WM QRS West Midlands Quality Review Service

NHS

Care of Adults with Long-Term Conditions

Care of Children & Young People with Diabetes

South Staffordshire (West) Health Economy

Visit Date: 16th, 17th, 18th October 2012

Report Date: January 2013

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INTRODUCTION

This report presents the findings of the review of the care of people with long-term conditions which took place on 16th, 17th, 18th 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.

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 South Staffordshire (West) health economy. Appendix 2 contains the details of compliance with each of the standards and the percentage of standards met.

South Staffordshire (West) was one of the first health economies 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 South Staffordshire (West) 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

Across the health economy reviewers met staff who were caring, committed and keen to improve the care of people with long-term conditions. A new programme of work had started, looking at defining and improving pathways of care. This programme had the support of all local organisations and was aiming to have defined pathways and plans for their implementation within four to five months.

Concerns

Some common themes emerged from the review of care of people with long-term conditions in South Staffordshire (West):

1 **Service Integration**

There was a lack of integration between services caring for people with particular conditions. With the exception of services for people with chronic neurological conditions, overall pathways of care were not in place and staff in one service did not communicate and liaise well with those in other services for people with the same condition. As part of the planned pathway work, consideration should be given to operational integration of specialist teams caring for people with the same condition.

2 **Information Technology (IT) Systems**

IT systems did not enable communication between services. Much of the communication was paper-based and staff were often not able to see the latest information about patients in their care, especially when they were under the care of several services. Reviewers were told that community staff were able to access imaging and pathology results and details of hospital admissions but, in practice, several community-based staff did not think that they had this facility.

3 **Documenting pathways, guidelines and procedures**

Many of the services reviewed did not have documented pathways of care, including referral and discharge criteria, clinical guidelines and operational procedures. Staff were usually aware of how the service was organised but this lack of documentation contributed to the lack of integration of care and robust communication between teams. Agreeing joint guidelines and procedures, as part of an overall pathway, could make an important contribution to integration of services and to ensuring patients receive consistent, high quality care.

Further Consideration

1 The work taking place on pathways of care had the potential to improve the quality of care for people with long-term conditions. Reviewers noted that some of the staff who they met were not aware of this work. Good project management and clear timescales will also be needed to ensure this project delivers the expected improvements.

2 Risk stratification was available in primary care and being shared with intensive case managers. A manual system was being used at the time of the review and there were plans to re-use the BUPA tool when technical difficulties had been overcome. Condition-specific specialist teams were not yet using these data to target interventions at people at highest risk of unscheduled admission.

3 Arrangements for care of people with multiple long-term conditions were not yet robust. The model of case management in Cannock Chase was developing well but was not yet implemented in Stafford and Surrounds and did not yet link effectively with specialist condition-specific teams. Condition-specific teams

did not yet have arrangements for working together to ensure integrated care for people with multiple long-term conditions and more complex needs.

4 Access to psychological support services was identified in several of the pathways reviewed. A health economy strategy and approach to meeting needs for psychological support may be a helpful development.

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Primary Care

Further Consideration

1 The contribution of primary care to engagement and joint working with local providers may benefit from further discussion. Some of the more specialist services described attempts to improve liaison and communication with primary care which had not been successful.

2 Several people with long-term conditions who met the visiting team said that they had not had an annual review of their care. The arrangements for ensuring that all patients have had, at least, an annual review may benefit from further consideration.

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

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Specialist Care of Children & Young People with Diabetes

MID STAFFORDSHIRE NHS FOUNDATION TRUST

General Comments and Achievements

The service for children and young people with diabetes was provided by dedicated and committed staff who were working hard to improve the quality of care offered. The young people and families who met reviewers were positive and enthusiastic about the service they received. A notable achievement was the organisation of weekend trips away to activity centres.

Good practice

1 A 'nurse psychologist' was available which ensured access to psychological therapies for children and young people with diabetes.

Immediate risks: No immediate risks were identified.

Concerns

1 Reviewers were seriously concerned about some several aspects of the service:

a. The 'sick day rules' advice given to patients was out of date.

b. There was no structured education programme and no group education for children and young people with diabetes. Some education was provided on a one to one basis. Reviewers could see no evidence that the education provided covered carbohydrate counting or teaching self-adjustment of insulin doses and the proportion of patients on fixed doses of insulin appeared to be high.

c. There was only one paediatric diabetes specialist nurse (PDSN) for 140 patients and no cover for absences, although some support during absences was offered by the play specialist. The workload for the PDSN was twice the nationally recommended level of one whole time equivalent diabetic specialist nurse per 70 children with diabetes (RCN, 2011).

d. At the time of the review, dietician staffing was insufficient. One dietician was on maternity leave and the other dietician was responsible for Stafford patients and did not have time within her weekly timetable to cover those from Cannock. Although efforts were made to see those families in the greatest need of dietetic advice, staffing was insufficient for input to reviews and education and self-management programmes for all patients.

e. Arrangements for medical input to the care of children and young people on insulin pumps were unclear. Approximately 30 patients had insulin pumps and the paediatric diabetes specialist nurse was the focus for their care. The lead consultant would provide advice if available and guidelines were available in the Paediatric Assessment Unit. A staff grade doctor was also interested in the care of children with diabetes but was unable to attend multi-disciplinary team meetings.

2 The paediatric diabetes specialist nurses and lead consultant provided an informal on call service outside of their contracted hours. This commitment was appreciated by patients and staff but should not be considered as a robust approach to 24/7 advice from the paediatric diabetes service.

Further Consideration

1 It appeared that little attention had been paid to implementation of the *Best Practice Tariff*. Achievement of this tariff will be important to the sustainability of the service.

2 Given the issues facing this service, serious consideration should be given to whether a robust, high quality sub-specialist service for children and young people with diabetes can be achieved by the Trust without cooperation with another provider.

3 There was no evidence that the HbA1c machine used in clinic had been subject to external quality assurance.

4 A nominated link nurse was identified on the paediatric ward but she had no time allocated to undertake training for herself or to train other ward staff in the care of children and young people with diabetes.

5 Some guidelines were on paper and some on the Trust intranet. It may be helpful to simplify this arrangement and remind all staff of the location of guidelines.

6 Arrangements for documenting clinic attendances and annual reviews may benefit from the use of a structured proforma to ensure that all aspects are covered and the information can be easily accessed at a later date. Foot examination should be formally included as part of the annual review.

7 There was no Local Network (or equivalent) with responsibility for improving services for children and young people with diabetes. This issue is identified as a concern for commissioners. The contribution of the service to this group, when established, will be essential.

8 The service was submitting only limited data to the National Diabetes Audit and did not have a rolling programme of audit of implementation of guidelines. These issues should be addressed in the further development of the service.

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COMMUNITY LONG-TERM CONDITIONS SERVICES

STAFFORDSHIRE AND STOKE ON TRENT PARTNERSHIP NHS TRUST

General Comments and Achievements

A good model of case management was planned with nursing teams providing intensive case management and linking with physiotherapy and occupational therapy services. Teams were holding practice-based multi-disciplinary team meetings with general practices and integration with social services was being considered. This

model had the potential to provide a holistic, flexible response to patients' needs. At the time of the review, implementation of this model was further ahead In Cannock Chase than in Stafford and Surrounds. Reviewers met staff who were motivated and enthusiastic about providing good long-term conditions management. Patient feedback on the service provided in Cannock Chase was good. Work had started on developing a competency framework and ensuring all staff had appropriate competences. Community staff had good links with community respiratory and heart failure services. Links with the diabetes service in Stafford were good but those with the Cannock service were less well developed. A comprehensive integrated personalised care plan had been developed and implemented.

Good Practice

1 Intensive case management staff were available 24/7 in the Cannock Chase area.

Immediate Risks: No immediate risks were identified.

Concerns

1 Clinical and pathway guidelines were not yet documented.

Further Consideration

1 Reviewers encouraged continuation of the work on implementation of the model of integrated care in Cannock Chase and 'roll out' to Stafford and Surrounds. Evaluation of the service in Cannock Chase may help to inform the development of services for Stafford and Surrounds.

2 The work taking place on clinical pathways for people with long-term conditions should be used to support development of clinical and pathway guidelines which are consistent with those in primary care and more specialist services.

3 There was no service specification for the services offered in Stafford and Surrounds. It will be important to work with commissioners to define the services that are needed for this area.

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Specialist Care of Adults with Diabetes

STAFFORDSHIRE AND STOKE ON TRENT PARTNERSHIP NHS TRUST AND MID STAFFORDSHIRE NHS FOUNDATION TRUST

Mid Staffordshire NHS Foundation Trust (MSFT) provided an in-patient service and community services for Stafford and Surrounds CCG. Staffordshire and Stoke on Trent Partnership NHS Trust (SSOTP) provided a community service for Cannock and Rugeley. One consultant had input into both community services and worked in both Stafford and Cannock.

General Comments and Achievements

Specialist care for people with diabetes was provided by motivated and dedicated staff who were committed to improving the quality of local services. Patient feedback on the care they received was generally good.

Good Practice

1 The community (SSOTP) Diabetic Foot Service was well organised with good clinical guidelines. Reviewers were particularly impressed by the arrangements for emergency access. Urgent 'slots' were available in clinics each Wednesday and Friday. In an emergency, patients could also be seen daily (Monday to Friday).

Immediate Risks: No immediate risks were identified.

Concerns

ALL SERVICES

1 The pathway of specialist care for people with diabetes was fragmented and there was little evidence of integration between the three services (acute service, community service for Stafford and Surrounds and community service for Cannock Chase). Communication between the services was limited and reviewers saw several examples of insufficient or delayed communication which could potentially impact on patient care. Effective links with primary care were also not evident.

2 Medical staffing was low for the population and number of patients with diabetes (approximately 16,000) and consultant diabetologists were not working effectively together to support the pathway of care. One consultant worked in both community services and there were no arrangements for cover of his absences. Two consultant diabetologists were employed by Mid Staffordshire NHS Foundation Trust, each spending half of their time on acute medicine and half on diabetes and endocrinology. There appeared to be no cooperation and liaison between the community and acute consultants and no shared arrangements for, for example, cover, guidelines development or audit.

3 No structured education programme was in place for people with type 1 diabetes.

4 Many of the expected clinical guidelines were not documented. Where guidelines were documented, some were inconsistent or out of date (see compliance section of this report for more detail).

5 Dietician input to services for people with diabetes was limited. The Mid Staffordshire NHS Foundation Trust services had six sessions per week of dietician time but it was not clear what these sessions were being used for. The SSOTP service had no specific dietician sessions allocated to work with people with diabetes.

MID STAFFORDSHIRE NHS FOUNDATION TRUST – ACUTE AND COMMUNITY SERVICES

1 Clinical leadership of the services provided by Mid Staffordshire NHS Foundation Trust was unclear. No clinical lead was identified for the services and consultant diabetologists did not appear to be involved in the review process.

2 Several aspects of the service, including out of hours arrangements and much of the service organisation appeared to depend on one nurse. Arrangements for cover of her roles were not clear. The lack of cover was of particular concern because of the lack of documented policies and procedures which could be followed in her absence.

3 The competences needed for nursing staff within the diabetes services were not defined. Reviewers were also told that nursing staff were not accessing continuing professional development and did not have personal development plans.

MID STAFFORDSHIRE NHS FOUNDATION TRUST – ACUTE SERVICE

1 In-patients had very limited access to a podiatry or foot care service. A clinic was held once a week but there were no arrangements for urgent review of people with diabetes and foot problems between clinics. As a result, patients were often discharged and referred to the community diabetic foot service rather than having the care of their feet considered as part of their in-patient care. There were no multi-disciplinary meetings or other arrangements for collaboration with the foot care service, or with vascular surgeons, about in-patients. Reviewers were told of delays when patients were referred to vascular surgeons. A foot care pathway was shown to reviewers but they were told that this was not always implemented.

2 Diabetic specialist nurses within the hospital setting recorded patient contacts in paper notes. No templates or electronic recording of information was in place and communication to primary care and community services was not routine. Communication with community diabetes teams and primary care

about the diabetes care of surgical patients seen by consultant diabetologists also did not appear to take place.

MID STAFFORDSHIRE NHS FOUNDATION TRUST – COMMUNITY SERVICE

1 A template was used to record annual reviews but this did not cover all the expected aspects of the annual review. Arrangements for sharing annual reviews with the patient's general practitioner were unclear and reviewers could find no evidence that this happened routinely.

STAFFORDSHIRE AND STOKE ON TRENT PARTNERSHIP NHS TRUST – COMMUNITY SERVICE

1 The SSOTP community diabetes service did not use an IT system for its clinical records. Staff other than the consultant did not routinely access the hospital IT system for information on patients who were admitted. Arrangements for communication with primary care were also paper-based and it was not clear that annual reviews were routinely communicated to the patient's general practitioner. Discharges by the consultant were not entered onto Lorenzo and so this information could not be accessed by other staff.

BOTH COMMUNITY SERVICES

1 Community services were available during normal working hours with no out of hours availability. Reviewers were told that staff gave patients their mobile phone numbers and staff provided an informal on call service outside of their contracted hours.

Further Consideration

1 Some patients with type 1 diabetes who met reviewers were under the care of the specialist diabetes services but said that they had not had an annual review. It may be helpful for the specialist teams to standardise the information covered in their annual reviews and ensure that the outcome is communicated to patients' general practitioners.

2 The care coordinator arrangements relied on nurses giving patients their mobile phone number. Arrangements for covering leave were not clear. Patients said that they had a care coordinator but it was not clear that the name of the care coordinator was always recorded in patients' notes and care plans.

3 Patients who met the visiting team said that they would welcome increased access to psychological support services.

4 Administrative support for all services appeared insufficient and clinical staff, especially in Mid Staffordshire NHS Foundation Trust, were spending time on administrative work which could be spent on clinical care.

5 The criteria for discharge from the community services may benefit from review. It appeared to reviewers that the culture within the community services was of 'see again in six months' rather than of actively encouraging self-management and GP-care whenever possible with arrangements for re-referral if required.

6 There did not appear to be routine communication to the community services when a patient under their care was discharged from hospital.

7 The Type 2 structured education programme in Stafford did not meet all the key criteria laid down by the Department of Health and the Diabetes UK Patient Education Working Group as referred to in the NICE Diabetes in Adults quality standard.

8 Patient information and guidelines seen by reviewers included little information about retinal screening. It may be helpful to review whether this should have more attention.

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SPECIALIST CARE OF PEOPLE WITH COPD

General Comments and Achievements

Specialist services for people with chronic obstructive pulmonary disease (COPD) were provided by three teams; two community respiratory services – one in Cannock and one in Stafford, and an acute service provided by Mid Staffordshire NHS Foundation Trust. The three teams worked independently from each other.

Reviewers were impressed by both community respiratory teams although there were differences in their organisation and models of service delivery. Patient feedback about both community teams was excellent. Both community teams provided an integrated pulmonary rehabilitation service and cared for patients with all types of respiratory disease. The in-patient service had a proactive respiratory physiotherapist and was also staffed to provide non-invasive ventilation for two patients.

Good Practice

1 The Stafford community team provided a very good admission avoidance service.

2 The Cannock community team ran a good educational programme for primary care.

Immediate Risks: No immediate risks were identified.

Concerns

ALL SERVICES

1 The acute and community teams worked separately from each other and there was a lack of integration and robust communication across the patient pathway. Community teams did not routinely access medical advice on the care of patients with COPD from consultants in the acute Trust. Acute Trust staff did not appear routinely to communicate with community teams, for example, when patients were discharged from acute care. There was no overall pathway for patients with COPD on which all services were agreed.

STAFFORDSHIRE AND STOKE ON TRENT PARTNERSHIP NHS TRUST – COMMUNITY SERVICES

1 The community teams did not have access to an appropriate IT system for their clinical work. Community staff were not accessing imaging and pathology results and details of hospital admissions of their patients, although reviewers were told that this access should be available to them. Reviewers were particularly concerned about the arrangements for checking and acting on results of chest x-rays requested by community teams as it appeared that these results may be sent to the patient's general practitioner rather than the requesting team.

2 Patient transport was not available for patients attending pulmonary rehabilitation. This may limit the ability of some people to access this service particularly if they are unable to drive or have other means of transport available to them. This would disadvantage these individuals from accessing pulmonary rehabilitation.

3 There was no medical Consultant support for either of the two community teams.

MID STAFFORDSHIRE NHS FOUNDATION TRUST – ACUTE SERVICE

1 Some staff on the in-patient respiratory ward were not aware of how to refer patients for smoking cessation and the approach to smoking cessation within the acute service did not appear to be proactive.

Further Consideration – ALL SERVICES

1 Both community services provided excellent care but this was organised in different ways. It may be helpful to share the good practice between the two teams and consider whether standardisation of the teams' approach to care may be helpful. The approach to follow up after pulmonary rehabilitation was different between the two teams.

2 Reviewers did not meet a respiratory nurse specialist from the acute service and it was not clear whether specialist nursing support was sufficient for the number of in-patients with COPD.

3 Arrangements for liaison and cooperation with palliative care services may benefit from review, in particular, to ensure an integrated approach to the care of people in the community who are nearing the end of life.

4 The acute service had achieved an impressive reduction in the hospital Standardised Mortality Ratio for COPD. It would be helpful to understand how this has been achieved so that lessons and best practice can be shared with other localities.

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Specialist Care of People with Heart Failure

STAFFORDSHIRE AND STOKE ON TRENT PARTNERSHIP NHS TRUST AND MID STAFFORDSHIRE NHS FOUNDATION TRUST

General Comments and Achievements

Services for people with heart failure were provided by a community heart failure nursing service run by Staffordshire and Stoke on Trent Partnership NHS Trust and an acute service provided by Mid Staffordshire NHS Foundation Trust. Some informal links between these services were in place and there was a formal arrangement for clinical supervision of the nursing staff by one of the consultant cardiologists. There were also good links with cardiac surgeons at Stoke. Patient feedback about the community service was good. A business case had been prepared for the introduction of cardiac rehabilitation for people with heart failure. The heart failure teams were also involved in the local improvement work looking at pathways of care for people with heart failure.

A good range of echocardiography modalities was available. There was also a good echocardiography database, good arrangements for storage and a twice monthly quality control meeting. GPs had direct access to echocardiography.

Good Practice

1 The community heart failure team had good links with palliative care staff, good availability of palliative care guidelines and a palliative care representative attended multi-disciplinary heart failure team meetings in order to give input to the care of people with heart failure.

Immediate Risks: No immediate risks were identified.

Concerns

1 The process of diagnosis of heart failure and referral to the specialist team was of concern for a number of reasons:

   a. Guidelines on referral for specialist team assessment in accordance with NICE guidance were not in place.

   b. The acute service was not commissioned to provide a diagnosis and assessment service in accordance with NICE guidance.

   c. There were no arrangements for urgent specialist assessment for patients with suspected heart failure and a previous myocardial infarction for including echocardiography within two weeks of referral. Reviewers were told of delays of four to six weeks in the availability of out-patient echocardiography.

   d. The acute service did not undertake care planning, including giving information and support to patients as expected by the Quality Standards. This was seen as the role of the community heart failure team.

e. Patients diagnosed with heart failure by the acute Trust did not usually see a heart failure specialist nurse within a week of diagnosis. Some patients were referred for follow up by the community heart failure team whereas others were not. The criteria for referral were not clear.

f. Survey results had also suggested that only 50% patients had sufficient information on medication titration included on the referral to the community heart failure service which was resulting in delays in treatment.

g. GPs did not have access to serum natriuretic peptide testing.

The combination of these issues meant that the process of diagnosis, assessment and care planning for people with heart failure was taking much longer than necessary and involving patients in many more contacts with healthcare professionals than necessary.

2 There was a lack of integration and effective joint working between the acute and community heart failure services, although one consultant cardiologist did provide clinical supervision for the community team There was no evidence of routine communication between the two services, for example, letters from the acute Trust about patients in the care of the community team were not copied to the community team.

3 Few of the expected guidelines and procedures were documented. As a result, audit of their implementation was not possible. Reviewers were told that care was based on NICE guidance but this had to been localised to show how it was being implemented locally.

4 Cardiac rehabilitation was not routinely available for people with heart failure.

Further Consideration

1 Reviewers suggested that there was considerable potential for streamlining the diagnostic pathway, probably through a one-stop, rapid access clinic with the cardiologist, community heart failure service and with immediate availability of echocardiography.

2 Approximately one third of patients admitted to the acute Trust with heart failure were cared for on outlying (non-cardiac) wards and data on these patients were not submitted to the National Heart Failure Audit.

3 Implementation of guidelines on deactivation of medical devices may benefit from audit to ensure that these guidelines are being fully implemented and patients are not being admitted unnecessarily at the end of life.

4 Reviewers noticed that staffing on the coronary care unit did not meet recommended staffing levels for high dependency care. Although outside the scope of this review, reviewers suggested that staffing levels may benefit from further consideration.

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Specialist Care of People with Chronic Neurological Conditions

MID STAFFORDSHIRE NHS FOUNDATION TRUST

General Comments and Achievements

Mid Staffordshire NHS Foundation Trust provided acute services for people with chronic neurological conditions at Stafford Hospital and rehabilitation services from Cannock Hospital. There were also rehabilitation services from Stone Rehab Team for those that lived in that region of Mid Staffordshire. Teamwork and communication between team members was good. Reviewers were also impressed by the environment and facilities at the Rehabilitation Day Unit at Cannock, including good displays of patient information and good signposting. The atmosphere and approach was positive and patients who met the visiting team were positive about the services provided.

Communication with GPs was well organised, including communication about the outcomes of rehabilitation sessions. The services were generally very well organised, including producing good annual reports. There was strong leadership, especially from the Parkinson's and rehabilitation nurse specialists.

A small community rehabilitation service was provided by Staffordshire and Stoke on Trent Partnership NHS Trust for patients from Stone and Eccleshall. This service was not reviewed in detail, but they were integrated with current services provided elsewhere. This team was very motivated and had plans to further develop their services to meet the needs of their patient group, including lifestyle initiatives around weight management and smoking cessation.

Epilepsy: A nurse-led service for people with epilepsy had strong links with neuropsychiatry and neurology services in Birmingham as well as other services that were provided locally. A fast-track 'first seizure' service was in place and weekly multi-disciplinary team meetings were held to discuss the care of more complex patients. Cognitive behavioural therapy was access by GP referral. Clear guidelines for the care of women of child-bearing age with epilepsy were available and the epilepsy nurse specialist chaired the non-medical prescribing group.

Parkinson's Disease: Patient information and support were well organised with patients receiving copies of all letters about their care and good arrangements for peer support. Specific clinics for people with Parkinson's disease were run at the rehabilitation centre at Stone. Eight additional weekly clinics and a home visiting service were also provided. The team had good links with mental health services and there was access to rehabilitation programmes for younger patients. There was good leadership of the service by the clinical nurse specialist.

Multiple Sclerosis: A nurse-led service with links to the multiple sclerosis nursing service at University Hospital of North Staffordshire NHS Trust (UHNS). Patients were seen in clinic and disease modifying therapies commenced locally which prevented the patients having to attend services at UHNS. There was a range of patient information available including a guide to the MS Nursing service and who to contact in and out of hours. An annual report was also available which identified plans for the next 12 months.

Spasticity: Good services were available for people with spasticity, although reviewers suggested that further audit of outcomes may be helpful to demonstrate the effectiveness of services provided. Documentation of guidelines and protocols was generally good and showed compliance with national standards for the organisation of care.

Rehabilitation: Staff were very enthusiastic at all levels and there was very good leadership for this service with evidence of good teamwork and communication throughout. There was a range of very good information displayed on the walls as well as artwork from participants of the various rehabilitation programmes. The service also carried out small local audits.

Good Practice

1 An impressive and imaginative range and variety of rehabilitation activities was offered by the services with rehabilitation tailored to individuals' needs. The service had been able to utilise their facilities for real lifestyle rehabilitation for those using the service such as forestry, woodwork, metal work, baking, specialist cookery, flower arranging, art and crafts and use of 'Wii fit' activities. For some of the produce and work the rehabilitation service had started to provide 'orders' for local communities.

2 Rehabilitation included consideration of basic numeracy and literacy skills and, when appropriate, these skills were included in the rehabilitation programme.

3 Living after Rehabilitation (LARF) was a loyal and very actively supportive patient group, who met regularly and were active in ensuring that patient and carer involvement was embedded in any service improvement and development.

4 The service provided 'outreach' care for people in prison who lived with long term neurological conditions.

5 Communication to patients and GPs accessing the Parkinson's service was very good. There was a very detailed checklist for patient reviews, which was then communicated to all with a comprehensive letter detailing any updates in treatment plans.

Immediate Risks: No immediate risks were identified.

Concerns

1 One consultant neuorologist post was filled by a locum consultant. The arrangements for recruitment to a substantive post were not clear and reviewers were told of delays in approval and recruitment.

2 The overall pathway for patients with chronic neurological conditions was not documented and several of the clinical guidelines expected by the Quality Standards were not yet in place.

3 Patients did not have easy and timely access to psychological support services.

4 Reviewers were told that only 1.5 wte community speech therapist was available to support all community services. This caused particular problems for patients of the neurological rehabilitation service.

5 Arrangements for cover for the epilepsy nurse specialist and the rehabilitation specialist nurse were not formalised. Future funding for the multiple sclerosis nurse specialist post was unclear.

Further Consideration

1 Rehabilitation was organised in eight week programmes at the Day Unit with no outreach or follow up after the programme was completed. It may be helpful to consider arrangements for patients unable to attend the Day Unit and arrangements for ongoing support and further rehabilitation, if required.

2 Once the substantive neurologist consultant has been appointed, developing a 'clinical champion' role to ensure the quality of and development services for **all** long term chronic neurological conditions, in the context of the acute trust, may be helpful .

3 Links between the consultants and specialist nurses may benefit from review to ensure that all appropriate patients are receiving specialist nurse support.

4 As part of the work on documenting guidelines and policies it may be helpful specifically to consider: a) arrangements for documenting and recording of care plans, b) making the arrangements for education and self-management more formalised, c) criteria for home visiting and d) reviewing the policy of following up those patients with epilepsy who did not attend their appointments following completion of the audit.

5 Reviewers suggested that the rehabilitation service may want to widen the use of peer support within the patient self management and patient education frameworks.

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TRUST-WIDE

STAFFORDSHIRE AND STOKE ON TRENT PARTNERSHIP 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, but the following comments were made in relation to the care of people with long term conditions.

General Comments and Achievements

This Trust had made considerable progress in establishing high quality services. Considerable work had gone into setting up Board assurance processes, an annual cycle of quality visits and themed reviews of services. Progress was being made on harmonisation of policies and procedures. Reviewers were told that levels of mandatory training had increased significantly. Competency-based job descriptions and training to achieve expected

competences was being given a high priority. The Trust was aware of the issues which needed to be addressed. The Trust was actively participating in local health economy work to improve pathways of care for people with long-term conditions.

The Trust had approximately 700 non-medical prescribers and had developed a formulary in liaison with Mid Staffordshire NHS Foundation Trust. Links were also being established with staff in nursing homes in order to improve coordination and quality of care for people with long-term conditions.

Good Practice

1 Integration with social care was enabling the establishment of holistic services with the potential to provide responsive, holistic care for people with long-term conditions.

Immediate Risks: No immediate risks were identified.

Concerns

1 Service integration: See health economy section of this report.

2 Information Technology: See health economy section of this report.

3 Documenting pathways, guidelines and procedures: See health economy section of this report.

Further Consideration

1 Service specifications were not yet in place for several of the services provided by the Trust. Input from provider staff to commissioners' work on service specifications, including referral and discharge criteria, will an important part of improving local pathways of care.

2 Trust-wide arrangements for document control may benefit from further consideration as part of the Trust's work on documenting guidelines, policies and procedures.

MID STAFFORDSHIRE NHS FOUNDATION 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, but the following comments were made in relation to the care of people with long term conditions.

General Comments and Achievements

Considerable work had taken place on improving discharge information for GPs. Reviewers also noted good pharmacy support within the Trust and good arrangements for pharmacy follow up. The approach to audit within the Trust had been re-defined with greater emphasis on actions being taken after audits were completed. A trial of self-administration of medication was taking place.

Good Practice

1 A GP Helpline allowed GPs to give immediate feedback if they were having problems with a service. Staff from the Trust would immediately investigate the problem and communicate with the GP concerned.

Concern

1 Service integration: See health economy section of this report.

2 Documenting pathways, guidelines and procedures: See health economy section of this report.

3 The Trust document ratification process may benefit from review. The visiting team was told of delays in this process and several documents seen by reviewers were not document-controlled or were out of date. Reviewers were told about Trust and Directorate arrangements for approval of documents and it was not clear how these arrangements fitted together.

Further Consideration:

1 Further consideration of the Trust's approach to disease prevention may be helpful, including the possibility of introducing more formalised approaches. In particular, the approach to smoking cessation advice appeared to be 'ad hoc' and some staff were not aware of services to which patients could be referred.

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COMMISSIONING

STAFFORD AND SURROUNDS CLINICAL COMMISSIONING GROUP and CANNOCK CHASE CLINICAL COMMISSIONING GROUP

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

The peer review of care of people with long-term conditions took place as Clinical Commissioning Groups were just being established and, in particular, at the same time as the authorisation process. Reviewers met commissioners from Stafford and Surrounds Clinical Commissioning Group but did not meet commissioners from Cannock Chase Clinical Commissioning Group. Little documentary evidence relating to the commissioning of care for people with long-term conditions was available and much of the evidence seen was still in draft form.

Concerns

1 Service integration: See health economy section of this report.

2 An overall strategy for the care of people with long-term conditions was not yet in place. Some individual disease-specific strategies had been agreed but these did not cover the care of people with multiple long-term conditions.

3 Service specifications were not yet in place for several of the services reviewed. Key performance indicators were therefore not clear and the quality of service delivery could not be monitored.

4 Cardiac rehabilitation was not available for people with heart failure.

5 There was no Local Network (or equivalent) with responsibility for improving services for children and young people with diabetes.

6 All provider sections of this report identify issues which will require input from commissioners as well as providers.

Further Consideration

1 GPs did not have direct access to serum natriuretic peptide testing for patients with suspected heart failure. Reviewers suggested that this should be considered as part of the review of the pathway of care for people with heart failure.

2 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.

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APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Visiting Team

Dr Chizo Agwu	Consultant Paediatrician	Sandwell & West Birmingham Hospitals NHS Trust
Dr Sri Bellary	Clinical Director - Diabetes & Endocrinology	Heart of England NHS Foundation Trust
Helen Bladon	Diabetes Service Lead	Walsall Healthcare NHS Trust
Helen Coleman	Clinical Manager	The Shrewsbury & Telford Hospitals NHS Trust
Angela Cook	Diabetes Specialist Nursing Manager	Shropshire Community Healthcare NHS Trust
Donna Davies	Lead heart failure CNS	Heart of England NHS Foundation Trust
Adele Dean	Clinical Quality Manager	West Midlands Ambulance Service NHS Trust
Sian Finn	Self Care Programmes Manager	West Mercia NHS Cluster
Nick Flint	User Representative	
Dr Colin Gelder	Respiratory Consultant	University Hospitals Coventry & Warwickshire NHS Trust
John Grayland	Senior Strategy and Redesign Manager	NHS Birmingham East & North PCT
Joanne Gutteridge	LTC Commissioning Project Lead	NHS Dudley Clinical Commissioning Group
Hilary Kemp	Community Matron	Birmingham Community Healthcare NHS Trust
Mary Mansfield	Head of Patient Safety	Arden NHS Cluster
Dr Sushma Manthri	General Practitioner	Coalpool Surgery; Harden Health Centre
Dr Dinesh Mistry	Consultant Cardiologist	The Shrewsbury & Telford Hospitals NHS Trust
Andrea Read	Deputy Network Manager	Birmingham, Sandwell and Solihull Cardiac and Stroke Network
Gill Salt	Lead Paediatric Diabetes Nurse Specialist	The Royal Wolverhampton Hospitals NHS Trust
Wendi Shepherd	General Manager, Emergency Division	South Warwickshire NHS Foundation Trust

Dr Debbie Short	Consultant in Spinal Injuries & Rehabilitation Medicine	The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Trust
Wendy-Jane Walton	General Practitioner	Shropshire and Telford & Wrekin
Nicky Ward	Lecturer Practitioner in Multiple Sclerosis	Birmingham City University

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

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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	3	1	33
Specialist Care of Children & Young People with Diabetes	28	11	39
Trust-Wide: Mid Staffordshire NHS Foundation Trust	4	1	25
Commissioning	7	0	0
Health Economy	**42**	**13**	**31**
Care of Adults with Long-Term Conditions			
Primary Care	8	1	13
Community Long-Term Conditions Services	50	22	44
Specialist Care of Adults with Diabetes	60	14	23
Specialist Care of People with COPD	57	12	21
Specialist Care of People with Heart Failure	55	16	29
Specialist Care of People with Chronic Neurological Conditions (All Services)	112	57	50
Acute Services	(58)	(28)	(48)
Rehabilitation	(54)	(29)	(54)
Trust-Wide: Mid Staffordshire NHS Foundation Trust	7	0	0
Commissioning	12	3	25
Health Economy	**361**	**125**	**35**

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