WM QRS West Midlands Quality Review Service

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

Primary Care Addendum

Isle of Man Health Services

Visit Date: 12th March 2014 Report Date: November 2014

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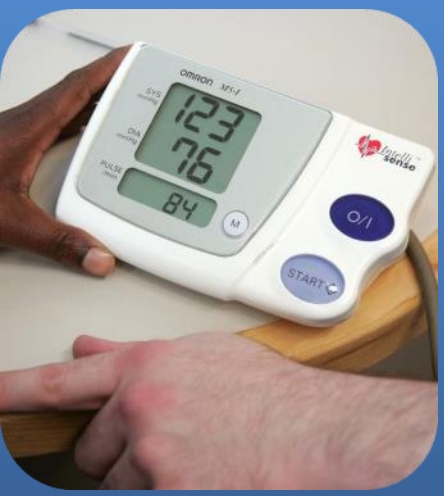

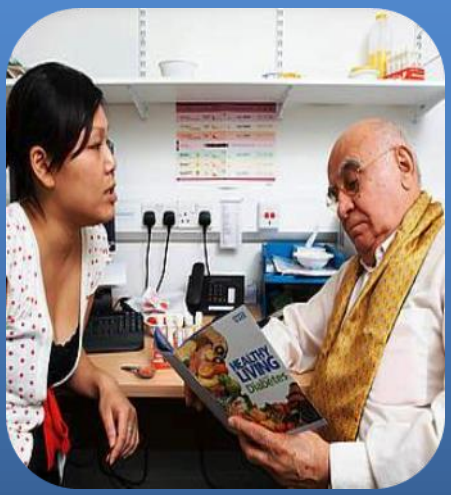

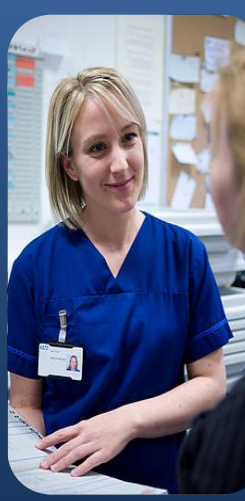

INDEX

INTRODUCTION

This report is an Addendum to the July 2014 report 'Acute Medical Admissions and the Care of People with Long-Term Conditions'. This Addendum replaces sections of the July report relating to primary care (pages 6-7 and Quality Standards JA-101 to JA-604). The table of percentage compliance with Quality Standards is also re-issued.

A self-assessment of compliance with the primary care Quality Standards was not completed at the time of the quality review visit (12th March 2014) although reviewers met a group of GPs. Following publication of the initial report, the Isle of Man Department of Health and Social Care asked WMQRS to accept addition evidence for primary care services. This was agreed for two reasons:

a. There had been some confusion about primary care involvement in the WMQRS review of the Isle Man health services.
b. WMQRS reviews of health serivces are pathway-based, covering primary and specialist care, and it was important that primary care aspects were accurately represented.

This Addendum is therefore based on the the original findings of reviewers plus subsequent information submitted after the review.

PRIMARY CARE

General Comments and Achievements

Twelve GP practices involving 45 GPs provided primary care for the Isle of Man. GPs who met the visiting team reported that there had been concerted efforts to improve information exchange and liaison between primary and secondary care. Implementation of quarterly GP education meetings had helped this process. Some shared care pathways were in place, especially for patients with COPD, diabetes, and heart failure. Care coordination was usually undertaken by the patient's GP. All practices collected Quality and Outcomes Framework (QOF) data.

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.

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 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 who met the visiting team said that they followed *Map of Medicine* guidelines rather than the local pathway.

2 It was not clear how other services could influence the programme for the quarterly GP education sessions. The heart failure team had set up a specific training session for GPs but this had been poorly attended. Further consideration of arrangements for agreeing the programme may be helpful.

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. Reviewers also noted that achievement of QOF indicators for epilepsy was lower than for most other conditions with five and six of the 12 practices below the achievement threshold for indicators EP002 and EP003 respectively.

Return to *Index*

APPENDIX 2 COMPLIANCE WITH 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

Service	Number of Applicable QS	Number of QS Met	% met
Care of People with Long-Term Conditions			
Primary Care	8	3	38
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**	**154**	**40**

Return to *Index*

PRIMARY CARE

Ref	Standard	Met?	Comments
JA-101	**Primary Care Information and Support** Information and support for people with long-term conditions and their carers should be in use, covering at least: a. Smoking cessation b. Pathway information (QS JN-101) c. Condition-specific information (QS JN-103) d. Personalised care planning (QS JN-104) e. 'Care Coordinator' (QS JN-105) f. Formal reviews (QS JN-106) g. Self-monitoring and self-care (QS JN-107) h. Education and self-management programmes (QS JN-108)	N	Some patient information was available but this did not cover all aspects of the Quality Standard.
JA-299	**Primary Care Development Programme** General practices should participate in the local programme of training and development of primary care staff in prevention, early identification and management of the care of people with long-term conditions (QS JZ-602).	Y	Since 2012 quarterly educational meetings had taken place and included discussion of pathways for those with long-term conditions.
JA-501	**Primary Care Guidelines** Guidelines on the primary care management of people with long-term conditions should be in use, covering at least their role in: a. Diagnosis including indications for referral to a specialist service and information to be sent with each referral b. Self-care c. Monitoring and management including indications for referral to a specialist service d. Acute exacerbations and acute complications including arrangements for rapid access to a specialist opinion e. Chronic complications f. Other pathway-specific guidelines g. End of life and preferred place of care Guidelines should be clear about the criteria for referral to, and discharge from, community LTC and specialist services.	Y	Guidelines were in place for COPD, Diabetes, Heart Failure and Epilepsy on the EMIS GP computer system.

Ref	Standard	Met?	Comments
JA-501N	**Primary Care Guidelines – Chronic Neurological Conditions** Guidelines on diagnosis of chronic neurological conditions should include: a. Referral of all people with a first seizure to a specialist service and advice to take an eyewitness to the first appointment b. Referral of all people with a suspected chronic neurological condition to a specialist service	N	Guidelines were not yet in place, though visiting neurologists had expressed an interest in working with primary care on the development of pathways.
JA-601	**Local Pathway** A summary of the primary care aspects of the local pathway should be in use. The pathway should cover: a. Contact details for community LTC, specialist and rehabilitation services serving the local population b. Details of the role of each service c. Indications for referral to and discharge from each service d. Arrangements for Personalised Care Planning and Formal Reviews (QS JN-104 and JN-106) e. Responsibility and arrangements for allocation of the 'Care Coordinator' (QS JN-105) f. Responsibility for giving information (QS JN-103) and referral to Education and Self-Management Programmes (QS JN-108) g. Arrangements for urgent review by a team member within 24 hours h. Arrangements for follow up and review within two weeks of an exacerbation or hospital admission	N	Pathways were on EMIS for Stroke, COPD and Diabetes but not for other chronic neurological conditions.
JA-602	**Early Identification and Case Finding** Each general practice should have arrangements for early identification and case finding of people with long-term conditions and should be aware how the practice prevalence compares with other practices, after taking out of demography and risk factors.	Y	

Ref	Standard	Met?	Comments
JA-603	**Risk Stratification** Each practice should use a risk stratification tool to identify people with long-term conditions at high risk of unscheduled admission to hospital. This information should be used to support personalised care planning and should be shared with relevant local community LTC and specialist services for people with long-term conditions.	N	Risk stratification had not yet been introduced.
JA-604	**Follow-up of Women with Gestational Diabetes** Each practice should have arrangements for annual follow-up of women who had gestational diabetes, including an annual check and HbA1c measurement.	N	Although this was agreed as best practice, reviewers did not see an audit or other assurance, that this took place.

Return to *Index*