WM QRS West Midlands Quality Review Service

Isle of Man Government
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Women's and Children's Services

Isle of Man Health Services

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INTRODUCTION

This report presents the findings of the review of Women's and Children's Services that took place on 13th, 14th, 15th and 16th October 2015. The purpose of the visit was to review compliance with the following West Midlands Quality Review Service (WMQRS) Quality Standards and other standards:

- NHS Litigation Authority: Level 1 Maternity Clinical Risk Management Standards 2013-14, Clinical Negligence Scheme for Trusts
- WMQRS Quality Standards for Gynaecology Services, Draft 2, May 2015
- Department of Health: Toolkit for High-Quality Neonatal Services, 2009
- WMQRS Care of Critically Ill & Critically Injured Children, Version 5 Draft 24, July 2015
- Children and Family Service: Isle of Man Standards
- WMQRS Generic Patient Pathway Quality Standards, V2 D1, October 2014
- WMQRS Quality Standards for Care of Children and Young People with Diabetes, Version 1.2, June 2012
- WMQRS Towards Children and Young People's Emotional Health and Well-Being: Quality Standards for Local Services, Version 1, October 2014
- Royal College of Speech & Language Therapists: Supporting Children with Speech, Language and Communication Needs within Integrated Children's Services, January 2006

These Quality Standards are based on the 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. Compliance with the NHS Litigation Authority 'Maternity Clinical Risk Management Standards 2013-14' was judged in accordance with Level 1 definitions of compliance, that is, only on whether or not policies were in place. This is inconsistent with the way in which compliance was judged for other Standards, that is, that policies were in place and implemented.

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 1 lists the visiting team that reviewed the services at Noble's Hospital. Appendix 2 contains the details of compliance with each of the standards, and the percentage of standards met.

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

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

About West Midlands Quality Review Service

WMQRS is 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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WOMEN AND CHILDREN'S SERVICES

COMMON THEMES

General Comments and Achievements

Throughout the review of services for women and children, reviewers were impressed by the commitment, dedication and hard work of staff on the Isle of Man. Some examples of very good services were seen, and many staff had clearly worked very hard in preparation for the review visit. Staff were enthusiastic and keen to provide a good service for local people. Reviewers also recognised the challenges and difficulties in providing an up to date service for this group of patients in a small, isolated community.

Concerns

1 **Strategy**

A clear strategy for the development of women's and children's services for the Isle of Man was not in place at the time of the review. A Health Strategy was being considered at the time of the review, but this was a high level document that did not provide details of plans for the development of the care of women and children. A separate document covered 'Mission and Objectives 2015 – 2018' for the Women, Children and Outpatients Division at Noble's Hospital. Although this addressed some of the issues identified in this report, it was based on a strategic 'status quo' and did not include detailed analysis of needs or proposed actions. Reviewers considered that, given the challenges facing the Isle of Man services, a plan for the development of sustainable services, with clear timescales and milestones, was needed as a matter of urgency. Social care and education services would need to be part of this planning exercise. This plan would need to be clear about services to be provided on the Isle of Man, their staffing, staff training and facilities.

2 **Leadership for children**

At the time of the review, executive leadership for children within the Isle of Man Department of Health and Social Care had not been clearly identified. Staff were not aware who had lead responsibility for children within the hospital, community services or the Department of Health and Social Care. Senior staff within the Women's and Children's Directorate had responsibility only for services managed by that Directorate, and did not have overall responsibility for improving the care of children. For example, leadership for children's safeguarding (see below) and for surgical services for children was not clearly defined, and issues appeared to fall between Directorate responsibilities.

3 **Sustainability of Women's and Children's Services:**

a. **Medical staffing**

Medical staffing of obstetrics and gynaecology services was under severe pressure at the time of the review (see maternity services section of this report). Only 3.5 consultant paediatricians took part in the acute on-call rota and, outside normal working hours, paediatric services had a single on-site tier of medical staff covering neonates, the children's ward, maternity services and the Emergency Department. A business case had been prepared for additional medical staff in order to increase staffing to two on-site tiers. Reviewers were given different views about the sustainability of medical staffing, with senior staff confident that appointments would be made but other consultants very concerned that the situation was not sustainable. Reviewers considered that the job plans of some obstetrics and gynaecology consultants (14 to 14.5 Programmed Activities per week) were not sustainable and that the expectation of recruiting high quality trainees or other staff to additional posts in both obstetrics and gynaecology and paediatrics (assuming funded business cases) may not be achieved. A clear medical staffing plan, and senior-level monitoring of its implementation, will be

essential in order to avoid unreasonable pressure on existing staff, increased reliance on locum staff and, in the worst case, unplanned interruptions in availability of services.

b. **Nursing and midwifery staffing levels**

Shortage of nursing and midwifery staff is a common theme in the services reviewed. The Isle of Man Department of Health and Social Care was working with a range of universities and also undertaking overseas recruitment. Work permit arrangements had also been changed to make recruitment of nursing staff easier. Reviewers saw little evidence of the development of extended roles for health care assistants and assistant practitioners, although they were told that an Assistant Practitioner Module, linked with Chester University, was in development.

c. **Maintenance of competences**

Levels of completion of role-specific training were low in some services, with variable prioritisation of key clinical skills and variable understanding of the need for, and commitment to, maintenance of competences. Reviewers suggested that a multi-layered approach to competence development and maintenance would be helpful, including training, updates and simulation training for staff at different levels.

d. **Integration of services**

With some exceptions, effective integration and joint working between services was not evident in this review. Each service appeared to be working in relative isolation, with links with other services dependent on personal relationships. The extent to which services were working in 'silos', without effective communication with and involvement of other services, was of concern to reviewers. In general, service planning, training and arrangements for multi-disciplinary review and learning were undertaken separately without arrangements for involving all relevant services.

4 Development and use of clinical guidelines

Within hospital services, reviewers did not find a strong culture of using clinical guidelines. Many guidelines had been developed shortly before the review and had, therefore, not yet been fully implemented or audited. With notable exceptions, for example the paediatric diabetes services guidelines, most of the newly developed guidelines did not follow the hospital document control policy. Guidelines had often been developed by one person or a small number of people, and robust plans for ensuring full implementation were not evident. One of the benefits of WMQRS reviews is that they often act as a useful spur to the development of guidelines. Reviewers were surprised by the proportion of guidelines developed shortly before the review visit, by the lack of some pre-existing guidelines and by the lack of plans for ensuring full implementation.

5 Safeguarding of children

Arrangements for safeguarding children within community services appeared well-organised, with clear processes, good levels of training, clarity about who should be contacted with problems or concerns, and clear escalation routes. Within hospital services the processes were less clear; reviewers were given differing views about training levels (ranging from 50% to 84%), and found a lack of clarity about escalation routes. Some staff did not demonstrate good awareness of safeguarding issues. Little progress had been made since the external review in 2014. A strategy had been developed, but reviewers were given differing views on whether or not this had been approved. Reviewers were also given differing views about the levels of training expected, although these were clearly defined in the draft safeguarding strategy. The Safeguarding Lead Nurse appeared well-organised and had good plans, but it was not clear to reviewers that these plans were supported by more senior managers. The Safeguarding Lead Consultant had undertaken a survey of the need for safeguarding training, but it was not clear that this was being used by other departments.

6 **Infection control**

Several staff were in uniform but were not 'bare below the elbow' including staff wearing stoned rings, wrist watches, necklaces, ties and long sleeves when in uniform. A 'bare below the elbow' policy was in place although some staff were not aware of this.

Further Consideration

1 The environment and facilities for hospital-based services for women and children were excellent, with several services newly enlarged or refurbished. Reviewers commented that some of the facilities may be larger than required to meet the population's needs. Larger facilities can be more difficult to staff and can act as a disincentive to discharge home. Reviewers encouraged senior staff within the hospital to be aware of this potential as part of their ongoing monitoring of services.

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MATERNITY SERVICES

General Comments and Achievements

In 2014, 798 babies were delivered by the maternity service based at Noble's Hospital. The service provided antenatal, intrapartum and postnatal care. A home birth service had previously been provided but was suspended at the time of the review visit. Very good continuity of care was provided, with midwives often able to support a mother through her prenatal, birth and postnatal care. Most of the mothers who met the visiting team were very positive about their care, and commented specifically on the good communication from staff providing maternity care.

Staff who met the visiting team were welcoming and friendly, and were highly committed to providing high quality care. Considerable work had gone into preparing for the review visit, and several improvements had been made to the service. A second emergency obstetric theatre had been organised and new processes around obstetric theatre management had been introduced, led by the new midwifery theatre lead and lead obstetric anaesthetist. Learning from incidents was evident, and staff were clear about the criteria for transferring mothers off the island. Joint working between obstetric, theatres and anaesthetic staff was evident. Several parentcraft initiatives had been implemented, including a 'visual Isle of Man circuit', 'daddy day care' and re-useable nappies for babies in the maternity unit. Caesarean section rates had fallen from 42% in June 2015 to 24% in September 2015, and further measures to reduce section rates were being considered. The Eclipse records system had been introduced in most areas and there were plans for this to be implemented throughout the service. Student midwives were spending part of their training on the Isle of Man.

Good Practice

1 The team caring for women with diabetes during pregnancy was particularly well-organised. Teamwork was strong, and the team was keen to explore and develop new ideas. A pre-conception clinic was run for all women with a BMI or 30 or more, ensuring full compliance with relevant NICE guidance.

2 Care of women with drug and alcohol problems and other particularly vulnerable women was also well-organised. As soon as a referral was received these women were automatically invited to a clinic run jointly by the health visitor for vulnerable women, the lead midwife for drug and alcohol problems and a consultant psychiatrist. This ensured a multi-disciplinary approach to care throughout the pregnancy and after the birth of the baby.

Immediate Risks

1 **Ongoing training of midwives** [1]

Levels of midwife training in several areas were very low. Reviewers were particularly concerned about low levels of training in important clinical skills including BLS and NLS, PROMPT, CTG foetal monitoring, safeguarding and antenatal screening. Reviewers considered that this training was particularly important because of the geographical isolation of the service and low staffing levels. The service therefore could not guarantee that a member of staff with up to date training in these areas was on duty at all times. This issue was not on the risk register and reviewers saw no evidence of discussion of training levels at governance meetings.

Concerns

1 **Local Supervising Authority**

The Local Supervising Authority had, without consultation, given notice of its withdrawal of support for the supervision of midwives. Reviewers considered that this was an inappropriate decision given reports showing problems in other small and geographically isolated maternity services. Legislative change was not taking place until 2017 and so there was no requirement to change arrangements in 2015/16.

2 **Risk management**

A risk management strategy had been developed but had not yet been implemented. A risk management group was in place, but minutes of its meetings were minimal and minutes of some different meetings were identical. Documentation showing arrangements for monitoring risks and ensuring actions were taken were not clear. In particular, reviewers were concerned that arrangements for monitoring the implementation of action plans following incidents were not clear. Only one maternity-related risk was on the risk register (staffing levels, with an action: “new staff to start in November”). The risk register did not include details of action to mitigate this risk until new staff were in post and had completed their induction and any other training required.

3 **Consultant staffing levels**

Obstetrics and gynaecology consultant staffing establishment at the time of the review was 4.5 wte, some of whom were employed on a contract for 14 to 14.5 Programmed Activities. One consultant was off sick at the time of the review, leaving four consultants in post of whom only three were on the on-call rota. At least one consultant was due to retire in 2016 although this had not yet been confirmed. Reviewers did not consider this workload to be sustainable in anything other than the very short term. As indicated above (common themes section of this report), consultants who spoke to the visiting team had a different view of the seriousness of the situation from that given by senior managers, and medical staffing was not included on the risk register.

4 **Implementation of policies and guidelines**

All policies and guidelines seen by reviewers were new (dated September 2015) and it was not clear whether or not they had been finally approved. It appeared that only a few staff had been involved in their development. Reviewers commended the work that had been undertaken, but were concerned that there

[1] **IoM response:** An up to date data base has been created to ensure compliance. All midwives to complete Annual Midwifery Competency Framework Booklet and review as part of personal development reviews / personal development plan by February 2016. All midwives and midwifery care assistants to complete BLS and PROMPT training. K2 CTG training within four weeks. Antenatal screening training to be made available for all midwives by December 2015 and completed by June 2016. NLS training to be rolled out to all midwifery staff.
WMQRS response: The timescales for ensuring midwifery staff have completed NLS training were not defined in the response. The proposed actions will mitigate the risks identified once all the relevant staff have completed the appropriate training.

was no clear plan for ensuring the implementation of the newly developed guidelines, for example those covering training, review and audit. A few pre-existing policies were available but these were very out of date (due for review in 2009). This suggested that mechanisms for the review of guidelines and policies were not robust. The number of new policies developed also suggested that prior to starting preparation for this review visit the service had been a long way from achieving the minimum expected standard of risk management for maternity services.

5 **Control of infection**

Several examples of poor control of infection were seen by reviewers. Some 'sharps' boxes had been open for over four weeks. Syntocinon was not being disposed of in purple 'sharps' boxes. Some delivery rooms had wooden furniture, some of which was broken. The kitchen was used for staff drinks as well as baby feeding materials. The maternity unit was quite cluttered, and several staff were not 'bare below the elbow'.

6 **Antenatal screening arrangements**

Reviewers were told of a Screening Board chaired by the Director of Public Health, but did not see evidence of the work of this group. There was no apparent link between screening and governance arrangements in maternity services. Screening was not mentioned in the risk management strategy and was not on the 'trigger' list. The screening midwife and deputy screening midwife had no time allocated for screening work in their job plans / weekly timetable.

Further Consideration

1 Reviewers were presented with evidence that midwife staffing levels were seven short of the 'Birthrate Plus' recommended level when the analysis was undertaken (January 2015, based on 920 births). Reviewers were told verbally during the course of the visit that birthrates had fallen (to 798 in 2014), which had reduced the shortfall to three posts. Later written comments from the Isle of Man indicated that midwifery staffing levels were at establishment for the birthrate. Reviewers suggested that this issue should be kept under review.

2 Response times for emergency Caesarean section may benefit from audit. Some of the patients' notes seen by reviewers included examples of long waiting times for category 2 sections (for example, up to one hour 50 minutes from decision to section). Data were not available on usual waiting times, and an audit of this subject may be helpful.

3 A quality 'dashboard' for maternity services had been developed and items for inclusion on the 'dashboard' had been identified. At the time of the review, data were not yet included on the 'dashboard'. Reviewers suggested that the number of data items may need to be prioritised and reduced. The 'dashboard' did not include any items on staffing levels, and reviewers suggested that these should be considered for inclusion. Also, staff working in maternity services were not aware of the 'dashboard', and its future use for quality monitoring was not clear.

4 Although there were generally good links between maternity, theatre and anaesthetic staff, reviewers suggested that these could be improved further by, at least, the occasional attendance of a consultant anaesthetist on the morning ward round on the delivery suite.

5 The home birth service was suspended at the time of the review. Given the low staffing levels this decision was understandable, but reviewers were surprised that the suspension of the home birth service was not identified on the risk register.

6 Both staff and reviewers identified several opportunities for increasing 'normality' – for example, community-based booking and midwife-led care for appropriate women. Some dedicated time from a consultant midwife, for example, may be needed in order to progress these ideas. It may be difficult to develop the service effectively in this way while staff are busy with operational responsibilities.

GYNAECOLOGY SERVICES

General Comments and Achievements

In-patient and out-patient gynaecology services were provided at Noble's Hospital by a hard-working, cohesive team who were clearly committed to providing high quality care for their patients. In-patient care was provided on Ward 4, a 13-bedded ward consisting of two four-bedded bays and five single side rooms. The treatment room was also used by sonographers for the Early Pregnancy Assessment Clinic. In 2014/15 the service cared for 1,008 in-patient admissions, of which 415 were elective, 375 were emergencies and 218 were day cases. In addition, 215 patients were transferred in from other specialties (usually medical in-patients), and there were 806 ward attenders. An appropriate range of services was provided, including general gynaecology, early pregnancy assessment, uro-gynaecology, percutaneous tibial nerve stimulation, colposcopy and infertility support. A procedure clinic was also undertaken.

Good Practice

1 The environment on Ward 4 was particularly good. It was welcoming, uncluttered and had good visual displays for patients.

2 The Early Pregnancy Assessment Clinic provided a streamlined process with good involvement of sonographers and gynaecology staff.

3 Good multi-disciplinary links were in place with the cervical cytology screening service at Peterborough, the gynaecological oncology service in Liverpool and the fertility centre in Leeds.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Medical staffing:** See maternity services section of this report

2 **Ward nurse staffing levels and training**

The nurse staffing establishment for Ward 4 was based on five day occupancy. In practice the ward was running seven days a week with 30% of beds occupied by medical patients. Compliance with expected training had dropped because of the pressure on nursing staff; for example, only 77% of staff had completed infection control training. Three registered nurses were on duty in the day (morning and late) and two at night. Reviewers also saw some evidence of incidents and errors that might not have occurred if staff had not been so stretched and had completed appropriate training.

Further Consideration

1 Key performance indicators for the service had been agreed shortly before the review visit. Reviewers encouraged the service actively to use these for ongoing monitoring.

2 Wording of the newly developed operational policies and guidelines may benefit from review. Pathways had been defined, but significant text had then been added with the aim of turning the pathways into guidelines. In several cases this had resulted in some confusion about the pathway.

3 Uro-gynaecology services were under particular pressure due to staffing difficulties, with a 12 month wait for first appointment at the time of the review. One part-time physiotherapist had been recruited to provide 7.5 hours per week in term times for the uro-gynaecology aspects of the women's health physiotherapy service. The backlog of patients was being actively reduced by a full-time locum who was in post for three to six months.

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NEONATAL SERVICES

General Comments and Achievements

A well-designed Neonatal Unit had been opened in 2015 that provided a spacious, high quality environment for babies and their families. The Neonatal Unit had nine beds, three of which were for intensive care / high dependency care and six of which were special care cots. The unit design had been well thought out, and the unit provided a welcoming and practical facility for parents and staff. Staff were welcoming and friendly, and most parents who met the visiting team were positive about the care they had received.

Staff provided an effective neonatal transfer service. Shortly before the review the service had reached a formal agreement to join the Mersey & Cheshire Neonatal Network. Family-centred care was provided, with parents actively involved in the delivery of care. The BadgerNet data collection system was about to be introduced, which would enable monitoring of activity and outcome data. Nursing staff worked flexibly, which enabled a good response to fluctuations in activity within the unit.

Good Practice

1 Good parent information had been developed, particularly a local leaflet about the neonatal unit.

2 A locum consultant was always provided when the lead neonatologist was away on leave.

3 Palliative care guidelines were excellent. These included arrangements for transfer of care to the hospice, enabling babies to be extubated in the hospice setting.

Immediate Risks

1 Medical staff did not have up to date training in neonatal life support although they had undertaken EPLS or APLS training.[2]

Concerns

1 **Checking of transport equipment**

Reviewers were told that transport equipment was checked regularly, but these checks were not documented. There was also no list of 'grab bag' contents against which the contents could be checked.

2 **Audit and outcome monitoring**

Reviewers saw no evidence of audits demonstrating quality and safety outcomes for the unit. Arrangements for ensuring feedback from parents about their experience, including their comments on quality and safety, were also in the very early stages of development. Implementation of the BadgerNet system would enable this issue to be addressed. Arrangements for referral for two year developmental follow up for babies born at less than 32 weeks gestation were not formalised and it was not clear that all babies received developmental follow up.

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[2] **IoM Response:** The Syllabus for both APLS and EPLS courses provide satisfactory levels of training in neonatal resuscitation for doctors. However to ensure compliance with the recommendation, NLS training to be rolled out to all doctors, nursing and midwifery staff in addition to the EPLS and APLS training. To arrange Neonatal Life Support training with external faculty, communicate the requirement for all paediatric doctors to attend by December 2015. Ensure all paediatric doctors have completed the NLS training.
WMQRS Response: APLS and EPLS training do not provide practical experience of neonatal resuscitation and therefore do not provide satisfactory levels of training in neonatal resuscitation for doctors working on neonatal units. Competence and confidence in neonatal life support is particularly important for doctors working on the Isle of Man because of the small size of the unit caring for babies from 27 weeks and the resulting relative infrequency of resuscitation, especially for general paediatricians on call for the unit at night. The actions will, however, mitigate the risk identified once all training has been completed.

3 **Escalation policies**

The criteria for escalation of problems were not clearly defined in the unit's clinical guidelines. Some shifts were covered by only two nursing staff, often with a third person on call. The policy or threshold for calling in the third person was not clear.

4 **Staff training**

Reviewers were told of difficulties in accessing Continuing Professional Development and in obtaining 'back fill' to cover staff who were undertaking training. Blood awareness in-house training had been completed by only 45% of nursing staff. This issue will become more important as revalidation for nursing staff is introduced.

5 **Single tier of medical staff on site at night and weekends**

Outside normal working hours, paediatric services had a single on-site tier of medical staff covering neonates, the children's ward, maternity services and the Emergency Department.

6 **Availability of therapy staff**

Therapy professionals had no job plan time allocated to work on the neonatal unit. Support was provided on request if staff were available but there were no ongoing arrangements for input to assessments, care of newborn babies or preparation for discharge home. Two year developmental follow up for babies born at less than 32 weeks gestation was not formalised and it was not clear that all babies received developmental follow up.

Further Consideration

1 A skill mix review may be helpful in increasing the value for money of the service provided, in particular, by looking at the potential contribution of health care assistants to the work of the unit.

2 Reviewers suggested that greater parental involvement in reviewing and developing the literature for parents may be helpful. Reviewers also considered that there were significant opportunities for greater parental involvement in arrangements for the governance and service improvement of the unit. Involvement with the neonatal network may also provide opportunities for peer support for parents on the Isle of Man, possibly using social media. Reviewers suggested that the potential benefits for parents should be actively explored as part of the unit's network involvement.

3 Some of the clinical practice within the unit, for example, the use of Oromorph and support for tube feeding at home, may benefit from review. Reviewers considered that some clinical practice was increasing length of stay on the unit, thereby also increasing separation of mothers and babies, and may not be in line with usual practice in larger units.

4 The unit did not have a specific recruitment and retention policy, as expected by the Standards for neonatal services.

5 Screening tests were being carried out on babies in the neonatal unit, including the use of UK NSC Northgate Failsafe solution for newborn bloodspot screening, but reviewers saw no evidence of coordination of screening programmes or a mechanism for raising concerns or incidents arising from the screening pathways. Audits of screening tests had not been undertaken and staff appeared unaware of the standards relating to newborn screening. Including screening key performance indicators within the unit's outcome monitoring may be helpful. Establishing an overall governance pathway covering all antenatal and newborn screening programmes may also be helpful, especially as newborn hearing screening was managed separately from other newborn screening, by the audiology service. Midwives were performing newborn infant physical examinations but timescales for completion of these were not clear.

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CARE OF CRITICALLY ILL AND CRITICALLY INJURED CHILDREN

General Comments and Achievements

Staff providing hospital-based care for children were friendly, approachable and clearly committed to improving patient care, often going well beyond the call of duty. Staff had worked hard in preparation for the review. Parents who met the visiting team were generally happy with the hospital-based care they or their children received, and the service's reputation at units to which children were transferred was good. Reviewers were impressed by the portable image projector and the good training package for ward-based registered and non-registered nursing staff. The environment on the paediatric ward was very good, with large rooms and lots of facilities. Plans were being made for further improvements to the environment in the Emergency Department and paediatric ward, including a larger play room and an adolescent ward area. Paediatric medical staff were very supportive of staff in the Emergency Department.

Good Practice

1 Feedback from children and young people was being collected using iPads, which had significantly increased the response rate.

Immediate Risks

1 **Lack of shared care for surgical patients** [3]

Children needing elective surgery and those admitted as emergencies where surgery might be needed were admitted to the paediatric ward but under the care of a consultant surgeon. These children were clerked by surgical junior doctors, and consultant surgeons were called if there were problems. Reviewers considered this was an immediate risk to clinical safety and clinical outcomes because these doctors would not be expected to have training in the care of children, and reviewers saw no evidence of additional training or clear guidelines covering this area of practice. Reviewers' concerns were compounded by issues relating to the early warning system (see concerns).

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[3] **IoM response: First response:** A clear policy outlining the care of 'Care of Surgical Patients in the Children's ward and ITU and Safe Surgical and Paediatric Input' has been drafted by the Lead Consultant paediatrician and approved by Clinical Directors of the Women, Children and Outpatients Division and Surgical Division. The policy guidelines to be submitted to the Patient Safety and Quality Committee for ratification and implementation by November 2016.
Second response: Wider discussion with anaesthetists and surgeons has taken place. The Paediatric Early Warning Score (PEWS) policy is to be re-launched and further discussion will take place through the IoM Critically Ill and injured Child Group which will receive additional support from the Chief Nurse for the Isle of Man. One further change to the policy is to add 'Any surgical patient with a PEWS score of 4-6: The nurse in charge of the patient to escalate to both the surgical Speciality Doctor and Paediatric Speciality Doctor for review'.
WMQRS First response: The proposed policy does not address the issue identified. The policy does not ensure systematic paediatric input to the care of children needing surgery, including young children and those needing high dependency care. Paediatric input for many children is left to the discretion of the surgeon concerned. The policy does not ensure that all children needing high dependency care are seen by a paediatrician. It also does not cover training for surgical staff in use of the early warning system and escalation arrangements, or appropriate paediatric resuscitation training for surgical staff. Although the Isle of Man response states that the policy has been agreed by the Clinical Director of the Surgical Division, it is not clear that other surgeons and anaesthetists have been involved in discussions about the arrangements.
Second response: The actions identified represent an improvement on the previous situation for children whose condition has deteriorated, although the response is not clear about involvement of paediatric medical staff in the care of children with a PEWS score of more than 6. The actions do not fully mitigate the risk identified. Also, If children continue to be seen initially by surgeons (rather than under shared care arrangements), you will need to be assured that all surgeons have undertaken appropriate CPD of relevance to recognising sick children, paediatric resuscitation and paediatric pain management, as well as relevant paediatric surgery-related CPD. Reviewers also suggest that an audit of admissions of children under the care of surgeons would be helpful, looking at, for example, the source of referral, the number of children who actually had an operation, time to see a surgeon (of any grade), time to analgesia, time to actual surgery and whether pregnancy tests were undertaken on admission for pubertal girls.

2 **Emergency Department resuscitation trolley**[4]

The resuscitation equipment in the Emergency Department was not checked in accordance with hospital policy. The trolley was not sealed and, on the day of the review visit, appropriate equipment was not available. Some items had been identified as missing or with a problem (for example, wrong leads for a machine), but these issues had not been addressed. The trolley in the Emergency Department was not a standard paediatric resuscitation trolley; a standard red paediatric trolley was also in the Emergency Department but contained adult resuscitation equipment.

Concerns

1 **Paediatric early warning and escalation policy**

Reviewers were seriously concerned about the early warning and escalation arrangements. An early warning chart was used in both the Emergency Department and the paediatric wards but, on the examples seen by reviewers, scores on the charts were not added up to give a total early warning score. The observations that should have contributed to the score were not always undertaken, and reviewers saw evidence that the documented escalation policy was not followed (for example, a score was recorded that should have resulted in observations every 15 minutes, but the next recorded observation was 1.5 hours later). Some nursing staff recognised that the escalation policy was not fit for purpose. The early warning chart appeared to have been implemented without full discussion and documentation of the policy underpinning it, and implementation had not been audited.

2 **Governance of the care of children**

A hospital-wide Group had been established but the accountability of the group was not clear and the Resuscitation Training Officer was not included in the membership. The relationship of the work of the Group to hospital-wide systems for approval of policies and guidelines was not clear. The group appeared to be approving policies in isolation from hospital-wide systems, and reviewers were told that this was because of delays in hospital-wide approval. Several of the policies were still in draft form.[5] At the time of the review staff working in paediatric services were not aware that an Executive Lead for children was proposed for Noble's Hospital, and clear leadership over hospital-wide issues, for example, safeguarding, resuscitation training and care of children needing surgery, was not evident.

3 **Draft surgery criteria**

Draft criteria for surgery on children were available at the time of the review visit. The policy was not clear about which surgery would be undertaken at Noble's Hospital and which would be transferred elsewhere, including age cut-offs and co-morbidities. The draft policy left most decisions on surgery on children to a personal arrangement between the surgeon and anaesthetist concerned, and did not cover situations when these individuals did not agree. The policy also did not cover arrangements for audit of implementation. The situation in practice appeared to reflect the draft policy, that is, decisions were left to individuals, which could result in significant variations. Reviewers were also concerned that the draft policy provided greater consultant anaesthetist support for elective surgery than for emergencies. The policy stated that a consultant anaesthetist would be involved in all elective surgery on children aged under 10 but that for emergency surgery the consultant anaesthetist must be contacted and "should consider being involved".

[4] **IoM response:** Lockable resuscitation trolleys have been ordered and trolley locking devices are now available in the Emergency Department. A local protocol will be produced outlining and reinforcing the responsibilities of the person checking the paediatric resuscitation trolley and implemented by December 2015.
WMQRS response: The actions defined will mitigate the risk identified once all actions have been implemented.

[5] In some cases, compliance has been given as 'yes' on the assumption that these policies would be fully implemented. Compliance with expected Standards would have been low if this approach had not been taken. Any future reviews will expect all policies to be finalised and to have evidence of implementation.

The extent of the paediatric experience of middle grade anaesthetic staff was not clear (see paediatric anaesthesia section of this report).

4 **Single tier of paediatric medical staff on site at night and weekends**

Outside normal working hours, paediatric services had a single on-site tier of medical staff covering neonates, the children's ward, maternity services and the Emergency Department.

5 **Training of nursing staff**

Nursing staff reported difficulties in accessing mandatory training because of difficulty 'back-filling' staff so that they could be released for training. Access to safeguarding training was reported as particularly difficult. At the time of the review staff said that they could not access online training, and so face to face training was the only option available to them. Ward staff had recently completed appraisals but this had not previously been routine.

6 **Paediatric resuscitation**

Several issues relating to paediatric resuscitation and stabilisation were of concern to reviewers:

a. Checking of paediatric stabilisation trolleys was not consistent across clinical areas. The ward policy was that daily checks should be completed even though the trolley was sealed, which appeared an unreasonable additional workload for staff. Daily checks were not being achieved. The Emergency Department required weekly checks even though the trolley was unsealed (see also immediate risk in relation to Emergency Department resuscitation trolley). Trolleys in theatres were also unsealed. Reviewers suggested that the use of a simple paper seal around Emergency Department and theatre trolleys could increase security, ensure availability of equipment when needed and reduce workload.

b. Arrangements for monitoring the resuscitation training undertaken were not robust. The Resuscitation Training Officer did not have access to information on resuscitation courses undertaken off island, and it was not clear who was responsible for monitoring training and updates for each group of staff. Paediatric life support training for theatres and recovery staff was not included in any of the training plans seen by reviewers.

c. Multi-disciplinary scenario training in clinical areas had been tried but had ceased. A new simulation suite was available but it was not clear how the suite was to be used, and some staff thought that it was only for the use of medical staff. (See also further consideration 3 below).

d. ENT services were provided by a single-handed consultant, and arrangements for locum consultant cover for absences were not robust. ENT support for airway emergencies could not therefore be guaranteed.

7 **Emergency Department**

Specialty doctors in the Emergency Department did not have an ongoing programme of Continuing Professional Development in the care of children. (These doctors had completed APLS training.) Reviewers also noted that Emergency Department consultant presence in clinical areas appeared low, and that this issue did not appear to have been addressed since the WMQRS review in 2013.

8 **Paediatric Ward: Nurse staffing**

At the time of the review the paediatric ward had 5.8 vacancies for nurses. The service was trying to recruit to these vacant posts but did not have a clear escalation policy for occasions when additional nurses were needed because of the number and dependency of patients on the ward. (Staffing levels, registered and non-registered, were: early: 4+1; late: 3+1; nights: 2+1.) Joint work with the neonatal unit on the development of an escalation policy may be helpful.

9 **Paediatric Ward: Education for children**

Children did not receive schooling while on the paediatric ward. Reviewers saw examples of children admitted for over 100 days with no education during this time. Links between paediatric ward staff and schools / education services were not apparent. Reviewers considered that children with health problems could be being seriously disadvantaged by the lack of schooling and by the absence of effective links and communication with schools.

Further Consideration

1 Paediatric staff reported that a lead surgeon for children had not yet been identified, although reviewers were later told that the Clinical Director for Surgery had agreed to take on this role. Issues in both this and the paediatric anaesthesia sections of this report will require discussion with all surgical specialties if improvements in the care of children are to be made. Strong leadership and advocacy for good care of children needing surgery will be required if these issues are to be addressed.

2 The reported arrangements for theatre lists for children (see paediatric anaesthesia section of this report) imply that surgeons on the Isle of Man were not developing special interests in the care of children. The numbers, ages and types of surgery on children by different surgeons did not appear to have been audited. If this is taken together with the unclear criteria for surgery on children, there is the potential that surgeons were undertaking procedures or operating on very young children infrequently. As well as developing clear criteria for surgery on children, reviewers suggested that the number of operations of different types on children of different ages should be audited and the results discussed with surgeons as part of their appraisals.

3 Reviewers strongly suggested the re-introduction of multi-disciplinary scenario training in clinical areas. This approach can be very useful in practising a range of possible scenarios with all relevant staff, taking account of the environment, facilities and equipment that would actually be used. Scenario training is particularly helpful in small services where resuscitation happens infrequently. Reviewers suggested that any resistance to participation in scenario training should be taken very seriously by hospital managers.

4 Children, young people and parents were not yet involved in the governance of children's services and did not appear to have been involved in the re-design work. Reviewers considered that routine involvement of children, young people and parents in decisions about children's services would be a useful part of ongoing quality improvement. Further development of feedback mechanisms may be helpful in several of the services reviewed.

5 Reviewers heard from several sources that, on occasion, there were difficulties admitting children needing elective surgery to the children's ward because of capacity constraints. It may be beneficial to provide an ambulatory care area within the children's environment to help reduce the risk of cancellation of elective surgery. Audit of the frequency of the difficulties may be helpful as part of considering this development.

6 A paediatric early warning score of seven, if the policy was followed, resulted in the resuscitation team being called. Reviewers suggested that this may represent over-escalation, and that requesting immediate consultant paediatrician attendance may be more appropriate for this score.

7 Reviewers were told of delays in surgical staff attending to assess patients. Audit of response times by surgical staff may be helpful so that an informed discussion with surgeons on this issue can take place.

8 Reviewers suggested that Continuing Professional Development in the care of children for Emergency Department Specialty Doctors could be provided by consultant paediatricians. An ongoing programme of updates could be linked with arrangements for review and learning about the care of children.

9 Further links between paediatric services and the Emergency Department in relation to supporting children's trained nurses may be helpful. Given the relatively small size of both departments, some

flexibility or rotation of staff may be helpful in maintaining skills, ensuring consistency of care and maintaining a focus on high quality care for children.

10 Parents of children on the paediatric ward did not routinely access the excellent parents' facilities on the neonatal unit. Reviewers suggested that shared use of these facilities may provide a better environment for parents and more efficient use of the resources available.

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PAEDIATRIC ANAESTHESIA

General Comments and Achievements

Anaesthetic and critical care staff were clearly committed to and enthusiastic about the care of children. They were also very keen to improve the process of care for children needing surgery. Critical care staff were well-organised for the care of children on the unit, with plans for different situations that had been carefully thought through. All staff had completed mandatory training, and careful consideration had been given to which specific clinical skills were needed in order to ensure that at least one member of staff with these skills was available on each shift.

Anaesthetic services had worked hard to make their care as child-friendly as possible; including use of iPads, DVDs, tablets and videos in the holding bay and stickers on the ceiling counting the route to theatre.

Dental anaesthesia was also well-organised. The team worked well together and communicated well about children needing dental anaesthesia. The number of children needing general anaesthesia had reduced and the use of sedation had increased. The team was clear about which interventions were offered. Innovations were also being pursued, including conservation techniques being undertaken at the same time as general anaesthesia or sedation.

Immediate Risks: No immediate risks were identified

Concerns

1 **Organisation of theatre lists**

Children needing surgery were placed on many different surgical lists. This practice meant that it was very unlikely that theatre and recovery staff with specific expertise and experience in the care of children would be available. Reviewers were told that children were first on the list whenever possible, but it was not clear how often this actually happened. Also, an emergency theatre was not available 24/7. This issue, which affected both adults and children, was identified in the 2013 WMQRS review visit and had not yet been addressed.

2 **Anaesthetic support for paediatric resuscitation and surgical emergencies**

The extent of the paediatric experience of on-site anaesthetic middle grade doctors was unclear. Reviewers were assured that all doctors on the middle grade rota had appropriate paediatric airway skills and could provide anaesthetic support for emergency surgery, but it was not clear how often these skills were being used. Elective surgery on children aged under 10 was undertaken by consultant anaesthetists, and reviewers considered that the number of young children cared for by each middle grade doctor each year would therefore be small.

3 The main care of critically ill and critically injured children section of this report contains the following concerns with relevance to paediatric anaesthesia:

a. Governance of the care of children
b. Draft surgery criteria
c. Paediatric resuscitation

Further Consideration

1 Reviewers suggested that the number of children anaesthetised by each anaesthetist each year, possibly divided into age groups, should be monitored. This information should be easily available from the theatre information system. Specific arrangements could then be made for skills maintenance for staff undertaking low numbers by allocating them to lists with children or by arrangements for supervised practice.

2 Liaison and communication between surgeons and theatre staff in order to plan theatre lists involving children appeared to be limited. Reviewers were told that the forward planning and organisation of paediatric cases on lists was often ad hoc and disjointed. It may help both the theatres and the anaesthesia departments for specific lists to be designated as containing children in order to allow appropriate staffing of those lists. This would also provide significant benefits for these departments, in that it would identify a training resource where internal Continuing Professional Development could be offered to anaesthetists and to theatres and recovery staff. They would be able to access paediatric cases without travelling off the island.

3 Operating department and recovery staff familiar with paediatric work were not available for lists containing children. Plans for sending some staff to other hospitals in order to gain this experience were being considered. Reviewers considered that this was a laudable aim and, especially if delivered in conjunction with better organisation of theatre lists, could enable the delivery of paediatric training and experience for operating department and recovery staff. Reviewers also suggested that there may be a benefit if greater integration of operating department and recovery practitioners was considered further.

4 The resuscitation department's strategic plan did not include any paediatric life support training for theatre practitioners or recovery staff. Reviewers suggested that this should be discussed with resuscitation staff.

5 The main care of critically ill and critically injured children section of this report also contains issues for further consideration with relevance to paediatric anaesthesia:

a. Lead surgeon for children (further consideration 1)

b. Individual surgeons' activity levels (further consideration 2)

c. Multi-disciplinary scenario training (further consideration 3)

d. Ambulatory day surgery area (further consideration 5)

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CARE OF CHILDREN WITH LONG-TERM CONDITIONS

General Comments and Achievements

Reviewers met many staff providing care for children with long-term conditions who were committed and keen to provide a good service. Some staff had developed significant skills and experience in their particular area of interest. Two community children's nurses, one of whom was a nurse prescriber, provided excellent support for the children under their care. The children's community nurses provided support for some children needing constipation management and were extensively involved with the care of children with a wide range of other long-term conditions. The paediatric diabetes team had managed to establish an insulin pump service by accessing charitable funds for the pumps. The team had worked hard to develop the competences needed to support children with insulin pumps. A new GP with lead responsibility for children with long-term conditions and for transition had been appointed and was working closely with the community paediatrician.

Good Practice

1 HbA1c levels in children and young people with diabetes were below the average for the north west of England.

2 Good education packages about diabetes in children and young people were available for schools.

Immediate Risks: No immediate risks were identified

Concerns

1 **Multi-disciplinary and multi-agency working**

Effective multi-disciplinary and multi-agency pathways of care for children with long-term conditions were not yet in place. A forum for bringing together all relevant 'stakeholders' to plan and coordinate services was not in place. At an operational level, arrangements for bringing together the 'team around the child' were variable. Some pathways of care, for example a constipation pathway, had been developed but were not being fully implemented, and other pathways of care or agreed clinical guidelines were not yet in place. General practitioners, other community-based services and secondary care services were not linking together effectively, and arrangements for links with social services and education services did not appear to be standardised. GPs could ask advice from or refer patients to consultant paediatricians. The two community children's nurses were working very hard and were being transferred from management by the hospital to community-based management shortly after the review visit. This fragmented approach to the care of children with long-term conditions resulted in little standardisation of the care available for individual children and young people. One family could receive care because they, or their advocates, could manage to obtain agreement, whereas another family with similar needs could miss out on this care. Opportunities for preventive work and improving self-care and self-management (for example, asthma awareness training in schools) were not being fully exploited.

2 **Children and young people with complex needs**

Reviewers were seriously concerned about arrangements for the care of children and young people with more complex needs, and their families. At the time of the review visit, 206 of the Isle of Man's approximately 17,000 children and young people were on a disability register, and staff estimated that approximately 50 of these would have complex needs. A system for assessing the care needs of these children and young people, and the needs of their families, was not in place (or, if a system did exist, staff working in children's healthcare services were not aware of it). Care provided, including 24/7 care, therefore appeared to depend on who the family knew rather than on an assessment of their needs. Allocation of a social worker to these families had started only shortly before the review, and families were not allocated a key worker who they could approach with queries or for advice. Families who met the visiting team described in detail the extreme lengths to which they had had to go to access care for their child. Support for siblings and for parents appeared non-existent.

The community paediatrician was starting to coordinate care for these children, beginning with newly diagnosed children and with young people about to transition to adult care. A community nurse for children with complex needs had also been appointed shortly before the review visit. Support from health, social care and education staff will be needed if the community paediatrician and community nurse are to ensure that appropriate care and support are in place for all children and young people with complex needs.

3 **Staffing levels**

Only paediatric diabetes services were reviewed in detail during this review. Reviewers were concerned that paediatric diabetes services were not fully staffed, with one link nurse not yet fully trained and difficulties appointing to the 7.5 hours per week diabetic nurse role. Succession planning for the lead consultant and lead diabetes specialist nurse will also be required in the next few years.

Staffing of other aspects of the care of children with long-term conditions was not reviewed in detail, as a full assessment against Quality Standards was not undertaken. The pressures on community children's nurses, the limited care available for children with complex needs and the lack of an epilepsy specialist nurse would all suggest that staffing of services caring for children with long-term conditions may not be sufficient for the needs and case mix on the Isle of Man.

Further Consideration

1 **Leadership**

A lead clinician was nominated for the care of some childhood long-term conditions, for example, diabetes and cystic fibrosis. For most long-term conditions no lead clinician was identified and it was not clear how developments and improvements to pathways of care were being agreed and implemented.

2 **Community children's nurses**

The community children's nurses were providing a very good outreach service on Mondays to Fridays from 9am to 5pm that was responsive to the needs of individual children and young people. Management arrangements for the team were changing at the time of the review, and it will be important to ensure ongoing links with acute paediatric services. The community children's nurses calculated that five nurses would be needed to meet the needs of the population seven days a week. This could reduce admissions to hospital and reduce length of stay. At the time of the review their patients had open access to the paediatric ward, especially at weekends. Although providing good support for families, this arrangement can foster dependency and increase admissions of children who possibly could have been managed at home with advice from the GP.

3 **Children with asthma**

Asthma clinics were run by practice nurses and GPs and in Noble's Hospital. The criteria for referral to a hospital-based service and for discharge back to primary care were not clear, resulting in a possible duplication of services. Apart from consultant letters to GPs, communication and coordination between the services was not apparent.

4 **Children with neuro-developmental disorders**

Staff were working hard to provide responsive care for children and young people with neuro-developmental disorders. Pathways of care were not clearly defined, however, and appeared to vary for different children. It was not clear whether the 'team around the child' and 'key worker' were being utilised. Reviewers were told that most newly diagnosed patients were seen by the consultant paediatrician but that most children with neuro-developmental disorders were still under the care of a hospital-based consultant.

5 **Children with epilepsy**

Children with epilepsy were seen by all consultant paediatricians. A specialist nurse to support this care was not available, and it was not clear who was responsible for linking with schools and other services. Some children were referred to hospitals in England for their care. It was not clear that all children and young people with epilepsy were receiving optimal care.

6 **Children with skin conditions**

A consultant dermatologist visited the Isle of Man fortnightly. Waiting times for appointments with the dermatologist were reported to be long, although data on waiting times were not available. The two community children's nurses were supposed to deliver all skin-related education and support to children and families. In practice, some children were seen by consultant paediatricians as well as by dermatologists and the community children's nurses.

7 **Children with obesity**

Children with obesity were usually referred to dieticians either by consultant paediatricians or by GPs. Some young people were then referred to Weight Watchers. Other children were seen by the dieticians, who would direct appropriate children to the physiotherapist. Children with obesity could be referred to fitness programmes by either the dietician or the physiotherapist. Reviewers suggested the pathway of care for children with obesity is reviewed with the aim of achieving a clear pathway which appropriately meets their needs.

8 **Children with diabetes:**

a. Development of links with health visitors and school nurses in relation to the 'Henry' child obesity prevention programme for children may be helpful.

b. Participation in the National Paediatric Diabetes Association audits would be a useful further development for the service.

c. Involvement of the podiatry service in patients' annual reviews may be a helpful way of ensuring foot care is given an appropriate level of priority.

9 **Transition**

Arrangements for transition to adult care were variable. Children with cystic fibrosis and diabetes had clear transition plans but such plans were not in place for children with some other long-term conditions.

10 **Care records**

Children with long-term conditions could have up to 20 different records of their care, including records held by hospital services, school nurses and community-based services. The community paediatrician had started by using the hospital patient notes but could not get timely access to these, and operational difficulties in returning notes for hospital appointments were experienced. A patient hand-held record was in development but was not yet in use.

11 **Facilities**

Community paediatric clinics were held in Independent Living Centres. At the time of the review one clinic was held in a basement area which was not child-friendly and which stored unused equipment. The Isle of Man did not have a Child Development Centre or other facility where all health, education and social care staff working with children with long-term conditions, especially those with complex needs, could work together and provide integrated, holistic care for children and young people and their families.

12 **Needs of parents and families**

Needs of parents were not routinely assessed. Reviewers were told that parents could ask for a Carer's Needs Assessment but information about this was not available in any of the services visited by reviewers.

13 **Rebecca House**

Rebecca House was a children's wing in the Hospice and provided an excellent environment for the care of children. This facility did not appear to be fully utilised and parents and staff were not aware of support that could be available from Rebecca House. Reviewers suggested that further work on the contribution of Rebecca House, especially to the care of children and young people with complex needs and their families, would be helpful.

14 **MRI scanning under sedation**

The arrangements for MRI scanning under sedation were unclear. Children being sedated for MRI scanning should have continuous pulse oximetry for which a specific paediatric SATS monitor is required. Reviewers were told that this monitor was not available in the Isle of Man imaging department, and so children either had sedation CT scans or travelled to England for MRI scanning. Other staff said that children were being

admitted to Noble's Hospital for MRI scanning under sedation. Reviewers were not able to establish whether this meant that these children did not have appropriate monitoring during sedation.

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THERAPY SERVICES FOR CHILDREN

General Comments and Achievements

Occupational therapy, physiotherapy, dietetic, and speech and language therapy services for children were provided by enthusiastic and dedicated healthcare professionals. These services were actively working on the development of policies, guidelines and competences. The services were also working towards greater integration in order to achieve both coordinated, holistic care for children and young people and most effective use of resources. Reviewers supported this approach to the future development of services. Staff were clear about which aspects of their work were generic across therapy professions and which aspects required the specialist skills of each discipline. Occupational therapy and physiotherapy services had been formed into a single team with good leadership. Dietetics and speech and language therapy services were not yet part of the single management team but this was being considered. Dietetic services had in place many of the guidelines and policies expected by the Quality Standards and had particularly strong leadership**.** Speech and language therapy staff had worked hard on providing training to other professionals. Staff had worked hard to make their facilities as child-friendly as possible. Therapy staff linked well with specialist hospitals in England to which children were referred, and with the paediatric interest groups of professional organisations in order to ensure their competences were maintained.

Parents of children who had used therapy services were pleased with the care they received from individual therapists although they would have liked more therapy time.

Good Practice

1 The dietetic service had developed particularly good visual images about feeding regimes, and very accessible information for children, young people and families.

2 The speech and language therapy service provided a good programme of training for partner organisations, developing competences to deliver initial interventions and ensure referral of appropriate children to the speech and language therapy service.

3 The extent of integration across therapy professionals was an example of good practice (although see further consideration 1 below).

Immediate Risks: No immediate risks were identified.

Concerns

1 **Low staffing levels**

Several aspects of the low staffing of therapy services for children were of concern to reviewers:

a. Therapy professionals had no job plan time allocated to work on the neonatal unit. Support was provided on request if staff were available, but there were no ongoing arrangements for input to assessments, care of newborn babies or preparation for discharge home.

b. The Children's Therapy Service did not provide any input to child and adolescent mental health services (CAMHS). The CAMH service had some *ad hoc* input from the Community Adult Therapy Service, and one member of staff with an occupational therapy qualification was working in a different role within CAMHS. Arrangements for input to social care and education services were not clear. In particular, reviewers were given varying information about input to special schools to support the care of individual children and young people. With the exception of training provided by

the speech and language therapy service, an ongoing programme of support to the work of social care and education services was not evident.

c. Staffing levels in the paediatric dietetic service were particularly low. The 0.88 wte paediatric dietician provided strong leadership but had been on long-term sick leave and returned only on the day of the review. Even when fully staffed there was no cover for annual leave or sickness, and no paediatric dietetic service available on Mondays. A business case for an additional 1.0 wte band 6 paediatric dietician and administrative support had been prepared.

2 **Speech and language therapy service staffing and caseloads**

Several aspects of the organisation of speech and language therapy services were considered by reviewers to lead to a suboptimal use of the resources available. This was of concern especially because of the extent to which some Isle of Man children were not able to access therapy services to meet their needs, as evidenced by the sections of this report relating to neonatal services and care of children with long-term conditions, especially those with complex needs:

a. The speech and language therapy service had a high skill mix comprising band 6, 7 and 8 practitioners.

b. Face to face contact with children and families was limited to 50% of clinical time across all bands of staff. Reviewers suggested that staff should be aiming for approximately 70% of time being spent on clinical contacts, especially as each member of staff had one non-contact session per week. Patient contacts were limited to six per day across all settings, whereas reviewers would have expected an average of approximately twice this number.

c. The service had limited administrative support and, as a result, time that could have been spent on clinical work was being used for administrative work.

d. Some staff were holding 'open cases' where they were not undertaking active clinical interventions. This arrangement may not be appropriate, as staff will have an ongoing duty of care if cases are kept 'open'.

e. Some therapy interventions were provided in strict four session blocks. A more outcomes-based approach could lead to a better use of resources, with patients discharged as soon as the expected outcomes have been achieved. A trial model of outcome measures was taking place.

3 **Equipment**

Arrangements for the supply of equipment for children were not reviewed in detail. Some aspects were, however, of concern to reviewers:

a. Equipment forms were generic for adults and children and did not contain some of the detail needed for the supply of equipment for children.

b. The services did not have a policy in relation to beds supplied that covered, for example, eligibility, maintenance and mattress protection.

c. Equipment was maintained by therapy staff. It was not clear that staff had appropriate competences in equipment maintenance.

d. Transition of young people to adult services was often difficult as eligibility criteria were different; for example, beds were not supplied for adult patients.

Further Consideration

1 **Integration**

Reviewers encouraged the plans for further integration of therapy services. This could enable sharing of good practice across therapies as well as a more efficient use of staff and resources. As part of this work,

reviewers suggested that it may be helpful to review the line management structure in order to simplify arrangements, while still ensuring appropriate professional supervision.

2 **Skill mix**

The skill mix in all therapy professions appeared high, with little use of band 3 and 4 associate practitioners.

3 **Parental involvement**

Reviewers were given reports relating to several services by parents who did not feel they had had appropriate communication. Equipment supply was specifically mentioned, and also communication with parents about school-based speech and language interventions. Further work on obtaining feedback from parents and involving them in decisions about the running of therapy services would ensure issues such as these were raised directly with the service. This would allow the service to discuss parents' and carers' expectations and whether these could be met. Involving patients, parents and carers could also develop 'ambassadors' for the service, explaining the role and value of the interventions provided. Young people, parents and carers may also be able to help to review the language used in some of the patient information and the website.

4 **Speech and language therapy**

Further work with independent providers of pre-school education may be helpful. Reviewers were given examples of children being referred by primary schools who would have benefited from earlier interventions.

5 **Occupational therapy**

A good education care plan was in place, but handover to education staff did not appear to take place routinely.

6 **Guidelines**

Some of the guidelines in place at the time of the review may benefit from further work. For example, the guidelines on 'vulnerable adults' did not consider the identification of a vulnerable adult who was providing care for a child. The occupational therapy service had developed several pathways and guidelines. Further work to ensure these guide clinical practice, rather than just describing the service, may be helpful.

CHILDREN'S AND FAMILY SERVICE: HEALTH VISITING AND SCHOOL NURSING

General Comments and Achievements

Health visiting and school nursing services were provided as part of integrated teams, and some dual roles had been developed. Specific posts in paediatric liaison, mental health, Looked after Children, children with disabilities and youth justice were also available. Reviewers met several health visitors, two school nurses who had been trained as health visitors and one student school nurse.

Good Practice

1 **Health Visiting**

Health visiting was considered to be a service-wide example of good practice. Good policies and guidelines had been developed. Health visiting notes seen by reviewers were very clear, with the aim of the visit, content of the visit and actions to be undertaken clearly identified. Robust programmes of personal development reviews and personal development plans were in place for all staff, and staff said that they

were well supported in their personal development. A very good child safeguarding supervision programme had been developed. Team leaders had a good awareness of staff commitments and workload and were able to flex staffing to meet service needs. Arrangements for lone working and buddying were well-established, and staff were confident in their use.

Good support for antenatal care was available, with an established 'early steps' programme. Early intervention for particularly vulnerable families was well-organised, with joint clinics with a specialist midwife and consultant psychiatrist. An excellent display on sugar content in baby foods was available to highlight the effects of sugar on dental care as well as obesity. There was also a good 'Henry' child obesity prevention programme for children, to tackle obesity and promote healthy lifestyles.

Birthday cards were sent to all children as a means of reminding parents of the expected development of their child and of any actions that would need to be taken in the forthcoming year. Two versions of the birthday cards were available, one of which was specifically tailored for children with additional needs. Paediatric liaison arrangements worked well. Transition to school nursing care was well-organised, with 1:1 handover meetings for any children for whom there were particular concerns. A card was also sent to these children, welcoming them to the school nursing service. Arrangements for feedback from parents were well-established, and a set of clinical quality indicators, 'Test your Care', was in use.

Concerns

1 **Administrative and data collection support**

Health visitors and school nurses had no administrative and clerical support, and so clinical time was spent on administrative duties. Limited data on activity and outcomes were collected and all data collection was undertaken manually.

Further Consideration

1 Arrangements for ensuring school nurses have access to up to date information may benefit from review. School nurses kept the paper records of children with whom they were actively involved. Other records were kept at Crookall House. Notes of any Emergency Department attendances were put into the school nurses' tray for them to collect and then add to the notes. Emergency Department attendances that required a more urgent response were phoned through to the school nurse concerned, and a hard copy was then sent to the nurse. It was unclear to reviewers whether this arrangement was robust.

2 Managerial supervision was well-established, but staff reported that clinical supervision was not as well embedded. It may be helpful to clarify with staff the arrangements for clinical supervision.

3 Developing feedback from and involvement of young people in the school nursing service may be helpful. For example, some of the information leaflets may benefit from the involvement of young people in their design.

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TOWARDS CHILDREN AND YOUNG PEOPLE'S EMOTIONAL HEALTH AND WELLBEING

General Comments and Achievements

An integrated tier 2 and tier 3 child and adolescent mental health service was provided by a committed and dedicated multi-disciplinary team. The team comprised nurses, a psychotherapist, a social worker and occupational therapist, psychologists and two psychiatrists, and a total of 7.9 wte staff available for delivery of the clinical service. The team was facing an increasing referral rate, with an average of 319 referrals per year in the two years before the review visit and an average individual caseload of 67.

The team had strong leadership and a good understanding of its strengths and weaknesses. Staff were clearly committed to innovation and learning in order to improve the quality of care available. Good relationships with partner agencies had been developed and partners were highly appreciative of the support provided by the CAMH service. Pathways of care for a range of conditions had been developed. Some training on detection and early identification of mental health problems was delivered to staff working in universal services. A pathway for Looked After Children was in place. Links with adult mental health services appeared to work well. A transition policy had been developed and a 'transition champion' in adult mental health services provided a link role for young people moving to adult services. One practitioner was allocated to a 'crisis' role each day.

Good Practice

1 Coding of clinical data was robust, with high levels of ICD coding.

2 The service made good use of visual images and young people had provided art work for the waiting room and other areas.

3 Processes for personal development plans and clinical supervision were robust with a good mixture of on-island and external supervision.

Immediate Risks[6]

1 **Risk assessments and risk management plans**

Implementation of the risk policy was not robust in the care records seen. Parents, and other provider organisations, confirmed that they did not always get communication about risk assessments and risk management plans. Some records seen by reviewers showed that risk assessments had not been completed or, if completed, had not been recorded.

Concerns

1 **Care planning**

Reviewers did not see evidence of care plans being agreed, communicated and reviewed regularly for all young people, especially those not on the Care Programme Approach. 'Letting go' plans were also not evident in the notes seen by reviewers. Reviewers considered that increasing young peoples' involvement in their care planning, including holding their own care plan, could increase their commitment to achieving goal-based outcomes.

[6] **IoM response:** CAMHS assess and manage risk on all cases as a matter of course and record this in the child's contemporaneous RiO records. CAMHS acknowledge that there are issues in relation to compliance in adhering to the risk policy in that separate risk assessments, risk management plans are not also completed. CAMHS have been addressing this as a high priority. Risk management policy reviewed and standard agreed. All cases to have a separate risk assessment document risk management plan which is shared with patient / carer and partner organisations. Audit toll developed and will be incorporated into case management supervision. Audit to be undertaken in January 2016.
WMQRS response: The actions identified including ongoing auditing of compliance with the policy will mitigate the risk identified.

2 **Waiting times**

Waiting times for interventions were long. Waiting times for young people with eating disorders exceeded the draft recommended timescales of two weeks from referral.

3 **Crisis response and home treatment**

The service was not staffed to provide a crisis response outside of normal working hours. Adult mental health services could be contacted in a crisis but did not provide support to young people admitted to paediatric wards. Home treatment services (tier 3.5) were not available on the Isle of Man.

4 **Facilities**

Facilities for the child and adolescent mental health services were poor. The service was located in a small portakabin. Although every effort had been made to make this 'young people friendly' it provided a barely acceptable environment for the delivery of therapeutic interventions. The quality of the facilities contrasted sharply with the excellent facilities available for children and young people with physical health needs.

5 **Future plans**

Reviewers were concerned about the plans for the development of in-patient beds on the Isle of Man. Reviewers considered that the development of local in-patient facilities was not appropriate for a child population of approximately 17,000. The need for in-patient CAMHS can vary significantly but the availability of a service means that it is more likely to be used. Reviewers considered that an in-patient service was highly unlikely to provide value for money and could take resources from other services, including those that could prevent deterioration.

Reviewers recommended that any available additional resources should be used in the first instance to strengthen existing services, including a) providing crisis and home treatment support at weekends and into the evenings and b) ensuring waiting times are reduced and interventions offered quickly in order to prevent deterioration of young people's mental health. Reviewers suggested that alternative approaches to the care of children and young people in crisis overnight or those needing short-term breaks away from home are explored.

Further Consideration

1 Greater involvement of young people and their parents and carers in decisions about the running of the service may be helpful. The young people who met the visiting team had some very good ideas about ways in which services could be improved.

2 The way in which the service uses the organisational risk register may benefit from review. Some risks on the risk register were rated very high but had then not been reviewed. Reviewers were also surprised that the risk register did not include more issues arising as a result of incidents or near misses.

3 Reviewers were told that the transition policy was not yet consistently implemented by all staff. Audit of implementation may be useful with any outstanding issues addressed as part of the action plan.

4 Further work with Emergency Department and paediatric staff may be helpful so that the responsibilities and processes expected when children and young people with mental health needs attend and / or are admitted to Noble's Hospital are clearly defined. Senior management support may be needed to ensure that appropriate responsibility is taken for those young people for whom the most appropriate short-term place of care is Noble's Hospital.

5 Island-wide work on suicide prevention was being planned and reviewers supported the proposed work in this area.

6 Reviewers suggested there may be potential for greater use of the data available (see good practice) for audit and quality monitoring.

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APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Executive Lead

Mr Peter Thompson	Consultant Obstetrician / Medical Director	Birmingham Women's NHS Foundation Trust

Visiting Team

Dr Joanne Barton	Consultant Child and Adolescent Psychiatrist / Clinical Director Children and Young People's Division	North Staffordshire Combined Healthcare NHS Trust
Shawinder Basra-Dhillon	Sandwell Operational Manager / Clinical Lead – School Nursing	Birmingham Community Healthcare NHS Trust
Dr Julian Berlet	Consultant Anaesthetist & Divisional Medical Director of TACO – Theatres, Ambulatory, Critical & Outpatients	Worcestershire Acute Hospitals NHS Trust
Gordon Bigham	Head of Therapy Services and Lead Allied Health Professional	Birmingham Children's Hospital NHS Foundation Trust
Kate Branchett	Patient Voice and Insight Lead	West Midlands Strategic Clinical Network and Senate
Debbie Burden	Health Visitor	South Warwickshire NHS Foundation Trust
Elaine Day	Patient Representative	
Dr Penny Dison	Consultant Paediatrician	
Fiona Ellis	Commissioning and Redesign Lead – Women's and Children's / Strategy & Service Redesign	NHS Shropshire CCG
Karin Evans	Head of Children's Speech and Language Therapy, Northern Division	Staffordshire & Stoke on Trent Partnership NHS Trust
Carolyn Gavin	Clinical Director CAMHS	South Staffordshire & Shropshire Healthcare NHS Foundation Trust
Miss Rabia Imtiaz	Consultant Obstetrician / Associate Medical Director Clinical Effectiveness	Worcestershire Acute Hospitals NHS Trust
Shirley Jones	Midwifery Nurse	Wye Valley NHS Trust

Dr Simon Lalonde	Consultant Clinical Psychologist (CAMHS)	Birmingham Children's Hospital NHS Foundation Trust
Petrina Marsh	Head of Department, Children's Therapies	Sandwell & West Birmingham Hospitals NHS Trust
Elaine Newell	Director of Midwifery / Clinical Director for Maternity & Perinatal Medicine	Sandwell & West Birmingham Hospitals NHS Trust
Joanne Pugh	Advanced Paediatric Nurse Practitioner	The Shrewsbury & Telford Hospital NHS Trust
Sarah Rattigan	Neonatal ODN Director	Cambridge University Hospitals NHS Foundation Trust
Tracy Rowson	Gynaecological / Triage Sister	The Shrewsbury & Telford Hospital NHS Trust
Sandra Smith	Senior Quality Assurance Advisor (Clinical) ANNB screening programmes	NHS England
Marguerite Usher-Somers	Specialist Sonographer in Fetal Medicine	Birmingham Women's NHS Foundation Trust
Mr Adrian Warwick	Consultant Obstetrician and Gynaecologist / Clinical Director, Women & Children's Services	The Dudley Group NHS Foundation Trust

WMQRS Team

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

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APPENDIX 2 COMPLIANCE WITH THE QUALITY STANDARDS

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. Compliance with the NHS Litigation Authority 'Maternity Clinical Risk Management Standards 2013-14' was judged in accordance with Level 1 definitions of compliance, that is, whether or not policies were in place only. This is inconsistent with the way in which compliance is judged for other Standards, that is, that policies are in place and implemented.

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
Maternity CNST Level 1	50	30	60
Gynaecology Specialist Services	32	13	41
Neonatal Care	100	66	66
Care of Critically Ill and Critically Injured Children Hospital-wide	10	5	50
Paediatric Anaesthesia	21	12	57
Care of Critically Ill and Critically Injured Children - combined	96	53	55
Emergency Department	(44)	(23)	52
Paediatric Ward	(52)	(30)	58
Children and Family Service	48	37	77
Health Visiting	(24)	(20)	83
School Nursing	(24)	(17)	71
Children's Therapy Specialist Service	64	34	53
Children's Therapy	(32)	(14)	44
Dietetics	(32)	(20)	63
Paediatric Diabetes Services - Hospital Wide and Specialist Service	39	20	51
CAMHS Universal	4	4	100
Targeted and Specialist Child & Adolescent Mental Health Services	46	28	61
TOTAL	**510**	**302**	**42**

APPENDIX 3 ABBREVIATIONS

ACCEPT	Assessment, Control, Communication, Evaluation, Preparation & Packaging and Transport
AAGBI	Association of Anaesthetists of GB and Ireland
ADHD	Attention Deficit Hyperactivity Disorder
ANNP	Advanced Neonatal Nurse Practitioner
APLS	Advanced Life Support
ASD	Autism Spectrum Disorder
ATMIST	Age, Time, Mechanism of injury, Injuries suspected, Sign and Treatment given – Pre-Alert Tool
BAPM	British Association of Perinatal Medicine
BMI	Body Mass Index
BSPED	British Society for Paediatric Endocrinology and Diabetes
CCT	Certificate of Completion of Training
CEFM	Continuous Electronic Fetal Monitoring
CEMT21	Condensed Education Module for T21 screening
CMACE	Centre for Maternal and Child Enquiries
CAMHS	Child and Adolescent Mental Health Services
CPAP	Continuous Positive Airway Pressure
CPD	Continuing Professional Development
CT	Computerized Tomography
DSCNs	Data Sets Change Notices
ECMO	Extracorporeal membrane oxygenation
EFM	Electronic Fetal Monitoring
EIDO	Experts in Informed Consent
ENT	Ear, Nose and Throat
EPAU	Early Pregnancy Assessment Unit
EPAC	Early Pregnancy Assessment Clinic
EPAS	Early Pregnancy Assessment Service
EPLS	European Paediatric Life Support
EWTD	European Working Time Directive
FASP	Fetal Anomaly Screening Programme
FBS	Fetal Blood Sampling
GICU	General Intensive Care Unit
HbA1c	Haemoglobin A1c (a blood test for diabetes)
HCA	Health Care Assistant

HCG	Human Chorionic Gonadotropin
HCP	Healthy Child Programme
HeART	Happiness, Engagement, Adoption, Retention and Task success Framework
HENRY	Health Exercise and Nutrition for the Really Young
HoSCA	History of Severe Child Abuse Scoring
IUT	*in utero* Transfers
KPI	Key Performance Indicator
LNU	Local Neonatal Unit
MAWCH	Manx Association for the Welfare of Children in Hospital
MDT	Multi-Disciplinary Team
MEOWS	Modified Early Obstetric Warning Scoring System
NCCMDS	Neonatal Critical Care Minimum Data Set
NICE	National Institute for Health and Care Excellence
NICU	Neonatal Intensive Care Unit
NIHR	National Institute of Health Research
NLS	Newborn Life Support
NMC	Nursing and Midwifery Council
NNAP	National Neonatal Audit Programme
NPDA	National Paediatric Diabetes Audit
NVQ	National Vocational Qualification
NWTS	North West and North Wales Paediatric Transport Service
OOH	Out of Hours
PALS	Patient Advice and Liaison Services
PICU	Paediatric Intensive Care Unit
PMB	Postmenopausal Bleeding
PRISM	Paediatric Risk of Mortality
QS	Quality Standard
RCOG	Royal College of Obstetricians and Gynaecologists
RCPCH	Royal College of Paediatrics and Child Health
RSVP	Reason, Story, Vital Signs and Plan
SBAR	Situation Background Assessment and Recommendation
SCU	Special Care Unit
ST	Specialist Trainee
SUS	Secondary Users Service
TARN	Trauma Audit and Research Network

TNA	Training Needs Analysis
UK NSC	UK National Screening Committee
VBAC	Vaginal birth after caesarean
VTE	Venous thromboembolism
WHO	World Health Organisation