WM QRS West Midlands Quality Review Service

NHS

Care of Adults with Long-Term Conditions

Care of Children & Young People with Diabetes

South Warwickshire Health Economy

Visit Date: 9th & 10th January 2013 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 in the South Warwickshire health economy which took place on 9th and 10th January 2013. 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 South Warwickshire health economy. Appendix 2 gives details of compliance with each of the standards and the percentage of standards met.

SOUTH WARWICKSHIRE HEALTH ECONOMY

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

- South Warwickshire NHS Foundation Trust
- South Warwickshire 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 South Warwickshire 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 South 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.

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CARE OF PEOPLE WITH LONG-TERM CONDITIONS

HEALTH ECONOMY

General Comments and Achievements

Good progress was being made in improving the care of people with long-term conditions in South Warwickshire. In particular, reviewers noted the many initiatives being pursued by South Warwickshire NHS Foundation Trust and improving relationships within the health economy, especially with social care services. Several programmes were being taken forward including 'discharge to assess', a common assessment project, a capacity fluctuation project and an incentive schemes for home care staff in rural areas. Joint work was also taking place on ensuring the NHS number was included on all social care records – with the aim of improving the ability of all staff to access relevant records, and the development of 'Telecare'. Active health promotion through 'Making Every Contact Count' was also being actively pursued, including an appropriate framework of competences for staff.

Good Practice

1 The West Midlands Ambulance Service was working closely with the 'virtual ward', community matrons and primary care to improve the response to people with long-term conditions. This work had been taking place over several years. Ambulance staff, including a high proportion of Emergency Care Practitioners, were able to refer directly to intermediate care and other appropriate alternatives to hospital admission. Arrangements had been put in place for direct communication between ambulance staff and the hospital bed manager. Community matrons and ambulance staff were also linking closely with residential and nursing homes, including providing additional training. Ambulance crew 'down time' was being actively used and there had been close liaison with district nurses as part of implementing the community intravenous therapy scheme. The combination of these initiatives had increased the 'non-conveyance' rate to 60%. GPs were automatically informed of patients who were not conveyed to hospital and told about care given and alternative arrangements that had been made.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Variability in Care**

In some services (see below for more detail), the care available was dependent on individual members of staff with insufficient cover and /or was not available throughout the health economy. Processes were often not robustly documented to support systematic implementation by all staff and ensure appropriate communication with all others involved in the patients' care. This concern should, however, be seen in the context of the review highlighting several examples of good practice and a general trend towards improving the services available.

2 **Strategy for the Care of People with Long-Term Conditions**

The South Warwickshire health economy did not have a strategy for the care of people with long-term conditions which was agreed by all organisations and understood by staff providing services locally. Reviewers heard different views of what was required and what models were going to be developed. This was particularly evident in two areas: a) the roles and relationship between community long-term conditions services (such as the 'virtual ward' and community matrons) and specialist condition-specific services and b) the care of people with multiple long-term conditions. The potential contribution of specialist nursing staff to speeding up the patient pathway, avoiding admissions and reducing length of stay in hospital may not be being realised.

As part of this work, the criteria for referral for specialist care and for discharge back to primary care will need to be clarified. Data about the number of patients under the care of specialist condition-specific

services were not generally available during this review visit. Accurate data on this will be important to ensure staffing levels are appropriate.

The general impression gained by reviewers was that discussions between commissioners and South Warwickshire NHS Foundation Trust had historically been about individual business cases for service inputs – rather than commissioners specifying the type of service and service quality needed for the local population.[1]

3 **Local Networks**

South Warwickshire did not have groups or forums involving patients and carers, clinicians from all sectors, social care staff, managers and commissioners for developing the strategy for the care of people with long-term conditions, or for discussing and taking forward relevant initiatives. Local Implementation Teams had existed in the past but had ceased meeting and had not been replaced by other groups, with the exception of some work taking place on care of people with diabetes. The care of people with long-term conditions had, however, been agreed as a priority for the local health economy for 2013/14.

Further Consideration

1 High hospital mortality rates for some conditions had been investigated and further work in this area was planned. Participation in the West Midlands Mortality Group may be helpful to enable the health economy to take full advantage of learning from other areas.

2 Work was already taking place to reduce the number of patients whose discharge from hospital was being delayed, including the 'discharge to assess' initiative and will need to continue as part of improving the care of people with long-term conditions.

3 Reviewers did not meet primary care 'out of hours' services. This report may not, therefore, adequately reflect any problems – or good practice – in out of hours care. As part of the development of the strategy for the care of people with long-term conditions, reviewers suggested that the health economy specifically look at care outside normal working hours. Specialist condition-specific services were generally not able to provide urgent review within 24 hours at weekends except for patients who were admitted to hospital.

4 Some individual services were linking well with care homes to improve the care of people with long-term conditions and reviewers were told about several individual initiatives. As part of the strategy development, a systematic approach to supporting the needs of care home residents with long-term conditions may be helpful.

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PRIMARY CARE

SOUTH WARWICKSHIRE CLINICAL COMMISSIONING GROUP

Reviewers did not see any documentary evidence relating to primary care services but did meet one general practitioner representing the Clinical Commissioning Group. No specific concerns about primary care services were identified during the review visit, although the pathway-based sections of this report do include primary care-related aspects of the care provided.

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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[1] Reviewers were not provided with commissioner service specifications or strategy and so this comment is based on discussions rather than a review of relevant documentation.

SPECIALIST CARE OF CHILDREN & YOUNG PEOPLE WITH DIABETES

SOUTH WARWICKSHIRE NHS FOUNDATION TRUST

General Comments and Achievements

This service provided good support for children and young people with diabetes and their families and this care was appreciated by the parents who met the visiting team. Considerable progress had been made in improving services in the six months before the review and an ethos of multi-disciplinary working was developing. A new database had been funded and staff were being trained in its use. Guidance for staff who may be contacted outside normal working hours was good and clearly documented. Good support was provided for newly diagnosed patients including a Friday weekly telephone call for up to six months to check that all was well before the weekend and discuss any problems and queries. New guidelines for schools had been developed and agreed and a new school care plan was in place.

Good Practice

1 The annual review template was well-presented, clear and comprehensive.

2 Competences for school staff and teachers had been developed which were clear and helpful.

3 Specific educational sessions were run for children moving from primary to secondary school and their families.

4 An equipment cupboard on the ward had been designated solely for the storage of specific equipment and information needed for any child attending the ward with diabetes. The diabetes link nurses on the ward had responsibility for ensuring that stock and equipment was always available when needed.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Three Monthly Reviews**

Insufficient clinic appointments were available to ensure that the care of all children and young people with diabetes was reviewed three monthly, including reasonable flexibility for families and staff. A shortfall in capacity of one clinic per month had been identified. Only one consultant had a particular interest in the care of children with diabetes and cover for clinics during any absences was not available. An additional short-term locum consultant with an interest in diabetes was due to start in post in March 2013.

2 **Availability of HbA1c Results**

HbA1c was not available in clinic. Children and young people were asked to attend one to two hours beforehand and results were available in time for only approximately 50% of clinic appointments. At the time of the review, because of this issue and the lack of robust three monthly reviews, the service was not going to achieve the *Best Practice Tariff* which would affect its funding.

3 **Local Network**

No local network or equivalent group with responsibility for driving improvements in the care of children and young people with diabetes was in place.

Further Consideration

1 Information for children, young people and their families was available but was not well organised and the presentation of some of the information could be improved. In particular, reviewers suggested that information about services available should be more clearly documented. Also, no record was kept of the ongoing education which children and families had undertaken. Reviewers considered that this should be documented so that staff could easily identify whether appropriate education had been provided.

2 Communication between hospital and primary care would benefit from being strengthened. Reviewers did not see evidence that results of annual reviews were communicated to GPs and there was an assumption that GPs would access results from the pathology information system. Parents who met with the reviewing team also commented that GPs were not always sure what happened at the hospital. One parent commented that information had not been available to the GP following initial diagnosis and treatment, though support from the paediatric diabetes specialist nurse (PDSN) had clarified the requirements for subsequent prescriptions.

3 A new database for recording information on the care of children and young people with diabetes was due to be introduced but the service had insufficient administrative support for data entry.

4 Access to psychological support was limited and could only be accessed by referral back to the GP or through referral to CAMHS. Direct links with psychological support or, ideally, a member of staff with time allocated to support the service, would be helpful.

5 It may be helpful to review the guidance on 24/7 advice to reflect the agreed availability of Consultant advice from Birmingham Children's Hospital NHS Foundation Trust for very complicated issues that are about diabetes, which is available as part of their 'on-call' rota at the regional centre.

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COMMUNITY LONG-TERM CONDITIONS SERVICES

SOUTH WARWICKSHIRE NHS FOUNDATION TRUST

'Virtual wards' were provided across South Warwickshire by community matrons with links to district nursing services. A twelve week pathway was normally provided, which could be accessed to avoid admission or following an episode of acute care. At the end of the twelve week period patients could be transferred to the care of the district nursing service or to self-care. There was also the option to keep patients as 'outliers' where active care could be resumed quickly if the patient's condition deteriorated.

General Comments and Achievements

Staff providing the 'virtual wards' were enthusiastic and caring staff. There was a good understanding of the stage of development of the service and the further developments that were needed. A good range of care was provided with a focus on meeting the needs of individual patients. For example, specific patient education materials had been developed for one patient with learning disabilities. Patients who met the visiting team were very appreciative of the care they received.

Good condition-specific information was generally available and offered to patients. Individual patient care plans were detailed and comprehensive. The community notes folder was well-organised, including clearly identified sections. Relationships with social services were reported as good and services were working hard to ensure integrated, holistic care for patients and their carers. Links with palliative care services were good.

There was some geographical variation in the care provided and in the organisation of care as a result of historical differences in links with community hospitals and GP practices. Staff were aware of this and were working towards related to more standardised approaches. Managers and staff had a good understanding of the services, any differences across the county and what they were trying to achieve.

Good Practice

1 The COPD information and self-management plan booklet used by the community teams was comprehensive and useful.

2 The 12 week pathway made good use of community matron resource and pathways after this time were clearly defined. In particular, patients could remain in contact with the service as 'outliers'. There were also good arrangements for linking with other teams, especially the Community Emergency Response Team

and the Intermediate Care Team. These services had a review meeting each Friday to plan capacity over the weekend.

3 Good work had been undertaken with care homes, including developing specific resources for individual patients and using these for training staff in care homes.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Cover for community matrons in some areas**

Some geographical areas had 'single-handed' community matrons and arrangements for covering absences were not always robust.

2 **Guidelines and Protocols:** See Trust-wide section of this report.

Further Consideration

1 Some consultants who met the visiting team were not aware of the 'virtual wards' and their role. Further discussion with specialist condition-specific services may be helpful to ensure integration of care, especially for patients with multiple long-term conditions.

2 Some patients had not yet been offered self-management courses. The arrangements for ensuring this are offered to all patients, irrespective of where they live and their general practice, may benefit from review.

3 Links with mental health services, especially for the care of people with dementia, were not evident. Improving liaison with these services help to improve the care of people with mental health problems or dementia.

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SPECIALIST CARE OF ADULTS WITH DIABETES

SOUTH WARWICKSHIRE NHS FOUNDATION TRUST

General Comments and Achievements

The team providing specialist care for adults with diabetes was enthusiastic and cohesive and the service was highly appreciated by patients. The team were aware of issues which needed to be addressed and had a clear vision of how they wanted the service to develop and improve, based on a review which had been undertaken in 2012. Reviewers considered that the team's enthusiasm and achievements to date were commendable given the service's low staffing levels. A particular achievement was the development and training of ward link nurses.

Good Practice

1 The team had developed and implemented a training programme for midwives about the care of patients with diabetes. They had also implemented a system of weekly contact with pregnant patients with diabetes, including following up any patients who did not attend clinic appointments.

2 A well-organised multi-disciplinary clinic for people with diabetes and foot problems was running.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Staffing Levels**

Staffing levels were insufficient to provide cover for absences or urgent review within 24 hours at weekends. At the time of the review there were 1.5 w.t.e. consultants, 2.96 w.t.e. diabetes specialist nurses (0.32w.t.e. for antenatal care, 1.14 w.t.e for in-patients and 1.5w.t.e. for out-patients) and 0.16 w.t.e. dieticians in post serving a population of approximately 280,000. Increases of 1 w.t.e. consultant, 0.7

w.t.e. diabetes specialist nurses (DSNs) and 0.25 dieticians had been agreed. Administrative support for the team had recently been increased to 0.6 w.t.e. but clinical staff were still spending time on administrative work which could be used for clinical duties and the reviewing team were told of delays of up to six weeks in clinic letters being produced. The team had plans to develop aspects of the service when staffing improved, including a transition clinic and a multi-disciplinary 'insulin pump' clinic. Staff were not undertaking regular education and training in relation to the care of people with diabetes.

2 **Guidelines and Protocols**

See 'Trust-wide' section of this report in relation to the lack of documented guidelines and protocols. There was no overall service pathway for diabetes care and criteria for referral to specialist care and discharge to primary care were not clear.

3 **Care Planning, Care Coordination and Regular Reviews**

Patients did not have a formal plan of care. There was no system for allocation of a care coordinator and no structured review process. Patients were reviewed in consultant out-patient clinics and / or nurse-led clinics but there was no documentation of what should be covered in these reviews, no systematic recording of review information or communication of the outcomes of reviews to the patient and all services involved in their care.

4 **Education Programmes**

Patient education programmes were not in place. There was limited access to education programmes for patients with Type 1 diabetes at Rugby, there was and only limited access to the Desmond programme for patients with Type 2 diabetes. DAFNE was not available in Warwickshire. Some diabetes patients who met with the reviewing team had been on 'carb counting' courses but others had never been offered any education.)

5 **Local Network**

No local network or equivalent group with responsibility for driving improvements in the care of people with diabetes was in place.

Further Consideration

1 The plans for the future development of the service did not include developing links with renal services and reviewers suggested that further consideration should be given to the need for service improvement in this area.

2 Criteria for referral to specialist care and for discharge back to primary care were being discussed and reviewers considered that this work needed to continue until a clear pathway was in place and implementation audited.

3 As described in the 'health economy' section of this report, links with community long-term conditions services may benefit from further development, especially to improve the care of people with multiple long-term conditions and those needing palliative care.

4 A patient feedback form had recently been approved for use and it may be helpful to consider how information received from this process will be used to inform the re-design of the service,

5 Strong leadership will be needed to drive forward the planned improvements in the care of people with diabetes. The Trust should ensure that appropriate management and clinical leadership support is available.

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SPECIALIST CARE OF PEOPLE WITH COPD, INCLUDING PULMONARY REHABILITATION

SOUTH WARWICKSHIRE NHS FOUNDATION TRUST

General Comments and Achievements

Specialist care for people with COPD was provided by an enthusiastic team who were committed to providing good quality care. Patients who met the visiting team were very appreciative of the staff and service they provided. The team had a good understanding of the issues which needed to be addressed and were pursuing this through the 'transformation programme'. Access to lung function services was well-organised. There was also 24/7 critical care outreach support to patients on non-invasive ventilation. The team did attend Arden Cluster meetings and participate in some network-wide work.

Pulmonary rehabilitation was a well-established, well-organised service with good data collection and good outcomes. There was also evidence of review of practice and continuous improvement within the pulmonary rehabilitation service. Patients who had used the pulmonary rehabilitation service appreciated the choice of locations and times for accessing the service.

Good Practice

1 A respiratory 'pull nurse' was responsible for identifying patients who would benefit from specialist respiratory care in the Emergency Department and Acute Medical Admissions Unit, arranging appropriate investigations and ensuring they received specialist care as soon as possible. This had been shown to reduce length of stay and improve patient satisfaction.

2 A high quality, comprehensive oxygen service was available.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Review Arrangements**

NICE guidance is that all patients newly diagnosed with COPD should be reviewed two weeks after diagnosis. This happened for some patients but arrangements to ensure all patients received two week follow up were not robust. Arrangements for regular review of patients receiving specialist care were also not robust. Patients were reviewed in consultant out-patient clinics and / or nurse-led clinics but there was no systematic arrangement for making sure this happened and no systematic recording of review information or communication of the outcomes of reviews to the patient and all services involved in their care.

2 **Ward equipment**

Access to blood gas analysis was not available on the ward which created delays in an emergency. Equipment for continuous oxygen monitoring was not available for those on NIV on the ward, which could create difficulties in the ongoing monitoring of these patients. Staff did have pocket Oximetres and reviewers were told that six portable Oximeters suitable for continuous monitoring had been ordered.

3 **Guidelines and Protocols**

See 'Trust-wide' section of this report in relation to the lack of documented guidelines and protocols. Reviewers were particularly concerned about the absence of a clear protocol for admission of patients needing non-invasive ventilation to the Critical Care Unit, especially as there was anecdotal evidence of clinical differences of opinion in this area.

Further Consideration

1 Urgent review within 24 hours by a member of the specialist team was not available and would be difficult to achieve within the staffing resources available.

2 Personalised care planning including patient-defined goals and outcomes was not yet in place. Care coordinators were allocated to patients who had been admitted or those using the oxygen service but it was not clear that all patients had an allocated care coordinator.

3 Reviewers were told of some delays in CT scans for patients with COPD where there was a suspicion of cancer and, as a result, patients sometimes had a bronchoscopy before their CT scan. This pathway and timescales may benefit from review.

4 Patient information may benefit from review to ensure that it covers all of the areas expected, including information for carers about support available for them. It may also be helpful to involve patients in the review of the patient information and care planning documents. Information for carers

5 As described in the 'health economy' section of this report, links with community long-term conditions services may benefit from further development, especially to improve the care of people with multiple long-term conditions and those needing palliative care.

6 The programme of pulmonary rehabilitation may benefit from review to ensure that a rolling programme of sessions in appropriate locations is available. Reviewers were told that waiting times were up to one year for sessions in Alcester, although patients could access sessions in other locations more quickly.

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Specialist Care of People with Heart Failure

SOUTH WARWICKSHIRE NHS FOUNDATION TRUST

General Comments and Achievements

The team providing specialist care for people with heart failure was highly motivated, caring, friendly and committed to providing the best possible care for their patients. Members of the team worked well together and had a good awareness of the issues which needed to be addressed. The team also had good ideas and a vision for future development of the service, including for development of community clinics and community intravenous therapy. There was strong consultant leadership for the service and some examples of innovative work, including the development of a heart failure 'app' where patients' clinical data by the specialist nurse during community visits was immediately uploaded to the hospital database and so was immediately available to other clinical staff.

Good Practice

1 A cardiac 'pull nurse' was responsible for identifying patients who would benefit from specialist cardiac care in the Emergency Department and Acute Medical Admissions Unit, arranging appropriate investigations and ensuring they received specialist care as soon as possible. This had been shown to reduce length of stay and improve patient satisfaction.

2 Patients had good access to psychological support. This was available through direct referral to psychological support services or through the hospice for patients who needed a service more quickly.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Diagnostic Pathway**

The pathway for diagnosis of heart failure did not follow latest NICE guidance. A rapid access clinic had been introduced in October 2012 but the criteria for referral to this service were not documented. Reviewers were told that serum natriuretic peptide testing was not routinely used in primary care and patients with suspected heart failure were often referred for echocardiography to a service that was not linked with the specialist heart failure team. If patients were subsequently referred for specialist assessment the echocardiogram was often repeated. Also, multi-disciplinary specialist assessment was not

available; in particular, the heart failure specialist nurse was not able to attend the rapid access clinic. Little patient information was available to support the diagnostic pathway; in particular, there was no patient information before or after their echocardiography appointment.

2 **Low Staffing Levels**

Specialist nurse staffing was insufficient to support multi-disciplinary assessment and care for the population served (approximately 280,000). At the time of the review there was one heart failure specialist nurse and one specialist nurse caring for patients with arrhythmias who provided some cover for the heart failure specialist nurse. Charitable funding had been approved for a second heart failure specialist nurse for one year to support those patients with arrhythmias and implantable cardioverter defibrillators (ICD). The heart failure specialist nurse was based in the community and came into the hospital on one day each week; reviewers were told that the heart failure nurse would be notified of any patients discharged in her absence. Patients who were discharged before being seen by the heart failure specialist nurse should be given her contact details but that this did not always happen.

3 **Guidelines and Protocols**

See 'Trust-wide' section of this report in relation to the lack of documented guidelines and protocols.

4 **Care Planning, Regular Reviews and Care Coordination**

Patients did not have a formal plan of care. Patients were reviewed in consultant out-patient clinics and / or nurse-led clinics but there was no documentation of what should be covered in these reviews, no systematic recording of review information or communication of the outcomes of reviews to the patient and all services involved in their care. The specialist team assumed that general practitioners were responsible for the six monthly reviews of patients with heart failure but there was not regular communication of information to the specialist team. Although the heart failure specialist nurse acted as the care coordinator for patients with whom she was in contact arrangements for allocation of a care coordinator were not robust.

5 **Cardiac Rehabilitation**

Patients with heart failure did not have access to cardiac rehabilitation unless they had also had a myocardial infarction (MI). Cardiac rehabilitation for South Warwickshire was provided by two 0.5 w.t.e. staff. It was not clear to reviewers how this staffing resource could be sufficient for post-MI patients and would not be able to take on rehabilitation of all patients with heart failure.

6 **Local Network**

No local network or equivalent group with responsibility for driving improvements in the care of people with heart failure was in place.

Further Consideration

1 As described in the 'health economy' section of this report, links with community long-term conditions services may benefit from further development, especially to improve the care of people with multiple long-term conditions and those needing palliative care.

2 Ongoing support for people with heart failure was highly dependent on the heart failure specialist nurse who was due to retire within a year after the review. It will be important to ensure systems and approaches are documented fully before her retirement to ensure the quality of patient support continues after her retirement. This should also help the newly appointed arrhythmia and heart failure nurse to provide effective cover.

3 The arrangements for giving information about heart failure to patients depended largely on the heart failure specialist nurse being available. Some groups of patients did not have contact with her – or would not see her until after a hospital admission. Arrangements for giving out patient information should be

reviewed to ensure all patients received appropriate information when they were given their diagnosis of heart failure.

4 Because there was only one heart failure specialist nurse who was community-based, the need for specialist nursing input to the multi-disciplinary specialist care of people with heart failure may be being under-estimated. As part of planning the future service it may be helpful to review NICE guidance and look at the way in which other areas are making use of their heart failure specialist nurses.

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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.

Trust-Wide

SOUTH WARWICKSHIRE NHS FOUNDATION TRUST

General Comments and Achievements

South Warwickshire NHS Foundation Trust was pursuing several initiatives to improve care for people with long-term conditions. Prescribing pharmacists had been introduced onto respiratory, acute medicine and cardiac wards and also linked to the 'virtual ward' with the aim of improving medicines management for these patients. There were also plans to use ipads to give electronic access to patient records for community staff. Considerable effort had been put into integrating social, community and acute care for frail older people, and there was a strategy in place to continue this work across other areas over the next three years. A bi-monthly Community and Hospital Information Exchange Forum was held where anyone could come and raise issues. Progress was also being made on patient involvement with user groups and patient involvement for each specialty. The Trust 'patient satisfaction 'cards were concise and clear. Reviewers were also impressed with the trust poster on raising awareness of diabetes.

Concerns

1 **Guidelines and Protocols**

The adult condition-specific services reviewed generally did not have documented pathways of care, including referral and discharge criteria, clinical guidelines and operational procedures. NICE guidance was mostly in use but had not been localised to show how it was being implemented locally. Agreeing guidelines and procedures, as part of an overall pathway, should help to ensure patients receive consistent, high quality care and should also help with integration and communication with other services.

2 **Governance of Documents**

Several of the guidelines and protocols that were seen by reviewers did not comply with the Trust policy on document control. The governance team did not appear to have responsibility for maintaining an overview of guidelines and protocols which should be in place, and whether these had been developed and were being kept up to date.

Further Consideration

1 In addition to the strategic work outlined in the 'health economy' section of this report , further work on operational issues and communication between community long-term condition services and specialist condition-specific services may be helpful. Specialist condition-specific teams were not all aware of the community-based resources that were available and how they could work together in the interests of their patients.

2 The Trust had not yet published a formulary and the NICE approval process would not meet the national requirement for drugs getting into the published formulary within three months. Some clinical guidelines, for example, the heart failure prescribing guidelines, were not reflected in the Trust formulary.

3 Work had started on speeding up arrangements for issuing drugs 'To Take Out' and therefore the discharge process. Reviewers considered that the 'home for lunch' initiative had the potential to improve the care of people with long-term conditions by reducing length of stay in hospital.

4 Good staff training was taking place, especially in the community long-term conditions services, and the Trust had a good vision for the development of training in the care of people with long-term conditions. In the services reviewed there were, however, few competence frameworks detailing the competences expected for work in the team. Further development of such frameworks may be helpful to ensure training is focussed on the needs of the service.

5 Trust-wide arrangements for review and learning were in place but there was little evidence of clinical teams undertaking service-level multi-disciplinary review and learning. Services were participating in national audits and were looking at mortality data but rolling programmes of audit of implementation of guidelines were not in place in any of the services reviewed.

6 Information for patients and carers was not well-developed in several of the services reviewed. It may be helpful to review the approach being taken by clinical teams and whether some focussed work, including utilising resources or other forums available in other areas, would be helpful.

7 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.

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COMMISSIONING

SOUTH WARWICKSHIRE CLINICAL COMMISSIONING GROUP

Reviewers met one representative from the Clinical Commissioning Group (CCG) and representatives from the National Commissioning Board Local Area Team and Commissioning Support Service. No written information about the CCG's compliance with Quality Standards for the Care of People with Long-Term Conditions or for the Care of Children and Young People with Diabetes was provided.

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:

Concerns

1 Variability in Care: See 'health economy' section of this report.

2 Strategy for the Care of People with Long-Term Conditions: See 'health economy' section of this report.

3 Local Networks: See 'health economy' section of this report.

4 Care of Children and Young People with Diabetes: Three monthly reviews; HbA1c testing and Local Network.

5 Specialist Care of People with Diabetes: Low staffing levels; Care planning, care coordination and regular reviews; and Education programmes

6 Specialist Care of People with COPD: Review arrangements

7 Specialist Care of People with Heart Failure: Diagnostic pathway; Low staffing levels; Care planning, regular reviews and care coordination; Cardiac rehabilitation.

8 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 Jenifer Harding	Black Country Cluster Quality and Medicines Management Lead	Black Country Cluster

Visiting Team

Jenny Belza	Head of Quality and Patient Safety	Birmingham Cross City Clinical Commissioning Group
Diane Cluley	Paediatric Diabetes Specialist Nurse	Worcestershire Acute Hospitals NHS Trust
Adele Dean	Clinical Quality Manager	West Midlands Ambulance Service NHS Trust
Dr Lee Dowson	Consultant LTC	The Royal Wolverhampton Hospitals NHS Trust
Bernadette Faulkner	LTC Commissioning	Solihull PCT
Eunice Foster	Assistant Director	Shropshire and Staffordshire Heart & Stroke Network
Chris Groves	Service User	Rheumatology User Group
Sue Lahiff	Hospital Manager and Matron	Worcestershire Health & Care NHS Trust
Dr Dawn Moody	General Practitioner	North Staffordshire Clinical Commissioning Group
Dr Muyiwa Oso	Consultant Paediatrician	Mid Staffordshire NHS Foundation Trust
Bhupinder K Pawar	Senior Diabetes Specialist Nurse	The Royal Wolverhampton Hospitals NHS Trust
Sharon Ross	LTC Programme Manager	West Mercia Cluster
Dr John Scanlon	Consultant Paediatrician	Worcestershire Acute Hospitals NHS Trust
Lorraine Shaw	Diabetes Clinical Nurse Specialist	Birmingham Children's Hospital NHS Foundation Trust
Dr Suresh Upputuri	General Practitioner	Coventry - Forum Health Centre
Ananth Viswanath	Consultant Physician Diabetes & Endocrinology	The Royal Wolverhampton Hospitals NHS Trust

Sandy Walmsley	Respiratory Nurse Specialist & LTC Lead	Heart of England NHS Foundation Trust
Menna Wyn-Wright	Programme Lead	South Worcestershire Clinical Commissioning Group

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	Commissioner	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	1	33
Specialist Care of Children & Young People with Diabetes	29	13	45
Trust-Wide: South Warwickshire NHS Foundation 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	32	63
Specialist Care of Adults with Diabetes	60	25	42
Specialist Care of People with COPD (All Services)	121	78	64
COPD	(56)	(22)	(39)
Pulmonary Rehabilitation	(65)	(56)	(86)
Specialist Care of People with Heart Failure	57	19	33
Trust-Wide: South Warwickshire NHS Foundation Trust	7	4	57
Commissioning	12	4	33
Health Economy	**316**	**164**	**52**

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