WM QRS West Midlands Quality Review Service

NHS

Care of Adults with Long-Term Conditions

Care of Children & Young People with Diabetes

Coventry and Rugby Health Economy

Visit Date: 4th, 5th, 11th and 12th December 2012 Report Date: April 2013

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INTRODUCTION

This report presents the findings of the review of the care of people with long-term conditions which took place on 4th, 5th, 11th & 12th December 2012. The purpose of the visit was to review compliance with West Midlands Quality Review Service (WMQRS) Quality Standards for:

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

and the following national standards:

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

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

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

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

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

COVENTRY AND RUGBY HEALTH ECONOMY

This report describes services provided or commissioned by the following organisations:

- University Hospitals Coventry & Warwickshire NHS Trust
- Coventry & Warwickshire Partnership NHS Trust
- South Warwickshire NHS Foundation Trust
- Coventry and Rugby Clinical Commissioning Group

Most of the issues identified by quality reviews can be resolved by providers' and commissioners' own governance arrangements. Many can be tackled by the use of appropriate service improvement approaches; some require commissioner input. Individual organisations are responsible for taking action and monitoring this through their usual governance mechanisms. The lead commissioner for the service concerned is responsible for ensuring action

plans are in place and monitoring their implementation liaising, as appropriate, with other commissioners, including commissioners of primary care.

The lead commissioner for this report is Coventry and Rugby Clinical Commissioning Group.

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.wmqrs.nhs.uk

Acknowledgments

West Midlands Quality Review Service would like to thank the staff and service users and carers of Coventry and Rugby 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

The Coventry and Rugby health economy demonstrated a shared vision and good partnership working across all organisations, although local organisations wanted this to improve further, in particular, through improving liaison and cooperation with University Hospitals Coventry and Warwickshire NHS Trust. Organisational and employment arrangements were not being allowed to get in the way of good patient care. Several initiatives to improve integration of patient pathways were being pursued. Particularly good progress had been made on pathways of care for people with COPD and heart failure and there were plans to address the diabetes pathway.

Good Practice

1 Reviewers were given several examples of good integration of palliative care with the care of people with long-term conditions, including input to multi-disciplinary meetings with the COPD, heart failure and community long-term conditions teams. Palliative care services also take a lead role locally in the care of people with motor neurone disease and some other chronic neurological conditions. Reviewers noted, however, that the palliative care consultant who had been heavily involved with this work was leaving the area in January 2013 and arrangements for a replacement had not yet been agreed.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Rugby**

Several services were available in Coventry but not Rugby. In some cases the arrangements for the care of patients from Rugby were not clear and may not have been described in detail in this report. Further work is needed on the extent to which pathways of care for patients from Rugby meet the expected Quality Standards.

Further Consideration

1 Some specialist teams had clear, strong clinical leadership but clinical leadership of other pathways was not as clear. It may also be helpful to have clearer involvement of care of the elderly consultants in pathways of care for people with multiple long-term conditions.

2 Reviewers noted that work was taking place on improving the process of discharge from hospital, including improving communication with community services, availability of equipment and integration of health and social care assessments. A 'virtual ward' was being piloted in one GP practice. Reviewers supported continuation of this work. Ensuring specialist teams are able to do an urgent review within 24 hours may make a useful contribution to this work.

3 Patient education and enabling self-management did not appear to have a high priority in the health economy's approach to the care of people with long-term conditions. Greater attention in this area, including implementing Telehealth when appropriate and considering advance care planning may be helpful.

4 Service specifications included a large number of Key Performance Indicators, some of which were time-consuming to collect. Reviewers suggested that commissioners and providers should work together to agree a smaller set of Key Performance Indicators that all agreed as important and where data could realistically be collected.

5 Reviewers were told by some staff that agreement to implement integrated care pathways took a long time after clinical agreement had been reached because of health economy-wide business planning processes. These delays sometimes led to clinical disillusionment. The health economy may wish to consider whether there are ways of streamlining these decision-making processes.

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PRIMARY CARE

COVENTRY & RUGBY CLINICAL COMMISSIONING GROUP

General Comments and Achievements

Clinical leadership for the care of people with long-term conditions in Coventry was strong. Progress had been made with the implementation of community teams, integrated with social care, in seven clusters of GP practices. Changes had also been made to arrangements for access to community services. Coventry had good arrangements for 'protected learning time' twice a year for GPs in Coventry. PMS contracts had been renegotiated to give greater incentives to improving the care of people with long-term conditions.

Concerns

1 Rugby: See health economy section of this report.

Further Consideration

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

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SPECIALIST CARE OF CHILDREN & YOUNG PEOPLE WITH DIABETES

UNIVERSITY HOSPITALS COVENTRY & WARWICKSHIRE NHS TRUST

General Comments and Achievements

A motivated and enthusiastic team provided care for children and young people with diabetes. The service provided was highly appreciated by patients and their families. The team was well organised with clearly defined roles and responsibilities and good support from its Directorate. The team's motivation was especially commendable given the ongoing reconfiguration work and its impact on staffing. The development of the ward link nurses was noted as a particular achievement. There was a minimum of two ward link nurses on each ward who had received specific training in caring for children and young people with diabetes. The team had also worked to improve the service for Rugby patients by providing clinics in the diabetes centre.

Good Practice

1 The transition service offered patients a stepped transition to the adult service, dependent on the readiness of the child or young person. There was good joint working with the adult diabetes service and regular joint clinics. Flexibility within the system allowed children and young people to start the transition at the age that was most appropriate for them and reviewers were given examples ranging from 12 to 20 years.

2 The range of information available for patients and their families was comprehensive. Particularly good examples included 'Diabetes at Christmas', 'Leaving Home' and 'Completing a Disability Living Application form'. Reviewers considered that this information went beyond what was normally and routinely available.

Immediate Risks: No immediate risks were identified

Concerns

1 **Point of Care Testing**

Point of care testing was not available in clinics. At University Hospital bloods were sent to on-site laboratories when a patient was in clinic and reviewers were told that only 80% were returned whilst the patient was still in clinic. There was no point of care testing in clinics held in Rugby and no 'on the day' blood analysis.

2 **Staffing Levels**

Staffing levels were insufficient for the number of patients. At the time of the review, the team provided care for 221 patients, over 40 of whom were on insulin pumps. Staffing available comprised 1.25 w.t.e. consultants who, between them, had only 4.4 PAs directly attributable to the care of patients with diabetes, 2 w.t.e. Paediatric Diabetes Specialist Nurses (PDSNs) and limited dietician support (0.05 w.t.e. at Rugby and 0.3 w.t.e. at Coventry). There was no routine access to psychological support. Recommended medical staffing levels are one paediatric consultant per 100 children and recommended nurse staffing levels are one whole time equivalent diabetic specialist nurse per 70 children with diabetes and these recommendations may not fully take account of the additional workload involved in caring for children with insulin pumps.

3 **Administrative Support**

Administrative support was limited which resulted in clinicians using clinical time to input data onto the IT system. Consultants had secretarial support for clinics and discharge letters but the service had no other administrative or data collection support.

Further Consideration

1 Arrangements for 24/7 advice for children and young people with type 1 diabetes and their families were not robust. The PDSNs often responded to patient phone calls out of hours. Guidelines were available on the ward to support staff in giving advice but these did not contain sufficient detail. The team recognised that further work on these guidelines was needed.

2 The range of information available for patients and their families was excellent. It may be helpful to include more pictures / images in order to make relevant information more easily understood by younger children.

3 The database, DIAMOND, was not being used to its full potential as recent updates had made it less user-friendly. The team also reported that they had insufficient expertise in using the system, partly because of the lack of administrative support.

4 There was no local network or group concerned with improving the care of children and young people with diabetes.

5 A patient's family commented that it could be difficult to ascertain the carbohydrate content of hospital meals to ensure accurate insulin being administered. Discussions between catering and the ward link nurses may help to improve the available information on the carbohydrate content of ward meals.

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COMMUNITY LONG-TERM CONDITIONS SERVICES

COVENTRY: COVENTRY & WARWICKSHIRE PARTNERSHIP NHS TRUST

General Comments and Achievements

Community long-term conditions services for Coventry had changed six weeks before the review visit from a four sector 'Community Services Pathway' to a new model of integrated community and primary care services,

structured around seven clusters of GP practices with a registered population of approximately 50,000. The community teams operated from 8am to 8pm seven days a week. There was also a 'Fast Response' service and an overnight 'out of hours' nursing service. Several improvements had been implemented including a single point of access for all referrals, a caseload weighting system, a system for allocating patients to the most appropriate clinician, enhanced joint working with the City Council around re-ablement, and a new, integrated discharge pathway. The Fast Response service included an 'Enhanced Discharge Team' comprising discharge nurses, 'Move on Co-ordinators' and community matrons. The teams had seen a reduction in unplanned activity and an increase in face to face nursing time as a result of the changes which had been made.

The teams reviewed were enthusiastic and committed to providing good quality care for their patients. Services were well integrated, although some aspects were still in development. Good support was available from palliative care consultants. The teams showed a strong commitment to service improvement. Work was being undertaken to look at future implementation of Simple Telehealth (Florence). Good links were in place with nursing homes and the acute Trust and a good range of multi-disciplinary meetings was in place.

Good Practice

1 An audit of palliative care for patients with motor neurone disease had been used to drive improvements.

2 There was a good personalised care planning process, including clear, readable action-planning with colour-coding of the priority actions for each patient. A copy was left in the patient's home and specialist COPD and heart failure teams contributed to the care plan.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Information Technology**

The service was using paper-based systems for recording care plans. The IT systems which were available did not have appropriate connectivity to support integrated care of patients with multiple long-term conditions.

Further Consideration

1 Further involvement of patients and carers in decisions about the organisation and management of the services may be helpful.

2 The re-structuring of services around seven 'clusters' of GP practices had taken place only six weeks before the review visit. The new arrangements should be kept under review, in particular, whether the appropriate capacity has been allocated to each cluster.

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RUGBY: SOUTH WARWICKSHIRE NHS FOUNDATION TRUST

The report of the review of Community Long-Term Conditions Services for Rugby is also included in the North Warwickshire health economy report

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 w.t.e. community matrons, 3.8 w.t.e. case managers, 8.0 w.t.e. virtual ward nurses, 7.26 w.t.e. health care assistants and 1.52 w.t.e. 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 needed 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 PEOPLE WITH COPD – INCLUDING PULMONARY REHABILITATION

UNIVERSITY HOSPITALS COVENTRY & WARWICKSHIRE NHS TRUST

General Comments and Achievements

Specialist care for people with COPD was provided by a community COPD service, a pulmonary rehabilitation service and an acute respiratory service. Community-based staff visited the respiratory wards on two to three days each week to ensure integration of acute and community-based care. There was a strong community pathway and community focus for the services. Pulmonary rehabilitation was available to all patients registered with a Coventry GP with an MRC Dyspnoea score of three or more.

Patient feedback about the community service was very good with patients highly appreciative of the support they received. The service had strong leadership and a good vision for its future development. Links with other services appeared to be working well. The service had good, clear guidelines, including prescribing guidelines.

The team had undertaken good work with GPs, other primary care staff and care home providers. They had visited individual practices and held 'protected learning' sessions. A programme of spirometry training for practice nurses had also been undertaken. Links with the home oxygen service were good and there was a robust pathway for access to oxygen. The team also had good links with community pharmacies who checked inhaler technique and provided additional support for patients. Patients gave good feedback about community pharmacies and the support they provided. Risk stratification was in use.

Documentation, patient information and guidelines and protocols were shared between the community service and primary care but not yet with the acute part of the service.

Reviewers were also impressed by the team's active participation in research programmes.

Good Practice

1 The service provided consultant-led care for patients in the community. Patients had rapid access to respiratory and cardiology consultants without the need for admission to hospital.

2 Cardiac and pulmonary rehabilitation were run by the same staff and were provided from the same premises. The rehabilitation service was provided by a social enterprise from a purpose-built, well-designed accessible facility. This arrangement enabled access to a range of sources of funding. Programmes were run from 8am to 8pm and transport to rehabilitation was funded for patients who needed this support.

3 The SPACE programme, a home education and exercise programme, was available for patients who were not able to attend rehabilitation. Patients followed this programme with the support of a health care professional training in its use.

4 A good range of multi-disciplinary meetings supported the care of patients with multiple long-term condition, including:

   a. Meetings with community matrons and palliative care (not social care or pharmacist)

   b. Links with palliative care through monthly meetings and good working relationships

c. Plans for two weekly multi-disciplinary meetings with cardiology to discuss the care of bariatric patients

d. Weekly ward multi-disciplinary team meetings

e. Monthly 'breathlessness' multi-disciplinary team meetings.

5 The wheelchair service was located in the same building as the community COPD team which resulted in good liaison between these services and saved patients having to make multiple journeys.

The care record and personalised care planning process was good. The format was comprehensive and patients who met with the visiting team found it useful and informative. Community long-term condition teams and specialist COPD and heart failure teams all input to the same record.

Immediate Risks: See UHCW Trust-wide section of this report.

Concerns

1 **Ward Care**

Reviewers were concerned about several aspects of acute in-patient care for patients with COPD:

a. At the time of the review, there was only one respiratory specialist nurse for eight respiratory consultants and no cover for her absence.

b. No respiratory physiotherapy time was specifically allocated to the respiratory wards (88 beds). Out-patient physiotherapy was not available and the community COPD team had only 0.4 w.t.e. for direct patient care.

c. A significant proportion (reviewers were told up to 50%) of patients with COPD who were admitted to University Hospital Coventry went to non-respiratory wards where nursing staff did not have specialist expertise in the care of people with COPD. Respiratory consultants did, however, do a daily ward round of non-respiratory medical wards.

d. Some relevant ward staff had not had training in inhaler technique and placebo inhalers were not available for training patients in inhaler technique. This was a particular problem because of the shortage of specialist nursing time. Only one type of inhaler was available on the ward for training.

e. 'Rescue Packs' were not routinely issued for patients with COPD who were going home.

f. Care bundles, including for people with pneumonia, had not yet been implemented.

2 **Waiting Times for Pulmonary Rehabilitation**

Patients were waiting 24 weeks for access to pulmonary rehabilitation. (The recommended maximum waiting time is 10 weeks.)

3 **Information Technology**

The service was using paper-based systems for recording care plans. The IT systems which were available did not have appropriate connectivity to support integrated care of patients with multiple long-term conditions. There was limited IT access to radiology requests.

4 **Supply of Nebulisers for Long-Term Use**

UHCW did not supply nebulisers for long-term use and the few patients who needed nebulisers long-term had to buy their own equipment unless they were also under the care of the Coventry and Warwickshire Partnership NHS Trust community matrons.

5 Patients from Rugby did not have access to a community COPD service and had to travel to Leamington Spa for pulmonary rehabilitation. Consultant out-patient clinics were held in Rugby.

Further Consideration

1 The community service did not have access to point of care testing. This service was, however, due to start in January 2013.

2 The community team had only two days per week of a respiratory physiotherapist and no social worker, occupational therapist, dietician, pharmacist, psychologist or speech and language therapist with time allocated to the service. This support could be accessed via community matrons but did not then have specific expertise in the care of patients with COPD and was not able to take part in the community COPD team's multi-disciplinary approach to care.

3 Links with the community 'Fast Response' service may benefit from review to ensure that patients with COPD are able to access effective 'Early Supported Discharge' arrangements.

4 Increased use of telehealth may be helpful into support of routine monitoring of patients.

5 The community team, pulmonary rehabilitation and oxygen service were all based in different locations. Any opportunities for co-location of these services should be explored.

6 Discussion with staff in the Emergency Department and acute medical unit about guidelines for admission of people with COPD may be helpful. Reviewers were given examples of patients who were admitted because their respiratory function was low when this was, in fact, normal for the patient concerned.

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Specialist Care of Adults with Diabetes

UNIVERSITY HOSPITALS COVENTRY & WARWICKSHIRE NHS TRUST

General Comments and Achievements

Specialist care for adults with diabetes was provided by an acute team and a community diabetes team (Coventry only), based in the Warwickshire Institute for Diabetes, Endocrinology and Metabolism (WISDEN) Centre. Integration of these teams was being discussed with commissioners. Services were provided by staff who were committed to providing good care for their patients. Patients were appreciative of the care they received, especially that from the acute team. The WISDEN Centre had a strong commitment to research and was involved in multi-centre trials for both diabetes and weight management. Staff had several plans for the future development of the service, including for the development of an antenatal endocrine service. The transition service offered patients a stepped transition to the adult service, dependent on the readiness of the child or young person. There was good joint working with the paediatric diabetes service and regular joint clinics. Flexibility within the system allowed children and young people to start the transition at the age that was most appropriate for them and reviewers were given examples ranging from 12 to 20 years.

Good Practice

1 There was a good care pathway for access to the diabetic foot service and a well-organised multi-disciplinary team meeting to discuss the care of patients with diabetes and foot problems.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Access to Community Specialist Nurses**

Patients were waiting four months to see a community Diabetes Specialist Nurse (DSN) and patients could be without appropriate support during this time.

2 **Personalised Care Planning**

Personalised care planning was not implemented. Patients did not have a specific care plan or a copy of a GP letter and so had no written record of their plan of care. There was also no regular communication between acute and community diabetes services about changes to patients' care.

3 **Insulin Passport**

The 'Insulin Passport' had not yet been implemented.

4 **Guidelines, Data Collection and Audit**

The services had few documented clinical guidelines and some of the guidelines that were available were out of date. Appropriate data were not being routinely used for the management of the service. There was no rolling programme of audit of implementation of guidelines and no service-level arrangements for review and learning.

Further Consideration

1 Reviewers supported the proposed change to an integrated team providing specialist care for people with diabetes and suggested that several issues should be considered as part of this change:

a. The balance of consultants' clinical and academic time may benefit from review. Consultant staffing for the diabetes service was 4.4 w.t.e. but it was not clear that this time was, in practice, available for clinical work. None of the consultants had job-planned time to support the community aspects of the service, including input to training and education programmes for primary and long-term care (including care home) staff.

b. Further analysis of the role and workload of the hospital and community Diabetes Specialist Nurses (DSNs) will be needed. The hospital team were supporting in-patients and out-patient clinics. The patients who met reviewers were not aware of the community diabetes service and had not had contact with it. There were 7.8 w.t.e. DSNs in total and the integrated service may be able to make better use of this resource.

c. Reviewers were told of plans for a seven day a week DSN service because staff who lived near the hospital would 'call in' at weekends. The governance and sustainability of this model should be considered carefully before implementation.

d. Administrative staffing appeared low with 2.6 w.t.e. secretarial staff for the hospital service (including secretarial support to consultants) and 0.58 w.t.e. for the community team.

2 Arrangements for ensuring all patients are offered written information and education programmes may benefit from review. Some of the patient information was out of date, much of it was photocopied and some information was given only to patients attending the Desmond programme.

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SPECIALIST CARE OF PEOPLE WITH HEART FAILURE INCLUDING CARDIAC REHABILITATION

UNIVERSITY HOSPITALS COVENTRY & WARWICKSHIRE NHS TRUST

COVENTRY & WARWICKSHIRE PARTNERSHIP NHS TRUST

General Comments and Achievements

The pathway of specialist care for people with heart failure had been changed to an integrated hospital and community pathway shortly before the review visit (November 15th). Integration was working well with hospital and community teams working effectively together. In-patient facilities were good with a dedicated cardiology day case unit and beds on Ward 10. The team had strong leadership and patients who met the visiting team were

appreciative of the care and support they received. Serum natriuretic peptide (BNP) testing was available and being used in hospital and community settings. The service was not exceeding the expected waiting time for clinical diagnostics and echocardiography. The team was looking at the feasibility in delivering home intravenous therapy. A heart failure rehabilitation service was commissioned for patients from Rugby. One of the specialist nurses had a joint role covering heart failure and arrhythmias which was helpful for the support of patients with devices and heart failure. Ward staff had attended the Caledonian course. One consultant had sessions allocated for work with primary care.

Good Practice

1 The care record and personalised care planning process was good. The format was comprehensive and patients who met with the visiting team found it useful and informative. Community long-term condition teams and specialist COPD and heart failure teams all input to the same record.

2 On weekdays a heart failure ward round took place on the acute medical admissions unit and the cardiology ward. This arrangement ensured specialist input to the care of patients with heart failure at an early stage.

3 Multi-disciplinary meetings with the COPD team discussed the care of patients with heart failure and breathlessness.

4 Intravenous diuretic clinics took place in the cardiology day case unit. This avoided the need for admission for these patients. Also, patients were able to access ultra-filtration through the cardiothoracic surgery unit, which reduced the length of stay for some patients.

Immediate Risks: See UHCW Trust-wide section of this report.

Concerns

1 There was no direct access to psychology support for patients with heart failure.

2 The heart failure service did not have a dietician with time allocated to work with patients with heart failure.

3 Formalised guidelines covering the monitoring and ongoing management of patients with heart failure were not yet in place.

4 Formal six monthly reviews were not undertaken at the time of the review but there were plans to implement them shortly after the review visit.

5 Coventry patients with heart failure did not usually have access to cardiac rehabilitation. Requests for cardiac rehabilitation for these patients had to be made and were considered on a case by case basis.

6 Reviewers were told that letters detailing changes to treatment plans could take up to five days to reach the general practitioner.

Further Consideration

1 The diagnostic clinic used to be a ‘one stop’ clinic. Since the change to an integrated service patients needed to attend twice because echo-cardiography and cardio-physiology were not available in the clinic location. Reviewers suggested that ways of re-instating the ‘one stop’ diagnostic clinic should be explored.

2 A member of the heart failure team was not available for urgent review of patients at weekends.

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TRUST-WIDE

COVENTRY AND WARWICKSHIRE PARTNERSHIP NHS TRUST

General Comments and Achievements

A well-designed, comprehensive care planning document was in use by community matrons and specialist COPD and heart failure teams.

Good Practice

1 A Trust-wide 'Learning Group' looked at incidents every two weeks and distributed a monthly learning bulletin to all staff with a summary of incidents and lessons learnt.

2 Unannounced visits were undertaken regularly by one of governance team, a Trust non-executive Director and a clinician. These visits were reported to the Trust Board on a regular basis.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Information Technology**

Several services were using paper-based patient records. Teams were often not able to access pathology and imaging results and details of hospital admissions and discharges.

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UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST

General Comments and Achievements

The Trust demonstrated clear commitment to providing integrated care for patients with long-term conditions. The Trust also had plans for making sure that health care students were spending more time in the community and had better awareness of the needs of people with long-term conditions. The Trust was also undertaking innovating work with its REACT discharge team.

Good Practice

1 There was strong clinical engagement and leadership for the care of people with long-term conditions and several consultants were working in the community as well as in hospital and providing leadership to integrated hospital and community services.

Immediate Risk

1 **Access to Acute Non-Invasive Ventilation**

The Trust had insufficient access to acute non-invasive ventilation (NIV). Four beds on the respiratory wards were staffed for the care of patients needing acute non-invasive ventilation, but these were not 'ring-fenced' and so were often occupied by patients who did not need non-invasive ventilation. Reviewers were told that the Trust policy was, if more capacity than the four respiratory beds was needed, patients would be admitted to the critical care unit for non-invasive ventilation. Reviewers were also told that, in practice, capacity was not usually available and some staff did not consider that admission of patients needing non-invasive ventilation was a priority for the critical care unit. As a result, patients often remained in the Emergency Department or Acute Medical Admissions where there was only one machine for non-invasive ventilation and it was not clear that staff had appropriate competences in the use of this equipment. Reviewers reached this conclusion following reports of difficulties in access to non-invasive ventilation from respiratory, neurological, critical care and Emergency Department staff and from observing problems which had arisen in the care of a patient on the night before the review. Reviewers concluded that, because of the

limited access, patients who may benefit from this treatment may not be receiving non-invasive ventilation or may be being transferred to Leicester because this care cannot be provided locally.

The Trust's response to this issue is given below.[1]

Concerns

1 **Access to Therapy Services**

Several services had poor access to therapies especially physiotherapy, dietetics, psychology and speech and language therapy and low staffing for these services. Additional detail is provided in the individual service reports. Reviewers considered that there was potential to reduce length of stay in hospital by improved access to therapy services.

Further Consideration

1 Several patients who met the visiting team said that difficulties and delays in car parking at University Hospital Coventry caused them distress and detracted from the quality of care available at the hospital.

2 Some teams copied clinic and discharge letters to patients whereas this was not routine in other teams.

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COMMISSIONING

COVENTRY & RUGBY CLINICAL COMMISSIONING GROUP

General Comments and Achievements

Commissioners had good awareness of the services available for people with long-term conditions and the challenges they faced. Commissioning intentions were clear and had been well communicated to providers. Contracts had extensive Key Performance Indicators. Considerable work had taken place to develop and improve risk stratification tools and approaches.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Rugby**

Several services were available in Coventry but not Rugby. In some cases the arrangements for the care of patients from Rugby were not clear and may not have been described in detail in this report. Further work is needed on the extent to which pathways of care for patients from Rugby meet the expected Quality Standards.

2 **Strategy for the care of people with chronic neurological conditions**

Coventry and Warwickshire did not have a strategy for the development of services for people with chronic neurological conditions and there was no plan for the improvements needed. In developing and

[1] Trust's response to Immediate Risk: Following the review the Trust confirmed that issue of NIV capacity was on the Trust risk register and there had been no reported clinical adverse events. Specialist beds for NIV would be made available as required and a contingency plan had been put in place to provide additional capacity in GCCU or the Emergency Department should the need arise. Checking of completion of nurse competences and a root cause analysis will be undertaken and reported to the Serious Incident group in the Trust, this group which included commissioners, will monitor progress.

implementing this strategy, reviewers suggested that consideration should be given to:

a) Addressing the variation in access to services identified in this report so that availability of care does not depend on the patient's condition and where they live.

b) Ensuring arrangements for cover for absences are robust so that availability of services does not depend on who is on duty on a particular day.

c) Individual services for people with chronic neurological conditions in Coventry and Warwickshire were working in relative isolation from each other. In taking forward the development of services, reviewers considered that greater cooperation and integration between services and across Coventry and Warwickshire would support the development of robust, high quality services. Staff were employed by four different Trusts which may not be helping the effective integration of services.

d) Ensuring clinical leadership and care is available for patients with chronic neurological conditions other than those specifically mentioned in this report which, together, add up to a significant number of patients.

3 Cardiac rehabilitation was not available for people with heart failure from Coventry.

4 Patients were waiting 24 weeks for access to pulmonary rehabilitation. (The recommended maximum waiting time is 10 weeks.).

5 There was no local network or group concerned with improving the care of children and young people with diabetes.

Further Consideration

1 Reviewers were told by commissioners that a review of rehabilitation services had been commissioned. Clinical services did not mention this review and it may be helpful to ensure that all clinical teams are aware of the purpose and remit of the rehabilitation review.

Other Immediate Risk and Concerns Identified

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:

Immediate Risks:

1 Access to Acute Non-Invasive Ventilation: See Trust wide section of the report and associated footnote.

Concerns

1 Specialist Care of Children and Young People with Diabetes: Point of care testing; Staffing levels; Administrative support.

2 Community Long Term Conditions services: Pathways;

3 Specialist Care of People with COPD: Supply of nebulisers for home use; Access to pulmonary rehabilitation for Rugby patients.

4 Specialist Care of People with Diabetes: Access to community nurses; Care planning; Use of 'Insulin Passport'.

6 Specialist Care of People with Heart Failure: Access to Psychology and dietetic support; Formal reviews; Delays in communication to GPs.

7 Specialist Care of People with Chronic Neurological Conditions (see separate report): Variations in access to care and Future Strategy.

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APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Executive Lead

Dr Stephen Cartwright	Medical Director	Birmingham, Solihull and Black Country Local Area Team, National Commissioning Board

Visiting Team

Marie Adams	Physiotherapist	Heart of England NHS Foundation Trust
Dr Rajai Ahmad	Consultant and Clinical Director (Cardiology)	Sandwell and West Birmingham Hospitals NHS Trust
Dr Mona Arora	General Practitioner	North Staffordshire Clinical Commissioning Group
Dr Ansu Basu	Consultant Physician and Endocrinologist	Sandwell & West Birmingham Hospitals NHS Trust
Jacqueline Burke	Clinical Lead - Cardiac Rehabilitation and Prevention Services	Sandwell and West Birmingham Hospitals NHS Trust
Neil Davies	Practice Manager	Dr Machin & Partners GP Practice, Sheldon
Adele Dean	Clinical Quality Manager	West Midlands Ambulance Service NHS Trust
Eunice Foster	Assistant Director	Shropshire and Staffordshire Heart & Stroke Network
Joanne Gutteridge	LTC Commissioning Project Lead	NHS Dudley Clinical Commissioning Group
Jill Hill	Diabetes Nurse Consultant	Birmingham Community Healthcare NHS Trust
Maggie Johnson	Parkinson's Disease Specialist Nurse	Birmingham Community Healthcare NHS Trust
Lucy Jukes	Advanced Respiratory Physiologist / Pulmonary Rehab Coordinator	Walsall Healthcare NHS Trust
Dr Swati Karandikar	Consultant Paediatrician	Heart of England NHS Foundation Trust

Dr Raveendra Katamaneni	General Practitioner	Solihull PCT
Hazel Malcolm	Senior Commissioner	Birmingham & Solihull NHS Cluster
Tracy Millar	Acting Clinical Audit and Effectiveness Lead	Birmingham Community Healthcare NHS Trust
Dr Rahul Mukherjee	Consultant Respiratory Physician	Heart of England NHS Foundation Trust
Dr Mark Palmer	General Practitioner	Avonside Health Centre
Leonie Paterson	Clinical Specialist in Neurological Physiotherapy	Staffordshire & Stoke on Trent Partnership NHS Trust
Dr John Scanlon	Consultant Paediatrician	Worcestershire Acute Hospitals NHS Trust
Joanne Scott	User Representative	MS Society West Midlands Region
Dr Steve Sturman	Consultant Neurologist, Neurology and Rehabilitation	University Hospitals Birmingham NHS Foundation Trust
Dr Martina Walsh	Consultant in Rehabilitation Medicine	NHS South Birmingham PCT
Merleen Watson	User Representative	Diabetes UK
Mark Weston	Paediatric Diabetes Specialist Nurse	Wye Valley NHS Trust

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
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 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	2	67
Specialist Care of Children & Young People with Diabetes	29	18	62
Trust-Wide: University Hospitals Coventry & Warwickshire NHS Trust	4	2	50
Commissioning	7	1	14
Health Economy	**43**	**23**	**53**
Care of Adults with Long-Term Conditions			
Primary Care	8	5	63
Community Long-term Conditions Services	51	37	73
Specialist Care of Adults with Diabetes	61	14	23
Specialist Care of People with COPD (All Services)	121	112	93
COPD	(56)	(47)	(84)
Pulmonary Rehabilitation	(65)	(65)	(100)
Specialist Care of People with Heart Failure	54	37	69
Trust-Wide: University Hospitals Coventry & Warwickshire NHS Trust	7	3	43
Commissioning	12	6	50
Health Economy	**314**	**214**	**68**

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