WM QRS West Midlands Quality Review Service

DEPARTMENT OF HEALTH
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Surgical Specialties and Care of People with Cancer

Isle of Man Health Services

Visit Date: 7th & 8th October 2014 Report Date: March 2015 Version 1.1

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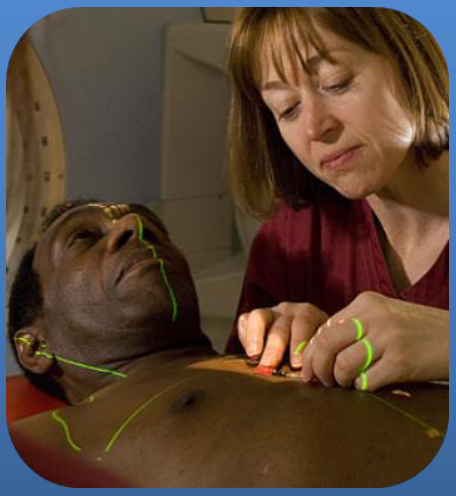
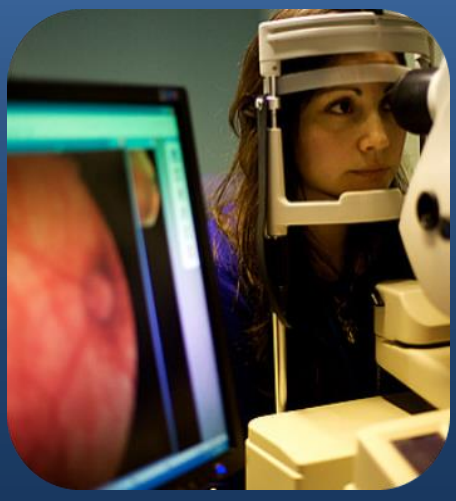
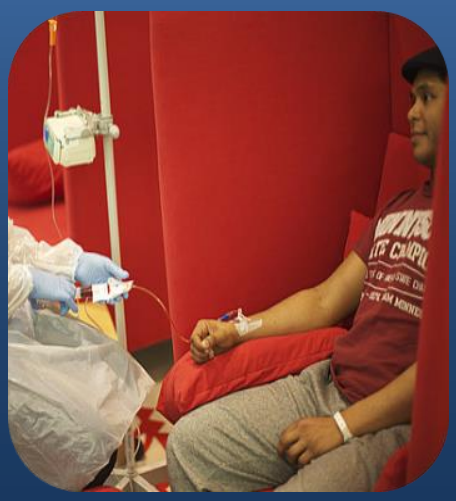


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Date Issued	Version	Page	Section	Amendment
29th January 2015	Version 1	-	-	-
5th March 2015	Version V1.1	18	Haematological, Skin, Bone and Soft Tissue and Children's Cancer	Word 'haematological' removed from first sentence.

INTRODUCTION

This report presents the findings of the review of surgical specialties and the care of people with cancer that took place on 7th and 8th October 2014. The purpose of the visit was to review compliance with the following West Midlands Quality Review Service (WMQRS) Quality Standards and other national quality standards:

- Generic Pathway Standards V1 July 2014
- WMQRS Acute Medicine and Acute Surgery QSs V2 D4 20131219
- National Peer Review Programme: Manual for Cancer Services – Chemotherapy Measures V1
- National Peer Review Programme: Manual for Cancer Services – Oncology Pharmacy Measures
- National Peer Review Programme: Manual for Cancer Services – Colorectal Cancer Measures V1
- National Peer Review Programme: Manual for Cancer Services – Breast Cancer Measures V1.1
- NHS Scotland: Quality Standards for Adult Hearing Rehabilitation Services – October 2008

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 and Social Care. Appendix 1 lists the Standards used for each service reviewed at this visit.

At the time of planning the review visit, multi-disciplinary team (MDT) meetings were running on the Isle of Man for breast and colorectal cancers but not for other cancer sites. Care of people with other cancers was therefore reviewed against a framework of questions (Appendix 2). By the time the review visit took place, a lung MDT meeting had been established, but this was not reviewed against the Manual for Cancer Services – Lung Cancer Measures. Lung and gynaecological cancer teams self-assessed against the framework. Self-assessments were not received for haematological, skin, bone and soft tissue, or children's cancers, and this report is less detailed about these pathways of care.

The Isle of Man audiology service was reviewed against the principles of the NHS Scotland Quality Standards for Adult Hearing Rehabilitation Services (October 2008). The service self-assessed against these standards, but a detailed compliance assessment was not conducted. The service did not self-assess against the standards for paediatric or transition services, and so this report is less detailed about audiology services for children and young people and about transition to adult care.

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

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

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

- **Achievements** made by the service reviewed
- **Good practice** that should be shared with other organisations

- **Immediate risks** to clinical safety and clinical outcomes
- **Concerns** related to the Quality Standards or prerequisites for their achievement. Some concerns may be categorised as 'serious'
- **Further consideration** – areas that may benefit from further attention by the service.

The text of this report identifies the main issues raised during the course of the visit. Appendix 3 lists the visiting team that reviewed the services at Noble's Hospital. Appendix 4 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. Patient questionnaires were distributed prior to the review visit and the following number of returned questionnaires were seen by reviewers: Breast care (19), Eye care (86), Ear, Nose and Throat and Maxillo-facial (41), Urology (12), Lung (2) Audiology (3) and Chemotherapy (30 from a range of tumour sites.

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.

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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VISIT FINDINGS

The findings of the review visit are summarised for acute surgical admissions and then for each of the site-specific topics reviewed. Site-specific findings cover the care of both people with cancer and those with benign conditions. Reviewers' findings in relation to chemotherapy, oncology pharmacy and the management of cancer services are then summarised, followed by findings that apply to all services (cancer and non-cancer).

PRIMARY CARE

'Two week wait' urgent referral guidelines for patients with suspected cancer had been agreed and adopted by all practices. One practice had undertaken a very good audit of suspected cancer referrals.

ACUTE SURGICAL ADMISSIONS

General Comments and Achievements

Care for people needing acute surgical admission was provided on Wards 1 and 2 of Noble's Hospital. The environment was clear and the ward was well-organised. Reviewers observed an appropriate and comprehensive service for patients. All clinical staff who met the visiting team were enthusiastic and committed to providing high quality patient care. Patient feedback on the care provided was good. Reviewers also heard about good multi-disciplinary working, and a willingness to learn from incidents was evident. Reviewers were impressed by the honesty and accuracy of the self-assessment against the Quality Standards.

Nursing leadership on Wards 1 and 2 was particularly strong. Good management of staff and of the environment was evident and good competence assessments for nursing staff were in place. The wards had been actively involved with LEAN initiatives. A comprehensive range of guidelines, policies and procedures was in place. Good supervision of junior doctors was also evident. The wards were supported by a good pain service.

Good Practice

1 A good range of nursing 'Key Performance Indicators' was in place with results visible to patients and staff.

Immediate Risks: No immediate risks were identified.

Concerns

1 Reviewers were seriously concerned that timely access to emergency surgery was not available, in particular because of the lack of availability of an emergency theatre. Life-threatening emergencies were 'slotted in' to theatre lists. In general, however, day cases were operated on in the morning, major cases in the afternoon and emergencies after that. Due to the frequency of theatre over-runs, emergency cases could be delayed for more than 24 hours from the decision to treat, with associated clinical deterioration while the patient was waiting for theatre. This issue was identified in the report of the November 2013 review visit, and progress did not appear to have been made on improving arrangements for emergency surgery.

2 Cover arrangements for consultant surgeons' annual and other leave were not robust. A 1:4 rota was in place, with leave being covered by the Associate Specialist. When covering annual and other leave the Associate Specialist did not have consultant supervision. This was of particular concern because patients presenting as an emergency are sicker and have higher morbidity and mortality.

Further Consideration

1 A clear strategy and guidelines about which conditions should be treated on the island, supported by robust pathways for transfer of patients when indicated, would be helpful in improving the governance of acute surgical services.

2 Timeliness of access to CT scanning and interventional radiology may benefit from further consideration. (See also: Hospital-wide section of this report.)

3 Only 20 hours of ward clerk time was available on each ward per week, and so nursing staff were spending time on administrative duties when the ward clerk was not available. Support for data collection was also not available.

4 Reviewers were told that nursing documentation was not always completed, despite reminders from the Ward Manager. Reviewers suggested that scenario training, for example the scenario of having to appear at a coroner's court, may be useful in improving compliance.

5 The frequency of consultants taking leave when it was their on call weekend appeared unusually high and, as a result, the Associate Specialist was covering weekends relatively frequently. Reviewers suggested that this should be investigated further to ensure that emergency care is not being inappropriately delegated.

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BREAST CARE

General Comments

This forward-looking service had embraced appropriate clinical practice, such as ultrasound of the axilla, sentinel node biopsy and neo-adjuvant treatment, and offered a full range reconstruction either locally or through referral to England. The move to the new breast unit and recruitment of a further breast radiologist would further improve the service. Reviewers were not able to judge the quality of the service because of the lack of documentation supporting clinical practice and of data to demonstrate appropriate outcomes.

Achievements

The progress on updating clinical practice and the planning and building of a standalone breast unit were significant achievements for this enthusiastic team, as was providing a comprehensive breast service for a small population.

Immediate Risks

1 The lack of cover for absences of the oncologist meant that treatment decisions and the start of treatment for patients with breast cancer were delayed. The Isle of Man team undertook relevant investigations but decisions were not made until the oncologist returned. The maximum reported delay was three weeks.[1]

2 See also: 'Care of People with Cancer – All cancer sites' section of this report.

Concerns

1 Patient pathway delays: See 'Care of People with Cancer – All cancer sites' section of this report. In particular, the Breast Team was unaware of available data on pathway waiting times ('two week wait': 54%; 31 days diagnosis to treatment: 68%; and 62 days referral to treatment: 83%) and did not have plans to improve the speed of the patient pathway.

2 Appropriate governance of the service, including clinical guidelines and audits of clinical practice and outcomes, was not in place. The service also did not have an operational policy or an annual report summarising, for example, MDT attendance and activity levels.

[1] **Immediate risk response:** One of the visiting consultant oncologists has been designated as the clinical champion for Noble's Hospital oncology services. Arrangements are being made to link with the Liverpool MDT should the visiting oncologist be away. **WMQRS response:** These actions, if fully implemented, address the immediate risk identified.

Further Consideration

1 Recruitment into clinical trials was not happening, as appropriate research infrastructure (on the Isle of Man or through links with England) was not yet in place.

2 The team had no administrative support, and so nursing time was spent on administrative duties such as preparing for MDT meetings, collecting patient notes and liaising with patients about changes to their clinic times. Support for data collection was also not available.

3 The Breast Team had not seen the patient questionnaires (breast and chemotherapy) that were returned prior to the review. Reviewers suggested that it may be helpful for the team to look at these and consider acting on some of the issues identified.

4 Reviewers were surprised that in the previous two years no patients had been referred to England for consideration of abdominal wall flap reconstruction. Review of the guidelines and pathway for this procedure may be helpful.

5 The out-patient clinic workload was high when one member of the team (consultant, staff grade or clinical nurse specialist (CNS)) was absent. As a result, clinics could overrun significantly.

6 Written Care Plans / Copies of clinic letters: See Hospital-wide section of this report.

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GASTROINTESTINAL CARE

General Comments and Achievements

The diagnostic pathway for patients referred with suspected upper or lower gastrointestinal (GI) cancer took place on the Isle of Man. The care of patients with suspected gastric or colorectal cancer was then discussed at the Noble's Hospital MDT, and treatment was provided locally unless the patient needed radiotherapy. Patients with suspected oesophageal, hepato-biliary or anal cancer were discussed at the local MDT and then referred to the relevant specialist MDT in England for consideration of treatment options.

The team providing gastrointestinal care was motivated and keen to move the service forward. The team saw approximately 80 new cases of colorectal cancer per year. At the time of the review, GI cancer MDT meetings had been running for about a year. The Somerset Cancer Register was being used effectively for recording MDT decisions and for GP communication. MDT meetings benefited from good palliative care support and input. A new endoscopy unit was due to open in spring 2015.

Good Practice

1 The team was utilising the Somerset Cancer Register and agreed and validated all action plans at the MDT meeting. The MDT was also using the prompt/alert system for following up actions.

Immediate Risks

1 At the time of the review one surgeon was performing the vast majority of the operations on patients with colorectal cancer. Cover for absences was available but the covering locum consultant did not attend MDT meetings and did not undertake the expected minimum of 20 operations per year on patients with colorectal cancer. This issue was considered an immediate risk because either a) treatment pathways were delayed when the lead surgeon was away or b) patients with colorectal cancer were operated on by surgeons who did not regularly attend MDT meetings and did not undertake the expected minimum number of operations per year on patients with colorectal cancer.[2]

[2] **Immediate risk response:** A system for pooling referrals for colorectal surgery has been introduced so that workload is more evenly distributed. Both colorectal surgeons will attend MDT meetings and operate on an

2 See also: 'Care of People with Cancer – All cancer sites' section of this report.

Concerns

1 The workload of the colorectal CNS was so high that she did not have time to fulfil the role of key worker and provide holistic care for patients with colorectal cancer. Her work included bowel screening, all aspects of stoma care, and care of all patients with colorectal cancer, and she spent 10% of her time in the community. The CNS was considering adding scoping to her responsibilities. The CNS had attended all the weekly MDT meetings in the year since they had started, and there were no arrangements for cover for her absence.

2 Pathways of care for patients with colorectal cancer were documented and agreed but had not been implemented. Only 36% of 'two week wait' referrals were seen within two weeks, 46% of patients received their first treatment within 31 days of diagnosis and 22% of patients started treatment within 62 days of referral. Waiting times for endoscopy were a major contributor to the patient pathway delays. A new unit was planned for spring 2015 but additional staffing had not been identified for the unit, and plans to reduce endoscopy waiting times were not evident.

3 Members of the colorectal MDT did not receive feedback about patients referred to England for any aspect of their care. Letters were sent to the GP but these were not copied to the Noble's Hospital colorectal MDT. The team was therefore not aware of treatments undertaken and other relevant clinical information.

Further Consideration

1 It was not clear to reviewers whether sufficient capacity was available to meet the expected patient pathway timescales. Patients were seen several times and reviewers considered there was some potential for streamlining the pathway. For example, the pathway before patients had a CT scan involved two visits at which patients were seen by the CNS and a consultant. Bowel screening had been introduced but it was not clear that the team had the capacity to cope with the resulting workload. Reviewers suggested that a capacity and demand study may be helpful, taking account of all pressures on the workload of the team.

2 Use of an electronic form for communication with tertiary centres and others may be a helpful development of the team's use of the Somerset Cancer Register.

3 Reviewers observed an MDT meeting and considered that its effectiveness as a forum for multi-disciplinary discussion of treatment options and the holistic needs of patients could be improved. Treatment decisions were presented with limited discussion and some members of the team did not contribute actively to the meeting. Reviewers suggested that some teamwork development may be helpful or, at least, the chair could give each member of the team the opportunity to contribute before treatment decisions were made.

4 Patient diaries were given out following diagnosis but did not appear to be used later in the patients' journeys. More active use of the local diaries or a defined 'information pathway' may help to improve patients' involvement in decisions about their treatment and care.

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UROLOGICAL CARE

General Comments and Achievements

The urology service was well-organised, and patient feedback about the care received was very positive. Good team-working was evident. Good secretarial support was available for the consultant, the staff grade doctors and the CNSs. The ward was well-organised and had actively adopted LEAN and productive ward approaches. Ward

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appropriate number of patients. **WMQRS response:** These actions, if fully implemented, address the immediate risk identified.

rounds were efficiently run and reviewers were impressed by the environment and cleanliness. A good range of audits had been undertaken, including an audit of complications of paediatric surgery.

The urological cancer service provided care for about 60 patients with urological cancer per year. In 2010 this comprised 52 patients with prostate cancer, eight with bladder cancer, five with renal cancer and fewer than five with testicular cancer. Diagnostic investigations were carried out locally, with a good haematuria clinic pathway, and MDT discussion and all treatment for people with cancer took place in England. Noble's Hospital had good arrangements for video-conferencing into the specialist MDT with a dedicated time slot for the discussion of Isle of Man patients. The CNSs collected good data on patients discussed at MDT meetings.

Good Practice

1 Multi-disciplinary review and learning meetings involving the whole team were held each week.

2 An excellent 'Guide to being a secretary' was in use. This ensured that the secretarial role was clear and that anyone providing cover for absences knew exactly what needed to be done.

3 An excellent guide for locums was in use. This was clear and comprehensive and was kept updated, and it ensured that any locum doctors working in the department knew exactly what procedures they should follow.

4 CNS documentation was detailed, accurate and well filed, which meant that clinical information about all aspects of patients' care was easily accessible to all members of the team.

Immediate Risks: See: 'Care of People with Cancer – All cancer sites' section of this report.

Concerns

1 The 'pick-up rate' from prostate biopsies was high, at approximately 60% in 2012 rather than a maximum of 50% and a desirable level of approximately 30%. The reasons for this were not clear but could include a high threshold for doing biopsies.

2 The CNS workload was very high and, as a result, the one-stop prostate assessment clinic had been suspended. One whole time equivalent post was shared between two nurses. Reviewers suggested that, based on similar services and workload, 1.5 to 2.0 wte CNS would be a more appropriate staffing level.

3 Reviewers were told that both the consultant and the staff grade doctor would be retiring within the next two years. Reviewers considered that these staff could be difficult to replace with the model of service and staffing in place at the time of the review visit. (See 'further consideration 7' below for reviewers' suggestions about possible approaches to this problem.)

4 The testicular cancer pathway had diagnostic investigations within 10 days of referral, surgery within 20 days of referral and tertiary referral to specialist MDT within 30 days of referral. This timescale was appropriate for confirmed non-metastatic tumours but not for potentially aggressive metastatic tumours, especially non-seminomatous germ cell tumours.

Further Consideration

1 Audit projects had action plans but there was no evidence of follow-up. It was therefore not clear whether the plans had actually been implemented. Audit and further work with public health in order fully to understand the reasons for the high prostate biopsy 'pick up rate' may also be helpful.

2 Data on waiting times, length of stay and clinical outcomes, including surgical complications, may be useful for streamlining the patient pathway. Broad timescales for the cancer pathways were available, but not detailed timescales, or expected timescales for non-cancer pathways.

3 MRI capacity may not be sufficient for the increasing trend for MRI to be undertaken before biopsy for suspected prostate cancer. It may be helpful to start planning for additional capacity, through consideration of extended hours, for example.

4 The lack of an MDT coordinator was adding to the pressures on CNS time. The ward clerk was only available for 20 hours per week, which added to the administrative burden for clinical staff.

5 Female urodynamic studies were undertaken by the gynaecology service at Noble's Hospital, whereas men had to travel to England for urodynamic studies. Reviewers considered that, if more CNS time was available, this service could be provided locally.

6 A dedicated urology treatment room was available in the surgical out-patient department. Over-run of other clinics sometimes prevented use of the room by urology services, and the room was used by the breast clinic three afternoons a week. As a result, urology patients could not been seen at short notice, as access to the specialist equipment in the treatment room was not available. If CNS time is increased and more services provided locally then an additional treatment room may be needed.

7 Reviewers considered that the impending retirement of both the consultant and the staff grade doctor provided an exciting opportunity to improve the resilience and quality of the service by improving site specialisation and cover arrangements and by reducing clinical isolation. Reviewers suggested that consideration should be given to innovative and flexible working arrangements and site specialisation, for example, in paediatrics, oncology, functional urology, stone surgery and female incontinence. This could be combined with the development of more local services if appropriate expertise was available, linked with a busier specialist centre. Discussions and negotiations would, however, need to start soon if these options are to be pursued.

8 Written Care Plans / Copies of clinic letters: See Hospital-wide section of this report.

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Eye Care

General Comments and Achievements

Eye care was provided by a friendly and helpful team of staff who appeared committed to providing good care for their patients. The facilities and environment were clean and well-organised with good signage. Nursing, Orthoptist and Eye Clinic Liaison Officer (ECLO) / Royal Institute for the Blind (RNIB) staff were working particularly hard in difficult circumstances (see below). Nursing staff were undertaking a wide range of duties and had undertaken appropriate training, including in Optical Coherence Tomography (OCT), visual field assessment and biometry. Links with services in England were good. Plans were in place for the development of medical retinal services on the Isle of Man to avoid the need for patients to travel for monthly review and, if indicated, treatment.

Immediate Risks[3]

1 Clinical practice in ophthalmic anaesthesia, as reported to reviewers, appeared to differ significantly from usual clinical practice in England, including a higher than usual rate of general anaesthesia. Reviewers considered that this had the potential for an increased complication rate.

2 Waiting times for new consultant out-patient appointments and for surgery were very long, with non-urgent patients waiting 12 to 18 months for their first out-patient appointments.[4] At the time of the review, 1,100 patients were waiting for new appointments and 280 for surgery, with the service seeing approximately 3,500 and 680 respectively per year. The length of the wait was considered an immediate risk because of the potential for deterioration or loss of sight during this period. The service expected GPs to re-refer or patients to attend the Emergency Department if their vision deteriorated while waiting for

[3] Several responses have been received to the eye care immediate risks. **WMQRS response:** The responses received do not address the immediate risks identified.

[4] Waiting times for new orthoptic patients were eight to twelve weeks.

their appointment, but this expectation did not appear to have been clearly communicated to patients or GPs.

3 Arrangements for the care of children were considered an immediate risk for a combination of reasons. Reviewers were told that substantive consultants were usually not involved with the care of children. Paediatric work was usually covered by a locum consultant, a retired Associate Specialist who was also doing refractions. Reviewers were told of a three-month wait for paediatric refractions. Overall, robust arrangements for the care of children with eye problems that would prevent further deterioration or loss of sight were not evident. The service expected that staff involved in the care of the child would monitor any deterioration in vision and, if necessary, bring this to the attention of the consultants. This expectation did not appear to have been clearly communicated to referring staff or families.

Concerns

1 Staffing levels, especially of non-medical staff, were low for the number of patients. Reviewers were particularly concerned about the following:

   a. A high proportion (reviewers were told approximately 50%) of out-patient clinics were covered by locum doctors.

   b. Nurse and technician staffing was insufficient for the number of patients. The team had neither a senior nurse at an appropriate band nor an identified nursing team leader. Nurse staffing comprised one wte nurse, one technician and three bank nurses. It was not clear to reviewers whether the bank nurses had the appropriate competences for their role in the eye care service. Good teamwork among nursing staff was not evident.

   c. The service had no medical photographer, no optometrist and only a part-time orthoptist (two days per week). As a result, medical and nursing staff who may not have appropriate specialist competences were spending time on duties that could have been undertaken by additional members of the MDT.

   d. Administrative, secretarial and data collection support appeared insufficient. The service had two wte clinic secretaries but delays in clinic letters were reported, and non-medical staff did not have access to secretarial and administrative support.

2 In addition to the issues identified above (see immediate risks), the care of children with eye problems was of concern for the following reasons: Robust arrangements for liaison with other services were not evident, in particular, liaison with the ECLO / RNIB service, with schools and with ENT and audiology services for the care of children with visual and hearing problems. Formalised arrangements for transition to adult care were not yet in place and there was no clear protocol for discharge from the service. No audits of the care of children with eye problems were evident. Children with complex syndromes were referred to specialist units in the UK.

3 Audits of the implementation of NICE and other relevant guidance had not been undertaken.

4 Governance arrangements for the work of the visiting orthoptist were not robust. The visiting orthoptist did not have a contract covering work on the Isle of Man, and appraisal arrangements for this work were not in place. The visiting orthoptist's time was insufficient to allow participation in multi-disciplinary review and learning events on the Isle of Man.

5 Feedback from patients and staff was that ECLO / RNIB support was not always offered by medical staff.

Further Consideration

1 Reviewers were surprised by the length of the waiting times because theatre activity was about half the expected level (an average of 4.2 cases per session compared with an expected level of seven to eight for a more complex case mix). Reviewers also noted significant inefficiencies in the organisation of out-patient clinics, such as bringing patients back to consultant out-patient clinics (although they were then seen by

nurses) on the day after cataract surgery, and a high ratio of recall to new appointments for consultant out-patient clinics. This suggested that the service had greater capacity available than was being used and that there may be the potential for more active discharge from the service.

2 It was not clear that the available information leaflets were actually given to patients and supported by appropriate explanations. Some of the patients who met the visiting team were not aware of the information that reviewers were told was available.

3 Written Care Plans / Copies of clinic letters: See Hospital-wide section of this report.

4 Multi-disciplinary review and learning arrangements were not yet in place. These may help the service to address many of the issues in this report. This issue was not categorised as a 'concern' at this visit because of the extent of the other issues facing the service. It would be a 'concern' at future visits if not addressed.

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EAR, NOSE, THROAT, MAXILLO-FACIAL AND AUDIOLOGY SERVICES

EAR, NOSE AND THROAT SERVICE

General Comments and Achievements

The ENT service at Noble's Hospital was staffed by a consultant, an Associate Specialist, a GP with a special interest (one session per week), and a CNS. Patients were admitted to different wards on different days of the week. The team had worked hard to establish rapid access clinics and to build a good working relationship with the head and neck cancer MDT at Aintree Hospital. Out-patient waiting times had reduced from two years to between two and four months for a routine appointment. Regular management meetings were held jointly with the audiology service, and plans to co-locate the services and implement joint clinics were about to be implemented. A patient satisfaction survey had been carried out in 2014.

Good Practice

1 A 'Swallow' patient forum was running and providing good support for patients and carers.

Immediate Risks: See: 'Care of People with Cancer – All cancer sites' section of this report.

Concerns

1 Reviewers were seriously concerned about the care of people with thyroid cancer. Reviewers were told of two pathways of care for people with thyroid cancer. One pathway involved the ENT surgeon who referred patients for discussion at the thyroid cancer MDT meeting in Liverpool. These patients were then operated on locally. The surgeon was not a core member of the MDT, did not video-link into MDT meetings and was operating on fewer than 10 patients with thyroid cancer per year. The second pathway involved referral from the endocrinologist to one or more general surgeons. It was not clear to reviewers whether the care of these patients received multi-disciplinary discussion, whether the surgeons involved were core members of a thyroid cancer MDT and whether they undertook sufficient operations per year to maintain competence.

2 ENT surgeons did not maintain a surgical activity log book and collected no data on surgical activity, complication rates or outcomes. The team was aware that 68 patients had been referred to England in the previous year but had no data on the reason for referral, whether cancer or non-cancer or whether further local care was needed. Surgeons had not undertaken any audits of outcomes, complications, or investigations of incidents or near misses. ENT surgeons also had no plans or intentions to undertake audits.

3 Waiting lists for non-urgent surgery were long, with 232 adults waiting and a maximum waiting time of two years five months. Thirty-seven children were on the in-patient waiting list, with a maximum waiting time of seven months.

4 Working relationships between medical staff in the team did not appear to reviewers to be constructive, and available medical staffing may not be being fully used. The consultant and Associate Specialist were working a 1:2 rota, which reviewers did not consider to be sustainable.

5 Shared care pathways with paediatric services covering the care of children were not in place. Arrangements for liaison with eye care services on the care of children with visual and hearing problems were also not evident.

6 The out-patient 'did not attend' rate was high (10%).

7 Some theatre equipment, especially some endoscopes and the stacker system, was in need of replacement.

Further Consideration

1 The ENT CNS was working towards RCN ENT-specific specialist nurse competences. All ENT-related training had been undertaken on the Isle of Man with supervision by the ENT consultant. Reviewers suggested that it may be helpful for some training to be undertaken in a larger ENT service. Consideration should also be given to developing appropriate cover for absences through, for example, professional development of one of the ward nurses.

2 The policy on referral of patients 'off island' may benefit from clarification. It was not clear that there was any consistent policy in who was referred and for what reason.

3 The Patient Safety Forum did not include ENT representation and ENT was therefore not included as a specialty for discussion.

4 The ENT team commented on the variable quality of GP referral information. Reviewers suggested that this could be audited and the results discussed with GPs.

5 Theatre time available to the service was limited and mechanisms for increasing theatre time did not appear to be in place.

6 The ENT surgeons suggested to reviewers that the appointment of an additional surgeon was desirable. Reviewers considered the workload was unlikely to justify this development, especially as the number of patients with cancer was likely to be in the region of 10 to 15 rather than the 40 to 50 reported by surgeons. Additional services could be provided locally, for patients with vertigo or tinnitus, for example, but these would probably be medical rather than surgical appointments and may not be full-time.

7 Written Care Plans / Copies of clinic letters: See Hospital-wide section of this report.

8 Multi-disciplinary review and learning arrangements were not yet in place. These may help the service to address many of the issues in this report. This issue was not categorised as a 'concern' at this visit because of the extent of the other issues facing the service. It would be a 'concern' at future visits if not addressed.

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MAXILLO-FACIAL SERVICE

General Comments and Achievements

The maxilla-facial surgery team had a very positive approach to the provision of good patient care. Good documentation was available, and clinical information was easily accessible and well-organised. Good team-working was evident and a second substantive consultant had been appointed. The team had worked with staff in the Emergency Department in order to increase their confidence in managing some clinical presentations. The team also had a proactive approach to managing patient pathways, including those for patients with cancer. Patients with suspected cancer could be seen without waiting, and urgent referrals were seen in two to three weeks.

The team took a proactive approach to maintaining their competence. The lead surgeon had honorary contracts with Aintree Hospital and undertook joint operating lists at Aintree four to six times each year. Regular CPD was

also evident. A forward-looking programme of clinical audit was in place. A patient satisfaction audit had been undertaken in 2014 and the team had plans to repeat this annually. A nurse-led audit on infection control had also been undertaken.

Good Practice

1 The team had developed clear definitions of the surgery that could be undertaken locally and of patients who should be referred 'off island'.

2 Dental nurses had access to 'on Island' updating opportunities through the Isle of Man dental education programme.

Immediate Risks: No immediate risks were identified.

Concerns

1 Maxillo-facial surgeons were working a 1:2 rota, which reviewers did not consider to be sustainable.

2 Patients were waiting up to nine months for a routine out-patient appointment.

3 The out-patient 'did not attend' rate was high (10%).

Further Consideration

1 Theatre time available to the service was limited, and mechanisms for increasing theatre time did not appear to be in place. The team had mitigated the impact of this by developing an anaesthetic role in out-patients.

2 The nursing establishment may benefit from review. The department had two wte dental nurses, but was heavily reliant on bank nurses to ensure cover for all oral surgery and orthodontics clinics.

3 The establishment of a monthly multi-disciplinary 'head and neck review clinic' may help to ensure that patients receive a holistic approach to their care, including input from speech and language therapy and dietetics. This clinic could include patients discharged back to the island following head and neck surgery in the UK.

4 It may be helpful to develop a protocol for the onward referral of patients with trauma, for example, those with a cerebro-spinal fluid leak, including a clear referral proforma.

5 Written Care Plans / Copies of clinic letters: See Hospital-wide section of this report.

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AUDIOLOGY SERVICE

General Comments

The service had performed a self-appraisal against the NHS Scotland Quality Standards for Adult Hearing Rehabilitation Services (October 2008). This report is therefore based on the ongoing process implemented by the service on the Isle of Man. *Detailed* specialist auditing of compliance, which would normally occur if the service was part of the national programme, was therefore not completed as part of this review.

The range of services offered appeared comprehensive apart from patients requiring implantable devices who were referred to Birmingham. A good range of modern medical equipment and information management and technology (IM&T) equipment was available. The paediatric and adult audiology services were managed as one service. Paediatric services were delivered at a community site in Douglas, which was not visited.

The service was provided by a small team comprising 2.7 wte non-medical clinical staff of whom 0.7 wte was based in paediatric audiology, supported by bank staff when available. The Head of Service provided good leadership and had a pragmatic and solution-focused approach.

Self-appraisal against the Scottish adult hearing rehabilitation service standards provided reviewers with a compliance score of 85%.[5] In the absence of formal participation in the national audiology peer review audit programme, the self-appraisal score should be considered an estimate. The Head of Service had made contact with UK colleagues with a view to partaking in the national audiology peer review programme.

In the time available reviewers were not able to review in detail low volume (activity) services, such as services for patients with tinnitus and balance problems, although balance test equipment was observed to be of a good standard.

Achievements

The audiology service had markedly improved the service offered since the time of the last review (circa 2007). A new audiology facility, adjacent to ENT out-patients, was due to be completed soon after the review visit which would further enhance the delivery of the service.

A 'Tinnitus Event' organised jointly with the independent sector and the British Tinnitus Association **(**BTA) had been held in March 2014 and had been attended by 120 members of the public and GPs to help raise the awareness of tinnitus. This had resulted in an increase in referrals to the service. Support for the ENT service, with the provision of ear syringing and post-operative grommets appointments, had helped improve the quality of the service for patients. The audiology service ran three 'open clinic' sessions for patients each week, which were well attended.

The working relationship with the ENT service was good. ENT and audiology also had plans to provide joint clinics to improve the management of children with complex health needs and hearing loss, or those requiring amplification.

Good Practice

1 The service had adopted the NHS England target of 18 weeks from referral to treatment as the standard measure for routine appointments through ENT. Data available to the reviewers showed that this target was 85% achieved. There was no waiting list for urgent referrals.

I**mmediate Risks:** No immediate risks were identified.

Concerns

1 Although national (Welsh or Scottish) service quality standards for paediatric audiology were available, a self-evaluation against these had not yet been completed. A brief self-appraisal by the Head of Service suggested the need for improvement relating to the following standards:

   a. Service access (waiting times 18 weeks for children referred from primary screening/surveillance);

   b. Patient outcomes (relating to completion of individual management plans), especially in adult services;

   c. Service effectiveness and improvement (clinical audit, planning and monitoring).

   This review visit therefore could not provide assurance of the safety and quality of services for children.

2 Effective cover for absences of members of the team was not available, especially for specific procedures or care of particular patient groups.

3 Arrangements for collaborative working between the adult rehabilitation (hearing aid) service and other services, voluntary organisations and service users, such as regular joint working groups, were not evident. This is particularly important for patients with tinnitus and balance problems.

4 Joint clinical audit activity with the ENT service was not yet taking place. Comparative appraisal against UK audiology services and collaboration with other professional networks were also not yet in place.

[5] The national target in Wales was around 95% compliance at the time of the review.

Further Consideration

1 Reviewers were told that the Head of Service had submitted a business case for measures to mitigate risk associated with staffing issues and to accommodate growth in demand of services. Reviewers considered that a speedy decision on this business case would be helpful, with particular consideration of the number and seniority of staff required to ensure that the service can safely deliver services to meet growing demand. Consideration of cross-training of staff to provide cover for absences of colleagues may also be a helpful service development and improve patient flow through the service.

2 Reviewers suggested benchmarking the whole range of service elements against a selected UK audiology service (matched for similar demographic profile), specifically looking at: i) resourcing, ii) staff bandings and roles, and iii) activity levels. This work may help to support further service development work.

3 Reviewers considered that the grading (banding) of the paediatric audiologist appeared low relative to their role and responsibilities. A formal review of responsibilities and bandings, and benchmarking staffing against available national guidance (for example, the British Academy of Audiology (BAA)or NHS Scotland guidance or by reference to the UK Modernising Scientific Careers (MSC) pathway) may be helpful. The isolation of the service means that it may also be helpful for the Head of Service to consider mentoring or networking with a senior UK head of service.

4 Reviewers suggested that appropriate timescales for further work towards achieving good performance on national paediatric standards (for example, Welsh or Scottish standards) would be a self-assessed audit conducted within the next three months, then verified with external input within a further six months. Support may be required by the local clinical audit team for these timescales to be achieved. Ongoing participation in one of the national audit service standards audit schemes for both paediatric and adult services would provide quality assurance and enable professional networking and sharing of good practice.

5 The split site arrangement for a small service may not provide the best arrangement for staff interaction, staff cover for absences and efficient use of specialist facilities. Consideration of a single site 'all age' audiology service may be helpful.

6 Three adult patients completed a service-specific patient satisfaction questionnaire during the course of the visit. Although a small sample, the responses were generally positive. The responses indicated, however, a need for improved patient information covering expectations before appointments and management of hearing aids following appointments.

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Other Cancer Sites

LUNG

The lung cancer MDT was not reviewed against the detailed Cancer Peer Review Measures for lung cancer MDTs because the team was not meeting when the visit was planned.

General Comments and Achievements

Members of the lung MDT had made significant improvements to the care of people with lung cancer. A weekly MDT meeting had been established in June 2014 and the team had been strengthened with several appointments, including the CNS, interventional radiologist and second pathologist. The team had done a lot of work on improving and speeding up the patient pathway and had plans for further improvements. Good arrangements for cross-cover between the lung CNS and the palliative care CNS were in place. The CNS also saw patients at home after the 'Breaking Bad News' clinic to ensure that they had understood all the information they had been given.

Immediate Risks: See: 'Care of People with Cancer – All cancer sites' section of this report.

Concerns

1 Several aspects of the diagnostic pathway were of concern to reviewers:

   a. The rapid access clinic did not offer any diagnostic investigations. The lead clinician was hoping to arrange for CT slots to be available but this had not yet been achieved.

   b. Lack of cover for the interventional radiologist delayed the diagnostic pathway, and access to image-guided biopsy was not available when he was away.

   c. The previous audit had showed that the pathology turnaround time was slow (over 60 days). This had been significantly reduced through the appointment of a second pathologist, but a re-audit had not yet taken place. Reviewers were given verbal assurances of a timely patient pathway but data were not available to support these assurances.

Further Consideration

1 The range of duties of the CNS may not be sustainable in the long-term and reviewers suggested that this be kept under review.

2 It may be helpful to undertake a self-assessment and ensure that progress towards full implementation of the lung cancer MDT Cancer Peer Review Measures is monitored regularly.

3 Written Care Plans / Copies of clinic letters: See Hospital-wide section of this report.

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GYNAECOLOGICAL

General Comments and Achievements

Diagnostic investigations for all gynaecological cancers were undertaken on the Isle of Man and a rapid access post-menopausal bleeding 'one stop' clinic ran weekly. Surgery for stage 1, grade 1 endometrial cancer (not of adverse histological type) took place on the Isle of Man, in accordance with Liverpool Women's Hospital guidelines. All other patients with cancer were referred to the Liverpool Women's Hospital oncology service for MDT review and treatment. Chemotherapy and follow-up, with some exceptions, were carried out on the Isle of Man. Patients needing radiotherapy were seen at the Clatterbridge Cancer Centre.

Nursing staff on the gynaecological ward appeared proactive in addressing patients' concerns, and patient feedback about the care provided on the ward was good. Cervical screening uptake on the Isle of Man was good and a 'screening clinic' was run outside normal working hours with entirely female members of staff.

Immediate Risks: See: 'Care of People with Cancer – All cancer sites' section of this report.

Concerns

1 The gynaecological cancer service did not have an identified clinical lead. All consultant obstetricians and gynaecologists saw women with cancer. This reduced the development and maintenance of specialist expertise. It also meant that there was no focus for improving the care of women with cancer and for links with the gynaecological cancer MDT.

2 Women with suspected gynaecological cancer did not have a 'key worker' (or equivalent) support through their diagnostic pathway. No key worker or specialist nurse with responsibility for providing ongoing care was present when they were given their diagnosis, and reviewers were told that the CNS's contact details were not always given to patients. Women whose surgery was carried out at Noble's Hospital did not have a key worker at all. Patients' feedback to the visiting team was that patients did not have their pathway of care clearly explained at the start of their journey.

3 The Noble's Hospital gynaecological team received only limited feedback about patients referred to England. They were informed of the outcome of MDT meetings but did not receive communication about subsequent treatment and care. Letters were sent to the GP but these were not copied to the Noble's Hospital referring consultant. The team was therefore not aware of treatments undertaken and other relevant clinical information.

Further Consideration

1 The team may find it helpful to video-conference into the Liverpool Women's Hospital gynaecological cancer MDT meeting to discuss their patients. This could lead to improved patient care as well as improving working relationships with the Liverpool MDT members. Isle of Man staff usually received confirmation of MDT decisions on the Friday following the Wednesday MDT meeting, with a formal letter two to three weeks later. Reviewers were told that information about patients who could be operated on locally sometimes had to be chased. Video-conferencing into the MDT for discussion of Isle of Man patients would avoid this problem.

2 Written Care Plans / Copies of clinic letters: See Hospital-wide section of this report.

HAEMATOLOGICAL, SKIN, BONE AND SOFT TISSUE, and CHILDREN'S CANCER

No self-assessment was submitted for skin, bone and soft tissue, or children's cancer pathways. Reviewers therefore did not look in detail at these cancers.

Haematological cancers:

General Comments and Achievements

An integrated reporting system for haematology had been implemented. Progress had also been made with approval of a plan to appoint a full-time haematology CNS.

Immediate Risks

1 Haematology MDT meetings were suspended during absences of the lead clinician. A locum was always employed to cover absences but, because MDT meetings did not take place, treatment decisions could be delayed.

2 See: 'Care of People with Cancer – All cancer sites' section of this report.

Further Consideration

1 Reviewers were told that patients were offered access to clinical trials by tertiary centres but that uptake was low due to patient choice. It may be helpful to audit this issue in order to have a better understanding of the reasons for the low uptake.

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CHEMOTHERAPY

General Comments and Achievements

The chemotherapy team was working hard to deliver a good service within the resources available. The lead nurse was very enthusiastic about her role and about the development of the service. The chemotherapy nursing team also provided the acute oncology service. Funding for an additional band 7 nurse and administrative support had been approved, although recruitment to these posts appeared to be delayed. The team was keen to increase the range of chemotherapy provided locally.

The environment within the chemotherapy unit was calm and friendly. There were four chemotherapy chairs and 10 to 12 treatments per day were delivered. Good working relationships with the pharmacy team were evident.

Chemotherapy was prescribed in a timely manner. The service was patient-focused, and patient feedback was good.

Good Practice

1 Pharmacist and nursing non-medical prescribers were using their skills for ad hoc treatment and supportive therapy adjustments, including when no oncologist was on site.

Immediate Risks: See: 'Care of People with Cancer – All cancer sites' section of this report.

Concerns

1 Reviewers were seriously concerned that appropriate governance arrangements were not yet in place in the chemotherapy service, including structured multi-professional meetings, attendance at Drug and Therapeutic Committee meetings, induction and training records, competence assessment, audit, and review and learning from incidents, morbidity and mortality. It was also unclear whether or not the hospital accepted competency assessments and evidence of updating of competences for medical staff from their host hospital.

2 At the time of the review the diary management of appointments was paper-based with no back-up arrangements to prevent loss of data. The unit was, however, considering moving to the CPORT system for diary management which would also meet the requirements of the Cancer Peer Review Measures.

3 Nurse staffing levels were insufficient for the level of service provided. At the time of the review there was a lead chemotherapy nurse (1 wte of which 0.2 wte was spent delivering chemotherapy), one band 6 nurse and one band 6 vacancy. Bank and agency staff were covering the vacant post. Some patients raised concerns with reviewers about bank and agency staff not following expected procedures, including pre-chemotherapy checks not being undertaken.

4 See also: 'Care of People with Cancer – All cancer sites' section of this report in relation to acute oncology.

Further Consideration

1 The service was planning to link with the Clatterbridge e-prescribing system. Reviewers supported this development as it would be a consistent prescribing system and would also provide audit and deviation analyses. Development of links with the Clatterbridge mortality, morbidity and incident review meetings may also be useful.

2 Clarification of the roles expected of the lead chemotherapy nurse and, for each role, arrangements for cover for absences, and succession planning, may be helpful.

3 Reviewers did not see evidence of evaluation and forward planning for the service. Two additional staff had been approved and plans for increasing the size of the unit were being considered. Staffing for the additional capacity did not appear to have been considered. Annual review and forecast of future demand and capacity may be helpful.

4 The 24/7 telephone advice service for patients with haematological malignancies was from a separate provider from the advice service for patients with solid tumours. It may be helpful to review whether this is the most appropriate arrangement.

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ONCOLOGY PHARMACY

General Comments and Achievements

Oncology pharmacy services were provided by a cohesive team that linked well with nurses and consultants working in other cancer services. The team had done well to maintain service provision despite problems with staffing capacity. Funding for a technical pharmacist had been obtained.

Good Practice

1 Pharmacist and nursing non-medical prescribers were using their skills for ad hoc treatment and supportive therapy adjustments, including when no oncologist was on site.

Immediate Risks: No immediate risks were identified.

Concerns

1 Staffing numbers in pharmacy were very low, with an establishment of nine pharmacists, of which 1.6 wte posts were vacant. Of the pharmacists in post, 2.4 wte staff were competent to release chemotherapy. Plans to resolve this through the appointment of an aseptic pharmacist had been developed.

Further Consideration

1 It may be helpful if pharmacist non-medical prescribers were present during oncology clinics. Reviewers were told how helpful staff had found this arrangement previously.

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PALLIATIVE CARE

General Comments and Achievements

The Hospice Isle of Man provided a wide range of services for patients and their carers. The Hospice was clearly a forward-looking and progressive organisation providing very high quality care. A broad range of services was accessible, although primarily focused on the care of patients with cancer. These included bereavement and survivorship services. An end of life plan had been developed, supported by a clear operational policy and staff training. This was being used by NICE as an example of good practice. The positive approach to care by the Hospice staff had been commended by the *Times* newspaper, and included excellent counselling support for staff. Both staff and patients were very positive about the Hospice Board and its approach.

The Hospice appeared to have excellent relationships with primary care, as well as with specialist cancer, services. Educational opportunities for GPs were provided and some GPs provided regular medical input to the Hospice.

Good Practice

1 Palliative care was provided on an integrated basis, with the palliative care team following the patient irrespective of where the patient's care was being provided. Palliative care specialist nurses worked as an integrated team across the Hospice and Noble's Hospital, which resulted in good continuity of care for patients. Medical staff attended MDT meetings at Noble's Hospital as well as providing advice on the care of patients. Arrangements for rehabilitation were available in the community as well as in hospital.

2 Good collaboration with paediatric services was evident, including a children's cancer MDT meeting. Children were assessed using a RAFT score (Rapid Assessment for Treatment). Parents were able to choose sessions for respite care, and staff were arranged around their needs, including availability of 'standby respite'.

3 Day case care was provided by appointment as well as through dedicated 'drop in' sessions on Mondays and Thursdays. These sessions could be accessed by carers as well as by patients.

Immediate Risks: No immediate risks were identified.

Concerns: No concerns were identified.

Further Consideration

1 Reviewers were told that the Gold Standards Framework had been embedded within primary care on the Isle of Man. Some of the feedback from politicians about patients' and carers' experiences was less positive, and further work to explore this difference of opinion may be helpful.

2 Further work on palliative care for people with long-term conditions (rather than just cancer) may extend the range of patients who could benefit from the excellent care provided.

3 Discharge policies clearly actively supported discharge from the acute hospital. In the information seen by reviewers, there was less emphasis on discharge from the Hospice. Further work on this may be helpful.

4 The provision of care for children and adults enabled good support during transition to adult care. It may be helpful specifically to consider involving older teenagers and young adults in improving the service provision.

5 The provision of overnight support for siblings was being considered and reviewers supported this development of the service offer.

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CARE OF PEOPLE WITH CANCER – ALL CANCER SITES

This section identifies issues relating to the care of people with cancer across the cancer sites reviewed at this visit.

General Comments and Achievements

A Cancer Plan 2012 – 2022 for the Isle of Man had been developed, and a multi-agency group oversaw its implementation, chaired by the Director of Public Health. A progress report (March 2014) included actions on health improvement and protection programmes and uptake of cervical, breast and bowel cancer screening programmes. Working groups covered five priority areas: Somerset Cancer Register, Multi-Disciplinary Team Meetings, Communication, Care Pathways and Cancer Survivors. A detailed analysis of Isle of Man cancer-related data had been commissioned from the NW Cancer Intelligence Unit to support the implementation and further development of the Isle of Man Cancer Plan.

The MDT subgroup had made progress with establishing breast, colorectal and lung MDT meetings, providing a dedicated MDT room and facilities for video-links to MDT meetings in England, and agreeing an MDT Operational Policy and guidelines for communication between Noble's Hospital and Specialist MDTs in the UK (October 2013). A Cancer Services Improvement Facilitator had been in post since 2009, and a Macmillan Cancer Project Lead had been appointed to support implementation of the Cancer Plan. Cancer pathways had been agreed for all cancer sites, although these were not yet fully implemented.

A range of other specific changes had been made including the introduction of a 'flag' system in radiology to show the date of the next MDT meeting so that reports could be made available, although an audit had shown that the new arrangements were not yet fully implemented. Other plans were in progress, such as improving chemotherapy service staffing, and the appointment of a full-time haematology CNS with cover from the anticoagulation nurse.

Most of the patients who met the visiting team reported that they had a CNS and knew how to contact him/her with queries or for advice. Patients were less clear about who they should contact after the active phase of their treatment.

Advanced communication skills training was available at the Hospice and several consultants and nurses working with people with cancer had attended (although see 'further consideration 3' below).

Good links with and support from voluntary sector organisations was evident. In particular, a Macmillan Information Centre based in Noble's Hospital provided information and support to anyone affected by cancer. A good range of information was available, and both volunteers and professional staff on duty at the time of the review visit were approachable, friendly and helpful. A Macmillan Bus also visited the island annually. The Cancer Services User Forum was a proactive support group for people with cancer, and had run a survivorship day attended by over 100 people. Other support groups included those for people with colorectal cancer (Bowel Cancer Isle of Man), breast cancer (Breakthrough Breast Cancer Isle of Man, Isle of Man Breast Care and Manx Breast Cancer Support Group) and haematological conditions (Anthony Nolan Isle of Man Group). The Isle of Man Anti-Cancer Association was involved in a variety of projects, including the 'Staywell Cervical Screening Clinic' and the psycho-oncology service, which provided psychological support for people with cancer. Work with the Hospice on the development of a six week 'survivorship programme' for people with cancer was also in progress. Manx Cancer Help provided a range of therapeutic interventions and support for people with cancer. The work of these voluntary groups was coordinated through the Council of Cancer Charities.

Immediate Risks

1 Reviewers found widespread evidence of re-prioritisation of urgent suspected cancer ('two week wait') referrals from GPs. These referrals were made using agreed 'two week wait' referral criteria but were then reviewed by consultants in several specialties. Some referrals were re-prioritised as 'routine', including some referrals for patients with imaging reports indicating suspected cancer. For some patients this practice was delaying diagnosis by up to a year.[6]

2 Only limited data on cancer-related incidence, activity, waiting times and outcomes, including morbidity and mortality, were available. As a result, patient pathways could not be actively managed, clinical staff were unable to reflect on and quality assure their clinical practice, and service delivery could not be effectively planned. Some clinical staff considered they were meeting expected waiting times when the limited available data indicated otherwise. Data on achievement of expected waiting times probably over-stated the actual position due to re-prioritisation of referrals (see above).[7]

Concerns

1 Reviewers were seriously concerned about delays in diagnostic and treatment pathways for patients with cancer. This was not categorised as an immediate risk because data covering all cancer sites and stages of the patient pathway were not available to support this conclusion. Diagnostic delays appeared particularly common due to delays in imaging, pathology or other diagnostic tests. Patient feedback from questionnaires was that patients were often unclear about the pathway and expected timescales for the diagnostic phase of their journey. Mechanisms for proactively allocating capacity for patients with cancer in order to speed up patient pathways were not evident.

2 The arrangements for external quality assurance of cancer-related histopathology work were unclear. The service took part in external quality assurance for suspected breast cancer, high grade dysplasia in Barrett's oesophagus and chronic inflammatory bowel disease, and lymphoma specimens. Reviewers were given mixed answers about participation in external quality assurance for colorectal cancer. Patients with cancer whose care was discussed at MDTs in England would usually have a review of histopathology as part of the

[6] **Immediate risk response:** The Medical Director will meet with the hospital and GP cancer leads to review processes around cancer referrals. The hospital is also working to improve communication with GPs. **WMQRS response:** This action has the potential to address the immediate risk identified.

[7] **Immediate risk response:** A business case for improvements in cancer-related data collection is being considered. Charitable support for funding of improvements in cancer services is also being explored. **WMQRS response:** This action has the potential to address the immediate risk identified.

MDT discussion, but arrangements for the feedback of any discrepancies to Isle of Man pathologists were not clear. Arrangements for external quality assurance of other cancer specimens, including those where cancer was suspected but not confirmed, were also not clear. This was of concern because the small numbers involved may mean that pathologists are not maintaining their 'field of expertise'.

3 Three oncologists provided care for patients on the Isle of Man, two of whom visited on alternate weeks. This level of staffing was low for the number of patients with cancer. The lack of appropriate cover for absences of the oncologist was delaying treatment decisions for some cancer sites, and reviewers were also told of delays in prescribing the first course of chemotherapy.

4 Arrangements for holistic needs assessment and holistic support for patients with cancer did not appear well-developed. Holistic needs assessments were generally not evident in the case notes seen by reviewers, and patients indicated that they had not been offered or taken part in such an assessment. Some staff who met reviewers were not aware of the wide range of support available from voluntary organisations. Self-care and well-being and support for carers did not appear always to be promoted actively by hospital staff. It was also not clear whether patients were proactively offered information and directed to sources of further information and support, although the Macmillan Information Centre was easily accessible within the hospital.

5 Arrangements for care of patients needing acute oncology were not clear. Chemotherapy nurses, especially the lead nurse, did their best to support patients needing acute care, and the Emergency Department and acute medical teams were aware of the neutropaenic pathway. Arrangements for sharing information with ward staff on patients undergoing chemotherapy or who had recently completed a course of chemotherapy were not in place.

Further Consideration

1 Members of two of the cancer team (colorectal and gynaecological) MDTs did not receive feedback about patients referred to England for care. Letters were sent to the GP but these were not copied to the Noble's Hospital referring clinician. Teams at Noble's Hospital were therefore not aware of treatments undertaken, follow-up required and other relevant clinical information. This finding may also apply to people with other cancers.

2 Reviewers suggested that 'door to needle' time for patients needing antibiotics should be re-audited. A previous audit had shown that only 7% of patients started antibiotics within one hour of arrival. Reviewers were told that this had then increased to 17%, after which a new pathway had been implemented. The actual 'door to needle' times since introduction of the new pathway had not yet been audited. Reviewers also suggested that, when the audit takes place, the second time category should be split. The first audit had the second time band as '1-4 hours' which allowed very wide variation. Only 50% of patients received antibiotics within this time band.

3 Advanced communication skills training was available at the Hospice but is was not clear that all relevant staff, including consultant medical staff, had attended this training. Some of the patient feedback suggested that this may be helpful.

4 Some of the patient information seen by reviewers was in need of review and revision. It was also not clear that a record was made of information provided to patients. The development of 'information pathways' clarifying the information that should be offered at each stage of the patient pathway may also be helpful.

5 Reviewers were shown an audit of cancer referrals from one GP practice that included approximately the expected number of 'two week wait' referrals. Repeating this audit in other practices may be helpful to provide assurance that appropriate numbers of 'two week wait' referrals are being made. Extending the audit to include cancers diagnosed from routine referrals and emergency admissions may also be useful.

6 The multi-agency Cancer Plan Implementation Group was functioning but there did not appear to be a forum in which staff involved in the clinical management of patients with cancer came together to discuss, for example, service improvement approaches, pathway mapping and achievement of expected pathway timescales, introduction of holistic needs assessments and tracking patients through their cancer pathway.

7 Where radiologists and pathologists did not attend or video-conference into MDT meetings, there were no mechanisms for feedback on the accuracy of reporting.

8 Links between managers at Noble's Hospital and management at the Clatterbridge Cancer Centre were not apparent at the time of the review visit. Development of these links may help to support clinical links in driving service improvement.

9 Arrangements for the care of patients with metastatic spinal cord compression were not clear to reviewers. Clarification of these arrangements may be helpful.

10 Arrangements for Isle of Man cancer site-specific clinical leads to link with the Mersey and Cheshire Cancer Network varied between the cancer sites reviewed. These links could be beneficial for guidelines and protocol development, and for access to training and audit. More formalised expectation of participation in network activities help teams in their service improvement.

11 Access to clinical trials appeared low. The development of a clear strategy and arrangements for offering access to trials, possibly through links with specialist MDTs in England, may be useful in increasing access.

12 Chemotherapy nurses and site-specific cancer nurse specialists did not appear to work together as an integrated team. It may be feasible to provide a better acute oncology service and address issues of cover for absences by the development of a 'multi-task' nursing team. Links with site-specific MDTs would, of course, need to be maintained.

13 The length of follow-up after cancer treatment appeared variable, and follow-up guidelines were not evident. Capacity that could be used for speeding up diagnostic pathways may therefore be being used on follow-up attendances that are no longer clinically indicated. Information for patients discharged from local services – covering, for example, who to contact for concerns or queries and indications for re-contacting the cancer MDT – was not generally available, and may be useful to support the implementation of follow-up guidelines.

14 The Isle of Man did not operate a 'Cancer Drugs Fund' to fund drugs prior to NICE approval. Some of the patient feedback heard by reviewers was that this had not been communicated to patients early in their patient journey. For some patients, expectations of treatment had been raised, only for the patient to be told later that they could not have the proposed treatment because they were from the Isle of Man. Work with consultant oncologists and both local and specialist MDT staff to agree the information to be given to patients on this topic may be helpful.

15 Communication by hospital and community staff about the hospice and hospital services may benefit from review, as reviewers were given some examples of where communication could have been improved.

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HOSPITAL-WIDE ISSUES

This section includes conclusions and comments that apply to Noble's Hospital more widely than just the care of patients with cancer. Issues identified during the review of clinical governance (visit date 4th July 2014; report date October 2014) are not repeated.

General Comments and Achievements

All patients who met reviewers and those who completed questionnaires reported a good experience when they travelled to England for part of their care. Travel, accommodation and care provided were all reported as excellent. A good range of ward performance indicators was in use on all wards at Noble's Hospital.

Concerns

1 Reviewers were told that 25% of hospital admissions data did not have an accurate diagnosis code. iHub data and other analyses of admissions data could be seriously skewed at this level of coding.

2 Patients were not generally given a copy of their clinic letter or a written Care Plan. Reviewers suggested that consideration should be given to sending patients a copy of their GP letter routinely, or writing to the patient and copying this letter to their GP.

3 Long waiting times are identified in several of the services reviewed at this visit. Specific measures to reduce waiting lists and improve waiting list management were not evident to reviewers.

Further Consideration

1 The following issues relating to imaging services were identified during the course of the review visit:

   a. Only one of the six consultant radiologists provided interventional radiology, and cover for absences was not routinely available. It was not clear whether the interventional radiologist was undertaking sufficient procedures to maintain competence. The appointment of an interventional nurse may also help to speed up the patient pathway for interventional radiology.

   b. Radiographer staffing levels were not sufficient to enable implementation of extended working hours. A business case for new staff had been developed but the progress with this was unclear.

   c. MRI capacity may not be sufficient for the increasing trend for MRI to be undertaken before biopsy for suspected prostate cancer. It may be helpful to start planning for additional capacity by, for example, considering extended hours.

2 Reviewers were told again about delays in the production of discharge summaries by Noble's Hospital. This issue has been identified in previous WMQRS visit reports. The same applies to the process of responding to complaints, which was raised by some patients.

3 Reliance on bank and agency staff is identified for 'further consideration' in several sections of this report (eye care, maxillo-facial surgery, audiology, chemotherapy). Mechanisms for ensuring appropriate induction and assurance of competence may benefit from review on a hospital-wide basis.

4 Ward performance indicators were good, but the consequences of poor compliance were not clear.

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APPENDIX 1 QUALITY STANDARDS USED

SERVICE / PATHWAY	STANDARDS USED
Acute Surgical Admissions	WMQRS Acute Medicine and Acute Surgery QSs V2 D4 20131219
Breast Cancer MDT	National Peer Review Programme: Manual for Cancer Services – Breast Cancer Measures V1.1
Breast Care (Non Cancer)	WMQRS Generic Pathway Standards V1 July 2014
Colorectal Cancer Diagnostic Service and MDT	National Peer Review Programme: Manual for Cancer Services – Colorectal Cancer Measures V1
Urology Care (Non-Cancer)	WMQRS Generic Pathway Standards V1 July 2014
Eye Care	WMQRS Generic Pathway Standards V1 July 2014
Ear Nose & Throat Care – Cancer and Non-Cancer	WMQRS Generic Pathway Standards V1 July 2014
Maxillo-Facial Care – Cancer and Non-Cancer	WMQRS Generic Pathway Standards V1 July 2014
Audiology Services (self-assessment only)	NHS Scotland: Quality Standards for Adult Hearing Rehabilitation Services – October 2008
Chemotherapy	National Peer Review Programme: Manual for Cancer Services – Chemotherapy Measures V1
Oncology Pharmacy	National Peer Review Programme: Manual for Cancer Services – Oncology Pharmacy Measures

APPENDIX 2 CARE OF PEOPLE WITH CANCER: QUESTIONS FRAMEWORK

Ref	To be discussed in relation to all cancer sites
1	**What is the diagnostic journey from initial referral (screen-detected or symptomatic) through to MDT discussion?** a. How much of the diagnostic journey happens 'on island' and how much takes place elsewhere? b. What are the timescales involved? c. How is the patient supported at this time?
2	**Does MDT discussion of treatment options take place? If so, where and who is involved?** a. If MDT discussion is 'off island', how are local clinicians involved in the discussion or how is the outcome of the discussion communicated to them?
3	**What treatment options are available and where do these happen?**
4	**Throughout the patient's journey what are the arrangements for:** a. Acute oncology and care of acutely unwell patients b. Allocation of key worker c. Liaison with palliative care services d. Communication with the patient and the patient's GP e. Communication between clinical staff based on the IOM and 'off island' clinicians including communication of clinical information f. Ongoing staff training and assurance of competence (including for medical staff seeing relatively small numbers of patients) g. Data collection and audit

APPENDIX 3 MEMBERSHIP OF VISITING TEAM

Visiting Team

Margaret Casey	Clinical Nurse Specialist Breast Care	The Royal Wolverhampton NHS Trust
Sara Connor	Colorectal Clinical Nurse Specialist	Sandwell & West Birmingham Hospitals NHS Trust
John Day	Clinical Director of Audiology	Betsi Cadwaladr University Health Board
Joan Dyer	Matron Inpatient Services	Walsall Healthcare NHS Trust
Val Ferguson	Senior Sister – ENT	Walsall Healthcare NHS Trust
Richard Gledhill	Prostate Cancer Charity Nurse Specialist	University Hospitals Birmingham NHS Foundation Trust
Wendy Godwin	Lead Commissioner Planned Care	NHS Walsall Clinical Commissioning Group
Michelle Ford	Clinical Nurse Manager	University Hospitals Coventry & Warwickshire NHS Trust
Dr Lydia Fresco	Consultant Oncologist	University Hospitals Coventry & Warwickshire NHS Trust
Sian Hallewell	User Representative	Chair - Peer Review National User Steering Group
Mr Richard Hughes	Consultant ENT Surgeon	Mid Staffordshire NHS Foundation Trust
Ruckie Khalon	Principal Pharmacist – Preparative Services	The Dudley Group NHS Foundation Trust
Mr Adel Makar	Consultant Urologist and Lead Cancer Clinical	Worcestershire Acute Hospitals NHS Trust
Suresh Munyal	Optometrist	Chairperson for Arden, Herefordshire and Worcestershire Local Eye Health Network
Heather Palin	Director of Patient Services	Severn Hospice, Shropshire
Dorinda Palmer	Lead Cancer Nurse	University Hospital of North Staffordshire NHS Trust
Mr Steve Parker	Consultant Breast Surgeon	University Hospitals Coventry & Warwickshire NHS Trust

Prof. Sunil Shah	Consultant Ophthalmologist	Sandwell & West Birmingham Hospitals NHS Trust
Wendi Shepherd	General Manager, Emergency Division	South Warwickshire NHS Foundation Trust
Wendy Thompson	User Representative	Shropshire
Mr Nigel Williams	Consultant Colorectal Surgeon	University Hospitals Coventry & Warwickshire NHS Trust
Louise Wilson	Quality Manager	National Peer Review Team – North Region
Sarah Wiltshire	Lead Nurse Haematology and Chemotherapy	Sandwell & West Birmingham Hospitals NHS Trust

WMQRS Team

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

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APPENDIX 4 COMPLIANCE WITH THE QUALITY STANDARDS

Analyses of percentage compliance with the Quality Standards should be viewed with caution as they give the same weight to each of the Quality Standards. Also, the number of Quality Standards applicable to each service varies depending on the nature of the service provided. Percentage compliance also takes no account of 'working towards' a particular Quality Standard. Reviewers often comment that it is better to have a 'No, but', where there is real commitment to achieving a particular standard, than a 'Yes, but' where a 'box has been ticked' but the commitment to implementation is lacking. With these caveats, table 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 Surgical Admissions	59	35	59
Breast Care	45	19	42
Breast Cancer MDT	(16)	(5)	(31)
Breast Care (Non-Cancer)	(29)	(14)	(48)
Colorectal Cancer Diagnostic Service & MDT	20	9	45
Urology Care (Non-Cancer)	29	14	48
Eye Care	32	11	34
Ear Nose & Throat and Maxillo-Facial Services	59	34	58
ENT Service	(30)	(15)	(50)
Maxillo Facial	(29)	(19)	(66)
Chemotherapy	35	22	63
Oncology Pharmacy	3	3	100
Total	282	147	52

Audiology Service – compliance based on self-assessment	85%

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