WM QRS West Midlands Quality Review Service

NHS

Care of Adults with Long-Term Conditions

Care of Children & Young People with Diabetes

Herefordshire Health Economy

Visit Date: 25th September, 8th & 9th November 2012 Report Date: February 2013

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INTRODUCTION

This report presents the findings of the review of the care of people with long-term conditions in the Herefordshire health economy which took place on 25th September, 8th & 9th November 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 team which reviewed the services at Herefordshire health economy. Appendix 2 gives details of compliance with each of the standards and the percentage of standards met.

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 Herefordshire 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 with considerable expertise in the care of people with long-term conditions were working very hard to provide good quality care. Within teams there was good integration with all condition-specific teams providing both community and hospital-based care. Community long-term condition services caring for people with multiple long-term conditions were not yet fully established but there were good plans and a determination to implement these.

Good Practice

1 A good Expert Patient Programme was running and involved people with a wide range of long-term conditions.

2 The integration of health and social care in Wye Valley NHS Trust was achieving several benefits for patients and further benefits were expected as progress with integration continued.

3 Education and training programmes for staff were working well, including excellent education and training in Wye Valley NHS Trust, good GP and primary care education programmes and good links between these.

Concerns

1 **Implementation of NICE Guidance**

A lack of implementation of NICE guidance is identified in this report relating to the care of people with heart failure and those with epilepsy (see relevant section below). Wye Valley NHS Trust had a system for reporting on NICE implementation but this did not appear to be supported by any assurance process involving senior clinicians, senior Trust management or commissioners.

2 **Integration between services**

Although good progress had been made on integration of hospital and community services, condition-specific teams were working in relative isolation from each other and from community long-term condition services. Addressing this issue will be key to improving the care of people with multiple long-term conditions. Innovative thinking about integration between teams may also help to address some of the issues of lack of cover identified in this report.

3 **Documenting Pathways and Guidelines**

In general, pathways and guidelines were not documented. Staff were generally experienced and aware of the action they should take. Reviewers were concerned that pathways could vary depending on who was on duty and, in particular, systems were not robust in times of staff absence.

4 **Strategy Implementation**

A strategy for care of people with long-term conditions was available but it was fairly general and did not identify either the gap between current services and strategic aims or the actions needed to bridge this gap. Senior staff within Wye Valley NHS Trust and Herefordshire Clinical Commissioning Group could each describe a more detailed strategy but this was not documented and operational staff were not aware of it. Risk scoring tools were available to practices but were not yet being used by all practices to identify people at high risk of unscheduled admission to hospital. Also, specialist condition-specific teams were not yet aware of the risk stratification data or using this to prioritise their work. Other aspects of the strategy, including integrated neighbourhood teams, person-centred planning, single assessment and integration between neighbourhood teams and condition-specific teams were in people's heads but not clearly

documented or communicated. Some work had started; a meeting had been held and work-streams had been formed. Timescales and priorities for action were not yet evident.

Reviewers saw considerable potential for service improvement through implementation of the strategy, including potential for quality improvement within existing resources (as well as some services where investment was needed). Informal networks and relationships to support this work were good.

5 **Care of People with Chronic Neurological Conditions**

Despite the serious problems facing local services (see below), care of people with chronic neurological conditions did not appear to be a priority for Herefordshire Clinical Commissioning Group or for Wye Valley NHS Trust. The shortage of consultant neurologists was not on the Trust risk register and neither commissioners nor the Trust seemed to be aware of the limited care available for people with epilepsy.

Further Consideration

1 Out of hours services were unable to refer to neighbourhood teams at weekends (before 10pm) or to the 'roving night service'. The out of hours services could not refer directly to 'rapid access' clinics of condition-specific specialist teams, even if the patient was already under their care. The out of hours service based on the hospital site in Hereford was not able to access the Trust pathology system to request tests or to look at results of previous tests. As a result, patient care may be delayed and some patients may be admitted to hospital when this could have been avoided.

2 Given the long distances which some patients had to travel, further consideration of the use of Telehealth in appropriate settings may be helpful.

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PRIMARY CARE

HEREFORDSHIRE CLINICAL COMMISSIONING GROUP

General Comments and Achievements

A good GP education and training programme was in place and there were good links between this programme and the condition-specific teams caring for people with long-term conditions.

Good Practice

1 A GP was contracted to work with nursing homes. This GP did 'ward rounds' of the homes, reviewed care plans and provided specific input to the care of people nearing the end of life. This approach had been running as a pilot project for four years.

Further Consideration – Primary care

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.

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CARE OF CHILDREN AND YOUNG PEOPLE WITH DIABETES

WYE VALLEY NHS TRUST

General Comments and Achievements

The review team was impressed by the individualised care given to children and young people with diabetes and their families. Parents who met with the review team were extremely grateful and positive about the help and support that was available to them, in particular, the open access to the Paediatric Diabetes Specialist Nurse (PDSN). The team was enthusiastic and motivated. Team-working had improved over the last few years. The ward layout was welcoming and the decor had been improved following some work with an 'artist in residence'. There was good joint working between health, social care and the education service to facilitate school access. A support group for parents had recently been established. The team was taking part in the regional Diabetes Self-Management Education course.

Good Practice

1 The information booklet for newly diagnosed children was very good. It was comprehensive and layout meant that it was easy to read.

2 The format of the School Care Plan was comprehensive.

3 The multi-agency process for completion of School Care Plans for infant and junior school aged children was very good. Reviewers saw very detailed examples where each individual plan addressed routine care, emergency care and appropriate training. Each plan was reviewed annually, or more frequently on request.

Immediate Risks: No immediate risks were identified.

Concerns

1 Several aspects of the service were not yet fully developed:

a. Arrangements for out of hours advice were not appropriate. The policy identified the PDSN as the first point of contact for newly diagnosed patients and parents were able to contact him at home at any time. Other patients and families could contact the ward, and these calls were logged and referred to a member of the paediatric diabetes team. Many queries were then referred to the PDSN because of the limited number of nursing and medical staff with the expertise on medication adjustments for children and young people with insulin pumps. The Trust was aware of this issue and was reviewing arrangements for out of hours support.

b. No dietician had specific responsibility for the paediatric diabetes service. Paediatric dietetic advice was available on the ward and during clinic times but there was no cover for absences. In the absence of the paediatric dietician, advice was sought from the adult diabetes dietician.

c. The psychologist was on maternity leave and cover was only available from the CAMHS team. One parent who met with the reviewing team felt that access to a psychologist would have been helpful when her son was diagnosed.

d. A link nurse was not yet in place on the ward and training of ward staff was therefore limited. One member of staff had just completed the appropriate training. Plans were in place to develop the link nurse role to ensure ward training was undertaken and further advice would be available from the ward.

e. Comprehensive data were not yet collected and submitted to the national diabetes database. Some of the missing data will be required to show compliance with the 'best practice tariff'. Some data were collected manually as there was no database to facilitate collection and retrieval of data. Reviewers were told that the part-time PDSN was spending the next month collating data to ensure that submission to the national database was complete.

Reviewers were concerned that the combination of these issues would affect the ability of the service to meet the 'best practice 'tariff and may therefore affect future funding and service improvements.

2 Several aspects of the service were running on an informal basis and were dependent on one PDSN. Formalising some processes is necessary in order to improve consistency of care and make best use of the resources available, including the new PDSN, the lead consultant, and other consultant staff and ward nurses. Processes in need of formalisation include training and education for both patients and staff, and out of hours advice. Leadership will be needed to drive these changes.

3 Children's outpatient clinics were run routinely in adult facilities which were not a suitable environment for children.

4 Joint transition clinics involving adult and paediatric diabetes consultants were not in place, although some transition work was undertaken with the PDSN and adult diabetes service.

5 There was no competency framework covering the competences expected for roles within the paediatric diabetes service and no routine training for the paediatric diabetes team or for ward staff. Mandatory training and some ward-based training was delivered by the PDSNs.

Further Consideration

1 Clinic letters may benefit from being standardised to ensure that all clinical staff (nursing and medical staff) give consistent, appropriate information. Reviewers considered that a patient management system may help to address this.

2 The clinic proforma was no longer fit for purpose: It was not consistently completed, as the template contained headings that were no longer used, and did not have room for detailed documentation of the consultation.

3 Newly diagnosed children and parents were encouraged to attend a five day in-patient induction / education programme. This initiative had started following an 'admissions and contact' audit and the team may wish to audit that the programme is delivering its objectives, including the practice of keeping children in hospital over the weekend when the programme was not running. It may also be helpful to include free education and support programmes if this is available from the insulin pump companies in the ongoing education programme for those requiring technical or equipment advice.

4 Parents who met the reviewing team commented on the cost of car parking. This was particularly difficult for newly diagnosed children admitted for a five day education and support programme. It may be helpful to explore ways to support families with this cost.

5 Further work was needed to ensure that senior school children's care plans are completed to the same high standard as those for infant and junior school children.

6 Members of the paediatric diabetes team had a clear view about the strategy for the development of the service. It was not clear that management within the Trust or commissioners shared and agreed this strategy. This is particularly important because of the link with the 'best practice' tariff.

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COMMUNITY LONG-TERM CONDITIONS SERVICES

WYE VALLEY NHS TRUST

General Comments and Achievements

Community long-term conditions services in Herefordshire were not reviewed because, at the time of planning the review, these services were not in place. In practice, a range of services providing care for people with long-term conditions, especially those with multiple conditions, was in place. Reviewers were told about a 'Local Access Team' which provided some case management and tried to prevent admissions, a 'complex discharge' team of two nurses, a triage district nurse (contracted through *Primecare)*, a 'roving night' service (also two nurses), an admission avoidance team and a 'signposting team'. Plans were in place to group community long-term conditions services into five with each integrated team providing a 'one stop' service. A duty desk and single point of access for Herefordshire would ensure that all enquiries were routed to the appropriate locality and a 'single point of access' manager was in the process of being appointed. A competence framework for the neighbourhood teams was being developed with the aim of improving early identification of people with long-term conditions and their symptom management**.** Community matron or case manager roles as part of the new integrated teams were being considered and a 'virtual ward' was being piloted in four practices. Work was taking place with commissioners on developing and agreeing the specification for the new neighbourhood teams.

Good Practice

1 Seven places at Worcestershire University for training in health assessment and needs assessment were funded.

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SPECIALIST CARE OF ADULTS WITH DIABETES

WYE VALLEY NHS TRUST

General Comments and Achievements

A small, cohesive team provided specialist care for people with diabetes. The team comprised consultants and 3.6 w.t.e. diabetes specialist nurses who were providing integrated care across hospital and community settings. The team was enthusiastic and clearly motivated to drive improvements in care for their patients. The service was linking well with primary care services.

Hand-held records for patients were being piloted and patients had been heavily involved in the design of this record. There were plans to roll out this development to more patients and funding had been identified for this.

A patient focus group met on a monthly basis.

Good Practice

1 A good 'New to Insulin' ward pack was available which was very clear and well laid out, and was easily accessible to all ward staff.

2 Different levels of care planning were in place based on the level of patients' needs. Patients with more complex needs had more detailed care plans.

3 Diabetes Specialist Nurses were running monthly joint clinics with GPs in 21 of the 24 GP practices.

4 Staff had accessed available training in motivational interviewing (see Trust-wide section of this report).

Immediate Risks: No immediate risks were identified.

Concerns

1 **Foot Care**

There was no cover for the podiatrist and so urgent review by a member of the diabetic foot team within 24 hours may not be available.

2 **Documented pathway**

The local pathway and some key clinical guidelines, especially those relating to monitoring and management were not documented. Work was taking place on this but, at the time of the review, the patient pathway was not clear and may vary depending on which member of staff saw the patient.

3 **Data Collection and Audit**

Data collection arrangements were not robust and data were not used routinely to review the performance of the service. Although Trust-wide audits were in place, a rolling programme of audit of implementation of guidelines was not yet in place. Service-level arrangements for review and learning were also not yet in place.

Further Consideration

1 Cover for absences was available, except for the diabetes specialist nurse covering the in-patient wards, but the arrangements for cover were informal and may benefit from being formalised to ensure that cover was always available.

2 The team had little administrative support and so clinical staff were spending significant amounts of time on administrative work which could have been used for clinical care.

3 Reviewers were told that a community podiatrist was available but did not provide cover for the hospital-based podiatrist. It may be helpful to explore whether cover arrangements could be formalised within existing resources.

4 It may be helpful to review the arrangements for care planning for patients with complex needs who are under care of specialist team. These reviews were done in primary care, usually with diabetes specialist nurse input. It may be more appropriate for the specialist team, including consultant diabetologists to undertake these reviews.

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SPECIALIST CARE OF PEOPLE WITH COPD- INCLUDING PULMONARY REHABILITATION

WYE VALLEY NHS TRUST

General Comments and Achievements

Specialist care for people with COPD was provided by an experienced, committed team who worked well together. Services were patient-focussed and feedback from patients about the care they received was very good. The team comprised consultants and three specialist nurses, one of whom had lead responsibility for the care of people with COPD. All specialist nurses had COPD-related competences and experience. Specialist nurses were taking significant roles within the service, including assessing, diagnosing and treating within agreed guidelines, and monitoring patients' ongoing needs at nurse-led clinics.

Good Practice

1 A good on-line information pack about the services was available.

2 The pulmonary rehabilitation service was providing a very good service for its patients. A high proportion of patients with COPD went through rehabilitation programmes. The pulmonary rehabilitation team also

provided training and education for palliative teams and hospices in order to increase their understanding of the needs of COPD patients and how this differed from caring for patients with cancer.

3 The oxygen service was particularly well organised and provided good support to patients.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Data Collection and Audit**

Data collection arrangements were not robust and data were not used routinely to review the performance of the service. An available 'data pack' had not yet been reviewed. Although Trust-wide audits were in place, a rolling programme of audit of implementation of COPD guidelines was not yet in place. Service-level arrangements for review and learning were also not yet in place.

Further Consideration

1 Care plans were in use but these were condition-specific and did not cover co-morbidities or other aspects of patient needs. It may be helpful to look at examples from other organisations that have successfully introduced shared care plans for patients with complex needs.

2 The team was not yet using risk stratification information, or linking with work in primary care about patients at high risk of unscheduled admission.

3 The potential for using Telehealth to help with patient monitoring and avoid journeys to hospital may benefit from further consideration, especially because of the distances which some patients had to travel.

4 Staffing was not sufficient to provide urgent review by a member of the specialist COPD team within 24 hours at weekends.

5 The team did not have effective links with neighbourhood teams, including for support to the care of people with multiple long-term conditions. There was little awareness of the potential benefits of more integrated working with these services.

6 Multi-disciplinary meetings, or other arrangements, to discuss the care of people with multiple long-term conditions were not yet formalised.

7 Criteria for discharge from the service were not clear and several patients appeared to be attending the hospital for review who could have been followed up in primary care.

8 Arrangements for supporting carers and ensuring they were given appropriate information and 'signposting' to support services and needs assessments were not well developed. This aspect of the team's work may benefit from further consideration.

9 All staff had undertaken appropriate training but there was no framework of expected competences or training plan to ensure that competences were kept up to date.

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Specialist Care of People with Heart Failure

WYE VALLEY NHS TRUST

The Wye Valley Heart Function Team comprised two specialist nurses and one more junior nurse, working with consultant cardiologists. The Cardiac Rehabilitation Team, including the Heart Function Team, provided hospital and community-based care for patients with all cardiac conditions, including those with heart failure. In the last year the Team had seen 138 new patients with heart failure and had undertaken 656 follow up appointments. The service provided care for people with heart failure who were referred for rehabilitation.

Reviewers met only two patients with heart failure and so the patients' perspective on these services may not have been fully explored.

General Comments, Achievements and Good Practice

The Heart Function Team was providing as good care as possible within the resources available for their patients. A pilot of practice-based serum natriuretic peptide testing was in progress. Good patient information was available although it was not clear whether all patients with heart failure were offered this information. All patients seen by the Heart Failure Team were offered access to cardiac rehabilitation.

A good rehabilitation service was provided. The rehabilitation team was enthusiastic and keen to deliver a high quality service. The service operated a flexible approach to rehabilitation for people with heart failure, including either separate sessions or sessions combined with other patients depending on the numbers referred. At the time of the review there was a four to six week waiting time for cardiac rehabilitation. A comprehensive programme of education, stress management and exercise therapy was provided for those patients who had access to the service.

Immediate Risks: No immediate risks were identified

Concerns

1 **Implementation of NICE Guidance and Patient Pathway**

Reviewers were seriously concerned that several aspects of NICE guidance and the care of people with heart failure were not yet implemented.

a. The specialist care of the Heart Function Team was available mainly to patients following admission to hospital or referral to a cardiologist. Arrangements for access to the service for patients diagnosed by GPs were unclear. Also, patients were identified by nurses going round relevant wards and so patients who were admitted and discharged before being seen by a member of the Heart Function Team may not be referred to the service. Nurses on the cardiology wards would sometimes make a note of these patients for the Heart Function Team but patients admitted to non-cardiology wards over the weekend would probably not be referred. Referral criteria and referral mechanisms were not documented.

b. Patients referred to the open access echocardiography who were diagnosed with heart failure were reviewed at a weekly meeting and then referred back to the GP with a letter with recommendations from the consultant. There was no mechanism for following up whether or not a referral to the cardiologist (and then to the Heart Function Team) was made. It was therefore unclear whether these patients had the support of the Heart Function Team.

c. Serum natriuretic peptide testing was not used routinely as part of the diagnostic pathway. In practice, GPs did not have direct access to serum natriuretic peptide testing, except in those practices involved in the near-patient testing pilot. Serum natriuretic peptide testing was rarely used within the Trust.

d. Echocardiography was not available within two weeks for people with suspected heart failure and a previous myocardial infarction. At the time of the review the waiting time for open access echocardiography was six weeks and there were no arrangements for requesting more urgent access.

e. Multi-disciplinary assessment, as envisaged by the NICE guidance, was not available. Patients were seen by the cardiologists and then referred to the Heart Function Team.

f. Cardiac rehabilitation was only available to patients referred to the Heart Function Team. Other patients with heart failure were not able to access this service.

Reviewers were also concerned that the patient pathway usually involved many separate, unconnected steps. Due to the delays inherent in the pathway, patients could become more ill and be admitted to hospital. In practice, the pathway had a built-in incentive for admission because this was the quickest and easiest route to accessing the support of the Heart Function Team.

2 **Data Collection and Audit**

The Heart Function Team had data on number of patients seen but not other data relevant to the service (for example, number of patients on GP heart failure registers or hospital admission data). Data were being submitted to the national audit of cardiac rehabilitation. There was little evidence of using the data to monitor and review activity and no rolling programme of audit. Multi-disciplinary review and learning was not taking place within the Heart Failure Team, including involvement of cardiologists.

3 **Staffing Levels and Cover for Absences**

It was not clear that staffing was sufficient for the number of patients, especially if the service were to operate as envisaged by NICE guidance. Robust arrangements for cover for absences were not in place. The number of patients referred to the service was expected to increase as a result of the new cardiac resynchronisation therapy service in the Trust. Urgent review by a member of the specialist team within 24 hours was not available at weekends because of staffing levels.

4 **Staff Competences**

It was not clear that all staff had the appropriate competences for their work. The junior nurse within the Heart Function Team did not have specific training in the care of people with heart failure but was providing cover for the specialist nurses (especially during sick leave).

Further Consideration

1 The Heart Function Team was not yet using risk stratification information, or linking with work in primary care about patients at high risk of unscheduled admission.

2 The team did not have effective links with community matrons and neighbourhood teams, including for support to the care of people with multiple long-term conditions. There was little awareness of the potential benefits of more integrated working with these services. Integration with primary care was also not well-developed, for example, the possibility of GP practices undertaking titration for patients with heart failure did not appear to have been considered and most patients referred to the service continued to be followed up by the team. Criteria for discharge back to primary care, and for re-accessing the service if necessary, were not yet in place.

3 The system of walking round the wards to find patients may benefit from review. A more robust referral system, with clear criteria, may free up time and also ensure referral when members of the Heart Function Team were not on duty.

4 One of the physiotherapy gymnasiums did not provide a user-friendly environment for rehabilitation. The gymnasium was small and dark and had several items balanced at high levels.

5 Further discussions on serum natriuretic peptide testing will need to take into account the reasons why this has not been fully implemented sooner. Reviewers commented on a reluctance within the Trust to use this test which may be influencing local GPs. Quality control of near patient testing should be given careful consideration and it may be helpful to involve laboratory staff in developing a laboratory-based approach. [NB. These comments are in the context of the need for an overall review of the patient pathway – see above].

6 Leadership of specialist care for people with heart failure may benefit from review. The identified lead clinician was not involved directly in the care for people with heart failure. A consultant cardiologist was identified as having a particular interest in heart failure and mentored two of the three specialist nurses.

This consultant had also developed the business case for the service and had worked on protocols and other initiatives. This consultant was not, however, identified as the lead clinician. Effective leadership will be crucial to driving forward improvements to the pathway of diagnosis and care for people with heart failure.

7 This service may need support in redesigning pathways. Staff appeared concerned that changes would increase the number of referrals to a level with which they would be unable to cope. Exploring options for improving the pathway and making better use of resources, for example through more formalised referral processes and shared care with community matrons, neighbourhood teams and primary care, will need time and support.

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Specialist Care of People with Chronic Neurological Conditions

WYE VALLEY NHS TRUST

General Comments and Achievements

An enthusiastic, committed team was working in a multi-disciplinary way, especially caring for people with Parkinson's Disease and multiple sclerosis. A specialist nurse for each of these conditions worked closely with a consultant neurologist from Birmingham and a local consultant geriatrician with a particular interest in Parkinson's Disease. Some occupational therapy support (0.4 w.t.e.) was also available. Palliative care services provided local leadership and support for people with motor neurone disease.

Hospital and community-based services had integrated well. Clinics were undertaken at several community locations as well as in the hospital. The Expert Patient Programme was working well locally.

Good Practice

1 Local palliative care service provided good support for patients with chronic neurological conditions and multi-disciplinary working with the neurological team was well-established. A palliative care consultant provided local leadership for the care of people with motor neurone disease.

2 The service had excellent links with Parkinson's Disease UK and the Multiple Sclerosis Society and staff were involved in several aspects of national work.

Immediate Risks: No immediate risks were identified

Concerns

1 **Low Staffing Levels**

Several aspects of staffing for the care of people with chronic neurological conditions were of concern to reviewers:

a. Reviewers were seriously concerned about the low level of consultant neurologist staffing available for people with chronic neurological conditions in Herefordshire. Consultant neurologist time in Herefordshire at the time of the review was 0.4 whole time equivalent with no cover for absences. An appointment had been made to an additional post but the person appointed was not due to start for some months and reviewers were told that only 0.2 whole time equivalent (ie one day per week) would be spent in Herefordshire. These staffing levels were inappropriately low for the number of patients with chronic neurological conditions and did not provide adequate support to local acute services, sufficient cover for absences or time for input to multi-disciplinary discussions about the care of patients. This issue would have been identified as an immediate risk but reviewers visited the acute medical admissions ward and met junior medical staff who were clear about the need to contact neurologists at University

Hospitals Birmingham NHS Foundation Trust if they had queries and about the arrangements for making contact.

b. Two clinical nurse specialists provided care for people with Parkinson's Disease and multiple sclerosis respectively. Because of the disease-specific nature of their roles, there was no cover for absences and no specialist nurse support for people with other chronic neurological conditions. The caseloads held by each specialist nurse were large with each nurse caring for 400 to 500 patients (although see below in relation to arrangements for discharge from their care).

c. Specialist psychological support for patients with chronic neurological conditions was not available.

d. Specialist occupational therapy support for patients with chronic neurological conditions was limited (0.4 w.t.e.) and there was no cover for absences.

e. Because of low staffing levels, access to rehabilitation for people with chronic neurological conditions was limited.

2 **NICE Guidance on Care of People with Epilepsy**

NICE guidance on care of people with epilepsy was not yet implemented. There was no specialist nurse support for people with epilepsy and no multi-disciplinary support. People with more complex epilepsy and related problems were referred to the consultant neurologist.

Further Consideration

1 Long-term management and follow up of people with chronic neurological conditions other than Parkinson's Disease, multiple sclerosis and motor neurone disease appeared to rely entirely on GPs and on consultant neurologists who had very little time in Herefordshire. In taking forward service improvements, consideration should be given to the most appropriate approach to supporting all patients with chronic neurological conditions.

2 The criteria for discharge from the care of the specialist nurses were not clear and it appeared that patients were not being actively discharged.

3 Data collection arrangements were not robust and data were not used routinely to review the performance of the service. The service contributed to national Parkinson's Disease and multiple sclerosis audits but a rolling programme of audit of implementation of local guidelines was not yet in place. Service-level arrangements for review and learning were also not yet in place. This issue would have been classified as a concern but, given the low staffing levels, staff could not reasonably be expected to undertake this work at the moment.

4 Reviewers were told that some patients needing non-invasive ventilation were referred to Birmingham. It may be helpful to consider whether these services could be provided locally.

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TRUST-WIDE

WYE VALLEY NHS TRUST

General Comments and Achievements

The integrated structure of the Wye Valley NHS Trust was providing many opportunities to integrate care and these opportunities were being taken in several services. Good progress had been made on integration of hospital and community condition-specific teams for people with long-term conditions. Staff within Wye Valley NHS Trust had good insight into the problems faced by their services and there was good awareness of the risks inherent in some of the services.

Good Practice

1 The Trust training and education team was providing excellent leadership and support for improving staff training. Over the last year compliance with mandatory training had increased from 40% to 69%. Several innovative approaches were being taken to encourage training and education. The team also came in at night to ensure that night staff were able to access training. The Trust was taking good advantage of its integrated structure, for example, programmes of training for district nurses in the care of patients receiving intra-venous antibiotics were supported by supervised time working on wards to ensure that competences were achieved.

2 Staff providing care for people with long-term conditions had access to specific courses in motivational interviewing, run by a psychologist.

Immediate Risks: No immediate risks were identified

Concerns

1 **Pharmacy Medicines Management Support to Community Hospitals**

On-site pharmacy support was not available to community hospitals. Pharmacists did not visit community hospitals to provide a clinical check on prescribed medicines for in-patients or a governance presence in relation to medicines management. The Trust was aware of this issue and a range of measures was in place to mitigate the associated risk. A Trust pharmacist supported the development of policy and procedures in community hospitals and the 'Care Closer to Home Service Unit' and had responsibility for coordinating the Patient Group Directives used in community hospitals and services. Stock lists used in community hospitals were agreed with the pharmacist. Any non-stock items required were faxed to the County Hospital for consideration by pharmacy. Discharge medication was also checked by the pharmacy before patients were discharged. Quarterly audits of controlled drugs and annual audits of handling and storage of medication were conducted.

2 **Documentation of pathways and clinical guidelines:** See health economy section of this report.

3 **Data collection, audit and multi-disciplinary review and learning**

Arrangements for collection of relevant data, rolling programmes of audit and team-based multi-disciplinary arrangements for review and learning were not yet in place in the services reviewed. Some data were collected, some audits were undertaken and Trust-wide governance arrangements were in place.

4 **Cover for absences**

Many of the services reviewed relied on key individuals with little or no cover for absences. The quality of the service provided therefore varied depending on whether these individuals were or were not at work. Because of the size of the Trust, innovative and flexible arrangements for cover may be needed.

Further Consideration

1 Medicines reconciliation was undertaken by pharmacists for only 60% of patients admitted to hospital. The Trust was aware of this. It may be helpful to prioritise patients for medicines reconciliation, for example, by patient group or length of stay.

2 Education and training provided was excellent (see good practice) but was mainly uni-disciplinary. Some integrated training with social work and occupational therapy staff had started. Further development of team-based training, including integration with medical staff training, may be helpful.

3 Available IT systems did not have functionality which allowed communication between systems. It was therefore not possible for all staff involved in the care of a patient to see the latest care plan or have access to up to date information on the patient's care.

4 The number of key members of staff, including specialist nurses, who were off sick at the time of the review, was striking. Further work on sickness levels among staff providing care for people with long-term conditions may be helpful in order ensure that the pressures on this group of staff and their sickness patterns are fully understood.

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COMMISSIONING

HEREFORDSHIRE CLINICAL COMMISSIONING GROUP

General Comments and Achievements

Herefordshire Clinical Commissioning Group was a newly formed organisation, although it inherited much good work previously undertaken by Herefordshire Primary Care Trust. The CCG had good intentions for the development of care for people with long-term conditions. NHS Herefordshire Clinical Commissioning Group had identified paediatric diabetes as an area for attention in 2012/13. Implementation over the next few years will be key to improving care for this group of patients.

Good Practice: See paediatric diabetes service

Concerns

1 Implementation of NICE Guidance: See health economy section of this report.

2 Integration between services: See health economy section of this report.

3 Documenting Pathways and Guidelines: See health economy section of this report.

4 Strategy Implementation: See health economy section of this report.

5 Issues identified in the Wye Valley NHS Trust section of this report require the attention of commissioners to ensure that high quality care is available for Herefordshire children and young people with diabetes.

6 There was no local multi-agency network group (or equivalent) with responsibility for improving services for children and young people with diabetes. There was a group responsible for adults with diabetes which sometimes specifically discussed services for children and young people.

7 Care of People with Chronic Neurological Conditions

Despite the serious problems facing local services (see above), care of people with chronic neurological conditions did not appear to be a priority for Herefordshire Clinical Commissioning Group or for Wye Valley NHS Trust. The shortage of consultant neurologists was not on the Trust risk register and neither commissioners nor the Trust seemed to be aware of the limited care available for people with epilepsy.

Further Consideration

1 From the data seen by reviewers, the prevalence of multiple sclerosis in Herefordshire appeared high. It may be helpful for commissioners to review whether this is the case and, if so, to understand the reasons for this.

2 Out of hours services: See health economy section of this report.

3 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 TEAMS

Visiting Team: Paediatric Diabetes Review, 25th September 2012

Dr Chizo Agwu	Consultant Paediatrician	Sandwell & West Birmingham Hospitals NHS Trust
Dr Kathryn McCrea	Consultant Paediatrician	The Shrewsbury and Telford Hospitals NHS Trust
Carol Metcalfe	Paediatric Diabetes Specialist Nurse	Shropshire Community Healthcare NHS Trust
Gill Salt	Lead Paediatric Diabetes Nurse Specialist	The Royal Wolverhampton Hospitals NHS Trust

Executive Lead: Long-Term Conditions Review, 8th & 9th November 2012

Dr Narinder Sahota	PEC Chair/Medical Director	NHS Walsall PCT

Visiting Team: Long-Term Conditions Review, 8th & 9th November 2012

Helen Bladon	Diabetes Service Lead	Walsall Healthcare NHS Trust
Julie Day	Senior Practitioner for Continuing Healthcare	NHS Worcestershire PCT
Julie Booth	Clinical Quality Manager	NHS Solihull Clinical Commissioning Group
Adele Dean	Clinical Quality Manager	West Midlands Ambulance Service NHS Trust
Jane Freeguard	Head of Medicines Management & Pharmacy	NHS Worcestershire PCT
Joanne Harding	Programme Lead - LTC	NHS Midlands and East
Dr Dinusha Ileperuma	General Practitioner	Solihull PCT
Rosalind Leslie	Superintendent Physiotherapist/Clinical Physiotherapist Specialist, Cardiac Rehabilitation	The Royal Wolverhampton Hospitals NHS Trust
Dr Waqar Malik	Consultant Diabetologist	Birmingham Community Healthcare NHS Trust

Tamara Millard	Commissioner	Birmingham & Solihull NHS Cluster
Ben Ellis	Physiotherapy Team Lead	Walsall Healthcare NHS Trust
Dr Dawn Moody	General Practitioner	North Staffordshire Clinical Commissioning Group
Dr Antony Thomas	Consultant Neurologist	University Hospitals Coventry & Warwickshire NHS Trust
Rhona Woosey	Planned Care Redesign Manager	Birmingham & Solihull NHS 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
Sharon Ensor	Director	Key Opportunities CIC

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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	3	100
Specialist Care of Children & Young People with Diabetes	29	14	48
Trust-Wide: Wye Valley NHS Trust	4	1	25
Commissioning	7	2	29
Health Economy	**43**	**20**	**47**
Care of Adults with Long-term Conditions			
Primary Care	8	1	13
Specialist Care of Adults with Diabetes	59	37	63
Specialist Care of People with COPD, including Pulmonary Rehabilitation	56	37	66
Specialist Care of People with Heart Failure	80	54	68
Heart Failure	(55)	(31)	(56)
Cardiac Rehabilitation	(25)	(23)	(92)
Specialist Care of People with Chronic Neurological Conditions (All Services)	113	60	53
Multiple Sclerosis, Parkinson's Disease	(56)	(35)	(63)
Motor Neurone Disease & other	(57)	(25)	(44)
Trust-Wide: Wye Valley NHS Trust	7	3	43
Commissioning	12	5	42
Health Economy	**335**	**197**	**59**

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