WM QRS West Midlands Quality Review Service

NHS

Care of Adults with Long-Term Conditions

Care of Children & Young People with Diabetes

Shropshire, Telford & Wrekin Health Economy

Visit Date: 2nd, 3rd, 4th, 5th October 2012

Report Date: January 2013

Images courtesy of NHS Photo Library

INDEX

INTRODUCTION

This report presents the findings of the review of the care of people with long-term conditions which took place on 2nd, 3rd, 4th, 5th October 2012. The purpose of the visit was to review compliance with West Midlands Quality Review Service (WMQRS) Quality Standards for:

- Care of People with Long-term Conditions, Version 1, May 2012
- Care of Children and Young People with Diabetes, Version 1.2, June 2012

and the following national standards:

- Pulmonary Rehabilitation Service Specification, Department of Health, August 2012
- British Association of Cardiovascular Prevention and Rehabilitation, Standards and Core Components for Cardiovascular Disease Prevention and Rehabilitation, March 2012

This visit was organised by WMQRS on behalf of the West Midlands Long-term Conditions Care Pathway Group and the West Midlands Paediatric Diabetes Network.

The aim of the standards and the review programme is to help providers and commissioners of services to improve clinical outcomes and service users' and carers' experiences by improving the quality of services. The report also gives external assurance of the care within the Health Economy which can be used as part of organisations' Quality Accounts. For commissioners, the report gives assurance of the quality of services commissioned and identifies areas where developments may be needed.

Care of people with long-term conditions was chosen as the main WMQRS review programme for 2012/13 for a variety of reasons. Six out of 10 adults report having a long-term condition that cannot currently be cured and the majority aged over 65 have two or more long-term conditions. Eighty per cent of primary care consultations and two thirds of emergency hospital admissions are related to long-term conditions. The Operating Framework for the NHS in England 2012/13 gave priority to improving the care of people with long-term conditions. Most services for people with long-term conditions had not previously been subject to external quality assurance. The focus brought to these services by the Quality Standards and peer review visits was therefore new for many staff involved in the care of people with long-term conditions. This review programme has given the opportunity for highlighting good practice and sharing this with others across the West Midlands, as well as identifying areas where action is needed by providers and commissioners.

The report reflects the situation at the time of the visit. The text of this report identifies the main issues raised during the course of the visit. Appendix 1 lists the visiting ream which reviewed the services at Shropshire, Telford & Wrekin health economy. Appendix 2 contains the details of compliance with each of the standards and the percentage of standards met.

Shropshire and Telford & Wrekin was the first health economy to be visited in the 2012/13 peer review programme. Compliance with Quality Standards may therefore be lower than in health economies which had a longer period of preparation.

ABOUT WEST MIDLANDS QUALITY REVIEW SERVICE

WMQRS was set up as a collaborative venture by NHS organisations in the West Midlands to help improve the quality of health services by developing evidence-based Quality Standards, carrying out developmental and supportive quality reviews - often through peer review visits, producing comparative information on the quality of services and providing development and learning for all involved.

Expected outcomes are better quality, safety and clinical outcomes, better patient and carer experience, organisations with better information about the quality of clinical services, and organisations with more confidence and competence in reviewing the quality of clinical services. More detail about the work of WMQRS is available on http://www.wmqi.westmidlands.nhs.uk/wmqrs

ACKNOWLEDGMENTS

West Midlands Quality Review Service would like to thank the staff and service users and carers of Shropshire and Telford & Wrekin health economy for their hard work in preparing for the review and for their kindness and helpfulness during the course of the visit. Thanks are also due to the visiting team and their employing organisations for the time and expertise they contributed to this review.

CARE OF PEOPLE WITH LONG-TERM CONDITIONS

HEALTH ECONOMY

General Comments and Achievements

Staff providing and commissioning care for people with long-term conditions in Shropshire and Telford & Wrekin were working hard and were highly motivated to improve the quality of services. Some good progress had been made, especially in some aspects of training and education programmes for primary care and for staff of care homes.

Staff generally had insight into the problems which they faced and were starting to address these issues. In particular, the Long –Term Conditions Patient Reference Group was looking in detail at care planning. A local network had been established and different work-streams were linked to this, with priority being given to the care of frail older people and those people with complex needs. This work was supported by a strategic partnership between the two provider Trusts. One of the work-streams related to tele-health and progress was being made on the implementation of simple tele-health for appropriate patients.

Concerns

1 **Pathways of Care**

Pathways of care for people with long-term conditions were generally not clear, including the role of each service, who should be referred, the responsibilities of different services within the pathway and when handover to another service was expected. As a result, reviewers identified several opportunities for using resources more effectively or improving the quality and continuity of care.

2 **Integration between Services**

Effective integration and coordination between services was not yet in place. Case managers had variable links with general practices and specialist teams (for care of people with heart failure, diabetes or COPD) did not link effectively with case managers. In particular, criteria for discharge from specialist teams were rarely in place.

Record systems were separate and many were paper-based. Some records were held by the patient but several services took their records with them and no record was left with the patient. As a result, it was rarely possible for the staff of one service to be aware of the activities of another service when they were both involved with the care of the same patient. Social care records were separate from health records. Reviewers were told that the hospital discharge team developed a discharge plan but this was not necessarily communicated in the discharge letter and so all services involved in the patient's care were not updated with the latest plan.

Reviewers were given several examples of multiple services seeing individual patients on the same day with each service being unaware of the involvement and contribution of the others. Examples of the lack of integration were both within some pathways of care and between pathways for people with multiple long-term conditions.

Further Consideration

1 **Risk stratification:** A lot of work had taken place on risk stratification and this was being made available to GPs. The information was not yet in a format that was easy for practices to use and a variety of initiatives was being pursued to address this. Case managers and specialist teams were not aware of the risk stratification information. The work on risk stratification and ensuring this information is easily available to all services will need to continue.

2 GPs who met review team worried that GPs were sometimes being asked to prescribe 'specialist only' medication drugs not on the area formulary. In the light of these comments if may be helpful to review how well the local Medicines Management Committee is working.

3 Expert Patient Programmes were available but referral rates appeared to vary. Greater awareness of these opportunities may be helpful.

Return to *Index*

PRIMARY CARE

SHROPSHIRE AND TELFORD & WREKIN CLINICAL COMMISSIONING GROUPS

Good Practice

1 *ShropDoc* provided an impressive range of services for people with long-term conditions, including triage, home visiting, education and a single point of access for queries and concerns.

2 A good development programme for GPs was in place. This was clearly linked to the Strategy for Care of People with Long-Term Conditions and to the End of Life Care Strategy. The education programme supported implementation of the strategy.

Further Consideration

1 Arrangements for ensuring all practices were following up women with gestational diabetes were unclear. An audit of whether practices had implemented prompts or recalls for these women may be helpful.

Return to *Index*

SPECIALIST CARE OF CHILDREN & YOUNG PEOPLE WITH DIABETES

THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST

General Comments and Achievements

The paediatric diabetes team at The Shrewsbury and Telford Hospital NHS Trust was a well-organised service caring for approximately 240 children and young people. Parents who met the visiting team were very happy with the care they received. Reviewers were impressed by the positive attitude of staff and their commitment to improving quality. The team had strong leadership and a clear vision for the future development of the service.

Other achievements included the training of two link nurses, one at Princess Royal Hospital and one at Royal Shrewsbury hospital. Two more link nurses were being trained. At Princess Royal Hospital there were particularly good links with a social worker. Links with the psychology service were also good. Dietician input to the care of children and young people with diabetes was good although constrained by staffing shortages (see below). There was a good school care plan.

Good Practice

1 Information for children, young people and their families was good. The information was comprehensive, clear and well-presented.

Immediate Risks: No immediate risks were identified.

Concerns

1 Paediatric Diabetes Specialist Nurse (PDSN) staffing levels were below the recommended level of 1wte: 70 patients. At the time of the review the ratio was 1:86 and PDSNs were working across two hospital sites. A business case for additional staffing had been developed but it was not clear how this was being taken forward. There were also delays in accessing PDSN advice. Young people and their parents had to ring a

central number and leave a message (if no one was available) when they wanted support or advice. It could therefore be up to 24 hours later by the time the call was returned, and longer at weekends.

2 Dietetic staffing levels were insufficient to achieve the expected Standard of a review with a dietician at diagnosis and at least annually thereafter. At the time of the review the service had only 0.3 whole time equivalent (wte) dietician for approximately 240 children and young people. This issue will affect the service's ability to achieve the *Best Practice Tariff* and therefore its future funding.

3 Two consultants were providing 24 hour direct contact advice to newly diagnosed patients or following pump initiation, including when they were not formally on call. There were plans to offer a 24 hour advice line run by consultant paediatricians and Paediatric Diabetes Specialist Nurses but not until April 2013.

Further Consideration

1 A local network group was in place, although social care and education services did not attend. Staff within the paediatric diabetes services were, understandably, not yet aware of who within the Clinical Commissioning Groups would be taking a lead role for their service. In taking forward the development of the service it will be important to ensure that a local network group with provider, commissioner, social care and education service involvement is functioning effectively.

2 Blood glucose targets were not clearly and consistently identified in patient documentation. Adjustments were usually recorded. Reviewers suggested that a system of clear identifying targets should be implemented.

3 A formal agreement with the Education Authorities covering the care of children and young people with diabetes was not yet in place. There was, however, a good school care plan.

4 Adult diabetes specialist nurses were not yet involved in transition clinics and there was no formal handover of nursing issues when a young person transferred to adult care.

Return to *Index*

COMMUNITY LONG-TERM CONDITIONS SERVICES

Services Reviewed

Name of Service	Provider	Geographic Area Covered
Community Nursing	*Shropshire Community Health NHS Trust*	*Shropshire and Telford and Wrekin*
Rapid Response	*Shropshire Community Health NHS Trust*	*Telford and Wrekin*

General Comments and Achievements

Reviewers met with a range of community staff who were all enthusiastic and thinking about how they would like services to develop. Work-streams were in place looking at the urgent care pathway and care of frail older people and those with long term conditions. Active case management had been implemented in Telford and Wrekin. A rapid response MDT, involving social care and health staff, was also in place. The community teams clearly embraced the concept of continuous learning and development through complaints reviews and risk management. The case manager service in Telford and Wrekin was available 8am to 6pm seven days a week.

Good Practice

1 In Telford and Wrekin the arrangements for access equipment were very good. These allowed rapid access to a good range of equipment.

2 The Rapid Response Service in Telford and Wrekin was a small team who were quickly able to instigate packages of care for patients.

3 A case manager was on duty at weekends who sign-posted patients to appropriate services in order to prevent admissions.

Immediate Risks: No immediate risks were identified.

Concerns

1 Active case management was not yet consistently implemented in Shropshire. The services were aware of this and were working with GPs to ensure their concerns about this approach were addressed.

2 There was no service specification for the services delivered and the roles staff were expected to take were not clearly defined. A reconfiguration of community roles had taken place but it was not clear how this linked with commissioners' intentions for the services.

3 IT systems were not able to support collaborative working with other services. Care records were paper-based and it was not possible for other services involved in a patient's care to see the latest care plan. Reviewers were told of several examples where more than one service was involved with the care of a patient but with no coordination or shared documentation.

Further Consideration

1 Several community nursing staff had the training and competence in COPD care but these skills were not being utilised to support the care of patients with COPD.

2 Quality and outcome metrics were not yet in place for the service and the IT system (Lorenzo) was being used to collect data on contacts but not for quality measurement. It may be helpful to work with commissioners on agreeing and monitoring expected KPIs for the services.

3 Reviewers were told of delays in access to mental health services. Staff also commented that further training in mental health issues would be helpful so that they were better able to support patients and their families.

4 Access to community beds varied across Shropshire and Telford and Wrekin but the impact of this on the work of the community nursing services did not appear to have been considered. (NB. This point links with concern 2 (above) about staff roles.)

5 Staff within the community nursing and rapid response services did not have access to risk stratification data and did not have formalised arrangements for identifying patients at highest risk of hospital admission.

Return to *Index*

Specialist Care of Adults with Diabetes

Services Reviewed

Name of Service	Provider	Geographic area covered
Diabetes Service	The Shrewsbury and Telford Hospital NHS Trust	Shropshire and Telford & Wrekin
Community Diabetes Specialist Nursing Service	Shropshire Community Health NHS Trust	Shropshire and Telford & Wrekin

General Comments and Achievements

Reviewers were impressed by several aspects of the specialist services for people with diabetes in Shropshire and Telford & Wrekin. There was good support for adults with type 1 diabetes and an education programme had been developed specifically for this group of patients. Support for the 30 adult patients on insulin pumps at the time of the review was from the acute service. A very good foot care service had been developed and foot examinations were part of routine checkups. There was access to retinal screening.

Good Practice

1 The Community Diabetes Specialist Nursing Service guidelines and care pathways were clear and comprehensive. Communication from the Community Diabetes Specialist Nursing Team to general practices was also clear.

2 Patients with diabetes who needed hospital admission were admitted to the specialist ward at Royal Shrewsbury Hospital whenever possible or transferred to this ward as soon as possible. Consultant diabetologists did a ward round daily, including of general wards at Princess Royal Hospital, which ensured that patients needing specialist care were identified and their needs addressed quickly.

Immediate Risks: No immediate risks were identified.

Concerns

1 **IT Systems**

The IT systems in use did not enable sharing of clinical information between the different services, including diabetic retinopathy screening. Community Diabetes Specialist Nursing Service were faxing information to GP practices. Reviewers were concerned that the hospital and community teams may not have the latest information available to them when they saw the patient and GPs may not always be aware of the care provided by these services.

2 **Overall Pathway and Integration between Services**

The overall pathway for people with diabetes who needed specialist care was not clear, including the role and contribution of each service. Operational policies and arrangements also appeared to vary for Shropshire and Telford & Wrekin patients. Effective integration, communication and joint working between the acute and community teams was not yet in place.

3 **Psychological Support**

Patients of the service did not have access to psychological support. Patients had to be referred back to the GP for access to psychological services.

Further Consideration

1 **Guidelines and Audit**

Some guidelines were not yet in place, including: a) a finalised pump initiation policy and b) guidelines, agreed with primary care, on initiation, early specialist monitoring and discharge to primary care of patients on GLP1s and c) guidelines on prescribing of GLP1 and insulin in combination. Although some audits had been undertaken, there was no evidence of, for example, whether NICE criteria for continuous subcutaneous insulin infusion were being followed or of achievement of NICE Quality Standards for Diabetes.

2 Patient feedback mechanisms were in place but there was no evidence that this feedback was used to drive improvements in the service.

3 Greater integration of the two services may be a helpful way to streamline the patient pathway, improve patient care and improve coordination with other services. Reviewers suggested that, as a minimum, joint

review and learning arrangements should be introduced in order to facilitate communication between the two services.

4 In taking forward the development of services, it will be important for clinical staff fully to understand the needs and wishes of commissioners. Reviewers were told that charitable funding was being raised for continuous glucose monitoring services.

5 Urgent review by a member of the specialist team was available for people who were in-patients but not for other patients.

Return to *Index*

SPECIALIST CARE OF PEOPLE WITH COPD – INCLUDING PULMONARY REHABILITATION

Services Reviewed

Name of Service	Provider	Geographic Area Covered
COPD Service – Shropshire	*Shropshire Community Health NHS Trust and The Shrewsbury and Telford Hospital NHS Trust*	*Shropshire*
COPD service – Telford and Wrekin	*The Shrewsbury and Telford Hospital NHS Trust and Shropshire Community Health NHS Trust*	*Telford and Wrekin*
Pulmonary rehabilitation service	*Shropshire Community Health NHS Trust*	*Shropshire and Telford and Wrekin*

COPD SERVICE INCLUDING PULMONARY REHABILITATION – SHROPSHIRE

General Comments and Achievements

Services for people with COPD in Shropshire were provided by a team comprising community-based and hospital-based staff. The separate parts of the service communicated well with each other. The community team was led by one consultant who had developed the service and was actively involved in the delivery of care. Community support was available during normal working hours and simple tele-health was used to help evaluate patients' condition. The team was doing its best to deliver a comprehensive service within the limited resources available.

Patients who met the visiting team were very positive about the education they had received. Self-management plans were generally in place and patients said that they felt empowered to manage their own condition. The community helpline for patients with COPD was particularly appreciated.

Good Practice

1 Good patient information was available. The information was clear, comprehensive and had particularly good explanation of the disease and disease progression.

2 Louisa House provided a good one-stop environment for the care of people with COPD. Consultant and nurse-led clinics, pulmonary rehabilitation, specialist nurse support and the oxygen service were all provided from the same venue which enabled collaborative working and good communication.

3 The team had a strong emphasis on teaching and had developed good links with practice nurses. There were opportunities for practice nurses to attend clinics to learn more about the care of people with COPD, quarterly meetings and teaching sessions with the practice nurse facilitator.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Pulmonary Rehabilitation**

Reviewers were seriously concerned about staffing levels for the pulmonary rehabilitation service. In practice, the service for both Shropshire and Telford & Wrekin was run by one band 6 physiotherapist with a health trainer (therapy technician). There was a vacancy for a second physiotherapist to work mainly in Telford. There was no administrative support for the rehabilitation service and so one week of clinical time at the end of each programme had to be devoted to administrative work. Waiting times were long and, at the time of the review, 178 Telford patients were waiting for pulmonary rehabilitation. The physiotherapist from Shrewsbury had been providing some cover for the Telford vacancy in order to ensure that waiting times did not increase. Activity levels and the number of patients waiting in Shrewsbury were not clear. In practice, respiratory specialist nurses did not have time to give input to the rehabilitation service and dietician, occupational therapy and pharmacy support was not available for the sessions. It was not clear, therefore, that the multi-disciplinary and holistic aspects of the rehabilitation programme could be fully delivered with the available staffing.

2 **In-Patient Care**

Approximately 20% of the in-patients with respiratory disease at Royal Shrewsbury Hospital were being cared for on wards where staff did not have specialist competences in the care of patients with respiratory disease (ie on 'outlying wards'). Respiratory specialist nurse support was available on only three days a week and had to support patients with all types of respiratory disease with no cover for the other days or for absences. This nurse was also supporting the servicing and consumables of 173 nebulisers on loan to patients in the community. A significant proportion of patients with COPD therefore were not cared for by a respiratory consultant or by a nurse with specific competences in respiratory disease and did not have access to specialist respiratory nurse support.

3 **Administrative and Clerical Support**

Insufficient administrative support was available and clinical staff were spending considerable time which could have been available for clinical duties on administrative work. Administrative support for the whole COPD service comprised 0.7wte band 2 and 0.5 band 3 (one not permanent). In addition to the pulmonary rehabilitation service (see above), community nurses were typing their own clinic letters.

4 **Access to nebulisers for home use** was from charitable funds there were no arrangements and nurses had to go and collect them from patients' homes if they broke or needed maintenance.

Further Consideration

1 The model of working may not be maximising the impact of the resources available:

a. Further clarifying the criteria for referral to and discharge from the service may help to ensure that the service is targeting those patients who may benefit most from the care of the team. Data collection about the service's work was not in place and it was not possible to audit whether the service was achieving its expected objectives.

b. Reviewers were told "we don't discharge if the patient does not want us to" and there appeared to be a culture of 'review in six months' rather than encouraging return to GP care.

c. Although training for practices nurses was in place, links with community LTC nurses did not appear as well developed. This fitted with the finding that the service may be 'hanging onto' patients for whom non-specialist services may have been appropriate. Reviewers considered there was potential for some patients to be cared for by primary care and community nursing services with access to advice from the specialist team, if required.

d. All clinics had consultant and specialist nursing staff present at the same time. Reviewers considered that there was potential for the development of regular nurse-led clinics with consultant advice available if required.

e. Reviewers were told that the focus of the team was on avoiding admissions. For patients needing admission, however, the model of support to the acute wards did not appear to achieve many of the benefits of the model used in Princess Royal Hospital.

f. Early supported discharge was not available for patients admitted to Royal Shrewsbury Hospital. The combination of this issue, the way specialist nursing support was organised in the acute Trust and the number of patients on 'outlying wards', means that there is probably potential for reducing length of hospital stay of patients with respiratory diseases.

g. See above in relation to the lack of administrative support.

Unless these issues are addressed, the workload of the team will increase to an unacceptable level. Respiratory specialist nurse staffing was 3.75 wte in the community team and 0.6 wte in the acute Trust.

2 It may be helpful to develop an 'alert' system and regular links with the Accident and Emergency Department and Acute Medical Admissions Unit to identify patients with COPD and, in particular, those who are already under the care of the community team. The maximum benefit of such a system would not be achieved, however, without an increase in the 'bed base' for patients with respiratory disease (see above).

3 At weekends, there were no arrangements for urgent review by a member of the team within 24 hours. This was achieved well on weekdays and reviewers considered that the admission avoidance achieved on weekdays could be extended to weekends if a member of the team was available.

4 The team did not have arrangements for multi-disciplinary review and learning. In addition to Trust-wide mechanisms, it may be helpful to implement arrangements for the team to reflect and learn together.

5 Arrangements for the care of people with co-morbidities or multiple long-term conditions may benefit from review with other condition-specific teams. The team appeared relatively isolated from other services and no regular multi-disciplinary forums with other services were in place.

6 The sustainability of the service may benefit from further consideration. The community service relied heavily on one consultant and the arrangement for cover for absences was telephone advice from the Royal Shrewsbury Hospital physicians. Reviewers were told that the consultant was contacted by staff at all times. The service was also heavily dependent on the physiotherapist running the rehabilitation service.

7 As part of defining the objectives and goals for the service, it may be helpful to improve links with commissioners in order that their commissioning intentions and the outcomes from the service are clear and are well-understood.

COPD SERVICE INCLUDING PULMONARY REHABILITATION – TELFORD & WREKIN

General Comments and Achievements

Services for people with COPD in Telford and Wrekin were provided by an integrated team working across hospital and community services. The team also provided county-wide support for patients on non-invasive ventilation. The team was patient-focussed and patients commented that staff knew them as individuals. The community helpline for patients with COPD was particularly appreciated. The team had undertaken training with staff in nursing homes. The team was doing its best to deliver a comprehensive service within the limited resources available.

Links between hospital and community services were good. The team was alerted to any admissions or Accident and Emergency Department attendances of patients with COPD. Specialist nurses worked in Princess Royal

Hospital, Telford for one week at a time on a rotational basis. This meant that all members of the team had a good understanding of both acute and community services and of the patients under their care. Early supported discharge from hospital was also in place.

Good Practice

1 Urgent referrals to the team were seen within two hours of referral (on Monday to Friday).

2 The in-patient non-invasive ventilation service was well organised. A dedicated bleep-holder ensured that support was available quickly when needed. The pathway of care was clear with well-organised training before patients went home. All junior medical staff received induction on non-invasive ventilation to ensure they had the appropriate competences to provide support.

Immediate Risks: No immediate risks were identified.

Concerns

1 Staffing was insufficient for the number of patients and the range of services offered. One nurse consultant post and the physiotherapist post were vacant, although some cover was being provided from the Shrewsbury team. The community team had a team leader, three wte respiratory specialist nurses and a respiratory health care assistant. Reviewers were not able to undertake a detailed analysis of staffing and workload in the time available but recommend that this takes place, looking at the whole service, including community and hospital duties and pulmonary rehabilitation.

2 Pulmonary rehabilitation: See Shropshire section of this report.

3 Administrative and clerical support: See Shropshire section of this report.

4 Access to nebulisers for home use: See Shropshire section of this report.

Further Consideration

1 Links with community nursing services may benefit from further consideration. Reviewers were told that several of these nurses had Diplomas in the care of people with COPD but these skills were not being used at present. More formalised guidelines on discharge to the care of community nursing services and case managers may help to reduce some of the pressure on the team.

2 At weekends, there were no arrangements for urgent review by a member of the team within 24 hours. This was achieved well on weekdays and reviewers considered that the admission avoidance achieved on weekdays could be extended to weekends if a member of the team was available.

3 Arrangements for the care of people with co-morbidities or multiple long-term conditions may benefit from review with other condition-specific teams. The team appeared relatively isolated from other services and no regular multi-disciplinary forums with other services were in place.

Return to *Index*

Specialist Care of People with Heart Failure – Including Cardiac Rehabilitation

THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST

General Comments and Achievements

The Heart Assessment Team provided community and hospital-based specialist care for people with heart failure and cardiac rehabilitation across Shropshire and mid Wales. The service aimed to provide a multi-professional, comprehensive approach, including prompt assessment, evidence based management, continuous monitoring, a comprehensive exercise and education programme and on-going emotional and psychological support for patients and their carers. The service covered in-patient care, early supported discharge, home visits including urgent review when needed, out-patient clinics and telephone contact for advice and support. The service was provided

by a team of specialist heart failure nurses with support from consultant cardiologists and was available Monday to Friday during normal working hours.

Patient feedback on the care received from the Heart Assessment Team was very positive and reviewers were impressed by the dedication and commitment of staff. The service had strong leadership and four separate teams had recently been successfully merged into a single service. There was good access to advice and support during normal working hours and patients reported that they did not have to wait long for someone to contact them. There was good teamwork between specialist nurses, physiotherapists and consultants. A good hand-held record was available and reviewers were told that it was used well by about half of the patients.

The team was keen to continue to develop the care offered, for example, arrangements for reviewing echocardiographs undertaken in the Trust had recently been introduced.

Good Practice

1 The team managed the daily troponin list and so identified patients with heart failure early in the diagnostic 'journey'.

2 The service provided was flexible depending on the skills, competences and interest of the practice and community nursing service. As a result, patients received as much care as possible close to home.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Guidelines**

The Shropshire Heart Failure Guidelines, although clear and well-presented, were out of date and did not refer to some of the newer drugs available for the care of people with heart failure. Some staff said that they were using these guidelines whereas others said that other formularies were used. There were plans to update the guidelines.

2 **Staffing Levels**

Staffing appeared low for the range of care provided and at least 1 wte nurse each week was taken from the service to provide care on the wards. The number of patients cared for by the service and the roles which it provided were not clearly defined but some aspects of care could not be provided within the staffing available, in particular, six monthly holistic review of patients, urgent review within 24 hours at weekends and cardiac rehabilitation for people with heart failure who had not had a myocardial infarction.

Further Consideration

1 **Overall Pathway**

The overall pathway of care for people with heart failure and the role of the service within this pathway was not clear. Two versions of the patient pathway were available, one in the evidence folder provided to reviewers and one in the Shropshire Heart Failure Guidelines. These two pathways were different and it appeared that the pathway followed in practice may be different again but not documented. Reviewers suggested that work with commissioners was needed to clarify what was expected of the service. The resources needed to deliver this activity should then be clarified. As part of this work, it may be helpful to define key performance indicators for the service which could be regularly reviewed.

2 Integration with community nursing services, in particular, with case managers many benefit from review. The triggers for hand-over to community nursing teams were not clearly defined and cooperation with these services did not appear to be well-developed.

3 The service depended heavily on the service manager who was the repository for much of the information about the organisation of the service. Documentation of operational policies may help to ensure consistency and sustainability of the service, may empower staff and would allow audit.

4 Staff were busy with the day to day running of the service, including the challenges of maintaining the service across a geographically large area despite pressure on staffing levels. It will be important to make time for documenting guidelines and policies, work with commissioners on the role of the service, for clarifying future plans and managing their implementation.

5 The hand-held record had increased in size and some patients commented that it was too big. At some point, it may be helpful to review whether further improvements to the hand-held record could be made.

Return to *Index*

SPECIALIST CARE OF PEOPLE WITH CHRONIC NEUROLOGICAL CONDITIONS

Name of Service	Provider	Geographic area covered
Neurology Service	The Shrewsbury and Telford Hospital NHS Trust	Shropshire and Telford & Wrekin
Shropshire Enablement Team	Shropshire Community Health NHS Trust	Shropshire and Telford & Wrekin

PATHWAY OVERVIEW

Care of people with chronic neurological conditions was provided by two services, the Neurology Service at The Shrewsbury and Telford Hospitals NHS Trust and the Shropshire Enablement Team. A social worker with specific responsibility for people with brain injury had previously been in post but this post no longer existed. Both teams were enthusiastic but working under considerable pressure. Pathways were not yet clearly defined and reviewers were not always clear where responsibility lay for a particular aspect of care. Carers who met the reviewers said that they were well supported although some patients were not clear about the services available to them, sometimes because services had changed since they were diagnosed.

Further consideration: See commissioning section of this report in relation to the lack of neurological rehabilitation for people aged over 65.

NEUROLOGY SERVICE – THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST

General Comments and Achievements

The Neurology Service comprised four consultants (3.1 wte) who were based at both Royal Shrewsbury Hospital and Princess Royal Hospital, specialist nurses for epilepsy, motor neurone disease, Parkinson's Disease, multiple sclerosis and spasticity management, and administrative support. Specialist nurses were nurse prescribers and worked across hospital and community services, although the balance between these varied. Access to telephone advice, clinics and some home visiting was available for those who were aware of the specialist nursing services. An in-patient EEG service was provided for patients who were too unwell to travel. Most patients were referred for neurophysiology at North Staffordshire (UHNS), Birmingham (UHB) or Wolverhampton. Patients needing neurosurgery were referred to North Staffordshire (UHNS) or Birmingham (UHB) and a surgeon from UHNS provided one clinic per month at both Princess Royal and Royal Shrewsbury Hospitals.

Considerable progress had been made on the development of this service. Neurologists worked on a shared care model with admitting consultants and were able to review acute admissions at both sites within 24 hours of admission. Education programmes were in place for patients with multiple sclerosis, including a stress and fatigue management course.

Good Practice

1 Information for patients on how to access the Multiple Sclerosis team and services available was very clear and concise.

Immediate Risks: No immediate risks were identified.

Concerns

1 Guidelines and protocols were generally not documented. Reviewers were told that the care provided was based on NICE guidance and staff were aware of relevant processes. It was not clear that patients were receiving consistent care and support and this was reflected in some of the feedback from patients.

2 There was no cover for absences of the clinical nurse specialists working with people with epilepsy, Parkinson's Disease or motor neurone disease. Reviewers were also told that future funding for the Parkinson's disease specialist nurse post was uncertain. There was also some concern whether the specialist nurses would have to take on general roles taking them away from their specialist service.

3 The criteria and arrangements for referral to clinical nurse specialists were not clear and it appeared that some patients were not offered the support that was available.

Further Consideration

1 The sustainability of the medical staffing model may benefit from review. An additional post for a general neurologist had been advertised but reviewers considered that appointment to this post may be difficult - because those completing consultant training are likely to have sub-specialised.

2 Arrangements for ensuring all patients received appropriate information at diagnosis and at later stages of the pathway may benefit from review to ensure consistency of information offered. It may also be helpful to review with previously diagnosed patients whether they have all the information that they need. Some patients who met the visiting team had not received information about the services available and how to access them.

SHROPSHIRE ENABLEMENT TEAM - SHROPSHIRE COMMUNITY HEALTH NHS TRUST

General Comments, Achievements and Good Practice

The Shropshire Enablement Team, a specialist community neuro-rehabilitation team, provided a multi-disciplinary approach to the rehabilitation of patients with long-term neurological conditions, including those with acquired brain injuries, stroke and chronic fatigue syndrome. The team was enthusiastic and caring, although working under considerable pressure. Patients who accessed the enablement service met reviewers and were very appreciative of the help, support and individualised care available to them.

Reviewers were told that some GPs were not aware of the service, although some work with primary care had taken place some years previously and some GP training and development was still undertaken.

The team had received 168 referrals for acquired brain injury and neurology in the previous year. Only 13 of these referrals were considered inappropriate and 60% of the team's activity was caring for people with chronic neurological conditions. The service was located at the Harlescott Centre in Shrewsbury. This facility had recently been upgraded, which had enabled consolidation of the service. The environment was welcoming and friendly and included lots of clinic rooms. Since the consolidation of the service the number of home visits had been reduced and, when appropriate, patients were encouraged to attend the Harlescott facility.

This team had been through two management reorganisations in the last year. The previous manager was no longer in post and, at the time of the review visit, the management of the service was the responsibility of the lead psychologist who also had clinical responsibilities.

Immediate Risks: No immediate risks were identified.

Concerns

1 Guidelines and protocols were generally not documented. Reviewers were told that the care provided was based on NICE guidance and staff were aware of relevant processes. It was not clear that patients were receiving consistent care and support and this was reflected in some of the feedback from patients. Reviewers were particularly concerned about the management of exacerbations in the absence of clear guidelines.

2 Waiting times to access an initial assessment for psychology and physiotherapy had increased significantly due to staff vacancies. Waiting lists for psychology were up to 12 months and for physiotherapy up to five months.

Further Consideration

1 Arrangements for discharge from the service were not clear and it appeared that patients could stay with the team for long periods of time. Reviewers suggested that more formalised discharge criteria and arrangements would be helpful, in order to ensure that the team's resources are used most appropriately.

2 People aged over 65 years were not able to access the Shropshire Enablement Team and discussion with commissioners on this issue is needed.

3 The psychologist was also acting as manager for the service and plans for the future of the manager post were not clear. This issue should be considered in the light of the waiting times for access to psychology assessment.

Return to *Index*

TRUST-WIDE

THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST

The care of people with long-term conditions peer review programme looked at care pathways, including those into acute services, and so did not look in detail at Trust-wide issues. Reviewers commented, however, on robust processes for governance of death certification, use of the West Mercia guidelines and on:

Good Practice

1 Arrangements for ensuring all in-patients received smoking cessation advice were very good. Everyone was asked about smoking on admission. If the patient smoked, a member of staff responsible for smoking cessation advice was bleeped and came to the bedside to discuss smoking cessation. The service was provided by two individuals and so cover for absences was available.

Immediate Risks: No immediate risks were identified.

Concerns

1 Reviewers were told about delays in discharge letters reaching the general practitioner. Patients who met the visiting team said that, as a result, they had to make another appointment to see their general practitioner (because a repeat prescription could not be issued until the discharge letter had been received). Acute Trust representatives said that discharge letters were produced quickly but the arrangements for ensuring reached the GP without delay did not appear to be robust.

Return to *Index*

COMMISSIONING

TELFORD AND WREKIN AND SHROPSHRE CLINICAL COMMMISSIONING GROUPS

The issues identified in the 'health economy', 'primary care' and provider sections of this report will require the attention of commissioners. The following specific points about commissioning were made by reviewers:

General Comments and Achievements

Reviewers recognised that both Clinical Commissioning Groups were in the early stages of their development. The care of people with long-term conditions was starting to be given more attention with good leadership, especially in Shropshire CCG. Commissioners had good awareness of the problems with local services, in particular the lack of integration and coordination and there was some evidence of a prioritised, systematic approach to addressing issues.

Shropshire CCG had started a pilot of practice-based care coordinators (band 4 non-clinical) who were making sure that risk stratification data were used and communicated to other services. Twenty six practices had volunteered to be part of this pilot.

Telford and Wrekin CCG had a more proactive approach to enabling the management of patients at home with a number of initiatives aimed at achieving this.

Both CCGs were aware of the need to take an active approach in the development of providers. The CCGs had appointed a joint end of life care commissioner who was working to ensure good coordination across the health economy.

Concerns

1 Service specifications were not in place for many of the services reviewed. It was therefore not clear what services were expected to deliver and monitoring of performance was not possible.

2 Telford and Wrekin CCG did not have a needs assessment or strategy for the care of people with long-term conditions.

Further Consideration

1 Some services were not yet commissioned including, at least:

   a. Access to palliative care for those with non-malignant conditions.

   b. Cardiac rehabilitation for people with heart failure who had not had a myocardial infarction

   c. Neurological rehabilitation for people aged over 65.

2 There were differences in access to Long term Oxygen Therapy services across the county which were creating operational difficulties.

3 Reviewers were given several examples of where different commissioning intentions between the two CCGs was resulting in operational difficulties for providers. While recognising that commissioning needs to reflect local needs, CCGs should ensure that they are aware the practical implications for clinical staff and avoid unintended operational difficulties.

4 The care of people with more common chronic neurological conditions is described in this report. Less common neurological problems, when considered together, affect a significant number of people. Services for this group of patients are usually less well organised than those for people with more common conditions and further consideration should be given to whether local services are meeting their needs.

Return to *Index*

APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Executive Lead

Dr Richard Mendelsohn	GP/Clinical Head of Commissioning and Redesign	NHS Birmingham South and Central CCG

Visiting Team

Dr Martin Allen	Consultant Physician - Respiratory Medicine (RPD)	University Hospital of North Staffordshire NHS Trust
Dr Meena Bandhakavi	Consultant Paediatrician	Sandwell & West Birmingham Hospitals NHS Trust
Helen Bladon	Diabetes Service Lead	Walsall Healthcare NHS Trust
Dr Manjari Bollu	General Practitioner	Forum Health Centre, Coventry
Jennie Brown	Senior Dietician	The Royal Wolverhampton Hospitals NHS Trust
Helen Charters	Specialist Stroke Nurse, Community Stroke Team	Staffordshire & Stoke on Trent Partnership NHS Trust
Samantha Colhoun	Clinical Nurse Specialist	University Hospitals Birmingham NHS Foundation Trust
Adele Dean	Clinical Quality Manager	West Midlands Ambulance Service NHS Trust
Pauline Ellis	Patient Safety Lead	Wye Valley NHS Trust
Dr Roland Etti	Consultant Neurologist	The Dudley Group NHS Foundation Trust
Bernadette Faulkner	LTC Commissioning	Solihull PCT
Nick Flint	User Representative	UHB patient groups
John Grayland	Senior Strategy and Redesign Manager - LTC	NHS Birmingham East & North PCT
Michelle Horn	Practice Nurse/Manager	Coventry Teaching PCT
Karen Joseph	Practice Manager	Sherbourne Medical Centre
Dr Raveendra Katamaneni	General Practitioner	Solihull PCT
Dr Melanie Kershaw	Paediatric Endocrinologist	Birmingham Children's Hospital NHS Foundation Trust
Elizabeth Malpass	Community Matron/Case Manager	Staffordshire & Stoke on Trent Partnership NHS Trust

Delia McCarthy	COPD Specialist Nurse	University Hospitals Coventry & Warwickshire NHS Trust
Deborah McCausland	Paediatric Diabetes Specialist Nurse	Walsall Healthcare NHS Trust
Dr Rajiv Nair	Consultant Physician	George Eliot Hospital NHS Trust
Andrew Riley	Strategic Lead for Medicines Management	Staffordshire NHS Cluster
Gill Salt	Lead Paediatric Diabetes Nurse Specialist	The Royal Wolverhampton Hospitals NHS Trust
Dr Gaurav Tewary	General Practitioner	Copsewood Medical Centre, Coventry

Observer

Sian Thomas	Business Support Manager	West Mercia Cluster

WMQRS Team

Jane Eminson	Acting Director	West Midlands Quality Review Service
Sarah Broomhead	Quality Manager	West Midlands Quality Review Service
Sue McIldowie	Long Term Conditions Programme Support	West Midlands Quality Review Service

Return to *Index*

APPENDIX 2 COMPLIANCE WITH THE QUALITY STANDARDS

Analyses of percentage compliance with the Quality Standards should be viewed with caution as they give the same weight to each of the Quality Standards. Also, the number of Quality Standards applicable to each service varied depending on the nature of the service provided. Percentage compliance also takes no account of 'working towards' a particular Quality Standard. Reviewers often comment that it is better to have a 'No but', where there is real commitment to achieving a particular standard, than a 'Yes but' – where a 'box has been ticked' but the commitment to implementation is lacking. With these caveats, table 1 summarises the percentage compliance for each of the services reviewed.

Table 1 - Percentage of Quality Standards met

Details of compliance with individual Quality Standards can be found in a separate document.

Service	Number of Applicable QS	Number of QS Met	% met
Care of Children and Young People with Diabetes			
Primary Care	6	6	100
Shropshire CCG	(3)	(3)	(100)
Telford & Wrekin CCG	(3)	(3)	(100)
Specialist Care of Children & Young People with Diabetes	29	23	79
Trust-Wide: The Shrewsbury and Telford Hospitals NHS Trust	4	3	75
Commissioning	14	4	28
Shropshire CCG	(7)	(2)	(29)
Telford & Wrekin CCG	(7)	(2)	(29)
Health Economy	**53**	**36**	**68**
Care of Adults with Long-Term Conditions			
Primary Care	16	4	25
Shropshire CCG	(8)	(2)	(25)
Telford & Wrekin CCG	(8)	(2)	(25)
Community Long-Term Conditions Services	50	27	54
Specialist Care of Adults with Diabetes	60	31	52
Specialist Care of People with COPD (All Services)	175	94	54
Shropshire	(55)	(25)	(45)
Telford & Wrekin	(55)	(28)	(51)
Pulmonary Rehabilitation	(65)	(41)	(63)
Specialist Care of People with Heart Failure (All Services)	80	40	50
Heart Failure	(55)	(21)	(38)
Cardiac Rehabilitation	(25)	(19)	(76)
Specialist Care of People with Chronic Neurological Conditions (All Services)	278	126	45
Epilepsy	(57)	(25)	(44)
Motor Neurone Disease	(55)	(24)	(44)

Service	Number of Applicable QS	Number of QS Met	% met
Multiple Sclerosis	(56)	(28)	(50)
Parkinson's Disease	(55)	(21)	(38)
Shropshire Enablement Team	(55)	(28)	(51)
Trust-Wide: The Shrewsbury and Telford Hospitals NHS Trust	7	1	14
Commissioning	24	10	42
Shropshire CCG	(12)	(6)	(50)
Telford & Wrekin CCG	(12)	(4)	(33)
Health Economy	**690**	**333**	**48**

Return to *Index*