WM QRS West Midlands Quality Review Service

NHS

Care of Adults with Long-Term Conditions

Care of Children & Young People with Diabetes

North Warwickshire Health Economy

Visit Date: 14th & 15th 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 North Warwickshire health economy which took place on 14th & 15th 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 North Warwickshire 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 North Warwickshire 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

Reviewers who visited North Warwickshire were impressed by the hard work and commitment of all the staff they met. Many staff were working far beyond the call of duty, sometimes in difficult circumstances. The patients who met the visiting team were highly appreciative of this care and dedication and very satisfied with the services they received. In general, the health economy had good insight into the issues facing their services for people with long-term conditions.

Operational relationships with social services appeared well established and mutually supportive. There was good commitment from social care to ensuring timely discharge from hospital, including 'discharge to assess' whereby social care assessments were undertaken after discharge rather than delaying the discharge process.

Good Practice

1 Arrangements for rapid discharge of people nearing end of life were very well organised. The 'Ripple' pathway was clearly documented and well understood by all relevant staff. Links between the acute hospital, primary care, 'hospice at home' and other relevant services were well defined and drugs and equipment could be supplied quickly. As a result, patients who wished to die at home could usually be discharged in less than six hours.

Concerns

1 **Strategy and Integration**

The health economy did not yet have a clear, shared strategy for the development of services for people with long-term conditions. The services reviewed appeared to be working in isolation from each other without appropriate integration and liaison. Particular issues relating to strategy and integration were:

a. Integration of community services

The 'virtual ward' was reviewed in detail. Reviewers were told about other community based health and social care services which were serving a similar group of patients, including the Intermediate Care and Community Emergency Response Team, Community Nursing Teams and social services teams. The GP out of hours service was not able to refer directly to the 'virtual ward', several staff in specialist LTC services and on wards were unaware of the community services available and how to refer to them, and the ambulance service was trying to maintain a paper-based directory of services which could be accessed. There was no community nursing service available between midnight and 8.30am. Community services provided home intravenous therapy for cellulitis but not yet for other conditions. Integration of the community services available may provide a simpler system with, ideally, a single point of access. This could make access easier and improve continuity of care for patients. This model may also enable the further development of community-based therapies which may avoid admissions or speed up return home. Managers of the community services said that a more integrated model was being implemented but this did not appear to be widely known by staff or other organisations.

b. Integration between community and specialist long-term conditions teams

Appropriate links were not in place between community services and the specialist condition-specific long-term conditions teams reviewed (that is, those caring for people with COPD, diabetes, heart failure and chronic neurological conditions). Specialist teams were generally not aware of the community services that were available. Formal and informal links between

services were patchy. Opportunities for shared care between specialist and community teams, access to specialist advice and handover of care to the most appropriate service, may therefore be being missed. The heart failure, diabetes and COPD teams reviewed were all wanting to develop or expand their community specialist nursing staffing but did not appear to have considered how these staff would link with community services and whether alternative models were possible. Also, links between the services reviewed and palliative care services did not appear well developed.

c. Integration with primary care

The COPD, diabetes and heart failure teams were all highly committed to providing good care for their patients and therefore may be 'holding on to' patients whose care could be managed in primary care, with appropriate arrangements for advice and re-accessing the specialist team if necessary. Reviewers saw several examples of patients making repeated visits to clinics when this could have been avoided. The lack of integration came over as an 'all or nothing' view (ie patients had their care by the specialist team **or** in primary care) without consideration of actively enabling self-management, agreed criteria for re-contacting the specialist team and other possible ways of encouraging independence and of bridging the gap between primary care and specialist teams.

d. Care of people with multiple long-term conditions

Although consultants and hospital-based specialist nurses may discuss patients informally, more formal arrangements for coordinating the care of people with multiple long-term conditions were not yet in place. Reviewers considered that this was another aspect of integration which had the potential to improve quality and improve use of resources.

e. Building resilience

Many of the services reviewed were available only during the working week and were dependent on a few key individuals with arrangements for cover for absences which were not robust. As well as addressing staffing shortfalls, the development of clear pathways and improved integration may provide opportunities for building resilience, ensuring services are available at weekends and cover for absences is available.

f. Coordinated planning and implementation

The mechanisms and structures for coordinating planning and implementation of care of North Warwickshire people with long-term conditions were not yet in place. Reviewers were told about the Arden Systems Board and the Emergency Care Partnership but these were not appropriate forums for North Warwickshire discussions about the long-term conditions strategy and its implementation. The North Warwickshire Clinical Commissioning Group had an outline strategy but this did not yet relate strategic aspirations to current services or include priorities for addressing the gaps identified. It will be important to ensure that out of hours and ambulance services are included in the mechanisms when established.

In summary, reviewers considered that a clear strategy, robust pathways and better liaison and integration between services could provide many opportunities for improving quality of care, improving use of resources and avoiding hospital admissions.

2 **Services for children and young people with diabetes**

Services for children and young people with diabetes were working with low staffing and access to insulin pumps was restricted (see below). Neither George Eliot Hospital NHS Trust nor North Warwickshire CCG had started to consider the implementation and implications of *'Best Practice Tariff'* for these services. Also, the implications of the proposed future move of in-patient paediatric services to University Hospitals Coventry and Warwickshire NHS Trust on paediatric diabetes services had not yet been considered.

Further Consideration

1 The models of care for people with long-term conditions in North Warwickshire were relatively 'traditional', with few examples of more innovative approaches, including actively encouraging self-management and self-care, nurse-led clinics, use of telehealth, flexible roles and innovative use of skill mix. As part of the health economy work on the strategy for care of people with long-term conditions, It may be helpful to identify a champion or champion/s for personalised, integrated care and to consider ways of supporting teams to challenge their current models and practice.

2 The care records and care plans for each service reviewed were separate, with several examples of multiple, paper-based records. As a result, other health and social care staff were not able to see the latest care plan or up to date information about patients' care. Out of hours services had little access to information about the care of patients with long-term conditions and the information they could access was not always up to date. As part of the health economy work on improving and integrating care for people with long-term conditions, ways of enabling access to care records and care plans should be considered. This will be challenging for some services with a strong commitment to separate paper-based systems.

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Primary Care

Further Consideration

1 Information on quality assurance of spirometry in primary care showed that some practices were not participating in a quality assurance process. As part of the health economy work on improving the COPD pathway, it will be important to ensure that all patients have access to quality assured spirometry, either in primary care or through the hospital-based COPD team.

2 There was no ongoing primary care education and training programme and reviewers were given some examples of practices not participating in training and education that was available. This was a particular concern for the care of children and young people with diabetes where reviewers were given specific examples of delays in referral to the paediatric diabetes service.

3 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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Specialist Care of Children & Young People with Diabetes

GEORGE ELIOT HOSPITAL NHS TRUST

General Comments and Achievements

This service was provided by a dedicated and enthusiastic team. The care that they offered was appreciated and valued by patients and parents. Uncertainty over the future strategy and management of paediatric services at George Eliot Hospital NHS Trust was making it difficult for staff to plan for the future of the service, including planning achievement of all relevant Quality Standards.

Robust 24 hour on call arrangements had been achieved, including telephone advice from a Paediatric Diabetes Specialist Nurse until 10pm. The ward link nurses were well trained and knowledgeable about the care of children and young people with diabetes. A good consultation exercise on patient and family education had been undertaken and plans for a structured education programme had been developed.

Good Practice

1 Contact details for the paediatric diabetes team were on the bottom of all clinic letters, making it easy for families to access up to date contact details.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Documentation of Telephone Advice**

Telephone advice given to young people and families of children with diabetes was not routinely documented, including the reasons for the call, details of advice given and any treatment changes.

2 **Low Staffing Levels**

Staffing was insufficient for the number of patients being cared for by the service. There was one paediatric consultant, 1.2 whole time equivalent paediatric diabetic specialist nurses (PDSNs) and 0.3 whole time equivalent dieticians in the team. The team was responsible for 140 patients. PDSN staffing was significantly below the recommended level of 1 PDSN to 70 patients and their responsibilities included being on call for telephone advice until 10pm. There were inadequate cover arrangements for staff absences and the team was not able to achieve the *Best Practice Tariff* within the resources available.

3 **Access to Insulin Pumps**

A decision had been made to restrict the number of patients offered insulin pumps because staffing was insufficient to support patients with pumps. At the time of the review, only 13 (9%) patients had insulin pumps.

4 **PDSN Ongoing Competence Assessment and Assurance**

Both PDSNs reported that they had undertaken relevant paediatric diabetes training but the arrangements for ongoing competence assessment and clinical supervision were unclear. These nurses were employed by South Warwickshire NHS Foundation Trust to work in dual roles, as school nurses and as PDSNs. The PDSNs were working in both hospital and community settings. Arrangements for feedback from George Eliot Hospital staff to South Warwickshire NHS Foundation Trust appraisal processes were also not clear.

5 **Administrative and Clerical Support**

The PDSNs did not have administrative and clerical support. Time which could have been spent on clinical work was being used for administrative and clerical work.

6 **Point of Care Testing**

Point of care HbA1c testing (or a robust alternative) was not available in paediatric diabetes clinics.

7 **Local Network**

There was no local Network or Trust-wide group involving families, providers and commissioners to drive improvements in the care of children and young people with diabetes. See also health economy section of this report in relation to the need for health economy-wide consideration of the future plans for the service, including implementation of *Best Practice Tariff* and the implication of any changes to in-patient services on the care of children and young people with diabetes.

8 **IT, Data Collection and Audit**

A minimum data set was submitted to the RCPCH National Paediatric Diabetes Audit but the team did not have access to the full range of monitoring data expected. The Trust IT system did not provide appropriate support for collecting the necessary data. A stand-alone database had been developed but was not linked with Trust systems or supported by the Trust IT department. There was little evidence of local audits and no programme of audit of implementation of guidelines.

Further Consideration

1 Updating the operational policy to cover all aspects of the relevant Quality Standard (QS JR-601) may be helpful to ensure consistency of care, especially during times of staff absence.

1 Work to formally document and improve the transition policy was underway and will need to be completed and fully implemented.

2 The use of a validated psychological assessment tool should be considered.

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COMMUNITY LONG-TERM CONDITIONS SERVICES

VIRTUAL WARD - SOUTH WARWICKSHIRE NHS FOUNDATION TRUST

The North Warwickshire 'Virtual Ward' service provided additional support and clinical care at home for selected patients with complex and chronic long-term conditions who were at high risk of admission to hospital. The service was available from 8.30am to midnight, seven days a week. Patients were identified through risk stratification or referral from general practices. Patients were then assessed and, if capacity allowed, cared for by the team for up to 12 weeks. Including vacant posts, the team was made up of 3.95 wte community matrons, 3.8 wte case managers, 8.0 wte virtual ward nurses, 7.26 health care assistants and 1.52 ward administrators. The team had links to a Warwickshire-wide community pharmacist.

The Virtual Ward linked with the Intermediate Care and Community Emergency Response Team (CERT), which also aimed to avoid admissions and provided care for up to six weeks after discharge from hospital, and neighbourhood community nursing teams.

General Comments and Achievements

Staff providing the Virtual Ward were a dedicated, passionate and hard-working team. There was a good team approach. The hospital base for the team was due to close and plans were in place to move to a new base alongside neighbourhood nursing teams. This move should help to improve liaison with community nursing services.

The team had worked well to establish the Virtual Ward including utilising simple Telehealth and achieving good engagement with GPs. Links with social care were also well established. There was a good patient leaflet to which there had been patient input. A reporting 'dashboard' had been established and good work on risk stratification had taken place, incorporating both the BUPA tool and local knowledge to identify patients at high risk of admission to hospital.

Good Practice

1 The Virtual Ward had good access to pharmacy support with one pharmacist covering all Warwickshire virtual wards.

2 The team could easily access information on pathology results and had access to the George Eliot Hospital IT system.

3 There was a good approach to competences and training, based on well-developed Long-Term Conditions Workbooks.

Immediate Risks: None were identified.

Concerns

1 Clinical guidelines and protocols were not yet localised to show how national guidance was being implemented in the local situation.

2 The pathway and links with condition-specific specialist services for advice and support were not yet robust. Reviewers were given examples of patients being cared for by the Virtual Ward who may have benefited from condition-specific specialist advice but where this was not sought.

3 The ability to transmit patient identifiable data securely was not yet available to all community staff. The Trust was aware that this facility was not yet in place.

Further Consideration

1 See health economy section of this report (Further Consideration 1) in relation to support for implementing integration with other services and new ways of working. The Virtual Ward may also benefit from more senior clinical leadership, for example, through an Advanced Nurse Practitioner and / or through links with a care of older people consultant. This may help further to develop the range of clinical interventions which the team can support and, while sustaining the core clinical role of the patient's GP, provide more specialist expertise on the care of people with more complex needs and multiple long-term conditions.

2 Care plans were in place but did not yet include patient-defined goals. The care plans provided an effective checklist but not yet a patient-centred summary.

3 Patient feedback was collected through a Virtual Ward Patient Experience Questionnaire but reviewers saw no evidence of the questionnaire results being used to support service redesign. Further work in this area may be helpful.

4 The criteria and arrangements for discharge from the virtual ward may benefit from review. The model of care was based on the assumption that patients could usually be discharged to community nursing teams and primary care after 12 weeks. In practice, some patients were needing ongoing support and were being referred back to the virtual ward soon after discharge.

5 Although Trust-wide arrangements were in place, the mechanisms for service-level review and learning within the community services were not clear and may benefit from a more robust team approach.

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Specialist Care of Adults with Diabetes

GEORGE ELIOT HOSPITAL NHS TRUST

General Comments and Achievements

This strong team was providing excellent care for adults with diabetes. The team was friendly, cohesive and innovative. Leadership was strong and there were many examples of innovative, robust education programmes for patients and for health professionals. There was a pro-active, patient-led local diabetes network and an active local patient support group. Patient feedback on the care received was excellent. The team was pursuing improvements to the care of patients with diabetes who are admitted for surgery. Work was also starting on risk stratification in order to identify patients at high risk of admission.

The team was mostly hospital-based, including diabetes specialist nurses (1.7 wte), associate practitioner (0.8 wte), specialist midwife (0.2 wte), specialist dietician (0.5 wte), administrative support (1.4 wte), diabetes consultants (1.2 wte for diabetes care) and volunteers (0.1 wte). A community diabetes specialist nurse (0.6 wte) was employed by South Warwickshire NHS Foundation Trust but worked closely with the George Eliot Hospital team. There was also a strong programme of research with associated research staff. Support was also available from an Asian link worker and a pharmacist.

Diabetes records were detailed and well maintained, but were separate from general hospital records. The team had recently started booking their own out-patient appointments.

The team worked from the Diabetes and Endocrinology Centre within the main out-patient department. Out-patient care was provided for approximately 850 patients who clinicians considered could not be discharged back to primary care due to their complex needs. Additionally, between 850 and 1000 patients were being followed up, the majority of whom would be discharged to primary care when specific clinical parameters had been optimised. Outreach clinics were provided in Polesworth and were being piloted in an area of high deprivation in inner city Coventry.

Good Practice

1 A very good range of pre-pregnancy, pregnancy and post-pregnancy educational leaflets was available.

2 An education programme prior to Ramadan was organised. Education for patients and families was organised in the month before Ramadan, supported by the Asian link worker. Community-based sessions with the opportunity for individual discussion covered dosage adjustment and diet.

3 Good information and supportive education programmes were available for families of newly-diagnosed patients, with a particular focus on prevention.

4 The lead clinician had developed the 'BMJ Masterclass' which provided excellent GP education on caring for people with diabetes.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Diabetic Foot Team**

Podiatry support to the specialist team was insufficient and the service could not access a multi-disciplinary 'diabetic foot team' to assess patients with diabetes and complex foot problems. The service had access to a part-time community podiatrist who provided foot care for approximately 300 patients with diabetes. Patients with an ischaemic foot were referred to vascular surgeons based at University Hospitals Coventry and Warwickshire NHS Trust. The pathway of care of the 'at risk' foot of a patient with diabetes was not clear and reviewers were concerned that in-patients and others with 'at risk' feet may not receive appropriate care. A 'foot at risk' clinic had previously been operational but had ceased. Both Trust staff and commissioners were aware of this issue but there were no clear plans or timescales for it to be addressed.

2 **'Out of Hours' Telephone Advice**

The community diabetes specialist nurses (0.6 wte employed by South Warwickshire NHS Foundation Trust) was identified as the 24/7 contact for queries and advice for patients and her mobile phone number was on the information given to patients. Arrangements for 'out of hours' telephone advice when she was not on duty and for cover for absences were not clear.

Further Consideration

1 The diabetes support group mentioned to reviewers that they would like more opportunities for publicising their work in the hospital.

2 Arrangements for notifying the diabetes team of patients admitted to the hospital who had diabetes were not robust. Patients admitted with a primary diagnosis of another medical problem were not routinely notified to the diabetes team.

3 Criteria for discharge to primary care may benefit from review. Reviewers were told that stable patients with type 2 diabetes were discharged to primary care but patients with type 1 diabetes were mostly followed up six monthly by the specialist team.

4 Annual reviews were undertaken and recorded but did not cover screening for depression or sexual health. It may be helpful to standardise prompts to ensure all appropriate areas are covered and relevant information is recorded.

5 See acute Trust-wide section of this report in relation to IT systems and data collection.

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SPECIALIST CARE OF PEOPLE WITH COPD – INCLUDING PULMONARY REHABILITATION

GEORGE ELIOT HOSPITAL NHS TRUST

General Comments and Achievements

Specialist care for people with COPD was provided by a dedicated and enthusiastic team which provided care across hospital and community settings. The service was made up of several elements: a) consultant chest physicians and the hospital-based Respiratory Support Service, b) the Respiratory Early Discharge Service (REDS) which provided specialist nurse and respiratory physiotherapy input patients with COPD for up to two weeks following discharge from hospital, c) the COPD Outreach Service which provided monitoring and support from a specialist nurse and respiratory physiotherapist for patients on discharge who did not meet the criteria for early discharge but would benefit from additional support in the community to prevent re-admission. Staff were well aware of the pathways of care and patients were very satisfied with the care they received. The team had clear insight into the difficulties they faced and were continuing to provide as good care as possible despite these problems.

Patients were receiving a comprehensive assessment and several innovative services had been developed, including the 'REDS' (Respiratory Early Discharge Service) and a 'Singing for Breathing' project. The REDS team comprised two specialist nurses with additional training in care of people with respiratory disease.

Good Practice

1 A comprehensive home oxygen assessment and review service was available with good data collection, which demonstrated the quality of care provided.

2 An active patient support group was running.

3 Members of the team had received training in cognitive behavioural therapy.

Immediate Risks: None were identified.

Concerns

1 **Administrative and Clerical Support**

The service had no administrative or data collection support. As a result, clinical staff were spending time which could have been used for clinical work on administrative and clerical tasks.

2 **Low Staffing Levels**

Staffing levels were low for the number of patients and the nature of the service offered. Less than two whole time equivalent (wte) respiratory specialist nurses identified and supported patients in hospital, delivered 'hospital at home' and supported the HOSAR service; only 0.6 wte physiotherapy support was available for pulmonary rehabilitation. There was no cover for absences and some aspects of the service stopped if staff were sick or away for other reasons. Only about 50% in-patients with COPD were receiving specialist nurse support because of the limited staffing. Staffing was not sufficient to offer urgent review by a member of the specialist team within 24 hours.

3 **Care Planning**

Care plans were not systematically documented. Reviewers were told that a national care plan form was used but there was no evidence of systematic documenting of care plans in the case notes seen by reviewers. Also, the notes seen by reviewers included little evidence of enabling self-management and patient-agreed goals.

4 **Guidelines, protocols, data collection and audit**

Guidelines and protocols were generally not documented. Also, the data collected on Trust systems could not be easily accessed by the team who therefore did not routinely review key performance indicators. There was no rolling programme of audit of implementation of guidelines, partly because they were not documented and partly because of the lack of administrative and data collection support for the team.

Further Consideration

1 At the time of the review, interim arrangements had been implemented while work was taking place to ensure that all nurses providing non-invasive ventilation had achieved appropriate competences in this care. It will be important to complete this work on competences before the non-invasive ventilation service is re-introduced, and to ensure that ongoing arrangements for maintaining competences are in place.

2 There was no evidence of effective integration with community long-term care services, including the virtual ward. Arrangements for discharge from the care of the COPD team to other services, for shared care and for access to advice and support following discharge were not yet well developed. A more integrated approach with community-based services and primary care services may help to reduce some of the workload of the team and improve the quality and continuity of care for patients, especially those patients with multiple long-term conditions.

3 The team was maintaining some separate, paper-based patient records. As a result, this information was not easily available to other team members and to others involved in the patients' care. A review of the need for and appropriateness of these record systems may be helpful.

4 A mechanism for quality assurance of spirometry was in place for George Eliot Hospital NHS Trust. Some information on quality assurance of spirometry in primary care was available but showed that some practices were not participating in a quality assurance process. The team should consider working with others in the health economy to improve this aspect of the diagnostic journey. [See also primary care section of this report.]

5 Although Trust-wide arrangements were in place, there was limited evidence of a team-based, systematic process for review and learning.

6 Links with palliative care services may benefit from review. There was no system for routinely identifying patients in need of palliative care and robust links with palliative care services were not apparent.

7 Some patients and staff who met the reviewing team were concerned about arrangements for access to wheelchairs. Reviewers were told that wheelchairs were available only for people who needed a wheelchair to get around the house and not for other patients. Others within the Trust said that wheelchairs were easily available for all patients who needed them. Staff within the COPD team should ensure that they are aware of the arrangements for obtaining wheelchairs and that patients are informed of these. If problems remain, it will be important to raise these at a Trust-wide level so that any issues can be addressed.

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SPECIALIST CARE OF PEOPLE WITH HEART FAILURE

GEORGE ELIOT HOSPITAL NHS TRUST

General Comments, Achievements and Good Practice

Specialist care for people with heart failure was provided by a hospital-based team who were dedicated and patient-focussed. The team worked well together and patient feedback was excellent. Despite staff having a heavy caseload, patients said that they did not feel rushed. The team had a strong ethos of respect and care for the well-being of their patients. The service was usually initially accessed by patients admitted to medical wards and there was good awareness among ward staff about how to refer to the service. After admission, patients were followed up in a specialist heart failure clinic. GPs had open access to echocardiography and could refer directly to the heart failure clinic. It was not clear what proportion of patients came through this route of referral. Patients were followed up in the clinic, sometimes on a long-term basis, and some patients were closely monitored, including weekly or two-weekly attendance.

Immediate Risks: None

Concerns

1 **Low Staffing Levels**

Staffing levels were low for the number of patients cared for by the team. Approximately 700 patients with heart failure had their care monitored and managed through the heart failure clinic. The Trust had only two cardiologists covering all cardiology patients, who also did sessions at University Hospitals Coventry and Warwickshire NHS Trust and participated in the medical on-call rota. A third consultant cardiologist had recently been appointed. Four cardiac specialist nurses covered the whole of cardiology. One of these specialised in care of patients with heart failure, did the clinic with the consultant and ran the titration service. Although one of the other cardiac specialist nurses would provide cover for absences, it was not clear that these nurses all had specific training in the care of people with heart failure and would be able fully to cover the role of the heart failure nurse. Staffing was not sufficient to offer urgent review by a member of the specialist team within 24 hours.

2 **Guidelines, Protocols, Data Collection and Audit**

Guidelines and protocols were generally not documented. The team did participate in the national heart failure audit but did not routinely review key performance indicators using available Trust data. There was no rolling programme of audit of implementation of guidelines, partly because they were not documented.

3 **Community-Based Care**

The team was entirely hospital-based and had no staff able to visit patients at home or in community locations. Also, there was no evidence of effective integration with community long-term care services, including the virtual ward. Arrangements for discharge from the care of the heart failure team to other services, for shared care and for access to advice and support following discharge were not yet well developed. As a result, in practice, the only patients able to access specialist heart failure care were those who were fit enough to travel to the clinic.

4 **Ward Nurse Training**

Nurses on the cardiology ward did not have specific competences in the care of people with heart failure. Some teaching sessions had been held but there was no competency framework or structured approach to the training of ward staff.

5 **Access to Echocardiography**

Echocardiography was not available within two weeks of referral for people with suspected heart failure and a previous myocardial infarction or high levels of serum natriuretic peptides. At the time of the review,

these patients were waiting three weeks for echocardiography. There was a two month wait for trans-oesophageal echocardiography. The reason for these delays was not clear as the echocardiography department appeared to be staffed appropriately for this workload.

6 **Access to Cardiac Rehabilitation**

Most patients with heart failure did not have access to cardiac rehabilitation. The cardiac rehabilitation service did provide care for a small number of heart failure patients (approximately 12 to 16 a year) but this service was not routinely available to heart failure patients.

Further Consideration

1 Recently introduced guidelines on emergency access to a cardiologist for patients presenting with a pace-maker problem should be audited to provide assurance that robust implementation has been achieved.

2 Further work on the number of patients accessing the service may be helpful and, in particular, whether all relevant patients are being referred by GPs. It was not clear to reviewers that all patients who may benefit from the service were able to access it prior to an emergency admission. As part of this work, it may be helpful to look at whether the lack of a community-based part of the specialist care pathway is limiting access to the service.

3 There was no system for routinely identifying patients in need of palliative care and links with palliative care services were not well developed.

4 A more integrated approach with community-based services and primary care services may help to reduce some of the workload of the team and improve the quality and continuity of care for patients, especially those patients with multiple long-term conditions. Reviewers suggested that active encouragement of independence and self-management may help to reduce dependence on the service. Consideration should also be given to the use of Telehealth in supporting independence and self-management.

5 Although Trust-wide arrangements were in place, the heart failure service did not have any mechanisms for multi-disciplinary review and learning (either separately, as part of cardiology-wide arrangements or across the Coventry and Warwickshire Network).

6 Reviewers saw little evidence of strategic planning for the service and links with commissioners were not evident. Consideration should also be given to involving service users in planning the future development of the service.

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Specialist Care of People with Chronic Neurological Conditions

Specialist care of people with chronic neurological conditions is covered in a separate Coventry and Warwickshire report.

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Trust-Wide

GEORGE ELIOT HOSPITAL NHS TRUST

Good Practice

1 The Trust had a good 'capacity team' made up of clinical staff who took a proactive approach to working with ward staff (for example on Expected Date of Discharge, training and discharge coordination). This team also used good Key Performance Indicators and had robust monitoring arrangements. A daily 'board round' was undertaken with social services.

2 Patients with dementia were not moved from ward to ward unless there was a clinical reason for their transfer. Patients with dementia were clearly identified to staff through the use of a bed-head butterfly symbol.

Concerns

1 Strategy and integration: See health economy section of this report.

2 Paediatric diabetes: See health economy section of this report.

Further Consideration

1 The Trust pharmacy service was not able to provide individual advice to patients, including those with long-term conditions. There was no electronic prescribing system and no pharmacy service (other than for emergencies) at weekends. This may also be delaying discharges as drugs 'To Take Out' were not easily available at weekends. A seven day a week pharmacy service was being considered. The pharmacy department did do a helpful monthly briefing for all staff on medicines management issues.

2 The Trust had clear processes for statutory and mandatory training but arrangements for ensuring staff had competences appropriate to more specialist roles were not robust. These responsibilities were devolved to individual services with no apparent mechanisms for monitoring that appropriate training had been completed and expected competences assured.

3 A small number of South Warwickshire NHS Foundation Trust staff were working in George Eliot Hospital. The arrangements for ongoing competence assessment, clinical supervision and for feedback to staff appraisal processes were not clear.

4 Service-Level Review and Learning: Trust-wide governance processes were in place but the teams reviewed were not undertaking review and learning at an individual service level. The Trust governance team was not resourced to support individual directorate or service review and learning processes and individual teams were not giving priority to this activity. This was understandable given the pressure under which teams were working but review and learning is fundamental to the improvement of services. Most of the teams reviewed (with the exception of the diabetes service) did not have easy access to data on key performance indicators and were not undertaking a robust process of audit of outcomes and of implementation of guidelines.

5 This review identified that the Trust's 'Policy on Policies' and 'Policy on Patient Information' were not yet robustly implemented.

6 The Trust's systems for assuring implementation of NICE guidance were limited. There was monitoring of NICE implementation but the system appeared to rely on verbal assurance from key individuals without any more detailed analysis or investigation.

7 Trust IT systems did not ensure that all staff involved with the care of patients with long-term conditions, including social care staff, could see the latest care plan and up to date information about patients. Some teams had developed separate paper-based records and databases which did not link with Trust-wide systems. IT systems did not, in general, easily provide the data needed by teams for monitoring key performance indicators and supporting audit. The Trust was aware of this problem.

8 Reviewers were told that problems with the out-patient booking system were leading to a large number of cancelled clinics and rescheduled appointments. This was particularly affecting the scheduling of reviews for people with long-term conditions.

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COMMISSIONING

NHS WARWICKSHIRE NORTH CCG

The issues identified in the 'health economy', 'primary care' and provider sections of this report will require the attention of commissioners. The following points are specifically drawn to the attention of commissioners:

General Comments and Achievements

North Warwickshire Clinical Commissioning Group had been formed shortly before the review visit and was still in the process of establishing structures and relationships with other organisations. The CCG representatives who met the visiting team were aware of the issues which needed to be addressed and the priority with which these should be considered. Work across the health economy was taking place on the care of people with COPD or diabetes.

Good Practice

1 Good practice profiles had been developed by public health staff which included people with long-term conditions.

Concerns

1 Strategy and integration: See health economy section of this report.

2 Paediatric diabetes: See health economy section of this report.

Further Consideration

1 South Warwickshire CCG was the lead commissioner for community health services and North Warwickshire CCG was not routinely attending Clinical Quality Review / Quality and Performance Review meetings. It will be important to establish links to these meetings so that issues relating to the performance of North Warwickshire community services can be identified and addressed.

2 Access to spirometry: See Primary Care and COPD sections of this report.

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APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Executive Lead

Dr Charles Ashton	Medical Director	Worcestershire Acute Hospitals NHS Trust

Visiting Team

Dr Chizo Agwu	Consultant Paediatrician	Sandwell & West Birmingham Hospitals NHS Trust
Dr Hedathale Anantharaman	General Practitioner	NHS Birmingham East & North PCT / Venkat Medical Centre
Amanda Best	Commissioning and Redesign Manager	Stoke Clinical Commissioning Group
Rachael Blackburn	Compliance Manager	Heart of England NHS Foundation Trust
Helen Charters	Specialist Stroke Nurse, Community Stroke Team	Staffordshire & Stoke on Trent Partnership NHS Trust
Suzanne Cleary	Head of Commissioning	Birmingham Cross City CCG
Dr Lee Dowson	Consultant LTC	The Royal Wolverhampton Hospitals NHS Trust
Lesley Drummond	Clinical Nurse Specialist/Diabetes Home Care Coordinator	Birmingham Children's Hospital NHS Foundation Trust
Tamsin Fletcher	User Representative	University Hospital of North Staffordshire NHS Trust
Paul Haycox	Head of Planning and Redesign	Shropshire County PCT
Jane Holmes	Community Matron	Staffordshire & Stoke on Trent Partnership NHS Trust
Cath Molineux	Nurse Consultant Primary Care	Shropshire Community Healthcare NHS Trust
Marcelle Rollings	Consultant Nurse Long Term Conditions / Clinical Lead Adult Community Services	The Royal Wolverhampton Hospitals NHS Trust
Gill Salt	Lead Paediatric Diabetes Nurse Specialist	The Royal Wolverhampton Hospitals NHS Trust

Dr Ateeq Syed	Diabetes Consultant	Heart of England NHS Foundation Trust
Dr Wendy-Jane Walton	General Practitioner	Shropshire and Telford & Wrekin
Merleen Watson	User Representative	Diabetes UK

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
Andrew Gill	Head of Competition Guidance and Strategic Project Team WM Liaison , NHS Midlands and East	Working with West Midlands Quality Review Service
John Grayland	Senior Strategy and Redesign Manager – LTC, NHS Birmingham East & North PCT	Working with 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 varies 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	29	13	45
Trust-Wide: George Eliot Hospital NHS Trust	4	3	75
Commissioning	7	0	0
Health Economy	**43**	**17**	**40**
Care of Adults with Long-Term Conditions			
Primary Care	8	2	25
Community Long-term Conditions Services	51	23	45
Specialist Care of Adults with Diabetes	60	45	75
Specialist Care of People with COPD (All Services)	121	78	64
COPD	(56)	(28)	(50)
Pulmonary Rehabilitation	(65)	(50)	(77)
Specialist Care of People with Heart Failure	56	18	32
Trust-Wide: George Eliot Hospital NHS Trust	7	3	43
Commissioning	12	0	0
Health Economy	**315**	**169**	**54**

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