WMQRS BOARD MEETING

Date: 12th September 2011
Time: 2 pm – 4 pm
Location: Conference Room No 4, St Chads Court, 213 Hagley Road, Edgbaston, Birmingham B16 9RG

AGENDA

1.	Apologies for Absence	
2.	Notes of the meeting held on 27th June 2011	Enclosure 1
3.	Actions from last meeting	Enclosure 2
4.	Matters arising from the last meeting: a Board Membership and Establishment Agreement b WMQRS Service User and Carer Involvement Policy – Section 25 c Feedback from Chief Executives' Meeting	 Enclosure 3 Enclosure 4 Enclosure 5
5.	2010 Reviews of Urgent Care, Critical Care, Stroke (acute phase) & TIA, and Vascular Services: Evaluation Report	Enclosure 6
6.	Review Programmes: Progress Report	Enclosure 7
7.	Review of services for people with long term conditions: Scoping Report	Enclosure 8
8.	Change to WMQRS Staffing Structure	
9.	Future of WMQRS	Ongoing discussion
10.	Any other business	
11.	Date of 2011 Meetings: Thursday 15th December 2 – 4 pm	
12.	Agenda for next meeting (in addition to standing items): a. Review Programmes – Progress Report b. Future of WMQRS (ongoing discussion)	

ENCLOSURE 1 NOTES OF THE MEETING HELD ON 27TH JUNE 2011

PRESENT	
Eamonn Kelly (Acting Chair)	Chief Executive, NHS Worcestershire
Simon Mitchell	Medical Director, Sandwell PCT
Donal O'Donoghue	Medical Director, Sandwell & West Birmingham Hospitals NHS Trust
Steve Sharples	Patient Member
Stephen Washbourne	Assistant Director, Specialised Commissioning (West Midlands)
Richard Wilson	Head of West Midlands QI
Jane Eminson	Acting Director, WMQRS
IN ATTENDANCE	
Sarah Broomhead	Quality Manager, WMQRS
Claire Launders	Business Manager, WMQRS

1. Apologies for absence

Apologies were received from Julie Moore, Rob Courteney-Harris, Richard Taylor, Jan Warren, Stan Silverman.

2. Notes of meeting held on 30th March

The notes of the meeting held on 30th March were agreed as a correct record.

3. Actions from the last meeting

Progress with actions from the last meeting was noted. The Board discussed the need for publicising the availability of 'other products' such as the evaluation of consultation proposals.

4. Board Membership

The Board received and discussed the report on Board membership. It was agreed that the proposed revisions to Board membership should be recommended to Chief Executives for approval with the following clarification:

- The four commissioner representatives should, ideally, provide a range of Cluster, Clinical Commissioning Group and specialised services commissioning perspectives.
- Trust representatives should, ideally, provide a range of acute and non-acute perspectives.

The Board agreed to seek re-nomination of all Trust and PCT WMQRS Board members and deputies. The need for continuity was recognised and the Board hoped that some of the existing nominations would continue to be members of the Board. The Board also agreed to seek expressions of interest for two new patient members from public and patient involvement leads in NHS Trusts and PCTs.

Action: WMQRS to ask Trust and PCT CEOs to re-nominate WMQRS Board members and deputies
WMQRS to seek expressions of interest for two new patient members.

5. Review Programmes – Progress Report

The Board noted the progress report on review programmes. The Board discussed the emerging findings of the 2011 review programmes, in particular, the relative lack of robust clinical guidelines, data collection and audit.

The Board's advice was that this should be identified for 'further consideration' but with a note that this would be a concern in two to three years time if not addressed.

6. WMQRS Policies

The Board discussed the proposed WMQRS 'Guidance on handling serious personal and professional issues identified during review visits' and, in particular, the sentence 'Reviewers who are registered health care professionals will, however, have guidance from their professional body that they will need to take into account'. Whereas this sentence was correct, and some Board members felt that it should be included, others considered that it drew unnecessary attention and may result in reviewers raising concerns with the GMC or NMC on the basis of very limited information. It was agreed that further advice from the GMC and National Clinical Assessment Service should be sought.

Action: WMQRS to seek advice from GMC and NCAS on the policy in general and the inclusion of this section in particular.

7. The Board discussed the proposed WMQRS Service User and Carer Involvement Policy. Steve Sharples considered that sections 25 and 26 on payment of honoraria to user and carer reviewers was unfair and that all service users and carers should be either offered honoraria or not (rather than the policy agreed at the August 2010 Board meeting that payment would depend on a) the normal practice for the service or care pathway concerned and b) the identification of additional funding by the network or care pathway group concerned). It was agreed that this would be considered again at the next Board meeting after Board members had had time to consider and discuss the issue with colleagues.

Action: All Board members to consider and gain views on the question of payment of honoraria to service users and carers for their work with WMQRS.

8. Overall Assessment

The WMQRS team reported that overall assessments had been revised and re-circulated to acute Trusts and PCTs. Responses received were circulated to Board members. The Board noted the general view that the overall assessments were more acceptable although some people were still uncertain about the approach. After discussion, the Board agreed that maintaining the confidence of stakeholders was very important and therefore:

- Overview Reports should be circulated without the overall assessments.
- Overall assessments should be presented to Chief Executives and their further distribution discussed during this presentation.
- The South Birmingham health economy should be included on the overall assessment summary.

9. Report to Chief Executives

The Board discussed the proposed report to Chief Executives. On the section about the future of WMQRS, Donal O'Donoghue suggested that the importance of WMQRS as a catalyst for local service improvements should be included. The Board discussed the available evidence that peer review leads to improved quality of services and the demonstrable benefits of the process. Some of this will not be available until evaluation of the 2010 review programme has been completed. Potential research projects looking at the link between compliance with Quality Standards and service outcomes were also discussed. The Board also queried the availability of international comparisons. The need to obtain the views of Clinical Commissioning Groups was also discussed. The Board then agreed the report to Chief Executives with minor modifications.

Action: WMQRS to revise report as discussed for Chief Executives meeting on 15th July

10. WMQRS 2010/11 Annual Report

The Board agreed that any comments on the 2010/11 should be sent by email. Subject to comments received, the Board agreed the 2010/11 Annual Report.

Action: All Board members to send comments on draft WMQRS 2010/11 Annual Report.

11. Scoping report on review of services for people with long term conditions

Jane Eminson reported that this work was not yet complete. Some work and discussions had started and WMQRS was hoping to bring in some additional support to lead the scoping exercise.

12. Overview Report – Services for Children and Young People with Haemoglobin Disorders[1]

The Overview Report on the reviews of services for children and young people with haemoglobin disorders was not available in time for the Board meeting. The Board agreed that this could be signed off by email. Jane Eminson reported that the Overview Report included a recommendation that peer review of services for adults with haemoglobin disorders should take place in 2012 and WMQRS had been asked to provide governance and administrative support for this work. The Board agreed to this so long as the programme was adequately resourced and, therefore, that supporting this programme did not impact on the West Midlands work programme.

13. Pilot of GP practice reviews

Jane Eminson informed the Board that Solihull PCT had approached WMQRS about supporting a programme of peer review of general practice. The two clinical commissioning groups in Solihull were interested in this as a way of supplementing their work on quality metrics. The PCT would provide staff to lead the reviews, organise reviewers and write the reports. WMQRS would provide support and guidance, including training reviewers. This model could potentially be rolled out to other areas if successful. The Board discussed whether this was achievable within the available WMQRS staffing resources. The Board agreed that it would be interesting to pilot reviews of general practice if a feasible way of organising these could be found which did not duplicate existing review systems. The Board supported ongoing discussions with Solihull PCT about the proposed pilot.

14. Any other business

There were no other items of business.

15. Dates of next meetings

Monday 12th September, 2-4pm

Thursday 15th December, 2-4pm

[1] Donal O'Donoghue had left the meeting prior to discussion of this item. His support for both of the decisions in this section was confirmed by telephone after the meeting.

ENCLOSURE 2 ACTIONS FROM LAST MEETING

Min.	Action	Who	Progress
4	Ask Trust and PCT CEOs to re-nominate WMQRS Board members and deputies	WMQRS	See agenda item 4a
4	Seek expressions of interest for two new patient members.	WMQRS	Public and patient involvement leads in Trusts and PCTs have been asked to distribute a flier asking for expressions of interest in becoming a patient member of the WMQRS Board. Several responses have been received and discussions will be held with interested individuals in September. A verbal update will be given to the Board meeting.
6	Seek advice from GMC and NCAS on the WMQRS Guidance on Handling Serious Personal and Professional Issues identified during Review Visits	WMQRS	GMC and NCAS have been contacted and their advice is awaited.
7	All Board members to consider and gain views on the question of payment of honoraria to service users and carers for their work with WMQRS.	All	See agenda item 4b
9	Revise report as discussed for Chief Executives meeting on 15th July	WMQRS	Report revised and discussed. See agenda item 4a
10	Send comments on draft WMQRS 2010/11 Annual Report	All	No comments have been received. The 2010/11 Annual Report will therefore be produced in September.

ENCLOSURE 3 BOARD MEMBERSHIP AND ESTABLISHMENT AGREEMENT

Purpose of Report:

This report updates the Board on matters relating to its membership and the WMQRS Establishment Agreement.

Key Points:

- The changes to the Board membership discussed at the last meeting were proposed to Chief Executives for approval on 15th July 2011. The meeting of PCT Cluster Chief Executives and the SHA Chief Executive requested that PCT Cluster representation should be increased to five (ie one from each Cluster) including Chief Executive and senior medical and nursing representation, with a spread across different levels of commissioning responsibility. Nominations on this basis have been received:

Cluster	Name	Role
Arden	Fay Baillie	Director of Nursing
Black Country	Simon Mitchell	GP involved in Clinical Commissioning Group
Birmingham and Solihull	No nomination received	
Mercia	Eamonn Kelly	Chief Executive
Staffordshire	Dr James Shipman	Assistant Medical Director, Quality and Governance

  This meeting also discussed that Trusts should be given the opportunity to nominate five representatives (so as to balance the number of commissioner representatives. The issue of future SHA representation on the Board was also discussed. There was no formal minute of this meeting.

- Trust Chief Executives will be considering their nominations for the Board and agreement to the changes to the Establishment Agreement at their September meeting.
- Expressions of interest for two new patient members have been sought and responses are being received. New patient members should be identified and briefed in time for the December Board meeting.

Implications:	
Financial, Human Resources and Legal	The WMQRS Board is an essential to robust governance of the work of WMQRS.
Equality impact	WMQRS review programmes improve quality of health services and reduce inequalities in access to and quality of care.

Recommendations:

The Board is recommended to:

a. Note the contents of this report.

b. Agree to review progress with Board nominations and agreement of a revised Establishment Agreement at its next meeting

ENCLOSURE 4 WMQRS SERVICE USER AND CARER INVOLVEMENT POLICY – SECTION 25

Purpose of Report:

This report is for the Board to re-consider Section 25 of the draft WMQRS Service User and Carer Involvement Policy.

Key Points:

- At its last meeting the Board approved the draft WMQRS Service User and Carer Involvement Policy with the exception of section 25. Board members had different views about whether honoraria should be paid always, sometimes or never. Board members agreed to give further consideration to this section.
- Section 25 of the draft policy is:

  The need for honoraria in recognition of service users' and carers' time and expertise should be considered at the time of scoping each review programme. Honoraria may be paid:

  - Where this is normal practice for the service or care pathway concerned and agreed by the programme Steering Group
  - If additional funding to meet this expense is identified by the sponsoring network or care pathway group. If additional funding is not available then alternative mechanisms of involving service users and carers should be considered.
- This wording reflects the Board's decision in August 2010 which has been implemented since that date.

Implications:	
Financial, Human Resources and Legal	The WMQRS Service User and Carer Involvement Policy covers payment of expenses and, when applicable, honoraria to service users and carers. Payments will only be made within the resources available to WMQRS.
Equality impact	WMQRS review programmes improve quality of health services and reduce inequalities in access to and quality of care. Section 25 as currently drafted does not treat all service users and carers in the same way.

Recommendations:

The Board is recommended to reach a decision on Section 25 of the WMQRS Service User and Carer Involvement Policy.

ENCLOSURE 5 FEEDBACK FROM CHIEF EXECUTIVE'S MEETING

Purpose of Report:

This report updates the Board on discussions and decisions at the West Midlands NHS Chief Executives meeting on 15th July

Key Points:

- The report on WMQRS discussed at the last Board meeting was considered at the all Chief Executives' (CEOs)meeting on 15th July. The subsequent PCT Cluster and SHA Chief Executives meeting also considered the report and it is going to the Trust Chief Executives meeting in September.
- CEOs received a presentation on the Overview Reports of the 2010 review programme.
- CEOs agreed that the 2010 Overall Assessment should be circulated to them, along with an explanation of the methodology used.
- CEOs were happy with the proposed priorities for 2012 and 2013 review programmes. As the joint CEOs meeting is not a decision-making forum, this decision was ratified (although this is not minuted) at the PCT Cluster and SHA Chief Executives meeting and will be considered at the Trust CEOs meeting in September.
- There was some discussion of the future of WMQRS. The general view was that WMQRS should continue after April 2013 but the funding mechanism was not yet clear.

Implications:	
Financial, Human Resources and Legal	None identified
Equality impact	WMQRS review programmes improve quality of health services and reduce inequalities in access to and quality of care.

Recommendations:

The Board is recommended to note the contents of this report.

ENCLOSURE 6

2010 REVIEWS OF URGENT CARE, CRITICAL CARE, STROKE (ACUTE PHASE) & TIA, AND VASCULAR SERVICES: EVALUATION REPORT

Purpose of Report:

This report presents the evaluation of the 2010 review programme for the Board's consideration.

Key Points:

- This evaluation of the 2010 WMQRS review programme has three parts: evaluation of training sessions, evaluations at the time of the visit and an overall evaluation carried out when all reports had been finalised and circulated.
- Learning objectives at the half-day training sessions were generally achieved well. In particular, 86% respondents said that they understood the role and responsibilities of reviewers fully or very well. The main comments were about insufficient time. These views have to be balanced against the impact on clinical time if training is increased to one day for all reviewers. The evaluations show high levels of satisfaction with reviewer performance at the visit and with the quality of the report.
- The health economy evaluations identified some issues with preparation and with the timetable and additional health economy-based briefings for future programmes are proposed to address these. Comments were very positive about the approach and attitude of the visiting teams. Reviewers were positive about the experience, including about the organisation of the visit, the welcoming attitude of staff being reviewed and the learning they gained from the experience. There was a variety of views on whether the timetables, with some people thinking that they were too busy.
- The response rate for the overall evaluation was low. Relative to other programmes, it shows poor use of the preparation time but good results for the experience of being a reviewer and for 'immediate risks and concerns' having been addressed. Seventy three per cent of respondents said that the peer review process overall had been useful or very useful to their organisation in improving services.
- Overall, this evaluation shows that the 2010 review programme was well received and achieved its aims of improving the quality of services, providing development and learning and helping organisations to develop greater competence and confidence in clinical quality assurance.

Implications:	
Financial, Human Resources and Legal	None identified
Equality impact	WMQRS review programmes improve quality of health services and reduce inequalities in access to and quality of care.

Recommendations:

The Board is recommended to comment on and approve the Evaluation Report

2010 Reviews of Urgent Care, Critical Care, Stroke (acute phase) & TIA, and Vascular Services

Evaluation Report

Key Points

1. This evaluation of the 2010 WMQRS review programme has three parts: evaluation of training sessions, evaluations at the time of the visit and an overall evaluation carried out when all reports had been finalised and circulated.

2. Learning objectives at the half-day training sessions were generally achieved well. In particular, 86% respondents said that they understood the role and responsibilities of reviewers fully or very well. The main comments were about insufficient time. These views have to be balanced against the impact on clinical time if training is increased to one day for all reviewers. The evaluations show high levels of satisfaction with reviewer performance at the visit and with the quality of the report.

3. The health economy evaluations identified some issues with preparation and with the timetable and additional health economy-based briefings for future programmes are proposed to address these. Comments were very positive about the approach and attitude of the visiting teams. Reviewers were positive about the experience, including about the organisation of the visit, the welcoming attitude of staff being reviewed and the learning they gained from the experience. There was a variety of views on whether the timetables, with some people thinking that they were too busy.

4. The response rate for the overall evaluation was low. Relative to other programmes, it shows poor use of the preparation time but good results for the experience of being a reviewer and for 'immediate risks and concerns' having been addressed. Seventy three per cent of respondents said that the peer review process overall had been useful or very useful to their organisation in improving services.

5. Overall, this evaluation shows that the 2010 review programme was well received and achieved its aims of improving the quality of services, providing development and learning and helping organisations to develop greater competence and confidence in clinical quality assurance.

Introduction

6. In 2010 the West Midlands Quality Review Service (WMQRS) undertook quality reviews of urgent care, critical care, stroke (acute phase) & TIA, and vascular services across the West Midlands. The reports of each review visit and Overview Reports which summarise the regional picture are available on the WMQRS website: www.wmqi.westmidlands.nhs.uk/wmqrs

7. WMQRS is committed to evaluation of its work and this report presents the evaluation of the 2010 review programme. The 2010 evaluation has three elements:

   a. Evaluation of training sessions
   b. Evaluations at the time of the visit
   c. Overall evaluation

   This report summarises the findings of each of these evaluations and compares the overall evaluation with other review programmes. Where comments have been analysed, the number of comments is shown in brackets (XX). One respondent may have made more than one comment.

8. These are internal evaluations with respondents aware that their replies will be read by WMQRS staff. The responses are from those who made the effort to return a form and generalisations should therefore be drawn with some caution. They give, however, the best available view of the value of the 2010 review programme. Evaluations were undertaken in a comparable way to other review programmes.

EVALUATION OF TRAINING SESSIONS

9. One hundred and eighty six reviewers attended a half-day training session between March and June 2010 and 181 (97%) of these completed an evaluation form.

10. Learning objectives at the training sessions were generally achieved well (table 1). In particular, 86% respondents said that they understood the role and responsibilities of reviewers fully or very well. Least positive were 'be familiar with the Quality Standards' and 'practice the skills'. This is not surprising given the extent of material that needed to be covered in a half-day session.

Table 1 Achievement of Learning Objectives

Learning Objectives	% Achieved (N= 181)				
	Not at all	Not very well	Fairly well	Very well	Fully
Be familiar with the Quality Standards you will be reviewing	2	2	35	48	13
Understand the way in which peer review visits will be organised.	0	1	16	53	30
Understand the role and responsibilities of reviewers and the relationship with other team members.	0	1	13	59	27
Understand what you need to do at each stage of the peer review visit	0	1	29	48	22
Have practised the skills you will need when reviewing.	0	3	39	46	12

11. The individual training sessions showed a similar picture (table 2) with most sessions evaluating well and the poorest response for the session on practising skills. This session has also evaluated the lowest in previous training sessions. It involves 'role play', which is often unpopular, but without which reviewers do not fully understand what they have to do.

12. Specific comments were made about the need for more time (17), more explanation of the evidence review (8), criticisms of the venue or food (9). A small number of comments were also made on the presentations, role play and Quality Standards. Other general comments were balanced between critical comments or suggested

improvements (16), and positive responses (17) including "*One of the best training days I have been on for a very long time. Very practical and helpful. Thank you".*

Table 2 Evaluation of Individual Sessions

	% (N=181)			
Session	**Poor**	**Adequate**	**Good**	**V. Good**
Presentation: Purpose, Quality Standards & Visit Principles	0	2	50	48
Group Work: Review of Evidence	0	13	60	27
Presentation and practise: Health Economy Presentation and 'litmus test'	1	8	55	36
Presentation: Gathering Information	0	5	56	39
Group Work: Practising meetings	1	21	51	27
Presentation and practise: Conclusions	0	6	58	36

13. The question of the length of training sessions is difficult. One of the WMQRS principles is that impact on clinical time should be minimised. Reviewer training days have been increased to a full day for the 2011 review programme but WMQRS staff do not consider that this should be the norm for all reviews. Training can be completed in half a day but some reviewers will think this is too short. This issue should perhaps be considered in the light of the outcomes of training, in particular, satisfaction with the reviewers' performance (section 18) and with the review report (section 25). For the 2010 programme, training lasted half a day but satisfaction with reviewer performance and with the report were high.

Evaluations at the Time of the Visit

14. Evaluation forms were given to reviewers and to the health economies which were visited. These evaluations are often not returned but have, in the past, been useful for quickly identifying specific problems which have occurred.

Health Economy

15. Only 39 evaluation forms were returned from nine of the 15 review visits (14 health economies plus West Midlands Ambulance Service). The number of returns for each health economy ranged from one to 11.

16. The responses showed general satisfaction with the pre-visit preparation and the performance of the visiting team (table 3). More informative, however, are the comments on the evaluation forms. In relation to preparation for the review visit, some respondents said that they had not been involved (5), some felt that communication before the visit was poor (5) and others that communication was good (3). Comments on the preparation of evidence were similarly varied with 10 finding the preparation useful and eight saying that the evidence preparation was too time-consuming and duplicated what was needed for Monitor, NHSLA and CQC. Examples include: "*It was helpful for my team to prepare for this visit and allowed us to update protocols etc – which we had always meant to do*" and "*Time consuming – large amount of work to complete*." Three comments specifically highlighted that the preparation had improved team-work within their service.

Table 3 Health Economy evaluation at the time of the visit

Question:	% (N=35)		
	Not helpful	Helpful	Very helpful
The pre-visit preparation was:	9	69	23
The visiting team was:	3	37	60

17. Views on the actual visit also varied. There were 24 comments that the visit timetable was too rushed or was unclear, for example, "*Poor organisation and last minute changes led to confusion and the timetable was disrupted"* and "*Timing during the day. Failure to follow the programme meant the assessors disappeared at one point. It was disorganised and shambolic"*. A few people specifically commented that reviewing four services on one day was ambitious. Nine people commented that the visit timetable worked well, for example "*The day went like clockwork",* and there were five comments about the value of visiting clinical areas. Other comments were about a lack of information about what was expected at meetings (5), of which three comments specifically related to patient groups. Comments on the feedback given on the day were both positive (5) and negative (3).

18. Comments about the reviewers were overwhelmingly positive with 37 comments that reviewers were friendly, approachable, supportive and knew what they were talking about compared with three critical comments. Typical examples are: "*Informed and knowledgeable. Had obviously read the folder of evidence that had been collated. Were approachable and supportive in attitude – non-threatening. Listened to what we had to say and gave useful feedback."* or *"They were very knowledgeable and willing to discuss emergency care with us which was a good source of information. I found them supportive and understanding."* Two comments highlighted the usefullness of reviewers' suggestions.

19. General comments were positive with either "*nothing went badly or could be improved"* (13) or specific comments about the value of the process (5). Examples include: "*Made me look at things with fresh eyes. Made us realise we had some really good areas of practice."; "Gave focus to the standards of service required. Highlighted standards that we are acheiving and identified areas that needed improving."; "Generally served as a stimulus to critically review where we were compared with the Quality Standards and encouraged consideration of care pathways."; "A very helpful and positive process. Lots of work to prepare for the visit but this was positive in that issues neeing to be brought up to date were done."; "I feel the review was constructive, fair and balanced - just right. Very supportive of staff and the development of the service. Reviewers were very professional but able to support staff in feeling comfortable and open during discussions."*

Reviewers

20. Evaluation forms were returned by 102 reviewers which represents 44% of individual reviewers and 22% of reviewer days. (Reviewers are less likely to complete an evaluation form for second and subsequent visits). Twelve comments from reviewers which were sent separately immediately after the visits have also been included in the analysis of comments. Table 4 shows that reviewers were generally positive about the pre-visit information and organisation of the visit.

Table 4 Reviewer evaluation at the time of the visit

Question:	% (N=102)		
	Not helpful	Helpful	Very helpful
The information sent to me before the visit was:	2	42	56
Overall, I found the organisation of the visit:	0	28	72
I found the recording form:	0	51	49

21. Reviewers also gave more detail in their written comments. There were 18 positive comments about the information sent in advance of the visit with only four comments that it was poor or incomplete and one person who said it was too much. Four people would have like printed copies rather than emailed information and two had difficulty opening the zipped files attached to the email. Three people would have liked more guidance on which information to look at. Two reviewers commented that the training was invaluable in making sense of the pre-visit information.

22. Comments on the organisation of the visit were overwhelmingly positive (55), for example "*Organisation of the visit was very slick. All parties turned up at the right time with the right information"* and "*Highly professional but pleasingly friendly, personal and understanding",* although some reviewers would have liked more time for the review of evidence (3), for visits to wards and departments and meeting staff (9) or for meeting patients (2). Some reviewers commented that timekeeping was not good (6), that they had insufficient time overall (3) or did not manage to speak to appropriate staff (6). Finding evidence in the folders or intranet was sometimes difficult (8) and two people would have liked to receive the evidence in advance of the visit. Reviewers made several suggestions for improving the organisation of the visit (6). Some reviewers were concerned about refreshments (5), parking (2) and problems with the base room (5).

23. Reviewers generally commented on the positive attitude of staff from the health economy (13). There were also positive comments about the review of evidence (4), meeting patients (2) and teamwork among reviewers (12). Reviewers commented on the learning that they had gained from the experience (15): "*Good opportunity to learn and share working practices."; "learned about services and the importance of having protocol and policy. Good insight of system. Good experience."; "As educational as ever."; "Every part of the visit was enlightening – so much to learn". "Great experience. Learned a great deal"; "It was a great experience and I think as a result of it there are messages I can spread across my own Trust."*

24. Eight reviewers commented positively on the support available from WMQRS staff, for example "*I particularly valued the response of WMQRS staff in dealing with my queries in a speedy and supportive way. I felt valued and "looked after" in undertaking a new experience."; "It is an extremely difficult process in bringing together a group of professionals who have not met or worked together before. However, WMQRS seem to have great skills in overcoming problems and generating cohesion and cooperation without being patronising. I can only say – very well done".* There were 20 comments about the Quality Standards or the recording form but no general themes within these comments.

OVERALL EVALUATION

25. Overall evaluation questionnaires were sent out in June 2011 to lead contacts in Trusts and PCTs, to reviewers, and to people who were both reviewers and lead contacts. Despite two reminders, the response rates were

poor with only 49 forms returned from reviewers and 15 from Trust and PCT leads. The responses from the two groups were very similar and so they have been combined. Table 5 shows the responses from the 54 individual people who replied (10 people were both reviewers and Trust / PCT leads). The results are generally positive, in particular, 88% of reviewers said that the experience was helpful or very helpful in improving their own services. Most organisations did not use preparation for the review as a way of making changes in services. This is probably not surprising given the relatively short preparation time which was available for this review programme. The first reviews were carried out less than two months after the Quality Standards were finalised.

26. Fifty six per cent of respondents to the overall evaluation said that immediate risks and concerns identified in the visit report had been addressed in full or nearly so. Examples of changes made included introduction of a seven day a week TIA service, nursing competences improved, involvement of critical care staff in outlying high dependency units, a new sluice, increased consultant numbers, joint vascular and diabetic foot clinics, improved availability of data, improved bed management arrangements, new resuscitation equipment, improved patient information available, *"departmental protocols on most things for the first time ever"* and relocation of an acute medicine service. Some issues had proved difficult to address including absence of a mental health liaison service, establishing an interventional radiology rota, maintaining patient flow of acute medical admissions and data submission to the National Vascular Database.

Table 5 Overall Evaluation Responses

Question		%						N
		1	2	3	4	5		
The pre-visit support available from West Midlands Quality Review Service was:	Not helpful	0	7	40	27	27	Very helpful	15
Did the preparation for the visit lead to changes in the services provided by the Trust/Health Economy?	No change	33	13	20	33	0	Significant improvement	15
Was the experience of being a reviewer useful in developing your own services?	Not useful	0	0	12	43	45	Very useful	49
Was the peer review visit to your own organisation a helpful or unhelpful experience?	Not helpful	2	4	21	47	26	Very helpful	53
Did the report of the visit give a fair reflection of the services at your own organisation at the time of the visit?	Unfair	0	8	19	43	30	Very fair	53
Has your organisation been able to address the 'immediate risks' (if any) and 'concerns' identified in the report of its peer review visit?	Not addressed at all	2	12	31	44	12	Addressed in full	52
Has the involvement of staff from your Trust or provider organisation in visits to other places been helpful in improving own services?	Not helpful	0	15	23	46	15	Very helpful	13
Has the peer review process overall been useful to your organisation in improving services?	Not useful	0	4	23	62	11	Very useful	53

27. Suggestions for disseminating good practice included conferences, newsletters and dissemination using existing networks.

28. Respondents made several general comments of which some were negative (4), for example, *"Lot of work for little long-term gain",* or made suggestions for improvement (3). The balance of the comments was, again, positive including the following comments:

- *"A very worthwhile exercise that enabled us to have a good look at how others may take a different approach to a similar workload. Many potential tweaks to practice are thus revealed and while all may not be suitable in our Trust the debate about them does concentrate attention in delivering the best possible care for our patients.*
- *Extremely useful to be part of the overall process from putting the Standards together to undertaking the reviews.*
- *I found this to be a very objective assessment when being reviewed. The experience of reviewing another department was incredibly valuable.*
- *Collating index of evidence was a useful exercise in terms of identifying good practice and areas where we could improve.*
- *Excellent process to drive up quality – follow up is needed and standards should be refined and developed.*
- *The process was very helpful for me personally- it was instrumental in bringing on changes to my organisation - it should continue and aim to alter and improve the service in future as it is doing presently - is very helpful in maintaining patients' confidence and experience about the service.*
- *A very useful exercise, it focuses the mind and brings quality to the fore.*
- *The experience of being a reviewer and being reviewed is very valuable. I am happy to contribute more to this process because it is very worthwhile.*
- *Enjoyable to be a part of and I know it benefits clinical care as it has helped the movement of ideas and thoughts.*
- *The review process has provided me with good skills to review services and practice, it has provided good contacts for sharing information. Quality Standards provide focus and prioritisation for essential improvements or changes.*
- *The review is very helpful - it focuses on the quality of service, local priorities and organisational strengths and weaknesses. Just the process of preparation for the review serves is an important check of local service.*
- *The organisation of the WMQRS visits proved most instructive, while the experience gained proved invaluable in conducting and reporting on my organisation's announced and unannounced visits to local hospital wards and care homes. The approach, method and appraisal of such has noticeably improved as a direct result of the understanding and knowledge gathered during the periods in question working under the instruction and guidance of WMQRS. (Comment by Chair of a LINk/ HealthWatch)".*

29. Table 6 compares the evaluation of the WMQRS 2010 review programme with other reviews undertaken by WMQRS or its predecessor organisations. This shows, relative to other programmes, poor use of the preparation time but good results for the experience of being a reviewer and for 'immediate risks and concerns' having been addressed. Seventy three per cent of respondents said that the peer review process overall had been useful or very useful to their organisation in improving services.

Table 6 Overall Evaluation – Comparison with Other Review Programmes

Question	Response	%					
		CIC 2003	Cancer 2005	CIC 2006	WMQRS		
					Renal 2009	SC&T 2010/ 11	2010
Did the preparation for the visit to your own organisation lead to changes in the services provided?	Improvement or Significant Improvement	34	41	71	14	50	33
Was the peer review visit to your own organisation a helpful or unhelpful experience?	Helpful or Very Helpful	72	47	78	80	100	73
Did the report of the visit give a fair reflection of the services at your own organisation at the time of the visit?	Fair or Very Fair	83	58	65	66	100	73
Was the experience of being a reviewer useful in developing your own services?	Useful or Very Useful	81	74	89	91	92	88
Has your organisation been able to address the 'immediate risks' (if any) and 'concerns' identified in the visit report?	Addressed in full or nearly addressed		43		48	23	56
Has the peer review process overall been useful to your organisation in improving services?	Useful or Very Useful	67	45	61	52	73	73

Key: CIC Critically Ill Children SC&T Sickle Cell and Thalassaemia

Overall Conclusions and Actions

30. This section summarises the overall conclusions from the evaluation of the WMQRS 2010 review programme and recommends action which should be taken as a result.

31. The training sessions generally evaluated well despite lasting only half a day, and reviewers were assessed as performing well. The session on practising meetings evaluated least well. **Action:**

    a. WMQRS to review again the session on practising meetings before the next training to identify whether improvements can be made.

    b. In general, training should last half a day in order to minimise the impact on clinical time.

32. Despite the advice in the Review Process Paper, several organisations found that the preparation of evidence was too onerous. **Action:**

    c. WMQRS to consider again whether the work involved in the presentation of evidence can be reduced.

    Several aspects of the preparation for the visits could be improved, including better communication. Organisations' experiences appeared to vary considerably, possibly depending on the interest and enthusiasm of the identified lead contact for the review. Some organisations had not fully understood the Review Process paper, in particular, the section on preparing evidence. **Action:**

    d. For future reviews, WMQRS should offer briefing sessions in each health economy for individual service leads (rather than region-wide briefings for lead contacts from each organisation). These briefings should cover all aspects of the review and, in particular, the preparation of evidence.

33. Some people, including patient groups, were unclear on the purpose of meetings. The Review Process Paper now includes guidance on the expected issues to be discussed at patient group and other meetings.

34. There was a variety of views on whether the timetables, with some people thinking that they were too busy. As well as the WMQRS commitment to minimising the impact on clinical time, reviewing several services together has many advantages. The links between services can be identified and good use is made of the time of 'generic' reviewers, staff within the Trust and WMQRS staff. The 2010 reviews did run up to seven, sometimes multi-site, clinical streams on one day and this may have been too many. In general, four or five clinical streams is probably the maximum which should be undertaken on one day in future reviews. Several detailed suggestions will also be taken into account in the design of future review programmes.

    Dissemination of good practice is the responsibility of sponsoring networks or clinical pathway groups and did happen to a varying extent for the 2010 review programme. **Action:**

    e. WMQRS should give greater consideration to the dissemination of good practice as part of the scoping of future review programmes.

35. Response rates in some parts of this evaluation were low. The evaluation used the methods developed for previous programmes, rather than the framework developed by *Finnamore,* in order to give data which could be compared with other programmes. The evaluation was internally collated and analysed and so does not give an independent view of the success of the programme. Full external evaluation of each programme would not be affordable within WMQRS resources but external analysis of collated responses could be commissioned. **Action:**

    f. WMQRS to consider ways in which the response to each stage of the evaluation of review programmes can be improved.
    g. WMQRS to commission external analysis of future evaluation responses.

36. Overall, however, this evaluation shows that the 2010 review programme was well received and achieved its aims of improving the quality of services, providing development and learning and helping organisations to develop greater competence and confidence in clinical quality assurance.

ENCLOSURE 7 REVIEW PROGRAMMES – PROGRESS REPORT

Purpose of Report:

This report updates the Board on progress with the WMQRS review programmes. Board comments and guidance are invited.

Key Points:

- 2010 reviews: Overview Reports and overall assessments have been distributed to all organisations. The Overview Reports were presented to Chief Executives in July and to the SHA Patient Safety Oversight Group on September 5th. The Overview Reports are not yet available on the WMQRS website as a response from the SHA on their plans for placing them in the public domain is awaited. The evaluation report (agenda item 5) concludes this review programme. Work continues on revising the Urgent Care Quality Standards.
- 2011 reviews: Three health economy reviews have now taken place (Dudley and Walsall, Coventry and Warwickshire, and Birmingham and Solihull). The learning disabilities part of the Birmingham and Solihull review was deferred and will now take place at the end of September. In July the Black County Partnership NHS Foundation Trust notified WMQRS that they wished to withdraw from their review. Further discussions have taken place and the Trust is reconsidering this position. A verbal update will be given to the Board.
- The review of renal services at University Hospital Birmingham NHS Foundation Trust took place on 12th July 2011.
- The Services for Children and Young People with Haemoglobin Disorders - Overview Report will be circulated in the first week of September and completes this programme of reviews.
- 2012 reviews: See agenda item 7.
- Funding of £152,845 has been allocated to WMQRS by the NHS Sickle Cell and Thalassaemia Screening Programme for the programme of reviews of services for adults with haemoglobin disorders. Recruitment of staff for this programme will start in September. This programme cannot be undertaken unless additional accommodation for WMQRS is identified.
- No further detailed discussions on the possible pilot of quality reviews of GP practices have taken place. This is being considered further by the staff at Solihull.
- WMQRS Quality Monitoring: Information on compliance with WMQRS Standards will be tabled at the Board meeting.

Implications:	
Financial, Human Resources and Legal	None
Equality impact	WMQRS review programmes improve quality of health services and reduce inequalities in access to and quality of care.

Recommendations / Action Required:
The Board is recommended to note the contents of this report.

ENCLOSURE 8 REVIEW OF SERVICES FOR PEOPLE WITH LONG TERM CONDITIONS: SCOPING REPORT

Purpose of Report: This report presents the Scoping Report of the planned 2012 reviews of services for people with long term conditions for the Board's consideration.

Key Points:

- In March 2011 the WMQRS recommended to Chief Executives that the care of people with long-term conditions should be the main WMQRS review programme in 2012. This recommendation was supported by Chief Executives in July 2011. It was recognised that further detailed scoping of the programme would be needed.
- Dr Doug Wulff, Medical Director of Birmingham East and North PCT, has been working with WMQRS on scoping this review programme.
- Key issues which have emerged during the scoping are:
    - Should Quality Standards be very 'high level' and general or specific to each pathway? A compromise of generic Quality Standards with pathway-specific prompts is proposed.
    - Should the reviews concentrate on specific long-term conditions and, if so, which? Should these be the same for each health economy?
    - Should the reviews cover both children and adults with long-term conditions?
- A workshop with service users, clinicians, providers and commissioners is being held on 30th September to discuss these issues.
- The Board's guidance and steer on the scoping of the review programme is sought.

Implications:	
Financial, Human Resources and Legal	The report recommends a 1 wte secondment / short-term appointment of a Clinical Support post for the Long-Term Conditions review programme for the period January 2012 to March 2013. This is within the WMQRS budget.
Equality impact	WMQRS review programmes improve quality of health services and reduce inequalities in access to and quality of care.

Recommendations: The Board is asked to comment on the scoping of the 2012 review programme of the care of people with long-term conditions.

LONG TERM CONDITIONS REVIEW PROGRAMME - SCOPING

1 Introduction

West Midlands NHS Chief Executives agreed in July 2011 that the main 2012 WMQRS review programme should cover care of people with long term conditions (LTC). This review programme is sponsored by the West Midlands Long Term Conditions Clinical Pathway Group. NHS West Midlands commissioned a feasibility assessment (May 2010[2]), which was considered by the WMQRS Board in August 2010, and a literature review[3]. The WMQRS Board recommended the programme to Chief Executives for 2012. This paper discusses issues around the scoping of the programme for the Board's consideration.

2 What is the scope of the pathway / service to be reviewed?

The definition of Long Term Conditions proposed for this review programme is that used by the *Our NHS, our Future* LTC Clinical Pathways Group, namely, 'conditions that cannot, at present, be cured, but can be controlled by mediation and other therapies'[4]

The feasibility study identified that a number of potential long term conditions are already included in other quality review programmes and so would not be included in the 2012 reviews: Mental health, health services for people with learning disabilities and dementia services are being reviewed during 2011. Cancer services are reviewed by the national peer review programme. The acute phase of stroke care was reviewed in 2010 but this review did not cover post-acute care or rehabilitation.

Using the *Our NHS, our Future* LTC Clinical Pathways Group definition, the 10 conditions with the highest prevalence and severity in the West Midlands are hypertension, asthma, diabetes, coronary heart disease, hypothyroidism, stroke & TIA, COPD, cancer, epilepsy and left ventricular dysfunction. Left ventricular dysfunction can be seen as an end point of coronary heart disease and so potentially these two conditions could be reviewed together.

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[2] Long term conditions quality reviews: feasibility assessment. The Evidence Centre. May 2010

[3] Key themes in managing long term conditions. The Evidence Centre. May 2011.

[4] *Our NHS, our Future* – NHS Next Stage Review Long Term Conditions Clinical Pathway Group Report. NHS West Midlands. Version 7 - 24th April 2008

Hypertension, although the LTC with the highest prevalence, is largely managed within general practice and the current measures of quality (QoF) are readily available. Simpson et al[5] demonstrated the increase in treatment of hypertension after the introduction of QoF in Scottish primary care. This could not be directly attributed to QoF nor does it demonstrate on-going improvement in quality of care. This makes the care of people with hypertension less amenable to a WMQRS review process. The management of hypothyroidism can arguably be seen in the same way as that of hypertension.

COPD, although of lower prevalence than many of the other LTCs, is a condition that leads to a high rate of hospital admission and is often diagnosed late in the disease process. The management of this condition spans the boundaries of prevention, primary, secondary and end of life care. Asthma could also be regarded in the same way.

Diabetes is an increasing problem with a rising prevalence as a result of increasing obesity within the UK population. As with COPD, the services for diabetes span the boundaries of health and social care and so this condition lends itself to a review programme.

Epilepsy is also a condition with both primary and secondary interfaces which, if not managed smoothly, can lead to issues of quality and safety. In the early stages of the scoping exercise the question was raised as to whether to include other long term neurological conditions, such as multiple sclerosis, as well as spinal injury and degenerative conditions. There may be scope for including these although the overall numbers are much smaller than for the other conditions identified.

Another aspect to be considered is whether to review generic or multi-condition service delivery systems such as admission avoidance teams and virtual wards. There is a good argument for including these as part of the health care system's approach to managing the care of people with long term conditions.

A further consideration is whether the review should cover both adult and children's services or be limited to one or the other.

Five main pathways are therefore considered further:

a. Coronary heart disease (CHD) and left ventricular dysfunction
b. COPD and asthma
c. Diabetes
d. Epilepsy
e. Stroke (post-acute care and rehabilitation)

[5] Simpson CR, Hannaford PC, Ritchie LD, Sheikh A, Williams D. Impact of the pay-for –performance contact and the management of hypertension in Scottish primary care: a 6-year population-based repeated cross-sectional study. British Journal of General Practice; 2011, Vol 61; 588 p 460 – 461.

Further discussion is also needed with the West Midlands Renal Network. Services for people with progressive and advanced chronic kidney disease were reviewed in 2009 and previous discussions had indicated interest in re-reviewing these services, possibly in 2012.

3 **Are there important inter-relationships with other services / pathways that should be considered in designing the review programme?**

All five pathways have significant and important inter-relationships with different parts of the health system and social care. People also often have more than one long term condition which is reflected in the development of generic or multi-condition services.

Prevention programmes, particularly smoking cessation and weight reduction, impact on four of the five pathways (ie. all except epilepsy). Primary and secondary care interfaces are important in all six pathways. Rehabilitation services are important for CHD and left ventricular dysfunction, COPD and stroke. End of life care is important in all with particular emphasis in left ventricular dysfunction and COPD. All five pathways have important links with social care services. There are also important links with mental health services. Associated mental health issues are found in all LTCs and there is a particular association between learning difficulties and epilepsy.

4 **Does the pathway / service meet the draft criteria for selection into the WMQRS work programme?**

1. **Pathway / service** not **covered by an existing clinical quality assurance / review process**
The five pathways identified are not fully covered by existing clinical quality assurance/review processes. The Quality and Outcomes Framework (QoF) review visits do cover primary care of some of these pathways. **ADULTS:** **CHD and left ventricular dysfunction:** Several national audit programmes cover this area, in particular the CCAD Audit Programmes and national audit of secondary prevention. The British Cardiac Intervention Society has produced an audit tool covering cardiovascular disease and heart failure. Cardiac and stroke networks undertake ongoing monitoring of services. The British Cardiovascular Society run a peer review programme but participation is voluntary and coverage is not complete. **COPD and asthma:** The National COPD Resources and Outcomes Project is run by the Royal College of Physicians, the British Thoracic Society and the British Lung Foundation. A respiratory peer review programme is run by the British Thoracic Society but participation is voluntary and coverage is not complete. **Diabetes:** The National Diabetes Audit of the NHS Information Centre and the National Clinical Audit of Diabetes UK are run annually on a voluntary participation basis. The Diabetic Retinal Screening Programme conducts national quality assurance reviews of the services. **Epilepsy:** WMQRS has not identified any existing clinical quality assurance process covering epilepsy services.

	Stroke (post-acute): Stroke services were reviewed by the Care Quality Commission in 2010. The National Stroke Sentinel Audit covers these services. In addition to cardiac and stroke networks' ongoing monitoring, visits are undertaken by the national Stroke Improvement Team. **Generic LTC services:** WMQRS has not identified any existing clinical quality assurance process covering generic LTC services. **Prevention Services** were reviewed across the West Midlands in 2009 as part of the *Inequalities in Health* review visits. There are no known other quality review programmes in preventive services apart from Diabetic Retinal Screening and the cancer screening quality assurance programmes. **Rehabilitation and End of Life Care** are reviewed for cancer services but WMQRS has not found any evidence of systematic quality assurance of non-cancer care. **CHILDREN:** The West Midlands Paediatric Diabetes Network has been developing standards and members have been interested in undertaking peer review for some time. Services for children with cystic fibrosis are peer reviewed by the Cystic Fibrosis Society. Services for children and young people with haemoglobin disorders were reviewed in 2010. WMQRS has not identified clinical quality assurance processes for other long-term conditions in children.
2.	**Pathway / service is an area of changing policy, strategy, clinical practice or service configuration.**
	The national policies of providing care closer to home and admission avoidance impact directly on the care of people with long term conditions. Other drivers include the increased ageing of the population and increased life expectancy resulting in greater numbers of people living with LTCs. Early detection and prevention strategies seek to improve LTC management.
3.	**Pathway / service has significant known variations in quality OR pathway / service has little or no information on service quality.**
	Most of them have variation. WMQI has baseline data for 2007/08 by SHA and PCT which demonstrates variation across areas using the medium of SPC (statistical process charts). (http://www.wmqi.westmidlands.nhs.uk/clinical-measures/clinical-measures-home/report/180). The Atlas of Variation in Healthcare further demonstrates variability across a number of measures in all of the LTCs identified as potential streams for review. (http://www.sepho.org.uk/extras/maps/NHSatlas/atlas.html).
4.	**Pathway / service is an SHA-wide priority for improving quality or is chosen by the local health economy or Specialist Commissioning Team (West Midlands).**
	Long-term conditions have been agreed by West Midlands Chief Executives as the priority for region-wide WMQRS reviews in 2012.

5 **Are agreed Quality Standards suitable for use in quality reviews available or would these need to be developed?**

NICE quality standards have been published for COPD, chronic heart failure and diabetes in adults[6]. NICE and other national guidance is available for each of the proposed pathways.

The NHS West Midlands QUIP report on *Long Term Conditions: Specialised Teams*[7] identifies seven priorities which will form the basis of the WMQRS Quality Standards:

1. Population stratification & case management
2. Commissioning and providing joined up, personalised and integrated services
3. Preventing disease progression
4. Supporting self care
5. Ensuring everyone is offered care planning
6. Using tele-healthcare to health manage people with long term conditions
7. Workforce development

This material is not yet in a format suitable for use in peer review programmes. It is envisaged that a generic set of LTC Quality Standards would be developed with pathway-specific prompts and detail. Quality Standards would need to be cover the primary care, rehabilitation and end of life aspects of the pathways.

6 **What is the best approach to quality review for the service (ie. full peer review programme, self-assessment)?**

Initial discussions suggest that there would be support for a full peer review programme. The main question is the balance between region-wide reviews and locally determined pathway reviews. If generic Quality Standards are developed then these could be used for local work with any LTC pathway. An approach that seeks to review all the proposed services may, however, prove too large for a single programme. Options include:

a. Continue with a full review programme
b. Review one or two conditions as exemplars of all LTC services;
c. Spread the review of different conditions a longer period (NB. This would delay the 2013 review programme.)
d. Allow health economies to 'pick and mix' different conditions;
e. Conduct less detailed reviews.

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[6] Chronic obstructive pulmonary disease (COPD) Quality Standards. NICE
http://www.nice.org.uk/guidance/qualitystandards/chronicobstructivepulmonarydisease/copdqualitystandard.jsp

Chronic heart failure quality standard. NICE
http://www.nice.org.uk/guidance/qualitystandards/chronicheartfailure/home.jsp

Diabetes in adults quality standard. NICE
http://www.nice.org.uk/guidance/qualitystandards/diabetesinadults/diabetesinadultsqualitystandard.jsp

[7] *Long Term Conditions: Specialised Teams.* West Midlands Regional QUIP Workstream. A model of the impact of implementation on activity, quality and costs. (Undated)

The Board is asked to consider these options and provide a steer on the way forward.

7 **Do clinical staff working in the service/ pathway agree with the need for strengthening quality review of the service and would they support the proposed approach?**

Initial discussions with clinical staff have indicated that there is a need for strengthening quality review of aspects of LTC management. There are some differences of views about the level of detail which the reviews should consider. In general, PCT LTC leads are interested in a high level review looking at the seven priority areas (see above). Clinical staff would not be interested in this level of review but would like to undertake pathway specific reviews. The cardiac and stroke networks have supported the review programmes of CHD / left ventricular dysfunction and stroke (post-acute care). A workshop is being held on 30th September to discuss the review programme with interested clinicians and others.

In the past it has been difficult to engage GPs in acting as WMQRS reviewers as specific payment is not available. Although this review programme should be highly relevant to Consortia Leads for Quality and Monitoring, in practice, this may not be sufficient to achieve GP engagement. Based on the assumptions in Appendix 2, paying one GP per day plus training would cost approximately £25,000 to £30,000. WMQRS does not have funding for this. This could be funded from the 2010/11 under-spend if this was not returned to PCTs (in line with previous Board decisions). This may, however, create a precedent about WMQRS funding of GP involvement in its review programmes.

Some discussion with Directors of Adult Social Services and, if included, Children's Services in the region will be needed to ensure they are aware of the programme (as took place for the 2011 reviews).

8 **How will users and carers be involved and recruited?**

Some interested service users and carers have already been identified through PCT long-term condition leads and have been invited to the 30th September workshop. A variety of pathway-specific user groups can also be involved following the Board's guidance on the pathways to be included. Service user and carers will be involved on Steering Group/s (see below) and as reviewers[8].

9 **How much of WMQRS resources will be needed to support review of the service / pathway?**

This will be the main review programme for 2012. During 2011/12 preparatory work will be needed, including developing Quality Standards appropriate for use in peer review. Appendix 1 gives an outline of the timetable for the review programme.

[8] WMQRS note: Depending on the Board decision on service user and carer honoraria, this may also need to be considered.

Dr Doug Wulff, Medical Director of Birmingham East and North PCT has supported initial work on scoping the review programme and may be able to provide some support for the preparatory work over the next few months.

The programme would need one whole time equivalent clinical support post for the LTC programme and a short-term contract / secondment from January 2012 to March 2013 will be advertised later in September 2011.

Initial scoping of the services to be reviewed (Appendix 2) suggests that this programme can be run within the existing WMQRS resources so long as:

a. Recruitment to the LTC clinical support post, the second support post and the haemoglobin disorder post is successful.

b. If included, care of children with long-term conditions is run as one large review rather than multiple small reviews.

c. The West Midlands Renal Network is able to provide support for the reviews of services for people for advanced and progressive chronic kidney disease (ie attending each review visit and supporting and guiding visiting teams).

d. West Midlands cardiac and stroke networks working together are able to provide support for the review programme (ie attending each review visit and supporting and guiding visiting teams).

APPENDIX 1 OUTLINE LTC REVIEW PROGRAMME TIMETABLE

Month	Actions
September 2011	• WMQRS Board consideration of Scoping Report • Workshop with users & carers, clinicians, providers, commissioners (30th) to discuss scope, review process and start to develop Quality Standards • Advertise LTC clinical support post

October 2011	• Second workshop to develop Quality Standards (21st)
	• Involve pathway-specific user groups
	• Initial contacts with health economies to:
	  ○ Identify lead contacts
	  ○ Confirm services to be reviewed
	  ○ Start to recruit reviewers
	• Interview LTC clinical support post

November 2011	• Telephone conference (?) to sign off Quality Standards (QSs) • Quality Standards sent out for comment • Recruit reviewers • Send out proposed visit dates and services to be reviewed
December 2011	• Recruit reviewers • Confirm visit dates and services to be reviewed
January 2012	• LTC clinical support post starts work with WMQRS • Deadline for comment on QSs (9th) • Steering Group/s agree QSs (w/c 20th) • Train and book reviewers • Start to agree timetables
February 2012	• Finalise QSs • Train and book reviewers • Agree timetables
March 2012	• Finalise QSs • Train and book reviewers • Agree timetables
April 2012	• Finalise preparations for review visits
May – October 2012	• Review visits • Produce reports
Nov 2012 – March 2013	• Finalise all reports • Produce Overview Report • Support sharing of good practice

APPENDIX 2 SERVICES TO BE REVIEWED – INITIAL SCOPING

The following table scopes the services to be reviewed based on the following assumptions:

- Up to five adult pathways would be reviewed on one day for each 'health economy' (see table)
- If included, care of children with long-term conditions would be run as one large review, possibly on the same day as the primary care, rehabilitation and end of life reviews.
- Generic long-term condition services would be reviewed only once in each health economy and would be reviewed on the same day as primary care, rehabilitation and end of life reviews.
- Primary care, rehabilitation and end of life reviews would cover all pathways. If included, care of children would be covered in these reviews and / or the children's review depending on the local configuration of services.
- One day would be needed for governance, commissioning and bringing together the findings for each health economy.

Key:	1 →←1	Hopefully review on same day	↓1 ↑1	May be able to do on one day

Table 1 Services to be Reviewed – Initial Scoping

Cluster	Health Economy	Acute Trust	Adult Pathway	Children's Pathway	Primary Care Rehabilitation End of Life Generic Teams	Commiss-ioning Govern-ance	Reviewing Days	Visiting Weeks	Reviewing days if combined	Visiting weeks if combined	Possible visiting dates
Staffordshire	North Staffordshire	UHNS	1	1	1	1	10	2	7	1.5	w/c 14th & 21st May 2012
	Stoke										
	South Staffs (E)	Burton	1	↑1→	←1						
	South Staffs (W)	Mid Staffs	1	1→	←1						
Mercia	Shropshire	SaTH (2)	1	1→	←1	1	13	3	10	2	w/c 11th & 18th June 2012
	Telford and Wrekin										
	Worcestershire	WAHT (3)	2	1→	←1	1					
	HH	1	1→	←1	1						
	Coventry	UHCW (2)	1	↑1→	←1						
Black Country	Wolverhampton	RWH	1	1→	←1	1	10	2	7	1.5	w/c 10th & 17th September 2012
	Dudley	DGH	1	1→	←1						
	Walsall	WH	1	1→	←1						
	Sandwell	S&WB (2)	1	1→	←1						
Birmingham & Solihull	HOB					1	11	2.5	8	2	w/c 8th & 15th October 2012
	BEN & Solihull	HEFT (3)	2	1→	←1						
	South Birmingham	UHB	1	x	1						
		BCH	x	1→	←1						