WM QRS West Midlands Quality Review Service

NHS

Care of Adults with Long-Term Conditions

Care of Children & Young People with Diabetes

Worcestershire Health Economy

Visit Date: 18th – 22nd March 2013 Report Date: July 2013

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INTRODUCTION

This report presents the findings of the review of the care of people with long-term conditions which took place on 18th, 19th, 20th, 21st and 22nd 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 Worcestershire health economy. Appendix 2 contains the details of compliance with each of the standards and the percentage of standards met.

WORCESTERSHIRE HEALTH ECONOMY

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

- Worcestershire Health and Care NHS Trust
- Worcestershire Acute Hospitals NHS Trust
- NHS Redditch and Bromsgrove Clinical Commissioning Group (CCG)
- NHS South Worcestershire Clinical Commissioning Group
- NHS Wyre Forest 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. Individual organisations are responsible for taking action and monitoring progress through their usual governance mechanisms. Commissioners have responsibility for supporting quality improvement across the whole patient

pathway. The nominated lead commissioners in relation to services provided by Worcestershire Acute NHS Trust and Worcestershire Health and Social Care NHS Trust are NHS Redditch and Bromsgrove, NHS South Worcestershire and NHS Wyre Forest Clinical Commissioning Groups. When addressing issues identified in this report, commissioners are expected to cooperate with each other and, where appropriate, with NHS England: Arden, Herefordshire and Worcestershire 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 www.wmqrs.nhs.uk

Acknowledgments

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

NHS organisations in the Worcestershire health economy were clearly working together to improve the care of people with long-term conditions. This group of patients had been identified as a priority for the three Worcestershire Clinical Commissioning Groups. County-wide groups were in place to drive improvements in services for people with diabetes, heart failure and respiratory diseases and lead GPs had been identified for each long-term condition.

Reviewers also saw increasing integration with social care and specific work on promoting independence and preventing admissions to hospital, for example, through the Enhanced Care Team, Unplanned and Unscheduled Care Team and Enhanced Interim Care Package Team.

Access to all health and social care services was coordinated through the Worcestershire Health and Social Care Access Service (WHASCAS).

Good pharmacy support was available for people with long-term conditions across the health economy. Ward pharmacists at Worcestershire Royal Hospital and on nearly all wards at the Alexandra Hospital did daily ward rounds (Monday to Friday) on each ward. Medication reviews were undertaken for all patients as part of these rounds. The service was pro-active in planning for discharge and 'time to TTO' (medication to take home) was estimated as 20 minutes. Changes in medications were faxed to the community pharmacy so they would know to expect new prescriptions before issuing further supplies. Changes of medication were clearly documented in the discharge letter plus reasons for stopping, starting or changing previous medication. A medicines help-line was available to anyone on five or more drugs. The Area Prescribing Committee had agreed a Worcestershire-wide formulary and had introduced a system for reporting breaches of this formulary. The new Worcestershire Health and Care Trust pharmacy team had excellent ideas for the development of the service. Prescribing support to community teams was limited at the time of the review but plans for increasing this level were being considered. A pharmacist attended each community hospital once a week and NHS South Worcestershire CCG was piloting additional pharmacy support to care homes.

Concerns

1 **IT Systems and Care Records**

IT systems in community and hospital services were separate and some community locations could not access pathology and imaging results or clinic and discharge letters. The acute service did not have electronic access to information about care provided by the community services. As a result, the latest clinical information may not be available when patients are seen. In some teams reviewers commented on the extent of paper and individual email communication between teams. These systems were trying to achieve effective communication within teams but, in practice, appeared to be creating a lot of paperwork and multiple records. In other teams reviewers saw no evidence of communication of information between acute and community services. The health economy was aware of this issue and work on achieving integrated IT solutions was starting.

2 **Care Plans and Review Arrangements**

Arrangements for review of care plans were generally not formalised. Patients mostly received regular reviews by the service caring for them, although some condition-specific services expected that reviews would be undertaken in primary care. Communication between services about the outcome of annual (six

monthly for heart failure) holistic reviews was variable. As a result, patients could have up to three annual reviews for the same condition with no communication between these.

3 **Integration of Services**

Although hospital and community condition-specific services for diabetes, COPD and heart failure were provided by Worcestershire Acute Hospitals NHS Trust, these services were not yet working together as integrated teams. Operational processes and documentation were usually different and there were few formalised multi-disciplinary meetings. This was also apparent in services caring for people with chronic neurological conditions. Arrangements for medical oversight of the work of the condition-specific community teams were not clear.

Further Consideration

1 Informal arrangements for coordinating care for people with multiple long-term conditions were in place but more formalised arrangements, especially for those needing input from condition-specific services, were not yet developed. Wyre Forest CCG was piloting 'integrated care meetings' as a forum for people with complex needs to meet primary, secondary and social care professions and feedback from the first three meetings had been positive. Further consideration of the mechanisms for integrating care for people with multiple long-term conditions may be helpful as part of taking forward work in this area.

2 Discharge or exit criteria from services were generally not documented. Some staff said that patients were discharged but it appeared to reviewers that many patients continued to be cared for by condition-specific and community long-term conditions services for long periods of time.

3 Limited access to psychological support and dietetics was a theme in several of the services reviewed. Reviewers were told that additional psychological support was being commissioned.

4 Reviewers commented that on the good work being undertaken by the Integrated Discharge Team but noted that the Alexandra Hospital had less extensive support. Reviewers also suggested that there may be the potential for more nurse-led discharges and for speeding up decisions about when patients are medically fit for discharge.

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PRIMARY CARE

NHS REDDITCH & BROMSGROVE, NHS WYRE FOREST and NHS SOUTH WORCESTERSHIRE CLINICAL COMMISSIONING GROUPS

General Comments and Achievements

Worcestershire CCGs were collaborating well and reviewers noted a strong culture of innovation and engagement with secondary care. There was a long history of encouraging the development of primary-care based skills in looking after people with long-term conditions and reviewers were particularly impressed by the uptake of Diplomas in the care of people with COPD and the monthly training sessions for GPs and practice nurses.

Good Practice

1 In Wyre Forest CCG, GP and consultant 'pairings' had been established to address issues at the primary care / secondary care interface. These 'pairings' acted as a lead for each specialty, looking at the service and how it could be improved.

2 Members of the CCG Board each had a 'patch' of three to four practices with which they linked, ensuring feedback on any concerns. In Redditch and Bromsgrove this was carried out by 'zoning visits' and in South Worcestershire through the 'Improving Quality and Supporting Practices' programme.

3 Local Enhanced Schemes (LES) for the care of people with long-term conditions were in place covering COPD, asthma, end of life care and diabetes. These were fully resourced with clear, proactive arrangements for managing the work of each LES, including activity thresholds and 'triggers'.

Concerns: No concerns were identified

Further Consideration

1 Primary care guidelines on the care of people with chronic neurological conditions were not yet in place, including guidelines on neurology referral of people with a first seizure.

2 Much of the development of innovative practice appeared to be taking place outside working hours and relied on the goodwill and motivation of people involved. Ways of ensuring sustainability may be worth considering.

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

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Specialist Care of Children & Young People with Diabetes

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

General Comments and Achievements

Specialist care for children and young people with diabetes was provided by a county-wide team comprising two consultants, 4.2 w.t.e. paediatric diabetes specialist nurses (PDSN), 1.1 w.t.e. dietitian, 0.16 w.t.e. clinical psychologist and administrative staff (0.2 w.t.e. plus consultant secretaries). At the time of the visit this team looked after 284 children and young people with diabetes (South Worcestershire 124, Redditch and Bromsgrove 95 and Wyre Forest 65) with between 30 and 35 newly diagnosed patients each year. Eighty children and young people had insulin pumps. In-patient care was provided at the Alexandra Hospital and Worcestershire Royal Hospital, with out-patient and community support in each of the three localities.

This team was working hard and flexibly to meet the challenges created by working across a large geographical area and three separate sites. The service was highly praised by the patients and carers who met the visiting team and the support and enthusiasm of PDSNs was particularly appreciated.

Good progress had been made in reducing patients' median HbA1c and in ensuring consistency across the three sites, although reviewers noted some differences in the way services were organised were still present. The team had been nominated for an award for their participation in the CASCADE (Children and Adolescents Structured Competencies Approach to Diabetes Education) research pilot.

Parents commented on the good relationships between the specialist team and local schools and the work with Worcestershire County Council to develop educational guidelines which facilitated this relationship. One outcome was that some schools' reluctance to allow staff to work with sharps had been overcome. The service was also starting to deliver group Diabetes Self-Management Education.

Good Practice

1 Patients had good access to 'Stay Positive' workshops. These were not diabetes-specific but provided general advice and support on self-management and were appreciated by the children and young people. A good range of other well-documented education programmes was offered, including age-banded 'Goals of Diabetes Education'.

2 The annual review sheet for nursing staff was a good prompt, ensuring annual reviews were completed and supporting assessment of competences in 'carb' counting and goal setting.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Staffing Levels**

Consultant staffing was low with only six PAs of consultant time allocated for work with children and young people with diabetes. Only limited access to psychological support (0.16 w.t.e.) was available.

PDSN staffing levels were within the expected ratio of 1:70 but were under pressure because of the rural nature of the county, the three-site structure of the service and the limited other staffing available.

Further Consideration

1 Arrangements for multi-disciplinary discussion with patients during the transition to adult services may benefit from review at the Alexandra Hospital site to ensure regular input from senior paediatric and adult medical staff during the transition process.

2 Guidelines on surgery in children and young people with diabetes were not yet localised. International guidelines were available.

3 The IT system used in clinics did not synchronise with the National Diabetes Audit and so more administrative time was needed to input data to the National Diabetes Audit.

4 Guidelines on high HbA1c management and 'did not attend' guidelines were combined. Reviewers suggested that separating the high HbA1c and 'DNA' guidelines may be helpful.

5 Reviewers noted differences in the organisation of services in different parts of Worcestershire, for example, clinic reviews, annual reviews and coordination of care. It may be helpful to review these differences and, where appropriate, simplify arrangements and patient information.

6 There was also no formalised system for ensuring annual reviews were 'flagged' and no process for 'flagging' and contacting patients with regularly high HbA1c. Both of these developments may be helpful.

7 HbA1c targets were not always clearly identified in clinic letters. Some letters seen by reviewers were in a new and improved format although this did not appear to have been introduced on both sites. Goals were clearly identified in the Redditch letters.

8 'Out of hours' advice was available but parents commented to reviewers that out of hours advice and information on insulin pumps could be clearer. It may be helpful to develop specific guidelines on this to help staff providing the 'out of hours' advice service.

9 Proposals to change the arrangements for dietitian appointments were under discussion, including with commissioners. Reviewers were concerned that some families may not be taking advantage of the support available because of the historically very low level of dietitian staffing. The service was aware of this issue and has ideas for promoting the use of the dietetic support available.

10 School care plans included a recommendation that all medication be kept in a central location. Reviewers considered that for some older children it may be more appropriate for hypoglycaemia medication and blood glucose testing equipment to be kept either in an agreed place, which could be a central point, or to be carried on the person and that the school care plans could reflect this variability in arrangements.

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COMMUNITY LONG-TERM CONDITIONS SERVICES

REDDITCH AND BROMSGROVE

General Comments and Achievements

Community Long-Term Conditions Services for Redditch and Bromsgrove were provided by a Virtual Ward (Enhanced Care Team) for people with the most complex needs. This was well-organised with three clear levels of support: 'red', 'amber' and 'green' wards. Other care was provided by a Planned Care Team who also gave some support to people on the 'green' ward. The different levels had clearly defined referral review and support arrangements. The Virtual Ward and Planned Care Teams were multi-disciplinary, including nurses, physiotherapists, occupational therapists, mental health nurses, health care assistants and administrative staff and, in the Planned Care Team, social workers and podiatrists.

Reviewers considered that good progress had been made in establishing these services, including setting up multi-disciplinary team meetings (daily for the 'red' ward, weekly for 'amber' and monthly for 'green'). Good working relationships and good communication between the teams was evident, and staff had a clear idea of how they wanted the service to develop. Clear idea of how they want to develop but need to consider sustainability and the efficiency of the team. 'Out of hours' care was well-organised using a combination of district nurses, GPs and 'sitters' from mental health services. These arrangements appeared to make good use of available resources.

The teams were co-located at Prince of Wales Community Hospital with the Redditch and Bromsgrove community rehabilitation team which enabled good communication and integrated working with this team.

A good county-wide multi-agency transition pathway was in the process of being developed which, when finalised and fully implemented, will help to support transition of children to adult services.

Good Practice

1 Good arrangements for access to medical records had been implemented which ensured all staff could easily monitor the patient pathway. A planned new IT system will make this easier.

2 Community mental health nurses were part of the Virtual Ward and the Planned Care Team which helped to ensure a holistic approach to patients' needs.

3 Good use was made of the community hospital for 'step up' from virtual ward care and for 'step down' from hospital. The community hospital was fully integrated into the community pathway.

4 Arrangements for access to equipment across the health economy were very good with quick, easy access to specialist equipment.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Discharge Pathway**

Criteria and arrangements for discharge from the Virtual Ward were not yet clearly defined. The policy was that 'patients will be discharged after a period of stability'. Staff said that patients were being discharged but a clear pathway and arrangements for this were not evident. The expected caseload for the Virtual Ward model and its link with risk stratification information was not clear (although various figures were included in the information supplied to reviewers). Reviewers were concerned that the capacity could become saturated unless patients were actively discharged when their condition improved.

2 **Guidelines and Protocols**

Most of the expected guidelines, protocols and operational policies were not yet documented and there was no over-arching pathway for the service. The team did not appear to be aware of or were accessing the localised 'Map of Medicine' pathways that were available.

Further Consideration

1 The development of cross-boundary agreements with Birmingham in relation to equipment and social care may be helpful.

2 There was no overarching competence framework for the virtual ward. An assessment of current skills for the service had been undertaken.

3 Further emphasis on self-care and self-monitoring may be helpful as this did not appear to have a high priority in the case notes seen by reviewers. This work may also help the service's ability to 'step down' or discharge patients from the Virtual Ward.

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WYRE FOREST

General Comments and Achievements

The Wyre Forest Virtual Ward model had been operational since July 2011 with the aim of ensuring that those individuals with long term conditions who are most at risk are identified and supported proactively through multi-disciplinary case management. The Risk Stratification toolset and Admission Prevention Team (APT) were established as a means of identifying the 'at risk' individuals. Community matrons, care managers and the intermediate care team had been brought together into the Admission Prevention Team. The APT looked after patients identified by the Risk Stratification tool as well as patients referred through the Worcestershire Health and Social Care Access Service (WHASCAS).

The Virtual Ward team was clearly valued by primary care services in Wyre Forest. Team working and communication across all services were well-established. The Virtual Ward and Admission Prevention Team were actively using risk stratification information in order to target interventions at those patients at highest risk of admission.

A good county-wide, multi-agency transition pathway was in the process of being developed which, when finalised and fully implemented, will help to support transition of children to adult services.

Good Practice

1 Integrated Care Meetings had recently been introduced which provided a forum for multi-disciplinary discussion and review by secondary care physicians, specialist nurses and social care as well as the patient's GP and community matron.

2 Community mental health nurses were part of the Admissions Prevention Team which helped to ensure a holistic approach to patients' needs.

3 Nurse Advisors for the older person who were integrated within the Community Nursing services and had a pro-active approach to health and healthy lifestyle promotion, including undertaking falls prevention assessments. This ensured that patients of the Virtual Ward had timely access to falls prevention advice.

4 Arrangements for access to equipment across the health economy were very good with quick, easy access to specialist equipment.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Discharge Pathway**

Criteria and arrangements for discharge from the Virtual Ward were not yet clearly defined. Staff said that patients were being discharged but a clear pathway and arrangements for this were not evident. The expected caseload for the Virtual Ward was 300 and 180 patients were being cared for at the time of the

review. Reviewers were concerned that the capacity could become saturated unless patients were actively discharged when their condition improved.

2 **Guidelines and Protocols**

Most of the expected guidelines, protocols and operational policies were not yet documented and there was no over-arching pathway for the service. The team did not appear to be aware of or accessing the localised 'Map of Medicine' pathways that were available. Reviewers also saw little evidence of use of audit and review of significant events in order to improve the services offered.

3 **Care Planning and Reviews**

Arrangements for care planning and review were not formalised. Only one care plan was evident in the case notes seen by reviewers and this related to a patient of the neuro-rehabilitation service.

Further Consideration

1 Staff who met the visiting team were not fully aware of Trust-wide governance arrangements. Errors and incidents were recorded and locality meetings had been introduced ensure lessons learnt were fed back to staff. Trust-wide arrangements were clearly in place but staff may not be appropriately linked to these mechanisms and could give no examples of lessons learnt or improvements made.

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SOUTH WORCESTERSHIRE

General Comments and Achievements

The South Worcestershire integrated care service was made up of three integrated care teams providing both planned and enhanced care in three localities: Worcester and Droitwich, Malvern and Tenbury, and Evesham and Pershore. These multidisciplinary teams aimed to reduce avoidable hospital admissions and facilitate timely discharge from hospital. The enhanced care element of the service provided short-term intensive nursing and therapy support to patients at home during acute crises or exacerbations of their long term condition.

A twelve month Registered Care Home Project was using senior community nurse practitioners with independent prescribing, advanced health assessment and long-term condition management skills to support patients in Registered Care Homes including, when necessary, accessing the wider integrated care team.

A good county-wide, multi-agency transition pathway was in the process of being developed which, when finalised and fully implemented, will help to support transition of children to adult services.

Good Practice

1 The Community Enhanced Team had very good multi-disciplinary input, including therapists, nursing staff, community mental health nurses, rehabilitation staff, care managers and an intermediate care team as well as two sessions per week of a care of the elderly consultant.

2 Arrangements for access to equipment across the health economy were very good with quick, easy access to specialist equipment.

3 Good arrangements for access to medical records had been implemented which ensured all staff could easily monitor the patient pathway. A planned new IT system will make this easier.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Skill Mix**

The staffing levels and skill mix of the team were not clearly related to the needs of the patients served. The service specification was not clear about what the service should offer (inclusions and exclusions).

Reviewers were given inconsistent information about the expected caseload of the team and the caseload at the time of the review, with some staff saying that the service was at capacity. The enhanced service competences were still being developed which impacted on the district nursing service. Overall, therefore, it was not clear that the service had the appropriate skill mix for the role it was being expected to fulfil.

2 **Clinical Leadership**

The clinical leadership of the South Worcestershire teams was not clear. Reviewers met team leaders (case managers) but the clinical accountability of these staff was not clear. Allied health professional staff talked to reviewers about informal leadership but clinical accountability arrangements were not clearly defined.

3 **Administrative Support**

Administrative support was only in place for physiotherapy and occupational therapy teams**.** Some administrative support had been available from apprentices previously but this was no longer in place.

4 **Guidelines and Protocols**

The guidelines and protocols seen were not yet aligned to the new integrated community teams. Most of the expected guidelines, protocols and operational policies were not yet documented and there was no over-arching pathway for the service. The service specification for the integrated community care neighbourhood team included some scope and service descriptions. The team did not appear to be aware of or accessing the localised 'Map of Medicine' pathways that were available.

Further Consideration

1 Staff who met the visiting team were not fully aware of Trust-wide governance arrangements. Errors and incidents were recorded and locality meetings had been introduced ensure lessons learnt were fed back to staff. Trust-wide arrangements were clearly in place but staff may not be appropriately linked to these mechanisms and could give no examples of lessons learnt or improvements made.

2 Reviewers encouraged continued work on developing the additional competences of enhanced service staff in order to reduce pressure on the district nursing service.

3 District nurses appeared to be spending considerable amounts of time going to people's homes when some interventions could have been offered at community hospitals. The balance of home and community hospital-based activity may benefit from review.

4 Further work with commissioners on criteria for discharge or 'step down' from the care of the team would be helpful to ensure the service does not become 'saturated' and continues to be able to take on new patients.

5 Dedicated pharmacy support for the service was not yet in place but Trust-wide plans for increasing pharmacy support to teams had been agreed and were being implemented.

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SPECIALIST CARE OF ADULTS WITH DIABETES

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

General Comments and Achievements

Specialist care for people with diabetes was provided by two integrated community and acute teams who worked across the three localities. Staffing comprised 4.8 w.t.e. consultants with time allocated for work with people with diabetes, diabetes nurse specialists in hospital and community teams, and a dietitian. All diabetes specialist nursing teams were managed by the Lead Nurse. Each of the five nursing teams (two hospital and three community) had two specialist nurses with support and cover built into the working of the teams.

Community and acute teams were working well together and specialist nurses were receiving support from consultants. The diabetes wards at the Alexandra Hospital and Worcestershire Royal Hospital appeared to be efficiently organised, clean and tidy with good documentation and information for patients. The 'Oasis' system provided access to the 'patient at a glance' and gave a good overview of the patient pathway. The specialist teams were supported by Local Enhanced Services in primary care in which all but one in Redditch & Bromsgrove general practice participated. The specialist team was providing good advice and support to primary care, including to LES services.

Patients who met the visiting team were particularly appreciative of the easy access to advice and support available from the teams based at Alexandra and Worcester Royal Infirmary Hospitals. The clinical lead for this service was the Lead Nurse for diabetes who was providing good direction and leadership for the team.

A good range of education programmes was offered, including XPERT, XPERT Insulin and DAFNE courses, although waits for some programmes – especially DAFNE – had increased to six months while a new dietitian was being recruited. Patients who met the visiting team were appreciative of the educational support and the confidence which this gave them. A 'buddy' system was run for patients on insulin pumps.

Good Practice

1 'Map of Medicine' had been localised to show the local pathway. This included all relevant information and guidance for clinicians and supported integrated working across the patient pathway.

2 The ward Insulin Chart in use across Worcestershire Acute Hospitals was very clear and concise.

3 In South Worcestershire, 'link nurses' for people with diabetes were identified in the integrated care community service as well as in the acute wards. This supported flexible, integrated care for people with diabetes.

4 In Worcestershire teams were taking a proactive approach to admissions avoidance, including linking with the West Midlands Ambulance Service to 'flag' patients who had been admitted or for whom an ambulance had been called for hypoglycaemia, and an admission prevention pilot with GPs in the Wyre Forest area.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Diabetic Foot Care**

A multi-disciplinary diabetic foot team was not yet functioning effectively. Orthopaedic consultants were immediately available at the Alexandra Hospital and vascular surgeons attended out-patients clinics. At Worcestershire Royal Hospital vascular consultants were immediately available and orthopaedic consultants attended out-patient clinics. A podiatry service was available but was not effectively linked with orthopaedics, vascular surgery, diabetes and tissue viability services. At Worcestershire Royal Hospital podiatry was available only on three days each week and there was no cover for absences. Formalised arrangements for referral to the diabetic foot team, prioritisation of patients, multi-disciplinary discussion and review were not yet in place.

2 **Care Planning and Review**

Arrangements for care planning and review were not robust. Ward care plans were evident but not care plans for patients in contact with the service. Clinic letters were not copied to patients. Patients who met the visiting team said that they did not have documented information about their plan of care and some did not understand the implications of their HbA1c levels. Reviewers were told that care planning and reviews were undertaken in primary care but information about the outcome of these reviews was not communicated to the specialist team.

3 **Staffing Levels**

Direct access to psychological support was not available and patients who needed this care had to see their GP and then be referred for psychological support.

Dietitian support to the diabetic specialist teams was provided by one dietitian with a special interest in diabetes, although support from general dietitians was available. In practice, cover for absences was not available. Reviewers were told by the team of variations in access to dietitian advice including, for example, differences in waiting times for patients who had gestational diabetes from those who had pre-existing diabetes who had become pregnant.

Administrative support was insufficient at WRH, especially to support organisation of the education programmes. Clinical staff were therefore spending time on administrative work which could be used for patient care.

Further Consideration

1 Patients who met reviewers commented on the poor facilities at the Diabetes Centre in Redditch, including difficulty with parking. Patients also had several suggestions about service improvements, including evening clinics. Further discussion with patients about their experiences and suggestions may be helpful.

2 It was not clear that nursing staff on wards other than the specialist diabetic wards had appropriate competences in the care of people with diabetes with sub-cutaneous insulin pumps. This was a particular problem because of the number of 'outliers' at the time of the review.

3 Urgent review by a member of the specialist team was not available within 24 hours at weekends (unless one of the diabetic consultants was on call). It may also be helpful to review patient information about what to do if help was needed out of hours. The list in the information shown to reviewers included attending the Accident and Emergency Department, which may not be appropriate.

4 Commissioner and provider arrangements for issuing insulin pumps may benefit from review in order to ensure pump therapy can be initiated without delay when appropriate. Reviewers were told of different systems by the provider which commissioners who met the team did not recognise.

5 Some of the patients who met the visiting team commented on the support available from diabetes specialist nurses compared with that available under the LES. Some patients appeared to be by-passing the LES because they got a quicker, more trusted answer to queries by ringing the specialist nurse. Further discussion with patients on this issue may be helpful in improving the services which are available.

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Specialist Care of People with COPD

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

General Comments and Achievements

Specialist care for people with COPD in Worcestershire was provided by acute teams at both the Alexandra Hospital and Worcestershire Royal Hospital, and by a county-wide community COPD team (five specialist nurses and four physiotherapists). Respiratory specialist nurses at both hospitals also provided leadership for the Home Oxygen Assessment and Review Service and supported home non-invasive ventilation in North Worcestershire. The community COPD service also provided pulmonary rehabilitation for the whole of Worcestershire, run from five community locations.

On the services' emergency care pathway, patients attending the Emergency Department or Medical Admissions Unit were considered for home care by the COPD community team or the intermediate care team and, following hospital admissions, patients were followed up by the community team. The out-patient pathway was that,

following consultant assessment, patients were referred for oxygen or non-invasive ventilation assessment, or for pulmonary rehabilitation.

The services were participating in the British Thoracic Society care bundles project, which was starting to address a number of issues surrounding COPD admission and discharge.

The Worcestershire Royal Hospital service was a well-established respiratory service. Ward-based non-invasive ventilation was provided (although in a mixed sex bay) with appropriate medical and nursing staff support. Very good guidelines and protocols were available. Reviewers also commented on the good leaflets and displays on the ward, including information on spiritual support and complaints. A good relationship with the critical care team was evident with several members of staff commenting that critical care services were happy to be contacted with queries. The respiratory team undertook a daily ward round of all patients. Urgent review within 24 hours by a member of the specialist team was available at Worcestershire Royal Hospital.

A well-established pulmonary rehabilitation service was provided in eight locations by a multi-disciplinary team. Referrals of any patients who could benefit from pulmonary rehabilitation were accepted. Patients could attend sessions in other locations if they wished and the service had very flexible arrangements for accepting patients. Seven week rehabilitation programmes were offered and education packages were 'menu-driven' so that they could be tailored to individual patients' needs. Staff were highly motivated and keen to provide a good services for their patients. Competency-based training was in place and peer review was used within the team to review practice.

Patients who met the visiting team were highly appreciative of the services and the care they received. All staff were motivated and committed to providing high quality care.

Good Practice

1 Community COPD service: A self-management programme for newly diagnosed patients included a 'Pre-hab' programme. Patients who were not considered appropriate for pulmonary rehabilitation because they were more fit were offered a home visit and home self-management programme. A five week 'Inspire4life programme' mini-rehabilitation programme was offered. Good guidelines for the care of newly diagnosed patients with COPD were also in place.

2 Good communication between community and hospital respiratory nurses and primary care was evident and patients commented that all staff were aware of their role. The specialist team had undertaken a great deal of training of primary care staff and a monthly session for practice nurses and GPs was available.

3 At Worcestershire Royal Hospital a very good care plan and assessment form was in use for people with COPD. Clear criteria for referral to the specialist respiratory services were in place.

4 The ward-based pharmacist for the respiratory ward at Worcestershire Royal Hospital contributed actively to supporting respiratory patients, including undertaking Medicine Use Reviews with patients and training in inhaler technique.

5 An excellent competence framework and training plan had been implemented across the Trust, including a regular non-invasive ventilation (NIV) training programme.

6 Ward nurse staffing levels on the respiratory ward at Worcestershire Royal Hospital had been reviewed and by altering shift patterns it had been possible to appoint more registered nursing staff at no additional cost. Nursing leadership for the respiratory ward was strong. Nurses from the acute Medical Admissions Unit were offered access to the same non-invasive ventilation (NIV) training programme as the respiratory ward staff. Nurses sometimes attended when off duty but were able to 'bank' the hours and take the time back at a later date.

7 The pulmonary rehabilitation service had a very thorough approach to home-based assessment.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Non Invasive Ventilation – Alexandra Hospital**

Reviewers were seriously concerned about the non-invasive ventilation service at the Alexandra Hospital. Nurse staffing levels for the provision of non-invasive ventilation and the competences available, especially at weekends were insufficient. Four hospital-based respiratory specialist nurses set up the service and were available Monday to Friday 9am to 5pm. Outside of these times patients were cared for by the nurses on the respiratory ward. These nurses had undertaken in-house training in non-invasive ventilation. Respiratory consultants were not always available out of hours, depending on which consultant was on the on call medical rota. Reviewers were also told that consultants would only see their own patients and would not regularly review all patients on non-invasive ventilation. Patients were therefore medically reviewed only twice or three times a week as this was when ward rounds were scheduled in job plans. (Registrar ward rounds were undertaken daily if a registrar was available.) Arrangements during unexpected absences of consultants were not clear. Clinical guidelines on non-invasive ventilation did not cover liaison with critical care teams.

A plan to increase nurse staffing levels from April 2013 was in place, although this would create a mixed sex dedicated non-invasive ventilation bay. This would meet the British Thoracic Society expected ratio for nurse staffing. Five additional nurses were being recruited, (band 5 and 6) and these nurses may not have non-invasive ventilation competences on appointment.

Advice was available from the critical care service but reviewers were told that, in the event of problems with non-invasive ventilation, staff would call the medical registrar (not critical care). The medical registrar on call may or may not have competences in non-invasive ventilation and a respiratory registrar was not always available. Critical care staff who met reviewers said that they had not been contacted to advise on the care of patients on non-invasive ventilation, which supported the information given to reviewers that the first point of contact for advice was the medical registrar. Formalised arrangements for contacting critical care were not documented and outreach nurse support was available only to 8pm.

Everyone who met the visiting team appreciated the benefits of providing non-invasive ventilation on the respiratory ward but were worried about nurse staffing levels and arrangements for medical review. The proposed changes to staffing levels would address nurse staffing (although by creating a mixed sex bay) but not consultant input and review arrangements.

2 **Staffing Levels**

Reviewers were concerned about two aspects of staffing:

a. Respiratory consultant staffing at the Alexandra Hospital was insufficient for the workload of the team. There were 2.2 w.t.e. consultants, made up of four different people - three of which were shared with the medical admissions unit. Registrar support was not always available. For example, on the day of the review, the on call respiratory consultant at the Alexandra Hospital had 30 patients under his care, 16 of which were on non-respiratory wards, with no registrar. Reviewers were told that a business case for a third consultant at the Alexandra Hospital and a fifth consultant at Worcestershire Royal Hospital was being considered.

b. Administrative support was insufficient, especially at the Alexandra Hospital and in the community COPD service, with clinical staff typing their own letters and inputting data onto database.

3 **Guidelines and Protocols**

Several of the expected guidelines and protocols were not yet documented, especially at the Alexandra Hospital. NICE guidance was used but had not yet been localised to show local implementation. (At Worcestershire Royal Hospital pathway guidelines had been developed and were in draft form.)

Further Consideration

1 At the Alexandra Hospital, 3.8 w.t.e. respiratory specialist nurses provided specialist nursing support to in-patients, provided non-invasive ventilation (home and domiciliary), led the home oxygen service, ran a nurse-led sleep service and other nurse-led clinics, coordinated home intravenous therapy for patients with bronchiectasis and did sputum checks. At Worcestershire Royal Hospital 2.4 w.t.e. respiratory specialist nurses and 1 w.t.e. advanced nurse practitioner provided support to in-patients, including patient education and checking inhaler technique, and out-patient support at WRH and Kidderminster Treatment Centre, other nurse-led clinics and coordinated home intravenous therapy for patients. In addition, 2.8 w.t.e. nurses based at Droitwich provided county-wide support to the oxygen service. (1 w.t.e. sleep nurse was also available). Five specialist nurses and four physiotherapists provided the community service, including pulmonary rehabilitation. It was not clear to reviewers that the best use was being made of the nursing and physiotherapy expertise available, especially to ensure cover during times of annual leave and other absences.

2 Teamwork and integration between community and hospital-based services for people with COPD happened on an informal basis and reviewers considered that there was significant potential for more teamwork and integrated working to improve the patient pathway and service efficiency. Multi-disciplinary team meetings took place between the community service and GPs and there were ad hoc meetings between the community team and hospital-based respiratory nurses. There were no formal arrangements for meetings between the consultants and community COPD team, or between community and hospital specialist nurses, although one consultant at the Alexandra Hospital ran a 'virtual clinic'. The teams did not meet together to review patients, to review systems and processes or to look at outcomes. Consultant input to the work of the community COPD team was therefore only if they were contacted about queries. Patients could be being seen by consultants and by the community teams without effective coordination between these services.

Reviewers also suggested that there may be potential for specialist nurses more actively to support the patient journey in hospital and, in particular, to facilitate discharge. The community team was notified if one of the team's patients was admitted to hospital but this did not appear to trigger any action to speed up their discharge. Average length of stay appeared relatively long (approximately eight days) and reviewers suggested that targeting hospital-based specialist nurse work at speeding up the in-patient pathway for COPD patients and enabling discharge may help to reduce this. Reviewers recognised that this may involve a change in roles between hospital and community teams, and suggested that rotation of staff may help to ensure relevant skills are maintained.

Length of stay could also be reduced by team-based consultant review at the Alexandra Hospital and by county-wide weekend support for admission avoidance and early discharge.

3 Arrangements for follow-up after discharge from hospital may also benefit from review. Patients were seen by a consultant following discharge within three weeks. Specialist COPD nurses looked at whether they knew patients or not and patients known to the service were telephoned within 48 hours of discharge. Patients not known to the service were offered a home visit. These arrangements appeared to comprise multiple follow-up for some patients but, for others, only telephone follow-up in the two weeks after discharge. It was not clear that this arrangement complied with NICE guidance on the care of people with COPD.

4 Urgent review within 24 hours by a member of the specialist team was not available at weekends for Redditch and Bromsgrove patients. Specialist nurses were available only during normal working hours. Arrangements to access specialist review at Worcester with the aim of avoiding admission did not appear to be in place.

5 Occupational therapy competences were not available as part of the community COPD team and psychological support was accessed only through referral from the patient's GP. Further consideration of occupational therapy support for the team may be helpful.

6 Systems for getting feedback from patients with COPD and their carers were not yet well developed and further work in this area may be useful.

7 The South Worcestershire home non-invasive ventilation service was run by the sleep service nurse who liaised with the relevant consultant. Patients were seen in general respiratory clinics. Identifying a respiratory consultant to take a lead role in relation to this service may be useful. This may also help in discussions with commissioners about the service which should be commissioned.

8 The pulmonary rehabilitation service supplied data about activity in 2009/10. Reviewers were told that later data were available but there was no evidence of these data being used to inform and drive service improvement. Further use of activity and outcome data and patient feedback to monitor performance and drive improvements in the service should be considered.

9 Further work on auditing patients with inappropriate diagnostic delay may be helpful.

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SPECIALIST CARE OF PEOPLE WITH HEART FAILURE, INCLUDING CARDIAC REHABILITATION

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

General Comments and Achievements

Specialist care for people with heart failure in Worcestershire was provided by acute services at both the Alexandra Hospital and Worcestershire Royal Hospital and by a community team of four specialist nurses for North Worcestershire and four for South Worcestershire (7.4 w.t.e. in total). A specialist nurse (0.5 w.t.e.) was based at Worcestershire Royal Hospital. Plans to co-locate acute and community services were being discussed.

Patients were very appreciative of the care they received and the easy access to specialist support. Those patients with heart failure who had accessed cardiac rehabilitation were also very grateful for the care they received. A newly-appointed consultant at Worcestershire Royal Hospital had a particular interest in cardiac devices and had good plans for the development of local services.

An audit of the use of serum natriuretic peptide testing had been used to drive implementation of NICE guidance in primary care.

Good Practice

1 A very active *Heart Support* group was providing patient-led support, advice and education, especially for newly-diagnosed patients in Redditch and Bromsgrove.

2 Good liaison and access to palliative care was in place for patients with heart failure.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Implementation of NICE Guidance**

Some aspects of NICE guidance on the care of people with heart failure were not yet implemented:

a. Echocardiography was not available within two weeks for appropriate patients. Delays in access to echocardiography also meant that patients admitted to hospital with suspected heart failure were often discharged before their echocardiogram and so did not have a definitive diagnosis.

b. Newly diagnosed patients were not all seen by a cardiologist or by the GP with a special interest in heart failure. Discussion with the teams suggested that approximately 10% patients with heart failure were not receiving appropriate specialist assessment at the time of diagnosis or specialist oversight of their ongoing care.

c. Some patients diagnosed with heart failure did not receive advice and support from a specialist nurse. In particular, only 0.5 w.t.e. specialist nurse was available at Worcestershire Royal Hospital and there was no hospital-based specialist nurse support at the Alexandra Hospital. The specialist nurse at Worcestershire Royal Hospital was able only to see patients with echo-confirmed heart failure and not those awaiting an echocardiogram.

d. Patients with heart failure did not have access to cardiac rehabilitation unless they had a history of myocardial infarction or acute coronary syndrome, although a few (15/542) North Worcestershire patients had been able to attend the programme.

A clear strategy for the development of services for people with heart failure was not evident. The services available did not appear to be modelled on the needs of the population, including potentially undiagnosed patients.

2 **Care Planning and Reviews**

Arrangements for care planning and review were not formalised and reviewers saw no evidence of care planning in the case notes available to them.

Further Consideration

1 Clinical leadership of heart failure services for Worcestershire may benefit from further consideration to ensure equity of provision and consistency across all areas. One consultant had a particular interest in heart failure and two different consultants acted as the links with the community heart failure services. A GP with a special interest provided monthly clinics in South Worcestershire. Although one consultant was named as the lead it was not clear that this individual had sufficient time to provide overall leadership for the service.

2 Teamwork and integration between community and hospital-based services for people with heart failure happened on a quarterly basis, reviewers considered that there was significant potential for more teamwork and integrated working to improve the patient pathway and service efficiency.

3 In developing the future strategy for Worcestershire services, further consideration should be given to:

a. Specialist nurse support for the work on heart failure and cardiac devices.

b. Access to psychological support for patients with heart failure. This was available at the time of the review only through GP referral.

4 Criteria for discharge from the heart failure specialist service may benefit from review as some data suggested that some patients were staying with the team longer than may be appropriate.

5 There were no formalised arrangements for follow up of patients with a high serum natriuretic peptide level and an echocardiogram indicative of heart failure. It was assumed that these patients would be referred for consultant or GP with a special interest assessment and specialist nurse support but no check on whether this actually happened.

6 A localised 'Map of Medicine' pathway was in development and reviewers encouraged continuation of this work.

7 Urgent review by a member of the specialist team within 24 hours was not available for Redditch and Bromsgrove patients. This was available at Worcestershire Royal Hospital through the cardiology rota.

8 Administrative and clerical support was insufficient for the size of the patient group and clinical staff were undertaking data entry and other administrative tasks in time which could have been spent on the care of patients.

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SPECIALIST CARE OF PEOPLE WITH CHRONIC NEUROLOGICAL CONDITIONS

WORCESTERSHIRE HEALTH AND CARE NHS TRUST and WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

General Comments and Achievements

A wide range of services was available for people with chronic neurological conditions in Worcestershire:

Consultant-led services:
Provided by Worcestershire Acute Hospitals NHS Trust through visiting consultants from University Hospitals Coventry and Warwickshire NHS Trust (UHCW), University Hospitals Birmingham NHS Foundation Trust (UHB)and Birmingham Community Healthcare NHS Trust (BCHC).

Service	W.t.e.	Head-count	Based at	Clinics
Consultant neurology out-patient clinics (UHCW)	0.6	3	Alexandra Hospital	Clinics held at Redditch and Bromsgrove
Consultant neurology out-patient clinics (UHB)	0.9	2	WRH	Clinics held at Worcester, Malvern and Kidderminster
In-patient and out-patient neuro-rehabilitation (BCHC)	0.4	1	Evesham Hospital (in-patient beds)	Clinics held at Evesham and Worcester

Community rehabilitation services:
Worcestershire Health and Care Trust

Team		W.t.e.	Head-count	Based at	Care for people with	Care for people from
Complex physical neuro-disability	Nurse consultant Specialist nurse Administration	1.0 0.8 1.0	3	Evesham	Mostly ABI & spinal injury	All SW
Multiple sclerosis	Specialist nurse Specialist nurse (Shared admin.)	1 1	2	Evesham Kidderminster	MS	SW NW
Parkinson's Disease	Specialist nurses Administration	1.4 1.6	4	Bromsgrove (POWCH)	PD	All
Acquired Brain Injury	OT S&LT Rehab assistant	1.0 P/T 1.0	3	Headway, Worcester	ABI	SW All All
Chronic neuro-rehabilitation (Wyre Forest)	Specialist nurse OT Physiotherapist Admin. (shared)	0.4 0.4 0.6 0.5	4	Kidderminster	All CNC	WF
Chronic neuro-rehabilitation (Redditch & Bromsgrove)	Specialist nurse OT Physiotherapist Rehab assistant Administration	0.6 0.9 0.6 1.0 1.0	4	Bromsgrove (POWCH)	All CNC	B&R
Other Services						
Neuro-physiology				WRH	All CNC	
Consultant neuro-psychologist		1.0	1	WRH	All CNC	
Out-patient physiotherapy				WRH	All CNC	SW
Epilepsy specialist nurse for people with learning disabilities					Epilepsy & LD	All

Staffing Summary:

Role	W.t.e.
Consultant neurologist	1.4
Consultant in neuro-rehabilitation	0.4
Consultant neuro-psychologist	1.0
Nurse consultant & specialist nurses (excluding epilepsy & LD specialist nurse)	6.2
Occupational therapy	2.3
Speech and language therapy	P/T
Physiotherapy (excluding WRH out-patient physiotherapy)	1.2
Rehabilitation Assistant	2.0
Administration (excluding consultants' secretaries)	4.1
Note: This table excludes any staff with specialist competences in the care of people with chronic neurological conditions who are supporting the in-patient rehabilitation beds at Evesham Hospital.	

Key:

ABI	Acquired Brain Injury	PD	Parkinson's Disease
CNC	Chronic Neurological Conditions	POWCH	Princess of Wales Community Hospital
LD	Learning Disabilities	S&LT	Speech and Language Therapist
NW	North Worcestershire = Wyre Forest and Redditch and Bromsgrove.	SW	South Worcestershire
MS	Multiple Sclerosis	WRH	Worcestershire Royal Hospital (Worcestershire Acute Hospitals NHS Trust)
OT	Occupational Therapist	WF	Wyre Forest

A good range of specialist nurses was available, with a range of specialist expertise, and this support was appreciated by some patients who met the visiting team. Good patient information and contact leaflets had been developed by the community rehabilitation services. Care plans were evident in the community notes and all parts of the services were undertaking annual reviews of patients' neurological conditions. The community services had developed good patient surveys.

A consultant neuro-psychologist was available for patients with acquired brain injury (although there was no cover for absences). A transition clinic for young people with epilepsy was in place, attended by the paediatric consultant, paediatric learning disabilities specialist nurse, specialist nurse for adults with learning disabilities and epilepsy, and a consultant neurologist.

A good county-wide review of care of people with chronic neurological conditions was undertaken in 2010 but the actions being taken as a result of this review were not clear. The WINRS (Worcestershire Integrated Neurological Rehabilitation Service) was beginning to bring people together and bi-monthly meetings of all the services involved were scheduled.

Good Practice

1 A very good neuro-physiology service was available. Facilities were good and patients were usually seen within six weeks of referral. GPs had direct access to the service which also provided support to in-patient, out-patient and community services within Worcestershire and beyond. The service was well-organised, providing a single point of access for county-wide care.

2 Data collection and monitoring information in the community services was meticulously collected and well-used, including data on trends over time.

3 Specialist nursing support was available for people with all chronic neurological conditions except epilepsy. The three generic teams ensured that people with rarer chronic neurological conditions had access to support.

4 The acquired brain injury team provided specialist support for this group of patients and linked well with the voluntary sector, including being based in the *Headway* day centre.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Service Integration**

Ten separate services plus two county-wide services (neuro-physiology and neuro-psychology) provided care for people with chronic neurological conditions in Worcestershire. Although the nurse consultant and the WINRS network were beginning to bring community rehabilitation services together, this did not include acute neurology services and the community services were still managed separately and had separate budgets. There was no cover for many of the staff in the individual teams.

Consultant neurologist and neuro-rehabilitation input was provided by six different individuals which made it very difficult to develop appropriate cooperation and liaison with these individuals – or for them to input into the management and improvement of the services in Worcestershire. Some liaison was evident, especially between the multiple sclerosis team and consultant neurologists and between the complex physical neuro-disability team and the neuro-rehabilitation consultant, and ad hoc communication about individual patients took place.

There were no systematic mechanisms for coordinating the care of patients, including annual reviews, or for medical input into the work of most of the community teams. Parkinson's disease nurses no longer attended consultant clinics because of pressures on their time and did not regularly meet with consultants (see below). IT systems did not allow for acute-based and community-based staff to see up to date clinical information about patients, although some community locations could access imaging and pathology results and discharge letters.

As a result, patients could be being cared for by several specialist services or may not be referred to them at all. Services did not have all relevant up to date clinical information about the patients for whom they were caring. There was also overlap between the generic and specialist teams with generic teams caring for people with Parkinson's disease, multiple sclerosis and acquired brain injury even though specialist teams for these groups were available.

2 **Care planning, care coordinator and support**

A mixed picture of support available to patients was evident. Some patients had an allocated care coordinator, especially those under the care of the multiple sclerosis team. Robust arrangements for allocation of a care coordinator were not in place across all the pathways of care. Some of the patients who met the visiting team were very happy with the support they received but others were less satisfied. Patients also commented that when they contacted services they sometimes talked to someone who was clear about the services available whereas, at other times, they did not receive clear answers. One patient summed up the situation as "it's all or nothing" and examples were given on multiple service input at a time when this was not appropriate.

3 **Insufficient Consultant Staffing**

Consultant neurologist and neuro-rehabilitation input was Insufficient for the population served. Only 15 sessions of acute neurology and four sessions of neuro-rehabilitation time was available for the Worcestershire population of approximately 575,000. North Worcestershire was particularly short of consultant time. The neurology service was provided by five different people which did not lead to

effective coordination and liaison with other services. Reviewers commented that they would have expected between four and five consultant neurologists for a population of this size.

4 **Epilepsy specialist nurse**

No specialist nurse was available for adults with epilepsy, other than those who also had learning disabilities.

5 **Parkinson's Disease Service**

The Parkinson's disease specialist nursing service appeared to be overwhelmed by number of referrals and caseload. Reviewers were told that the team of two nurses was receiving 35 referrals per week and the team caseload had increased from 200 to 800. The referral and discharge criteria and working practices evident at the time of the review did not ensure that this caseload could be effectively managed. Parkinson's disease nurses no longer attended consultant clinics because of pressures on their time and did not regularly meet with consultants. Clinical guidelines covering the monitoring and management of patients with Parkinson's disease were not in place and there were no arrangements for medical supervision or medical oversight of the work of the team. The specialist nurses did contact the consultant neurologists if they had concerns but these arrangements were not formalised, for example, through clear criteria.

6 **Guidelines and Protocols**

In general, the expected clinical guidelines and protocols were not documented. NICE guidance was used but this had not been localised to show how it was to be implemented locally, including how different services should be involved. University Hospitals Coventry and Warwickshire NHS Trust guidelines were used at the Alexandra Hospital but it was not clear that these fully reflected the pathways and services available in Worcestershire. Community referral guidelines were in place but these were fairly general and, in practice, the services accepted anyone with a diagnosis of a chronic neurological condition and a Worcestershire GP.

Reviewers were particularly concerned about the lack of guidelines for the care of people with epilepsy. Some guidelines for the Clinical Decisions Unit were seen but these did not include a clear pathway for referral to neurology services. Many people with a first seizure may not be seen in the Clinical Decisions Unit. No 'first seizure' clinic was available. This, combined with the lack of epilepsy specialist nurse support, suggested that NICE guidance on the care of people with epilepsy was not yet fully implemented.

Further Consideration

1 A lead clinician was identified for the Worcestershire Royal Hospital neurology service and for the community services but there was no identified lead for the Alexandra Hospital service and no-one with overall responsibility for driving improvements in the pathways of care for people with chronic neurological conditions. The identification of an overall clinical lead may be a helpful part of improving pathways of care.

2 Community teams did not have regular pharmacy input. They could contact pharmacy services for advice but no regular meeting for oversight of medicines management with pharmacy. There were, however, plans to appoint additional pharmacy staff to address this issue.

7 There was no cover for absences for many of the staff, including all consultants. Neuro-physiology services were heavily dependent on one person. In practice, community teams had little or no cover for absences. Also, specialist nurses and other community staff were mostly fairly senior and there was little evidence of succession planning for community services or for neuro-physiology.

8 Some staff said that they had very good access to MRI and CT, especially at Worcestershire Royal Hospital. The patients who met the visiting team, however, reported waits of up to eight weeks for diagnostic imaging and further waits of between two and five weeks for reporting. It may be helpful to look at this

issue in more detail in order to ascertain whether the patient experiences related to historic events or waits for specialist equipment, such as the scanner at Birmingham Heartlands Hospital, or whether long waits are still happening.

9 Patients who met the visiting team said that they had not received any written information but this may be because the new leaflets had been produced shortly before the review and had not yet been distributed to existing patients. Patients commented that had not been given information about support groups at the time of diagnosis and details of 'sign-posting' to support groups were not noted in any of the case notes seen by reviewers. Clinic letters were available but these were not always copied to patients. It may be helpful to review information needs with existing patients as well as distributing the new leaflets.

10 Reviewers considered that the service model, including deployment of staff and working practices, was not making best use of the resources available, in particular:

a. The six community teams were each quite small and the service model included both county-wide specialist teams and generic geographically-based teams. The responsibilities of the generic and specialist teams overlapped. As a result, resources were 'spread very thinly' with little cover for absences and patients may have access to differing levels of expertise. A simpler service model could make all services more robust.

b. Referral and discharge criteria from all services may benefit from review, ideally in a coordinated way across all services and in discussion with primary care. This should enable services to be targeted at those at greatest need.

c. Further development of links with primary care may be helpful, including consideration of a model whereby community teams provide more training and support to primary care and generic community-based services while maintaining a caseload of patients with more complex needs.

d. The criteria for and frequency of home visits may benefit from review. Whilst not underestimating the value of seeing patients' home circumstances, reviewers considered that the number of home visits undertaken may not be the best use of specialist nursing time. Some of the patients who met reviewers also commented on this and said that they would have been happy to travel to the nurse.

e. Patients with multiple sclerosis were travelling out of Worcestershire for assessment for disease modifying therapies and for annual review thereafter. Some patients from the Alexandra Hospital were travelling to Coventry for neuro-physiology when this was available in Worcester. Reviewers considered that there may be potential for these patients to be cared for within Worcestershire.

f. Reviewers noted awareness of these issues and a willingness to consider alternative solutions from all the staff who they met. Although additional consultant sessions and an epilepsy specialist nurse were needed, reviewers considered services could be significantly improved within the resources available through greater coordination and integration and by introducing a different service model and different ways of working.

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TRUST-WIDE

WORCESTERSHIRE HEALTH AND CARE NHS TRUST

General Comments and Achievements

Governance and training arrangements for the services reviewed were robust. Competency frameworks for district nursing teams had been developed and linked to job roles and a skills matrix. Personal development plans did not yet fully link to training plans but the Trust was aware of this issue and working on it. Competence

frameworks were not yet fully in place but there were clear plans for achieving this through 2013. Good links with primary care were evident, including good support for GP and practice nurse training.

Further consideration:

1 Some staff were still not aware of Trust-wide governance mechanisms and ongoing work in this area may be necessary.

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WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

General Comments and Achievements

Competence frameworks were being developed for the teams under review although, in practice, specialist training was not yet linked to Trust-wide processes.

Good Practice

1 The 'Amber Alert' system for patients was implemented throughout Worcestershire Acute Hospitals NHS Trust for patients admitted with an uncertain outcome

Further Consideration

1 The development and consideration of business cases was often mentioned to reviewers. Some of these developments appeared to have been being considered for several years. The timescales for decisions on business cases were not always clear and reviewers commented that business cases could be seen as 'the' solution without staff considering alternative ways of working.

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COMMISSIONING

NHS REDDITCH & BROMSGROVE, NHS WYRE FOREST and NHS SOUTH WORCESTERSHIRE CLINICAL COMMISSIONING GROUPS

General Comments and Achievements

Worcestershire's Clinical Commissioning Groups were strong commissioning organisations with good arrangements for collaboration. A monthly meeting to coordinate commissioning intentions had been introduced and the balance between county-wide commissioning and local flexibility had been negotiated. The CCGs had a clear five year plan with six priorities, one of which was the care of people with long-term conditions. A range of work-streams supported developments towards this priority.

All commissioners had a good understanding of local issues and the actions which needed to be taken to address these.

Good Practice

1 'Map of Medicine' was being used effectively as the basis for local pathways. This included all relevant information and guidance for clinicians and supported integrated working across the patient pathway.

2 Risk stratification information was being used by all practices in Wyre Forest, most in South Worcestershire and being piloted in Redditch and Bromsgrove. Information was being used by the Virtual Ward with interventions targeted at those at highest risk of hospital admission.

3 Work was taking place in all CCGs to enhance the quality of care for care home residents. In South Worcestershire a service to all care home residents was delivered by six community nurses practitioners

who provided support and advice to care home staff in managing patients with multiple long term conditions. Every resident had a clinical management plan compiled by the nurse practitioner and agreed with the resident, relatives and GP. The plan was kept in the care home and was accessible to any 'out of hours' or ambulance professional. The plan recorded the resident's wishes and detailed actions to be taken to avoid exacerbations of their condition and avoid hospitalisation. Patients discharged from hospital were reviewed by a nurse practitioner within 72 hours and their clinical management plan adjusted as required. Care home residents also received an annual medication review by a pharmacist.

Further Consideration

1 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.

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: Staffing levels

2 Community Long Term Conditions services: Discharge pathway (B&R & WF); Care planning and reviews (WF); Skill mix; Clinical leadership; Administrative support (SW)

3 Specialist Care of People with Diabetes: Multi-disciplinary Foot team; care planning and review; Staffing levels.

4 Specialist Care of People with COPD: Access to NIV (Alexandra); Staffing levels

5 Specialist Care of People with Heart Failure: NICE guidance; Care planning and review.

6 Specialist Care of People with Chronic Neurological Conditions; Integration; Care planning and coordination; Staffing; Parkinson's Disease Service

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APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Visiting Team

Paul Bennett	Community Matron	Walsall Healthcare NHS Trust
Rachael Blackburn	Compliance Manager	Heart of England NHS Foundation Trust
Dr John Bowen	Consultant Neurologist	The Royal Shrewsbury Hospitals NHS Trust
Jacqui Elson-Whittaker	Community Heart Failure Specialist Nurse	Sandwell & West Birmingham Hospitals NHS Trust
Bernadette Faulkner	Commissioner	Solihull CCG
Chris Groves	Service User	Rheumatology User Group
Dr Andrew Hartland	Consultant Chemical Pathologist	Walsall Healthcare NHS Trust
Dr Dinusha Ileperuma	General Practitioner	Solihull CCG
Dr Muhammad Javed	Consultant Paediatrician	George Eliot Hospital NHS Trust
Karen Joseph	Practice Manager	Sherbourne Medical Centre
Hilary Kemp	Community Matron	Birmingham Community Healthcare NHS Trust
Dr Melanie Kershaw	Paediatric Endocrinologist	Birmingham Children's Hospital NHS Foundation Trust
Rosalind Leslie	Superintendent Physiotherapist/Clinical Physiotherapist Specialist, Cardiac Rehabilitation	The Royal Wolverhampton Hospitals NHS Trust
Sharon Letissier	MS Nurse Specialist	University Hospitals Birmingham NHS Foundation Trust
Dr Waqar Malik	Consultant Diabetologist	Birmingham Community Healthcare NHS Trust
Marie Maturi	Clinical Nurse Specialist Diabetes	Walsall Healthcare NHS Trust
Deborah McCausland	Paediatric Diabetes Specialist Nurse	Walsall Healthcare NHS Trust

Dr Jerome Ment	Consultant Cardiologist	Heart of England NHS Foundation Trust
Dr Shahid Nadeem	Consultant Respiratory Physician	Walsall Healthcare NHS Trust
Dr Binoj Nair	General Practitioner	Peterloo Medical Centre
Dr Rajib Pal	General Practitioner	Hall Green Health; Birmingham Cross City CCG
Marcelle Rollings	Consultant Nurse Long Term Conditions	The Royal Wolverhampton Hospitals NHS Trust
Lorraine Shaw	Diabetes Clinical Nurse Specialist	Birmingham Children's Hospital NHS Foundation Trust
Jane Smith	Patient Representative	
Theresa Smyth	Nurse Consultant in Diabetes	University Hospitals Birmingham NHS Foundation Trust
Dr Gaurav Tewary	General Practitioner	Copsewood Medical Centre
Ulrike Uta	Senior Physiotherapist	Heart of England NHS Foundation Trust
Sandy Walmsley	Respiratory Nurse Specialist & LTC Lead	Heart of England NHS Foundation Trust
Glynis Washington	Clinical Services Redesign Manager - Strategy & Redesign	NHS Coventry
Rhona Woosey	Planned Care Redesign Manager	Birmingham South and Central CCG
Helen Wylie	Nurse Practitioner	Lisle Court Medical Centre
Dr Venugopal Yuvaraj	General Practitioner	Park 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	3	100
Specialist Care of Children & Young People with Diabetes	29	17	59
Trust-Wide: Worcestershire Acute Hospitals NHS Trust	4	4	100
Commissioning	21	16	76
NHS Redditch & Bromsgrove CCG	(7)	(5)	(71)
NHS Wyre Forest CCG	(7)	(5)	(71)
NHS South Worcestershire CCG	(7)	(6)	(86)
Health Economy	**57**	**40**	**70**
Care of Adults with Long-Term Conditions			
Primary Care	8	2	25
Community Long-term Conditions Services (All Services)	156	79	51
South Worcestershire	(52)	(26)	(50)
Redditch & Bromsgrove	(52)	(27)	(52)
Wyre Forest	(52)	(26)	(50)
Specialist Care of Adults with Diabetes	61	43	70
Specialist Care of People with COPD	177	121	68
COPD: Alexandra Hospital – Acute & Community	(56)	(28)	(50)
COPD: Worcestershire Royal Hospital – Acute & Community	(56)	(38)	(68)
Pulmonary Rehabilitation	(65)	(55)	(85)
Specialist Care of People with Heart Failure	57	26	46
Specialist Care of People with Chronic Neurological Conditions	58	24	41
Trust-Wide: Worcestershire Acute Hospitals NHS Trust	7	0	0
Commissioning	36	22	61

Service	Number of Applicable QS	Number of QS Met	% met
NHS Redditch & Bromsgrove CCG	(12)	(7)	(58)
NHS Wyre Forest CCG	(12)	(8)	(67)
NHS South Worcestershire CCG	(12)	(7)	(58)
Health Economy	**560**	**317**	**57**

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