Royal College of Physicians | Quality in Primary Immunodeficiency Services

Quality in Primary Immunodeficiency Services accreditation scheme

Assessment report

University Hospital North Midlands

28 February 2018

Assessment team

Claire Bethune (Consultant Immunologist at Plymouth Hospitals NHS Trust)

Fran Ashworth (Immunology And Allergy Nurse Specialist / Home Therapy Coordinator at Sheffield Teaching Hospitals NHSFT)

Sharon-Ann North (Lay Assessor at North Yorkshire Police)

Assessment summary

North Midlands Allergy Service have provided evidence demonstrating that they achieve all the standards required for QPIDS accreditation. This is a significant achievement for a relatively new immunodeficiency service and is testament to the leadership and vision shown by Dr Goddard, creating an excellent, proactive and responsive team. The trust's support for this service and forward planning was demonstrated by the recent successful business cases resulting in expansion in medical, nursing and administrative establishment. The assessors were particularly impressed by the consistent approach to patient involvement in service design and development, the overwhelmingly positive patient feedback and excellent facilities.

The assessment team have recommended that the service should be accredited for 5 years subject to an annual renewal assessment. A number of recommendations have been made including a review of the home therapy commissioning arrangements, the name of the unit and budgetary arrangements for the service. Evidence that progress has been made in these areas will be required at the time of the annual review.

Congratulations to the whole team.

Assessment outcome

The assessment team found that University Hospital North Midlands are to be accredited for 5 years, subject to an annual renewal assessment.

Background

Quality in Primary Immunodeficiency Services (QPIDS) is the accreditation scheme for primary immunodeficiency services in the UK. The scheme originated from the UK Primary Immunodeficiency Network (UKPIN) accreditation scheme, and is now hosted by the Royal College of Physicians of London. Services undergo a programme of quality improvement before undergoing a rigorous assessment against the QPIDS standards. Services which demonstrate they meet the standards are granted accreditation.

The service above was assessed against the QPIDS standards 2015, and the assessment findings are detailed in this report. If any of the standards are not referred to then the reader should assume that they do not apply to the service. The assessors and the service have declared that there is no conflict of interest.

The QPIDS standards and further information on the QPIDS scheme can be found at www.qpids.org.uk.

Methodology

To be accredited, services undergo the following assessment process:

Self-assessment -The service performs a self-assessment of their adherence to the standards and provides evidence of this.

Remote assessment -The evidence is assessed remotely by the assessment team over a twelve week period.

Site assessment -The service's site(s) is visited, which includes a site inspection, staff interviews and further evidence assessment.

Quality assurance -Two quality assurance assessors adjudicate the assessment team's recommendation.

The assessment result -The service is accredited for five years, subject to an annual renewal assessment, or deferred, where the service is required to upload further information against the standards indicated by the assessment team.

Findings

The findings of the assessment are detailed in this report. These are categorised into the following areas:

Congratulation
Services which show excellent achievement against a particular standard may receive a congratulations.

Key action
Services which have not satisfied the assessment team that a standard has been met may receive a key action. This will detail how the standard hasn't been met, and what must be produced in order to meet the standard. Services which receive a key action are deferred from accreditation until this evidence has been provided.

Recommendation
Services which could show improvement against a particular standard but otherwise meet the standard may receive a recommendation. The service will be accredited and will be asked to provide evidence of improvement in their annual renewal assessment.

Revisit comment
Services which have received a key action will receive a revisit comment, which specifies whether or not this standard has now been met. Services must meet all the standards to gain accreditation.

Assessment findings

The service should be congratulated on:

A1 The assessment team are particularly impressed by the quality of the patient-facing information, in particular the website which is excellent..

B1 The assessment team are very impressed by the leadership and vision shown by Dr Goddard, the clinical lead. She has created an excellent pro-active and responsive team delivering patient centred care for patients with immunodeficiency.

B2 The assessors found the nursing team to be professional, competent and responsive to patient feedback. The team have a forward-looking plan in place to develop the nursing establishment in view of the continuing expansion in outpatient (new and follow up) and day case patient numbers.

B3 The feedback from patients was overwhelmingly positive, in particular they praised the service highly for accessibility and availability of advice.

C2 The proactive and outward looking attitude of both medical and nursing teams has led to strong and supportive links with other specialities in the hospital. The team are now focusing on the development of improved links with other local hospitals to facilitate the referral of appropriate patients with suspected immunodeficiency.

C4 The ward based pharmacy area provides excellent facilities for storage of immunoglobulin.

C6 IT systems are excellent, in particular the assessment team are impressed by the demonstration of the online notes system.

D2 There is comprehensive patient information available.

D4 The team should be congratulated on the strategy for entering information directly into the database at the team meeting immediately after clinics, ensuring that the database is kept up to date.

E1 The facilities for the training of patients to self administer immunoglobulin at home are excellent, patients have the option to have training in a single side room. The majority of patients choose to have training in the ward area where the facilities provide adequate privacy to maintain patient dignity throughout the training process.

F4 The service has demonstrated a exemplary approach to involving patients in service design and development. This is evidenced by the annual review of the service with involvement of both local patients and representatives of national patient support groups, the attention paid to patient surveys and the feedback from patients highlighting the regular informal opportunities to feedback to the medical and nursing teams. There are plans to improve this further with the introduction of coffee mornings for patients.

The service has received the following recommendations:

A3 The service has excellent support from the management team at both service and trust level. This is demonstrated by the recent successful business case that has led to significant expansion in staffing (medical, nursing and admin). As the clinical team has now expanded it is recommended that the service level management team attend the immunology/allergy management meetings on a regular basis in order to provide a platform for the whole clinical team to communicate regularly with the management team. We recommend a

standing agenda item on for the management meetings to include RTT, data quality and clincal coding.

A4 The assessors support the proposal to separate the immunology/allergy budget from the haematology budget in order to clarify issues relating to income and expenditure for this service.

C1 The facilities are excellent and there are clear benefits resulting from working closely with the haematology, oncology and palliative care teams, however feedback from patients highlighted that the name of the unit (the cancer centre) had led to unnecessary anxiety and distress, particularly around the time of the first appointment with the service. The assessors were reassured that this has already been escalated to the trust board and plans regarding a change of name for the centre are under discussion. It was clear that this has been a significant issue for patients and we will therefore plan to review progress in this area at the next annual review of accreditation (May 2019)

C5 Audit data uploaded demonstrate satisfactory turn around times for letters however recent difficulties regarding secretarial capacity were discussed and have been addressed by the appointment of a new immunology secretary (new post). The assessment team recommend that turn-around of clinic letters is kept under review and data for the next 12 months is presented at the next annual review. The team suggested that as the immunology secretary post is new a review after 3-4 months in post is undertaken to assess whether working from the existing secretaries office is practical in view of the location of nursing team and consultants in other areas.

E1 As the home therapy program is new, patient feedback has not included responses from patients who have been trained locally. It is requested that feedback from home therapy patients trained in this centre is provided at the next annual review.

E3 The training given to patients was shown to be of a high standard and in line with national recommendations. However the commissioning arrangements need to be addressed before the next annual review as by this time (as a result of anticipated expansion in patient numbers) the "cap" on numbers of new home therapy patients is likely to result in a significant delay for some patients transferring to home care. It is highly unusual for specialist commissioners to place a cap on the number of patients able to undertake training. The assessment team were reassured by the trust senior management team that this would be addressed with specialist commissioners at Trust level to support the Immunology service. The assessors will review home therapy commissioning arrangements at the next annual review.

Service summary

Service name: North Midlands Allergy and Immunology

Trust: University Hospital North Midlands

Service address:

Hilton Road

ST4 6QG

Date of assessment: 28 February 2018

Year established: 2010

Number of sites: 3

Assessors:

Claire Bethune (Consultant Immunologist at Plymouth Hospitals NHS Trust)

Fran Ashworth (Immunology And Allergy Nurse Specialist / Home Therapy Coordinator at Sheffield Teaching Hospitals NHSFT)

Sharon-Ann North (Lay Assessor at North Yorkshire Police)

Services provided:
In addition to the mandatory standards applicable to all centres, North Midlands Allergy and Immunology was also assessed against the optional standards relevant to the following additional services:

Provides a service to adults

Staff profile

The service has indicated that the following staff were employed at the time of their assessment:

Name	Role	Qualification	WTE	Years in Post
Dr Sarah Goddard	Clinical Lead	FRCPath, MRCP, PhD	0.85	>5
Lavanya Diwakar	Consultant	FRCPath,MRCP	0.60	<1

QPIDS standards

The service was assessed against, and was found to meet, the following standards.

Domain A: Organisation and administration

A1 There is a document describing the scope and organisation of the primary immunodeficiency service, including its managerial relationship within the hospital.

A2 The service has a sufficient caseload and appropriate staffing to maintain and develop requisite clinical skills.

A3 The service should have a clearly defined management process relating to the primary immunodeficiency service. This should include evidence of regular, minuted management meetings.

A4 There is appropriate budgetary management of the primary immunodeficiency service provided by the service.

Domain B: Staffing

B1 There is an appropriately trained consultant clinical immunologist in charge of the service.

B2 There are appropriately trained senior nurses to provide nursing care and run the home treatment programmes, who must be registered with the NMC.

B3 There is appropriately skilled medical cover available to offer advice to patients or other healthcare professionals involved in the care of patients with primary immunodeficiency.

Domain C: Facilities

C1 Hospital-based outpatient, day case and inpatient facilities must be adequate for the needs of the service.

C2 The service has appropriate support from other clinical specialties.

C3 The service has adequate and readily accessible support from diagnostic services for the management of primary immunodeficiency.

C4 There are appropriate storage facilities for drugs and immunoglobulin products.

C5 Nursing and medical staff have adequate office space and administrative support to enable them to organise and run the service effectively.

C6 There are satisfactory library and IT arrangements to support the service.

Domain D: Clinical care

D1 There must be protocols in place relevant to the management of all primary immunodeficiencies catered for in the service.

D2 There must be written literature on primary immunodeficiencies and their treatment available for both patients and healthcare workers.

D3 Regular monitoring arrangements for all patients with primary immunodeficiencies are appropriate and are documented.

D4 The service must maintain a database of patients with primary immunodeficiency.

D5 Patients' notes must be properly maintained in accordance with local hospital policies.

D6 There should be robust mechanisms for recording details of blood products used in patient management and for storage and archiving of appropriate specimens for monitoring and review purposes.

D7 There should be evidence that the risks and benefits of treatment have been considered and discussed with every patient with primary immunodeficiency.

D8 There should be evidence that every PID patient has given their consent to treatment and has received appropriate, relevant background and specific information.

Domain E: Home therapy

E1 There are adequate facilities and equipment available for undertaking home therapy training.

E2 There should be a home therapy caseload sufficient to maintain knowledge and expertise, and appropriate numbers of trained and experienced staff to provide adequate home therapy training and support.

E3 The home therapy training programme is organised in line with existing nationally agreed guidelines.

E4 There is documentation which indicates the consent of the patient for home treatment.

E5 Patients and partners/carers are given necessary training; successful training is documented and signed by the trainer, patient and, if appropriate, infusion partner.

E6 There are appropriate resources for home visits and facilities for hospital-based follow-up. Regular monitoring of all home therapy patients is documented, with regular reassessments of patient and carer competencies for those on home treatment programmes.

E7 The service must maintain a database of home therapy patients.

Domain F: Audit, education and management

F1 There is evidence of regular audit (internal and external).

F2 Staff participate fully in relevant programmes of continuing professional development.

F3 Regular performance appraisal of all staff shall be undertaken.

F4 The service should review (with patient participation) the quality of service which it provides.

F5 There should be evidence of a managed approach in the service to quality issues and a written quality policy for the service.

F6 All service protocols must be subject to document control.

Further information regarding this report may be obtained from the QPIDS office at the Royal College of Physicians.

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