU or specialist input prior to the decision to admit
- b. Specialist community long-term conditions services (see below)
- c. Rapid access acute medicine clinics offering a next day consultant review (7/7) other than for patients with transient ischaemic attack (TIA). Reviewers were told that patients could attend the ward as ward attenders but this did not appear to be used as an alternative to admission.

The hospital admissions policy was dated 2009 which suggested that these processes were not being reviewed regularly.

3 Process of discharge from hospital

Several factors appeared to be contributing to a relatively long length of stay when patients were admitted:

- a. There was no occupational therapy and limited physiotherapy input to the AMU. Reviewers were told that patients had to be transferred to another ward to access these services which would, inevitably, increase length of stay.
- b. Mobility assessment and assessment for aids and adaptations were only available Monday to Friday 9am to 5pm.
- c. Specialty in-reach to the AMU did not happen routinely. Reviewers suggested that this could be achieved relatively easily by specialist nurses visiting the AMU at least daily to identify patients needing specialist team care and supporting their early discharge or, if necessary, their move to a specialty-specific ward.
- d. Only one ward had a ward-based pharmacist (see acute hospital-wide section of this report).
- e. Arrangements for rapid identification and assessment of frail older people had not yet been fully developed and implemented.
- f. The discharge policy did not appear to be being effectively implemented. Full implementation of the existing policy could lead to reductions in length of stay, improve patient outcomes and patient experience and release resources for the development of community-based services.

4 Support at home

District nursing services were available 9am to 5pm seven days a week but there was no development of more specialist community-based services for the care of people with long-term conditions, especially those with multiple long-term conditions or who are particularly frail. Reviewers were also told that social care support was provided to a maximum of three visits per day. Reviewers considered that there was considerable potential to avoid hospital admission and reduce length of stay by the development of enhanced community-based services, ideally on an integrated health and social care basis. These services would need to be available seven days a week with the possibility of late evening and night-time enhanced support being achieved through further development of either the ambulance service and / or Manx Emergency Doctor Service.

5 Waiting times for diagnostic imaging

Patients needing Computed Tomography Pulmonary Angiography (CTPA) at weekends had to wait until Monday for this. Reviewers were told that some waiting times for routine imaging were long, including 16 weeks for vascular ultrasound and 13 weeks for a routine Magnetic Resonance Imaging (MRI). Some staff who met reviewers were unaware of the arrangements for urgent access to imaging outside of normal working hours.

6 Guidelines, data collection and audit

The compliance section of this report gives further detail of clinical guidelines which were either not available or were out of date. Reviewers saw little evidence of collection and use of data on key performance indicators, including timescales for initial assessment, full assessment and consultant review on the AMU. Some pathways had been developed but these covered referral into specialist services. Reviewers did not see shared care guidelines, clear criteria for discharge from specialist services or agreed follow up arrangements. Quality Standards for audit were not achieved in any of the services reviewed.

Further Consideration

1 Cover for specialist teams

Specialist teams for the care of people with long-term conditions were available Mondays to Fridays 9am to 5pm but there was no specialist advice and care available over the weekend unless that particular consultant was on call. Specialist nurses caring for people with COPD, heart failure and chronic neurological conditions did not have effective cover. Reviewers suggested that implementation of robust arrangements for advice from ward staff for patients of the specialist teams, including clear advice protocols, could help to improve the support for patients and avoid attendances at the Emergency Department. The heart failure team was also looking at rotation of staff from the coronary care unit into the specialist team. These initiatives may help with the provision of cover for absences of the specialist nurses.

2 The lead consultants for each service did not appear to have sufficient time for leading the development of pathways, guidelines, audit and training. This may adversely affect the development of high quality, sustainable services.

3 Reviewers were told of a business case for the appointment of two generic long-term conditions specialist nurses in the community. These posts may help to coordinate care if their roles and the relationship with condition-specific specialist teams are clearly defined. Two nurses will not be sufficient to provide a community matron or 'virtual ward'-type service.

4 Reviewers were given several examples of staff being contacted while not on duty by the hospital or by patients. Clear policies on this should be developed and implemented.

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APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Visiting Team

Dr Charles Ashton	Medical Director	South Warwickshire NHS Foundation Trust
Dr Sri Bellary	Clinical Director, Diabetes & Endocrinology	Heart of England NHS Foundation Trust
Lisa Carroll	Head of Nursing	Sandwell & West Birmingham Hospitals NHS Trust
Ben Ellis	Physiotherapy Team Lead	Walsall Healthcare NHS Trust
Nick Flint	User Representative	
Bie Grobet	General Manager- Integrated Adult Services	South Warwickshire NHS Foundation Trust
Daniel Meiring	Head of CRM	Sandwell & West Birmingham Hospitals NHS Trust
Cath Molineux	Nurse Consultant Primary Care	Shropshire Community Health NHS Trust
Dr Shaun Nakash	Clinical Director, Emergency Care/Acute Medicine Physician	Sandwell & West Birmingham Hospitals NHS Trust
Julie Thompson	Head Nurse, Frail Older Person & Dementia	Burton Hospitals NHS Foundation Trust
Andrea Vigrass	Senior Sister, Acute Medical Unit	University Hospital of North Staffordshire NHS Trust
Sandy Walmsley	Respiratory Nurse Specialist & LTC Lead	Heart of England NHS Foundation Trust
Maggie Williams	Senior Nurse Lead, Community Heart Failure Team	The Dudley Group NHS Foundation Trust

Observer

Ian Thompson	Chair, Isle of Man Programme Board	
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WMQRS Team

Jane Eminson	Acting Director	West Midlands Quality Review Service
Sarah Broomhead	Assistant Director	West Midlands Quality Review Service

APPENDIX 2 COMPLIANCE WITH THE QUALITY STANDARDS

Analyses of percentage compliance with the Quality Standards should be viewed with caution as they give the same weight to each of the Quality Standards. Also, the number of Quality Standards applicable to each service varied 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 Medical Admissions	64	22	34
Care of People with Long-Term Conditions			
Primary Care	8	0	0
Acute Hospital-wide	7	1	14
Diabetes	61	28	46
Heart Failure	56	19	34
Cardiac Rehabilitation	25	23	92
Chronic Obstructive Pulmonary Disorder	56	26	46
Chronic Neurological Conditions	175	54	31
Multiple Sclerosis & Motor Neurone Disease	(58)	(23)	(40)
Parkinson's Disease	(58)	(20)	(34)
Other including Epilepsy and Acquired Brain Injury (ABI)	(59)	(11)	(19)
Total	388	151	39

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