WM QRS West Midlands Quality Review Service

NHS

# Care of Adults with Long-Term Conditions

# Care of Children & Young People with Diabetes

## Walsall Health Economy

Visit Date: 5th, 6th & 7th March 2013 Report Date: July 2013

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# INDEX

# INTRODUCTION

This report presents the findings of the review of the care of people with long-term conditions which took place on 5th, 6th & 7th March 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 1.1, August 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 Walsall health economy. Appendix 2 contains the details of compliance with each of the standards and the percentage of standards met.

## WALSALL HEALTH ECONOMY

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

- Walsall Healthcare NHS Trust
- NHS Walsall 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 in relation to this report is NHS Walsall Clinical Commissioning Group. When addressing issues identified in this report, commissioners are expected to cooperate

with each other and, where appropriate, with NHS England Birmingham, Solihull and the Black Country Local Area Team commissioners of primary care and specialised services.

## 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 Walsall 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

**Good Practice**

Reviewers were impressed with many aspects of the care of people with long-term conditions in Walsall, where good patient care was provided in a well-organised and integrated way. Specific examples of good practice were:

1 **Robust, system-wide approach to the care of people with long-term conditions**

Robust arrangements for delivering and improving care for people with long-term conditions were in place. Strong integration and joint working between health and social care, between hospital-based and community-based services and between commissioners and providers were evident. A good draft Strategy for the Care of People with Long-Term Conditions was out for consultation at the time of the review. Condition-specific clinical leads were in place for all services except for care of people with chronic neurological conditions. These clinical leads were well known to all involved and it was very clear who was leading on particular pieces of work. Local networks were in place for all long-term conditions reviewed except chronic neurological conditions. Strategic Transformation and Redesign (STaR) Groups were driving improvements to services, working closely with Clinical Reference Groups. A Project Management Office (PMO) supported redesign projects.

A comprehensive range of services was available but clear roles for each service within agreed pathways of care. Patients, clinical staff and commissioners were all clear about the function of each service and how to access it. The documentation seen by reviewers was consistent with the pathways described and the way in which services were working in practice.

Good links with public health had been made and a strong focus on reducing inequalities, involving 'hard to reach' groups and prevention of long-term conditions through lifestyle interventions was clearly evident. A strong commitment to evaluation was apparent with several initiatives being piloted and evaluated before wider roll-out. The health economy had also de-commissioned some services when evaluation had shown that they were not effective.

2 **Training and education**

Training and education programmes run by Walsall Healthcare NHS Trust were made available, through a Service Level Agreement, to primary care staff and to staff working in care homes. Specific training was offered on issues which were identified as particular problems, for example, a problem with falls had been identified, training had been offered to care home staff, and a reduction in falls-related Accident and Emergency (A&E) attendances was then seen.

3 **Frail elderly pathway**

A very good pathway of care for frail older people had been implemented. This had several elements:

A GP and three nurses specialising in the care of frail older people were based in the A&E. This team identified 'frail older people', most of who were aged over 75, and assessed them. Those for whom acute admission was appropriate then went to the acute medical admissions unit. Those with less acute needs received appropriate assessment and investigations and then either went home or were admitted to the 'SWIFT' ward. Good links with the community matrons and intermediate care nurses were in place so that community support and review could be mobilised quickly. If medical review was considered necessary then the A&E-based GP could visit patients at home. Good links with consultant staff were also evident and consultant advice could be accessed quickly for patients on the 'frail elderly' pathway.

The 'SWIFT' ward provided 'GP beds' in the hospital setting. Priority was given to admissions from the A&E-based GP but other GPs could admit directly to the ward. The ward was also used for 'step down' from

acute care but it was clear that 'step up' from primary care took priority over 'step down'. There was continuity of care between the A&E services and the ward and, if necessary, review by the same team following discharge home. If a patient's condition deteriorated then could easily be transferred to acute care. Average length of stay for 'step up' patients was less than four days. Consideration was being given to involving the dementia care team in the work of the ward.

The 'frail elderly' team was available Monday to Saturday 8am to 6pm. After this time patients needing admission were admitted to acute beds. First thing each morning the team did a 'ward round' of all patients admitted the previous night and, if appropriate, transferred them to the 'SWIFT' ward or arranged their discharge home. Systems were in place to identify and 'flag' frail elderly people when they arrived at A&E and in their GP practices.

4 **Telehealth and Telecare**

A proactive approach to telehealth and telecare was evident. Reviewers were told about telehealth initiatives in the community long-term conditions (LTC) services and in the heart failure service. At the time of the review, over 60 people cared for by the community nursing long-term conditions teams were using telehealth. The heart failure team used patients' in-patient stay to introduce them to teleheath equipment. The Trust contract specified that telehealth should be embedded into all care pathways for people with long-term conditions and a joint health and social care steering group oversaw improvements in the use of assistive technology.

5 **Admission Alerts**

A good system of 'alerts' was in place where by community long-term conditions and specialist teams could be notified of the admission to hospital of one of their patients. For condition-specific teams the system could differentiate between a patient of the team and a patient admitted with that condition who was not known to the team. GPs could also be alerted to hospital admission of their patients and some GPs were using the system well.

6 **Single Assessment Process**

A Single Assessment Process (SAP) was in place and being actively used in many of the services reviewed for those with multiple long-term conditions.

**Immediate Risks:** No immediate risks were identified.

**Concerns:** No concerns were identified.

**Further Consideration**

1 Reviewers were told that a lot of work had been done on improving discharge from hospital but that processes were still cumbersome and lots of forms had to be completed. Staff had good ideas of improvements which they wanted to make. An integrated discharge team was in place, although staff were not yet fully integrated and there were particular problems with access to IT. Social and health care systems were separate and staff could not see information on the 'other' system. Further stream-lining of the discharge process may be helpful.

2 Some of patients and staff had heard about changes being made to services but did not appear fully to understand what was happening or implications for them. Examples quoted included podiatry services, Dartmouth House and the frail elderly service. Options for enhancing further communication with patients and staff about service changes may merit further consideration.

The Single Assessment Process (SAP) was working well in some areas but was not being used in others, for example, the epilepsy and specialist diabetes services. Further work on encouraging use by all services may be helpful.

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## PRIMARY CARE

**NHS WALSALL CLINICAL COMMISSIONING GROUP**

**Good Practice**

1 A CCG-employed practice pharmacist was running practice-based clinics in some practices to optimise hypertension management, including providing 24 hour blood pressure monitoring equipment. Consideration was also being given to spreading this model to other conditions and other practices.

2 All Walsall GPs had signed up to a Local Enhanced Scheme through which they would offer NHS health checks.

**Immediate Risks:** No immediate risks were identified

**Concerns:** No concerns were identified.

**Further Consideration**

1 Reviewers were told of some concerns that attendances at A&E were high when the GP 'Out of Hours' service was in operation. The CCG may wish to work with GPs and providers further to investigate this.

2 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

**WALSALL HEALTHCARE NHS TRUST**

**General Comments and Achievements**

Services for children and young people with diabetes were greatly appreciated by patients and families. The support provided by paediatric diabetes specialist nurses (PDSNs) was particularly praised. The team was committed, hard-working and had good plans for the improvement of the service. The transition service pilot had won a Queen's Nursing Institute award which included funding to extend the pilot. Patients who had taken part in the transition workshop found it very helpful, including the information on 'how to have a good consultation with the doctor'.

The 'My Diabetes' patient information pack included staff photos so that patients knew who they would be seeing. The 'Lifestyle Team' was available during clinics. This team was not specific to diabetes but provided general lifestyle advice and were routinely involved as part of the first assessment.

**Good Practice**

1 A good patient-held record was available with clearly presented information. As a result, families did not have to wait for clinic letters in order to have the most up to date information about their child's care.

2 A clearly structured document was used for education for newly-diagnosed patients. This described what to expect in the future and the expected frequency of contact in each week after diagnosis.

3 When a patient or carer contacted the ward for advice, staff completed an advice sheet which was then faxed to the PDSN so that she knew what advice had been given. The advice sheet was then filed in the nursing notes.

**Immediate Risks:** No immediate risks were identified.

**Concerns**

1 **Guidelines and Protocols**

a. Guidelines on surgery for children and young people with diabetes did not differentiate between major and minor surgery or between different insulin regimes. Fluids were started by the anaesthetist and there was little information on when to start intravenous insulin. Reviewers considered that these guidelines needed significant review and should take into consideration the latest guidance from the International Society for Paediatric and Adolescent Diabetes (2011).

b. The guidelines for primary care on the management of diabetes were adult-orientated and did not clearly identify that a child suspected of having diabetes should be referred to the paediatric diabetes team the same day.

2 **Administrative and Dietitian Staffing**

At the time of the review the service had no administrative support with time allocated for work with the paediatric diabetes service. As a result clinical staff were spending time on administrative work which could have been used for patient care. Only 0.1 w.t.e. dietitian time was allocated to the paediatric diabetes service which was insufficient to achieve the requirements of *Best Practice Tariff.* A business case for additional staffing had been approved but staff had not yet been recruited.

**Further Consideration**

1 There was no operational policy. Some components were evident in other documents but some of the expected elements were missing.

2 Re-ordering the information in the diabetic keto-acidosis guideline may make the guideline easier to follow.

3 The 'dashboard' process for annual reviews was labour-intensive, especially with no administrative support. An annual review proforma had been developed and included a comprehensive checklist. Reviewers considered that implementing this proforma would make capturing all the necessary information much easier.

4 The patient-held record and the 'My Diabetes' booklet was only given to newly diagnosed patients at the time of the review. The document had been emailed to existing patients who were asked to print it out themselves. Providing copies for existing patients may be helpful.

5 Documentation of education programmes undertaken was not complete. More formal documentation of education programmes undertaken within the patients' notes may be helpful. Education for newly-diagnosed patients was well documented and comprehensive.

6 Parents and patients had many ideas about the development of the service and were keen to work with the service. It may be helpful to consider more opportunities for patient and family feedback and involvement in decisions about the service. Documentation of changes made as a result of feedback may also be helpful.

7 Further guidance to staff providing 24/7 advice, including staff on the Paediatric Assessment Unit and registrars, may be helpful. Guidelines for illness management, hyper-glycaemia and hypo-glycaemia were in place. Some of the common paediatric diabetes issues, such as forgotten doses of insulin or too much insulin given, were not covered in the guidelines. Reviewers considered that improving the guidelines should reduce the need for escalation to the consultant or PDSN.

8 Audits had been carried out but there was no evidence of recommendations or follow up of recommended actions.

9 It was not clear that the service had enough clinic slots to implement the 'high HbA1c' policy. The policy stated that patients should be seen at two, four, six and eight weeks. A more structured approach to ongoing education may also help to reduce the need for high HbA1c management.

10 Process mapping within the paediatric diabetes out-patient clinic may be helpful. Reviewers were told that out-patient nursing staff used to do blood pressure and HbA1c measurement but that this did not happen any longer because staff were supporting several clinics at the same time. Optimising out-patient processes and ensuring staff have the appropriate competences for the role in the process may be helpful.

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## COMMUNITY LONG-TERM CONDITIONS SERVICES

**WALSALL HEALTHCARE NHS TRUST**

**General Comments and Achievements**

Nine teams of district nursing and community matron services, grouped into four 'hubs', were reviewed. These teams covered 8am to 6pm. The Rapid Response Team and Intermediate Care Teams also operated between 6pm and 10pm. A night service, based in A&E, covered 10pm to 6am. These services worked well together. The services had a strong emphasis on learning from mistakes and the number of complaints had reduced from 33 to six in three years. Shift patterns had also been changed in response to staff feedback. Patients and carers were very appreciative of the care they received. Daily handovers ensured good continuity of patient care. Staff morale appeared to be good and there seemed to be a strong emphasis on personalised care, enabling patients to set individualised goals and supporting patients to achieve these goals. Access to equipment was well organised, and included the option for patients themselves to ring and request equipment. Each community nursing teams was linked with, and supported by, one of the CCG-employed practice pharmacists.

**Good Practice**

1 Community nurses had additional competences so that they could undertake occupational therapy assessments. They had seven day a week access to an equipment store and so patients could be supplied with necessary equipment without delay.

2 The wound clinic was permanently staffed, which ensured good clinical care, because of staff expertise and continuity of care and in particular, the ability to monitor wounds.

3 The staff to patient ratio of 1:35 was very good. The levels of patient need were audited on a weekly basis and staff were moved between teams so that staffing matched the areas of greatest need.

4 The teams were able to provide continuity of care until end of life. Patients remained with the same community team for as long as necessary, with a named nurse as care coordinator. Each of the nine community teams had a lead nurse for palliative care with additional competences in palliative care. These nurses attended the Gold Standard Framework meetings on behalf of the team.

**Immediate Risks:** No immediate risks were identified

**Concerns:**

1 **Guidelines and Protocols**

Some of the expected clinical guidelines were not available in the community services, in particular, those relating to monitoring and management and chronic complications.

**Further Consideration**

1 Access to chiropody and podiatry: See Trust-wide section of this report.

2 The use of carbon paper when copying patient-identifiable information should be reviewed and the use of self-carbonated paper may be more appropriate.

3 Greater use of condition-specific patient information, such as that available from Diabetes UK or the British Heart Foundation, may be helpful.

4 Several of the documents seen by reviewers did not have review dates.

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## SPECIALIST CARE OF ADULTS WITH DIABETES

**WALSALL HEALTHCARE NHS TRUST**

**General Comments and Achievements**

A structured, tiered approach to the care of people with diabetes was working well. In addition to primary care services, 'Local Enhanced Schemes' in six practices provided enhanced care, including insulin initiation. The next tier was the team of community diabetes specialist nurses who received approximately 320 new referrals each month for short episodes of intensive management. The final tier was the hospital-based team who managed the care of patients with more complex needs, including in-patients with diabetes. These tiers of the service worked well together. Referral criteria for each part of the service were clearly defined. There was good communication and integrated working between hospital and community-based services who were able to respond flexibly to the needs of patients. The integrated diabetes team comprised two consultants, a registrar and specialty doctor, an integrated service lead (covering adult and children's services, extended scope podiatrist, 2.8 w.t.e. community-based diabetes specialist nurses, 1.9 w.t.e. hospital-based specialist nurses, 0.8 w.t.e. diabetes educator with specific responsibility for minority communities and 1.6 administrative support (covering hospital and community). Two dietitians worked across hospital and community offering individual consultations and group education.

The team was welcoming and open and good team-working was evident. Strong consultant and nurse leadership was in place. The information collated for reviewers was clear and well-presented. The team took part in the national audit programme and also undertook an annual in-patient audit. A good range of other audits had also been undertaken.

**Good Practice**

1 'Foot assessment' stickers were put into patients' notes to make it clear that a patient's feet had been assessed

2 Primary care guidelines on management of diabetes were simple, clear, easy to understand and were available in a PowerPoint presentation with links to supporting documents.

3 Education programmes were specifically targeted at the needs of the local population. Education programmes were run in several different languages, supported by the diabetes educator.

**Immediate Risks:** No immediate risks were identified

**Concerns**

1 **Staffing Levels Insufficient**

Staffing levels in the integrated diabetes team were insufficient. In particular, there were only 4.7 w.t.e. diabetes specialist nurses covering hospital and community services. The service had only 1.6 w.t.e. administrative staff covering data entry, education programme coordination and other administrative work in the hospital and community services. The posts worked separately and so, in practice, there was no cover for absences. Community diabetes specialist nurses' letters were often delayed at times when the administrator was on leave. No psychologist had time specifically allocated for work with patients with diabetes.

**Further Consideration**

1 It may be helpful to identify a clinical lead for the care of patients on insulin pumps. These patients were cared for by community nurses but no-one had particular specialist expertise in pump therapy and patients on insulin pumps did not have regular consultant input and oversight.

2 Diabetes clinics were run in the general out-patients department. The development of a 'Diabetes Centre' may be helpful, and could help to develop specialist expertise and continuity of care among clinic nursing staff, as well as a strong focus on the care of people with diabetes.

3 No diabetes support group was running at the time of the visit.

4 There was a plan for more work on diabetes prevention and reviewers encouraged continued implementation of this plan.

5 The 'did not attend' (DNA) section of the primary care diabetes guidelines may benefit from review to ensure that responsibilities were clear.

6 The high prevalence of diabetes in the Walsall population and the relatively low staffing levels of this service mean that some of the long-term complications of diabetes may not be being prevented. Complication rates and hospital admissions may start to rise if staffing levels are not increased.

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## SPECIALIST CARE OF PEOPLE WITH COPD INCLUDING PULMONARY REHABILITATION

**WALSALL HEALTHCARE NHS TRUST**

**General Comments and Achievements**

Services for people with COPD in Walsall included a respiratory ward, high dependency unit, community and hospital-based specialist nurses, specialist physiotherapists and a Home Oxygen Assessment and Review service. Pulmonary rehabilitation was provided both by the hospital-based team and by Walsall Cardiac Rehabilitation Trust. The Walsall Healthcare NHS Trust team provided specialist assessment and treatment of COPD in patients' homes, community clinics and hospital in-patient and out-patient services. Early supported discharge and A&E 'in-reach' were in place and the COPD triaged all relevant patients within two hours of admission. The team also provided education and support to GP practices in the care of people with COPD. Home support and treatment for COPD patients suffering from exacerbations aimed to avoid hospital admissions where appropriate. The team was providing care for between 1200 and 1300 of the 6000 Walsall people diagnosed with COPD (based on QOF data). The team was appropriately staffed.

Feedback from patients about the care they received was very positive. Patients and carers felt extremely well supported by the community services. Community and hospital-based services were well-integrated. It was clear from talking to patients that they knew who to contact and when. Medical and nursing leadership was strong.

The early supported discharge scheme had been shown to reduce length of stay by two days and the audit data collected by the service was ratified by patients' experiences. The team was starting to look at the 'discharge care bundle' before this becomes a national requirement. They were also working hard to train ward staff in inhaler technique and the care of people with COPD.

The COPD team also provided pulmonary rehabilitation for patients with more advanced disease (Medical Research Council or MRC 3 and above). This was organised as a six week course of two sessions per week and 10 patients per session. The sessions were run by a physiotherapist, physiologist and one respiratory nurse. The rehabilitation sessions had good access to other services, including smoking cessation, psychology, occupational therapy, dietetics and health trainers.

Review conclusions relating to the Walsall Cardiac Rehabilitation Trust service which provided community-based cardiac and pulmonary rehabilitation are given in the heart failure section of this report.

**Good Practice**

1 Personalised care planning was well-developed. A new modular COPD booklet was used with patients given relevant sections as the need arose. The same document was used in primary and secondary care with a different cover sheet of contact details. The booklet covered diagnosis through to end of life.

2 Links with palliative care services worked well. The community team had good links with palliative care and consultants were developing specific guidelines on palliative care for people with COPD. Respiratory specialist nurses had 'open access' to the palliative care multi-disciplinary team. They could put patients on the list for discuss and then attend the meeting to discuss them. One specialist nurse was dual-trained in COPD and palliative care. There were also good links between the oxygen service and palliative care and oxygen could be made available quickly for patients nearing the end of life.

**Immediate Risks:** No immediate risks were identified

**Concerns**

1 **Access to Non-Invasive Ventilation:** See Trust-wide section of this report

2 **Guidelines and Protocols**

Some of the expected clinical guidelines were not available in the hospital-based service, in particular, those relating to diagnosis, monitoring and management. Some of the guidelines which were available were not appropriately document-controlled. Guidelines were available for the early supported discharge team and the community team.

3 **Waiting Time for Pulmonary Rehabilitation**

The waiting time for the hospital-based pulmonary rehabilitation service was 15 weeks at the time of the review, compared with the maximum expected waiting time of 10 weeks.

**Further Consideration**

1 IT systems: See Trust-wide section of this report.

2 The team had many informal mechanisms for telling patients and carers who they should contact – and patients were clear about this. Care coordination was not always possible for those under the care of the community COPD team.

3 There was no cover for sickness or absences for the community COPD staff.

4 Patients under the care of the specialist team had a good care plan and regular review. Further work with primary care on care planning and review for the approximately 75% of COPD patients being cared for in primary care may be useful. The team had tried to work with GPs previously and reviewers encouraged ongoing efforts in this area.

5 Greater cooperation with the community-based rehabilitation service Walsall Cardiac Rehabilitation Trust may help to reduce waiting times. It may also be useful to see whether a rolling programme of sessions would help to reduce waiting times while maintaining the quality of the service offered.

6 The Home Oxygen Assessment and Review Service was still picking up patients who had been on oxygen for some time and who had not previously had regular reviews. This was known as a problem and staffing capacity was sufficient to provide care for these patients. Work on making sure all patients on home oxygen are linked with the service needs to continue.

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## SPECIALIST CARE OF PEOPLE WITH HEART FAILURE, INCLUDING CARDIAC REHABILITATION

**WALSALL HEALTHCARE NHS TRUST and WALSALL CARDIAC REHABILITATION TRUST**

**General Comments and Achievements**

Specialist care for people with heart failure was provided by an integrated hospital and community-based Walsall Healthcare NHS Trust team, with cardiac rehabilitation provided Walsall Cardiac Rehabilitation Trust. The Walsall Healthcare NHS Trust service was an impressive service provided by very enthusiastic staff. Patient information

was very good and the team had a very positive attitude to service improvement. Hospital and community-based services were well integrated but good mutual understanding of the responsibilities of different parts of the service. Specialist nurses (2 w.t.e.) were supporting telehealth, formal review and open access clinics. They were also working to increase the level of training and awareness of heart failure among ward nurses and community-based community nursing teams. Patients who met the visiting team were very appreciative of the care they received.

Cardiac and pulmonary rehabilitation (for people with less complex needs – MRC1 or more) was provided by Walsall Cardiac Rehabilitation Trust. This service worked from a good central venue, and home and web-based programmes were also available. The service was very well-organised with lovely facilities and very good patient feedback. The rehabilitation service linked well with other cardiac and respiratory services. An initial assessment session was run each Wednesday afternoon. Patients were seen for daily exercise sessions. Staffing comprised four cardiac physiologists, four respiratory nurses, one doctor, six heath care assistants and two cardiac rehabilitation nurses (some of which were part-time). These staff ran rehabilitation courses, after-care and weight management programmes. Patient feedback was very good and a good range of patient satisfaction surveys and mechanisms for feedback was available. GPs could directly refer patients for cardiac or pulmonary rehabilitation.

**Good Practice**

1 Serum natriuretic peptide (BNP) testing was available in all parts of the service.

2 Portable echo-cardiography was available.

3 The service had very good arrangements for proactively identifying patients, including through email alerts whenever a patient of the team was admitted to hospital. The heart failure nurse also reviewed the highest natriuretic peptides serum results from the pathology laboratory and tracked the patients to ensure that they were being appropriately referred.

4 A 'heart failure' sticker in the patients' notes identified clearly that the patient had a diagnosis of heart failure.

5 Liaison with palliative care was working well, including community heart failure clinics within the local hospice.

**Immediate Risks:** No immediate risks were identified.

**Concerns:** No concerns were identified.

**Further Consideration**

1 It may be helpful to include more detail in the clinical guidelines in relation to antenatal care, pregnancy and 'grown up' congenital heart disease.

2 The Walsall Cardiac Rehabilitation Trust community staffing did not include a physiotherapist. Reviewers considered that, when an appropriate opportunity arises, a physiotherapist could be a useful part of the skill mix.

3 Greater cooperation with the hospital-based pulmonary rehabilitation service may help to reduce waiting times for pulmonary rehabilitation, especially as the community service was achieving only half of its contracted activity levels (100 compared with a contracted level of 200). It may also be appropriate to increase capacity by reducing twice weekly rehabilitation sessions for eight weeks to six weeks.

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## SPECIALIST CARE OF PEOPLE WITH CHRONIC NEUROLOGICAL CONDITIONS

**WALSALL HEALTHCARE NHS TRUST**

**General Comments and Achievements**

Specialist care for people with chronic neurological conditions was provided by a hospital-based neurology team and a Community Neurological Rehabilitation Team (CNRT) based at Dartmouth House. The hospital-based service provided predominately out-patient care. There were no specific in-patent beds for people with chronic neurological conditions although the consultant neurologist (0.8 w.t.e.) provided advice on the care of in-patients. A consultant based with the rehabilitation teams with a particular interest in the care of people with Parkinson's disease was also available to provide some advice. The epilepsy specialist nurse was based in the hospital because previous work had shown a high rate of presentation with acute admission for people with epilepsy. Joint antenatal clinics were held with the epilepsy specialist nurse and the lead obstetric consultant for the care of people with long-term conditions.

The Community Neurological Rehabilitation Team was an enthusiastic team providing a very good, comprehensive community service. Three continuing health care coordinators were based in Dartmouth House and acted as case coordinators for the continuing health care funded clients, including piloting personalised budgets. Specialist nurses caring for people with Parkinson's disease or multiple sclerosis were based with the Community Neurological Rehabilitation Team. There was good liaison with the hospital-based consultants for the care of people with these two conditions, including arrangements for people with multiple sclerosis who experienced relapses to phone Dartmouth House in order to access a 'walk in' clinic. One of the elderly care consultants had a particular interest in the care of people with Parkinson's disease. A neurological rehabilitation consultant (a joint appointment with The Royal Wolverhampton NHS Trust) was part of the Dartmouth House team. Bi-monthly multi-disciplinary meetings to discuss the care of people with motor neurone disease were held, involving the community neuro-rehabilitation team, palliative care services, the Motor Neurone Disease Association and the specialist nurse for people with motor neurone disease from University Hospitals Birmingham NHS Foundation Trust.

Patients who met the reviewing team were very appreciative of the support and care received from all parts of the service.

**Good Practice**

1 The intermediate care team was able to provide intravenous steroid therapy in patients' homes.

2 The community rehabilitation team received email alerts when one of their patients was admitted to hospital.

3 Arrangements for transition from children's services were well-organised. The child development centre notified the specialist team when young people reached age 12 so that planning for transition to adult services could begin.

4 Comprehensive and user-friendly single assessment process documentation was being used effectively (although not yet used by the epilepsy specialist nurse)

5 There was a good multi-disciplinary approach to the diagnosis of Parkinson's disease. A multi-disciplinary assessment formed part of the diagnostic process, involving the consultant, specialist nurse, speech and language therapist and physiotherapist. As a result, patients met members of the team early in their 'patient journey'.

6 The Community Neurological Rehabilitation Service provided comprehensive, coordinated care for all people with chronic neurological conditions. The co-location of rehabilitation, specialist nurse, case managers and social work staff supported and enabled a holistic approach to the patient care. The team supported people with all chronic neurological conditions. Direct access to the team was available through a specific telephone number for queries; this was answered by a member of the team and patients' queries

could therefore often be resolved quickly. A range of education and self-management programmes were available, including a cognitive group and access to hydrotherapy provided by therapy staff. Newly diagnosed patients were also offered specific education courses.

**Immediate Risks:** No immediate risks were identified.

**Concerns**

1 **Staffing Levels**

Staffing levels were low for the population served and services were heavily reliant on key individuals, in particular:

a. Only 0.8 w.t.e consultant neurologist time was available in the hospital-based service with no on-site cover for absences.

b. Urgent review within 24 hours by a specialist was not available on Friday or a weekend.

c. Due to a vacancy, the neurological rehabilitation consultant was also covering the Wolverhampton neurological rehabilitation service and at the time of the visit, there was no cover for his absences.

d. There was no cover for any of the specialist nurses. The epilepsy specialist nurse was answering telephone calls when not on duty. Case management support for people with neurological conditions other than epilepsy, Parkinson's disease, multiple sclerosis and motor neurone disease was not available.

e. The rehabilitation service was heavily dependent on a small, highly committed team with limited administrative support. The service appeared to rely on the goodwill of staff rather than on a robust staffing establishment with appropriate arrangements for cover for absences.

f. Neuro-psychology staffing had been reduced to 0.5 w.t.e as part of cost efficiencies within the Quality, Innovation, Productivity and Prevention programme (QIPP) and capacity was now insufficient to meet the current caseload.

2 **IT Systems and Care Records**

The hospital and rehabilitation services had different IT systems and different case notes. It was therefore not clear that staff had all the necessary clinical information when they saw patients.

3 **Clinical Guidelines and Protocols**

Few of the expected clinical guidelines and protocols were documented. Staff said that they used NICE guidance but this was not localised to show the local implementation.

4 **Clinical Leadership**

The pathway of care for people with chronic neurological conditions in Walsall did not have a lead clinician with responsibility for coordination and driving service improvements. A lead clinician was identified for the rehabilitation service and for the hospital-based service but no-one had overall responsibility for the patient pathway.

**Further Consideration**

1 There was regular contact between individuals working in the community rehabilitation and hospital-based services but no formalised communication. The services did not meet together to discuss operational problems or for review and learning. Reviewers considered that there was the potential for greater integration between the services and improvements to the patient pathways through more collaboration and communication. Also, there was no health economy-wide mechanism for driving improvements to the pathway of care for people with chronic neurological conditions.

2 The service was not yet able to offer urgent review within 24 hours. Urgent review was available on Mondays to Thursdays.

3 The hospital-based service did not receive email alerts when their patients were admitted. Further consideration should be given to the benefit of linking consultant neurologists to this system.

4 Hospital-based and rehabilitation services did not come together in order to undertake review and learning. The rehabilitation service did have an annual review day. Bringing the teams together for review and learning may be helpful.

5 Arrangements for prescribing oral steroids for management of relapse for people with multiple sclerosis may benefit from review as reviewers were told of some problems with the current arrangements.

6 Arrangements for developing care plans for all patients could be more robust. Some patients had the single assessment proforma completed, some had the proforma but it was not completed, some had copies of clinic letters and some did not.

7 Audit of the multi-disciplinary diagnosis process for Parkinson's disease may help to confirm that all clinicians involved were using the same diagnostic criteria.

8 Patients who met the visiting team were concerned about possible changes in the location for the rehabilitation service. Additional communication with patients about any proposals may be helpful.

9 The 'walk in' clinics appeared to be a useful approach but may increase the pressure on staff. Review of working practices may be helpful to ensure time is freed up for this initiative.

10 The social worker within the community rehabilitation service was being allocated more general social work referrals. As a result, some patients who may have benefitted from her specialist expertise were being allocated to generic social workers. Given the complex needs of some of these patients, re-consideration of arrangements for allocation of referrals may be helpful so that best use can be made of the specialist expertise available.

11 The service was only commissioned to provide botulinum toxin treatment for a small number of patients. As a result, some patients needing complex spasticity management had to be referred out of area or required special funding on a case by case basis. Reviewers considered that the service had the ability to deliver this service locally if this was commissioned.

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## TRUST-WIDE

**WALSALL HEALTHCARE NHS TRUST**

**General Comments and Achievements**

Walsall Healthcare NHS Trust was making good progress with the development of services for people with long-term conditions, as described in the health economy section of this report. Specific comments from reviewers about Trust-wide systems were as follows:

A small pharmacy team had developed a film about medicines at discharge with the Clinical Commissioning Group and Local Pharmaceutical Committee. This identified different sources of information and advice on medicines. There was a good system of pharmacy 'alerts' which reminded staff of things that every clinician should do. Consideration was being given to greater involvement of community pharmacists in dispensing discharge medication. A local CQUIN had been agreed on pharmaceutical risk assessment with the aim of reducing admissions of patients on complex medication regimes. The team was not yet fully integrated with all the Trust's divisions but had a clear vision and plan for the future, including priorities for action.

The training and education department was linking well with the governance structure and with individual departments. Core training was all competency-based, supported by skills laboratories and skills assessments.

Basic and role-specific competence frameworks were in place. A long-term conditions pathway for training and education had been agreed. Links with governance ensured that issues identified through governance processes were build into training and education programmes.

The Trust had good patient involvement in divisional governance meetings as well as attendance at Trust-wide quality meetings. Care bundles were being actively implemented, especially in the respiratory service.

**Good Practice:** See health economy section of this report.

**Immediate Risks:** No immediate risks were identified

**Concerns**

1 **Non-Invasive Ventilation**

The Trust had only eight high dependency beds, which were used by the specialist bariatric surgery service and all surgical and medical patients, including patients needing non-invasive ventilation. Reviewers were told by respiratory and critical care staff that it was sometimes difficult for patients to access non-invasive ventilation in these circumstances. At the time of the review, nursing staff on the respiratory ward did not have the competences to provide non-invasive ventilation and the outreach service was available only 8am to 4pm Mondays to Fridays and so could provide only limited support to ward-based non-invasive ventilation. There was a plan to open two beds on the respiratory ward for patients needing non-invasive ventilation, with support from critical care consultants.

2 **Clinical Guidelines**

The expected clinical guidelines were not yet all in place, or were not yet localised to show how NICE guidance would be implemented locally. Some clinical guidelines did not have appropriate document control. Trust systems identified policies needing review but not clinical guidelines needing review. Updating clinical guidelines relied on individual clinicians' memories.

**Further Consideration**

1 Reviewers were given various views about chiropody and podiatry services, including comments about long waiting times for both routine and urgent appointments. Reviewers were told that the service was being changed in order to focus on high risk patients, with low risk patients being directed to other services. Absences within the team may have contributed to this problem. An action plan was in place. Reviewers did not have the opportunity fully to investigate this issue.

2 Limited access to psychology services was reported by several of the services reviewed. Further investigation in this area may be helpful.

3 IT systems in hospital and community services enabled all community-based staff to see discharge letters, imaging and pathology results. Staff wanted also to be able to see clinic letters that had been written about their patients. There were plans to move to *Lorenzo* shortly after the review which may improve access to clinical information for all staff.

4 Capacity in the pharmacy department appeared insufficient to ensure medicines management oversight for community-based staff. In practice, community staff were still accessing practice pharmacists for advice. This was a particular issue because of the number of nurse prescribers in the community, the governance of which was not entirely clear. Also, some wards did not have the support of a ward pharmacist. Consideration was being given to the development of a 'dispensing hub' in the community.

5 The Trust incident system required staff members to 'log in'. It was not clear how staff without easy access to computers recorded incidents. The benefits of an anonymous option for reporting incidents may also be worth considering.

6 Multi-disciplinary team meetings to discuss the care of people with multiple long-term conditions had just started. Reviewers encouraged continuation of this work.

7 Condition-specific competence frameworks were not yet in place for the specialist teams although a long-term conditions pathway for training and education had been agreed.

8 Some staff who met the visiting team were unaware that community staff were part of the same Trust as hospital staff. Ongoing work to support integration of community and hospital-based teams and Trust-wide awareness of the services available may be helpful.

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## COMMISSIONING

### NHS WALSALL CLINICAL COMMISSIONING GROUP

The issues identified in the 'health economy', 'primary care' and provider sections of this report will require the attention of commissioners. The following specific points about commissioning were made by reviewers:

**General Comments and Achievements**

Risk stratification work was developing well. Practices were routinely receiving and using risk stratification information. One approach to risk stratification had been tried and was being de-commissioned but a new approach was being developed.

**Good Practice:** See health economy section of this report.

**Immediate Risks:** No immediate risks were identified.

**Concerns:** No concerns were identified.

**Further Consideration**

1 The pathway of care for people with chronic neurological conditions was not as well developed as for other long-term conditions (see chronic neurological conditions section of this report). A Strategic Transformation and Redesign (STaR) group for this pathway and the identification of a clinical lead for the whole pathway may be helpful.

2 The very good 'frail elderly' pathway (see health economy section of this report) had been running on a pilot basis for approximately 18 months. Evaluation of this pilot and, if appropriate, commissioning of the pathway should be considered. As part of this work, the sustainability of the model should be considered as it appeared to be highly dependent on one individual.

3 The care of people with more common chronic neurological conditions is described in this report. Less common neurological problems, when considered together, affect a significant number of people. Services for this group of patients are usually less well organised than those for people with more common conditions and further consideration should be given to whether local services are meeting their needs.

See also 'All Commissioners' section below.

### ALL COMMISSIONERS

**Other 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:

**Concerns:**

1 Specialist Care of Children and Young People with Diabetes: Administrative and dietitian staffing

2 Specialist Care of People with Diabetes: Staffing levels

3 Specialist Care of People with COPD: Access to NIV, see Trust-wide section of the report; Pulmonary Rehabilitation waiting times

4 Specialist Care of People with Chronic Neurological Conditions : Staffing Levels; IT systems and care records; Clinical leadership

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# APPENDIX 1 MEMBERSHIP OF VISITING TEAM

**Executive Lead**

| | | |
|---|---|---|
| Lindsey Webb | Director of Nursing and Governance | The Royal Orthopaedic Hospital NHS Foundation Trust |

**Visiting Team**

| | | |
|---|---|---|
| Dr Naeem Ahmad | Consultant Paediatrician | Worcestershire Health & Care NHS Trust |
| Pam Bagri | User Representative | Diabetes UK |
| Dr Manjari Bollu | General Practitioner | Coventry - Forum Health Centre |
| Emma Briggs | Respiratory Nurse Specialist | Heart of England NHS Foundation Trust |
| Diane Cluley | Paediatric Diabetes Specialist Nurse | Worcestershire Acute Hospitals NHS Trust |
| Samantha Colhoun | MS Nurse Specialist | University Hospitals Birmingham NHS Foundation Trust |
| James Davies | CCG Commissioning & Redesign Manager | NHS Stoke on Trent CCG |
| Dr Purushottam Desai | Consultant Cardiologist | University Hospitals Birmingham NHS Foundation Trust |
| Tracy Fallows | Children and Young Person's DSN | Staffordshire & Stoke on Trent Partnership NHS Trust |
| Bernadette Faulkner | LTC Commissioning | Solihull PCT |
| Nick Flint | User Representative | UHB patient groups |
| Jane Freeguard | Head of Medicines Management & Pharmacy | NHS Worcestershire PCT |
| Wendy Hampshire | Locality Manager Adult Services | South Warwickshire NHS Foundation Trust |
| Jane Holmes | Community Matron | Staffordshire & Stoke on Trent Partnership NHS Trust |
| Joanne Humphries | Senior Advanced Practitioner in Cardiology | Mid Staffordshire NHS Foundation Trust |

| | | |
|---|---|---|
| Dr Melanie Kershaw | Paediatric Endocrinologist | Birmingham Children's Hospital NHS Foundation Trust |
| Caroline Lee | Lead Diabetes Specialist Nurse | Shrewsbury & Telford Hospitals NHS Trust |
| Annette Logan | Lead Parkinson's Disease Nurse Specialist | Mid Staffordshire NHS Foundation Trust |
| Jamie Maxwell | Clinical Governance Lead | University Hospital of North Staffordshire NHS Trust |
| Dr Dawn Moody | General Practitioner | North Staffordshire Clinical Commissioning Group |
| Dr Rajib Pal | General Practitioner | Vascular Lead; Hall Green Health; Birmingham Cross City CCG |
| Jennifer Sech | Community Practice Educator | Staffordshire & Stoke on Trent Partnership NHS Trust |
| Lizzie Smith | Heart Failure Specialist Nurse | The Royal Wolverhampton Hospitals NHS Trust |
| Dr Ateeq Syed | Diabetes Consultant | Heart of England NHS Foundation Trust |
| Dr Alice Turner | Consultant Respiratory Physician | Heart of England NHS Foundation Trust |
| Dr Martina Walsh | Consultant in Rehabilitation Medicine | NHS South Birmingham PCT |
| Karen Whitehead | Paediatric Diabetes Specialist Nurse | Mid Staffordshire NHS Foundation Trust |
| Rhona Woosey | Planned Care Redesign Manager | Birmingham & Solihull NHS Cluster |
| Helen Wylie | Nurse Practitioner | Lisle Court Medical Centre |

**WMQRS Team**

| | | |
|---|---|---|
| Jane Eminson | Acting Director | West Midlands Quality Review Service |
| Sarah Broomhead | Quality Manager | West Midlands Quality Review Service |
| Sue McIldowie | Long Term Conditions Programme Support | West Midlands Quality Review Service |

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# APPENDIX 2 COMPLIANCE WITH THE QUALITY STANDARDS

Analyses of percentage compliance with the Quality Standards should be viewed with caution as they give the same weight to each of the Quality Standards. Also, the number of Quality Standards applicable to each service varied depending on the nature of the service provided. Percentage compliance also takes no account of 'working towards' a particular Quality Standard. Reviewers often comment that it is better to have a 'No but', where there is real commitment to achieving a particular standard, than a 'Yes but' – where a 'box has been ticked' but the commitment to implementation is lacking. With these caveats, table 1 summarises the percentage compliance for each of the services reviewed.

**Table 1 - Percentage of Quality Standards met**

Details of compliance with individual Quality Standards can be found in a separate document.

| Service | Number of Applicable QS | Number of QS Met | % met |
|---|---|---|---|
| **Care of Children and Young People with Diabetes** | | | |
| Primary Care | 3 | 1 | 33 |
| Specialist Care of Children & Young People with Diabetes | 29 | 21 | 72 |
| Trust-Wide: Walsall Healthcare NHS Trust | 4 | 4 | 100 |
| Commissioning | 7 | 2 | 29 |
| **Health Economy** | **43** | **28** | **65** |
| **Care of Adults with Long-Term Conditions** | | | |
| Primary Care | 8 | 4 | 50 |
| Community Long-term Conditions Services | 52 | 35 | 67 |
| Specialist Care of Adults with Diabetes | 60 | 49 | 82 |
| Specialist Care of People with COPD (All Services) | 122 | 92 | 75 |
| COPD | (57) | (33) | (58) |
| Pulmonary Rehabilitation | (65) | (59) | (91) |
| Specialist Care of People with Heart Failure (All Services) | 82 | 67 | 82 |
| Heart Failure | (57) | (42) | (74) |
| Cardiac Rehabilitation: Walsall Cardiac Rehabilitation Trust | (25) | (25) | (100) |
| Specialist Care of People with Chronic Neurological Conditions (All Services) | 58 | 27 | 47 |
| Trust-Wide: Walsall Healthcare NHS Trust | 7 | 0 | 0 |
| Commissioning | 12 | 10 | 83 |
| **Health Economy** | **401** | **284** | **71** |

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