Royal College of Physicians | Improving Quality in Allergy Services

Improving Quality in Allergy Services accreditation scheme

Assessment report

University Hospital North Midlands

20 December 2018

Assessment team

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Carla Jones (CEO at Allergy UK)

Assessment summary

Congratulations to the North Staffordshire Immunology service on achieving accreditation. The team has worked very hard to achieve the full award and demonstrating that the standards are embedded in practice. Well done to the 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

Improving Quality in Allergy Services is the accreditation scheme for adult allergy services in the UK. The key objective of the scheme is to raise standards in allergy services. IQAS was initially launched in 2011 as a registration scheme with the aim of preparing the allergy community for the challenging and rigorous process of meeting high quality accreditation standards. Standards have now been developed and services are able to apply for accreditation.

The service above was assessed against the IQAS 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 IQAS standards and further information on the IQAS scheme can be found at www.IQAS.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:

1.1 There is clearly significant engagement from local and national patient representatives and organisation in the development and working of this service.

1.2 The assessment team noted that seeking feedback (formal and informal) from patients are part of the culture of this service. Importantly, there is evidence to suggest that appropriate actions have been taken based on the feedback. A minor concern was expressed by some patients that the waiting room space is very busy, but there was an acknowledgement that that's because the space is shared with other clinics.

1.3 The assessment team are particularly impressed by the quality of the patient-facing information, in particular the website. Further, GP are provided with a clear description of referral criteria and pathways. This is clearly a strength of this service.

1.4 The assessors felt that the team has coped remarkably well given significant increase in patient numbers over the last few years and they ought to be congratulated at keeping the waiting times to a manageable level. However, it is likely that the numbers will increase further in the near future and felt that planning for that increase in terms of staff and space is vital.

1.6 The assessors are pleased to see that there is a high level of communication with patients and satisfied that written information is routinely provided to patients who seem well informed.

1.7 The assessment team noted significant involvement of patients in the development of patient information leaflets.

1.8 The assessment team are impressed by the overwhelmingly positive feedback from patients, they describe the staff as friendly, pleasant, flexible and accessible. Education and advice was readily available. Indeed, they liked coming to the hospital because of the friendliness of the medical and nursing staff.

2.3 The team were particularly impressed by the expertise and organisational skills of the two specialist nurses. They are professional, competent and responsive to patient feedback. They are involved at all levels of the development of this service.

2.6 There was evidence of links with associated specialties such as ENT and Respiratory Medicine and a clear pathway of referral between these specialties at consultant level.

2.7 Assessors were particularly impressed by the detailed online records and the database. There was ample evidence of allergy related treatment codes being used.

2.8 With investment in the service by the Trust and the appointment of new staff, the service sees appropriate number of patients to meet the standard.

3.3 There is evidence to support communication links with the ENT service

3.7 Evidence is provided for the recent accreditation of the immunology laboratory.

3.8 Appropriate ITU facilities are available to the service

4.1 There is evidence to support that adverse effects/near misses are recorded and reviewed in the meeting.

4.10 There is evidence for an electronic database of patients being managed for drug allergy.

4.12 The assessment team were satisfied that a Trust wide policy is in place to deal with latex allergy.

4.12 A Trust wide policy is in place to provide effect management for latex allergy

4.3 The assessors were satisfied that guidelines are available and used by the clinical team.

4.4 Evidence was provided during the assessment visit that multidisciplinary clinical meetings are regularly held.

4.5 It is commendable that there has been no complaints. The assessors were satisfied that there are systems in place to deal with any complaints, including time lines and communication with PALS.

4.6 Information regarding the number of patients going through immunotherapy confirmed that this standard is met.

4.7 The team should be congratulated on the strategy for entering information directly into the database immediately after clinics, resulting in an extensive and up to date database that ensures accuracy and safety.

4.8 Evidence was provided for the use of SOPs based on published guidelines for both pollen and venom immunotherapy.

5.1 The assessment team were satisfied that there was ample evidence of local audit activity.

5.2 Evidence is provided for participation in two national audits in the last two years.

6.1 There is ample evidence that the department is actively involved in education and training.

6.2 There is evidence to support that both consultants have attended national/or international allergy meetings in the last two years.

6.3 Both nurses have acquired post-graduate qualification and assessment team were satisfied that they were competent to undertake their role as specialist nurses.

6.4 Evidence is provided that staff are trained in anaphylaxis management including a mock drill.

6.5 Evidence is provided that all staff members have had resuscitation training.

The service have completed the below actions following their deferral

1.5 The service is not meeting the current requirement. The letter turnaround times are currently over 4 weeks. However, increased secretarial support is imminent and it is likely that this will improve in the coming months. Evidence of improved timescales for letter turnaround is required.

2.2 The assessment team felt that the evidence presented does not provide sufficient evidence of consultant cover as required by the IQAS standard. However, given that the shortfall is marginal and the overall assessment of this service suggested that this shortfall had no bearing on the quality of service provision, the team is keen to consider a revised submission in due course where consultant cover is provided to the required standard.

2.4 The service does not currently have dedicated dietician support. The assessment team

advises that defined allergy dietician support is required. Evidence of appointment and role/ responsibilities is required.

4.11 Local SOPs for some drugs challenges are being developed. Food allergy SOPs have recently been acquired and these will need to be adapted for local use of food allergy diagnosis, with the help of an allergy dietician.

4.11 SOPs for some drug challenges, such as NSAID, are being developed for local use. For oral food challenges, SOPs have been recently acquired and these will be adapted for local use with the help of the allergy dietician. The assessment team will need to see evidence of both.

4.2 The list of protocols and SOPS is provided and the assessors were satisfied that these SOPs and protocols were generally followed in the clinic. However, two SOPs did not meet the required standard; (i) for skin prick test and (ii) for oral food challenges. These are/will be updated. However, the assessment team would like to see evidence for the use of updated SOPs for skin prick test and oral food challenge with dietetic support.

The service has received the following recommendations:

2.1 The assessors were satisfied that there is adequate description of the service structure and the information is readily available to the referrers and patients. However, the service is expanding and there are increasing demands on the existing nursing workforce. The assessment team recommend that consideration is given to additional Band 5 nursing time to support the delivery of the service.

2.9 There is evidence of monthly meetings being held to discuss management issues. The assessment team recommended an increased level of engagement by the Trust management in these meetings.

3.1 The current facilities are spread out but entirely adequate and fit for purpose. As the service continues to grow, consideration must be given to a single area where facilities are better coordinated for patients.

3.4 The assessor team felt that the facilities for immunotherapy were adequate. However, there was minor concern with regards to privacy due to the busy clinical area. The team acknowledges that space is a wider issue in the Trust; however, it was recommended that consideration be given to immunotherapy being carried out with improved waiting area facility in due course.

3.5 Patients undergoing challenge test should be observed in the outpatient areas. The assessment team felt that staff must be available to observe patients during challenge. A change in practice was recommended and agreed on the day that ensures safety.

4.9 The number of new patients for drug allergy (n=70) is less than the minimum required by IQAS standard (n=100); however, the figure provided does not include general anaesthetic allergy patients, which is referred to Manchester. The assessment team recommended that the service reviews these numbers and consider managing general anaesthetic allergy at this site, which would increase their numbers.

The service has received the following revisit comments:

2.4 Thank you for providing updated evidence and we take full note of your comment regarding recognition of the senior nurse workforce. We are entirely with your feedback and this was discussed with the clinical lead for the scheme following your assessment. We hope that this will be addressed in the revised standards.

4.11 Excellent update protocol and good to see that you have a new dietician appointment to support the service.

Service summary

Service name: North Midlands Allergy and Immunology

Trust: University Hospital North Midlands

Service address:

Royal Stoke Hospital

Hilton Road

ST4 6QG

Date of assessment: 20 December 2018

Year established: 2010

Number of sites: 3

Assessors:

Syed Hasan Arshad (Professor of Allergy and Clinical Immunology at University Hospital Southampton NHSFT)

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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:

Manages patients with allergen specific immunotherapy for allergic rhinitis and venom allergy

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,MB,BSc,PhD	0.85	>5
Angela Cooper	Advanced Nurse Practitioner	RN	0.50	>5
Deborah Hughes	Specialist nurse	RN	0.50	<1
Lavanya Diwakar	Consultant	FRCPath,MRCP,MSc,MBBS	0.60	<1
Marion Breslin	Dietician	RD	0.06	<1

IQAS standards

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

Domain 1: Patient experience

1.1	**Patient involvement in the service:** There are defined systems in place to involve patients in the development and management of the service.	Level B
1.2	**Biennial assessment of patient satisfaction with the service:** There are defined systems in place to obtain and manage feedback from patients.	Level B
1.3	**Policy for dealing with management of referrals:** There are agreements with commissioners what services are available to which group of patients. This includes the nature of the service and the way it is delivered.	Level A
1.4	**Timeliness of referrals:** There is agreement with commissioners in what timeframes services are delivered.	Level A
1.5	**Timeliness of letters:** There are systems in place to ensure effective communication with patients and referrers.	Level B
1.6	**Patient information:** There are systems in place to ensure effective communication with patients and carers about health conditions.	Level A
1.7	**Patient input into patient information:** There are systems in place to ensure patients feedback and frequently asked questions are built into all patient information.	Level A
1.8	**Patient education:** There are trained professionals and systems in place, supported by educational materials, which make the options for care and treatment explicit to patients and their carers.	Level B

Domain 2: Service structure

2.1	**Structure of the service:** There is a description of the service for referrers, patients and their carers.	Level A
2.2	**Consultants delivering the service:** There are sufficient consultant staff within the service to enable safe and effective delivery of the service.	Level B
2.3	**Specialist nurse support:** There are sufficient specialist staff within the service with an appropriate mix of skills to enable safe and effective delivery of the service.	Level A
2.4	**Dietician support (for services seeing patients with food allergy):** There are sufficient specialist staff within the service with an appropriate mix of skills to enable safe and effective delivery of the service.	Level B
2.6	**Referral to companion specialties:** There is agreed access to specialist clinical services to enable timely interventions and safe and effective delivery of patient care.	Level B
2.7	**Treatment codes:** There are systems in place to ensure that allergy-related treatment codes are used.	Level A
2.8	**New patient numbers:** There are systems in place to ensure that the service sees appropriate number of patients for an allergy service.	Level B
2.9	**Meetings structured to discuss management issues:** There are systems in place to ensure effective service delivery including communications in the allergy team.	Level A

Domain 4: Quality and safety

4.1	**Reviewing adverse events:** The service has a system for capturing, recording and reviewing adverse events.	Level A
4.2	**Standard operating procedures (degree of overlap with drug, food IT):** There are written standard operating procedures/protocols for the allergy service.	Level A
4.3	**Guidelines:** The service has written clinical guidelines with auditable outcomes for the allergy service.	Level B
4.4	**Clinical meetings:** The service has meeting systems in place for effective management of patients.	Level A
4.5	**Complaints:** The service implements and monitors systems to manage complaints.	Level B
4.6	**Immunotherapy (patient numbers):** There are systems in place to ensure that the service sees appropriate number of patients for an allergy service.	Level B
4.7	**Immunotherapy (database):** There is a patient register in place that is able to capture KPIs and auditable outcomes on a continuous basis.	Level A
4.8	**Immunotherapy (SOPs):** There are written standard operating procedures/protocols for clinical conditions.	Level B
4.9	**Patient numbers for diagnosis and management of drug and food allergy:** There are systems in place to ensure that the service sees appropriate number of patients for an allergy service.	Level B
4.10	**Drug allergy database:** There is a patient register in place that is able to capture KPIs and auditable outcomes on a continuous basis.	Level A
4.11	**Drug and food allergy SOPs:** There are written standard operating procedures/protocols for clinical conditions.	Level B
4.12	**Latex allergy:** There are written standard operating procedures/protocols for the allergy service.	Level A

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

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