WM QRS West Midlands Quality Review Service

NHS

Care of Adults with Long-Term Conditions

Care of Children & Young People with Diabetes

Wolverhampton Health Economy

Visit Date: 12th, 13th & 14th 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 12th, 13th & 14th 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 Wolverhampton health economy. Appendix 2 contains the details of compliance with each of the standards and the percentage of standards met.

WOLVERHAMPTON HEALTH ECONOMY

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

- The Royal Wolverhampton NHS Trust
- NHS Wolverhampton Clinical Commissioning Group
- NHS South East Staffordshire and Seisdon 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 Wolverhampton 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 Wolverhampton 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

Care of people with long-term conditions in Wolverhampton was generally well-organised with some areas of very good practice. Several good pathways had been developed and work on the care of people with multiple long-term conditions was starting, including GP practice-based multi-disciplinary teams with input from community matrons. Another example of good coordination of care was shown by the improvement programme for the care of people with COPD - the specialist COPD team had good links with community matrons, patients re-admitted within 30 days were automatically discussed at the COPD multi-disciplinary meeting attending by the COPD team, community matrons and palliative care. Risk stratification information was being used in primary care, community long-term conditions services and some condition-specific specialist teams, and there were plans to improve the information available.

Reviewers noted some interesting work with social care, especially for Wolverhampton and South Staffordshire patients, including a sensible, flexible approach to extending care packages for patients who are admitted to hospital.

Staff providing care for people with long-term conditions had good insight into areas where improvements were needed. Services generally had very strong leadership and staff were putting considerable energy and commitment into improving services. Reviewers considered that there was, therefore, considerable potential for services to improve beyond the high standards already achieved.

A health economy-wide 'Clinical Web Portal' allowed GPs and community staff to access discharge summaries and results of investigations. This system could also be used to send 'alerts' to teams when patients were admitted to hospital.

Good Practice

1 The integrated Lifestyle Team was responsible for all lifestyle interventions across community, primary care and hospital settings. The team was well-staffed (58 w.t.e.) and had access to good facilities, including a pilot of 'gym' sessions in a GP practice.

2 Urgent review within 24 hours was being achieved by all services except for those caring for people with chronic neurological conditions.

3 A hospital-based Rapid Response Team was available from 8am to 8pm seven days a week. This team reviewed patients in the Accident and Emergency (A&E) department, Medical Admissions Unit and wards and identified those who could be discharged quickly. The team had found that 80% of patients could be discharged home with clear instructions about care included in the electronic discharge summary. Good links with social care and community matrons had helped to achieve this.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Services for people with chronic neurological conditions**

The section of this report relating to specialist care for people with chronic neurological conditions identifies several issues which will require the attention of primary care, The Royal Wolverhampton NHS Trust and NHS Wolverhampton Clinical Commissioning Group. These issues include ensuring compliance with NICE guidance on the care of people with epilepsy and the need to develop clear pathways of care for all people with chronic neurological conditions.

Further Consideration

1 Some issues about primary care were raised with reviewers during the course of this review, including inappropriate referrals, referrals before appropriate investigations had been completed, difficulties in contacting primary care or difficulties in getting out of hours GPs to support community matrons. Community matron and condition-specific specialist services were then accepting these patients and undertaking investigations needed or further referral, and sometimes patients were being admitted when this could have been avoided. It may be helpful to build health economy-wide review and learning into some of the pathways that have been developed, in order to discuss where pathways are not working as intended and to support further improvements.

2 Reviewers found widespread, strong commitment to using risk stratification information and encouraged continuation of the work to improve the information available.

3 It may be helpful to remind all out of hours services of the arrangements for access to urgent specialist team review within 24 hours and to ensure that the GP out of hours service has access to this facility.

4 Reviewers saw many examples of good practice during the course of this review. The service developments and plans sometimes appeared, however, to be the result of dynamic leadership rather than as part of a health economy strategy. This was understandable given that NHS Wolverhampton Clinical Commissioning Group had only recently been established at the time of the review. The next stage of development and, in particular, achieving integrated care for people with multiple long-term conditions may require greater collaboration between teams, between primary care and specialist services and between commissioners and providers.

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PRIMARY CARE

NHS WOLVERHAMPTON CLINICAL COMMISSIONING GROUP

General Comments and Achievements

Good Practice

1 Team W "Together everyone achieves more in Wolverhampton" was a monthly primary care-led protected learning time meeting regularly attended by 40 to 50 people and held on different days of the week so that everyone had the opportunity to attend. This was providing a good forum for the discussion of care pathways. A lead GP had been identified for each pathway and the design of the pathways had been led by primary care. Care of people with COPD, diabetes (adults and children) and heart failure had been discussed at these meetings. Condition-specific specialist team were involved as appropriate to the subject under discussion.

2 'QP QOF' had been developed whereby pathways of care were embedded into GP clinical systems. By inputting the READ code, GPs had immediate access (without having to go out of one system and into another) to referral pathways, referral criteria and phone numbers.

3 Practice-based multi-disciplinary team meetings involving palliative care and community matrons had been started for the Gold Standards Framework and were being used also to discuss the care of patients with multiple long-term conditions or those about whom the GP or community matrons had concerns.

Immediate Risks: No immediate risks were identified.

Concerns: No concerns were identified.

Further Consideration

1 See health economy 'further consideration 1'.

2 At the time of the review, pharmacy support to primary care and community services was about to change, with some pharmacists remaining in the Clinical Commissioning Group and some transferring to The Royal Wolverhampton NHS Trust. Post-implementation evaluation may be helpful to ensure these changes are working as intended.

3 Some GPs who met the visiting team were concerned whether funding for 'Team W' would continue.

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Specialist Care of Children & Young People with Diabetes

THE ROYAL WOLVERHAMPTON NHS TRUST

General Comments and Achievements

The service for children and young people with diabetes was valued by the patients and parents who were complimentary about the team, the service, the support they received and, in particular, the quality of the care from the ward nurses. A comprehensive business plan had been agreed in advance of the allocation of the '*Best Practice Tariff*'.

Good Practice

1 The Youth Worker ran groups in conjunction with the Paediatric Diabetes Specialist Nurses (PDSNs) and provided a varied programme of group activities including, for example, a ski trip. This service was excellent in supporting young people to gain independence and confidence in self-management.

2 All school meals were 'carb-counted'.

Immediate Risks: No immediate risks were identified.

Concerns:

1 Newly-diagnosed patients and their families were not contacted daily for the first week after diagnosis (with the option of contact for two weeks).

2 Out of hours arrangements for advice were not yet robust. Some guidelines were in place but, in practice, the mechanism and criteria for formal escalation to the diabetes team was not clear and was based on good will arrangements. These arrangements would benefit from being formalised.

Further Consideration

1 A structured approach to ongoing training and education was not yet in place. There was a structured programme for newly diagnosed patients and for young people starting on pump therapy. A formalised approach covering all ages may be helpful in ensuring appropriate education is delivered on an ongoing basis.

2 Thirty school care plan templates had been developed, based on the age of the child and the treatment regime. Although these enabled very quick communication with schools as usually only the child's name needed to be completed, reviewers considered that there was insufficient individualisation of the plans.

3 The clinic proformas was used for annual reviews. It may be helpful to develop a specific annual review proforma which could then include all annual review issues, for example, foot checks. The annual review proforma could then include more space for free text information.

4 A validated psychological assessment tool was not yet in use.

5 Some families said that it had taken several weeks for their GP to issue the correct prescription for newly diagnosed patient. Including the 'PIP' code in the GP letter may help to avoid these problems.

6 The PDSN ran a clinic alongside the consultants but there was not a robust process in place for ensuring when they would see a consultant and how this was recorded.

7 Further development of patient information may be useful, in particular, to ensure an appropriate range of age appropriate information is available, for example 'sick day rule' information could be clearer.

8 Parents who meet the visiting team said that Trust car parking arrangements did not include the provision of reduced charge or free parking for families of children and young people with diabetes.

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COMMUNITY LONG-TERM CONDITIONS SERVICES

THE ROYAL WOLVERHAMPTON NHS TRUST

General Comments and Achievements

A good range of community long-term conditions services was in place, including 8.8 w.t.e. community matrons who were attached to virtual ward, Hospital at Home service which ran from 8am – 10pm seven days a week, discharge liaison team was available from 8am to 8pm seven days a week, and out of hours and in-hours district nursing services. Patients who met the visiting team all had the contact number for the out of hours district nursing service. Good teamwork within the team and with some GPs and condition-specific specialist services was evident

Patient feedback was excellent. Patients who met the reviewers said that they had been listened to "as a human being". They praised the time and compassion given, especially by community matrons.

The service had a strong leader who was very knowledgeable about the services and was driving further improvements. Staff were enthusiastic and improvements already achieved at the time of the review are described in the good practice section of this report.

Good Practice

1 Wolverhampton Urgent Care Triage and Access service (WUCTAS) provided 'single point of access' to nearly all community services.

2 Community matron service was working well, including:

   a. The Hospital at Home team was able to support home intravenous therapies, including for people with chronic neurological conditions and for the management of COPD exacerbations, with good medicines management support.

   b. There were 128 independent prescribers within the community services, including community nurses running INR clinics and titrating anti-coagulants, with good medicines management support and governance.

   c. Sixty patients were using telehealth machines and reported high levels of satisfaction. Staff had adjusted quickly and willingly to these developments.

   d. Community matrons were delivering good patient education about insulin and inhaler technique. They also were providing good drug education for patients. A programme of education for health care assistants in care homes was being offered.

   e. Good links had been established with the COPD and diabetes teams, including attendance at COPD multi-disciplinary meetings.

   f. Community matrons and district nurses undertook a daily 'ward round' and review of patients under their care.

Immediate Risks: No immediate risks were identified.

Concerns: No concerns were identified.

Further Consideration

1 Some of the expected clinical guidelines, policies and pathways were not yet documented.

2 All staff had undertaken condition specific and mandatory training but there was no framework of expected competences or training plan to ensure that competences were kept up to date.

3 Some GP practices were not yet engaging with the community matron service and may need to be specifically targeted with the aim of achieving their participation.

4 Reviewers were told by staff that district nursing caseloads were high. Reviewers did not see any information on activity and caseloads in relation to staffing and so were not able to comment specifically on this issue.

5 Links with social care were not yet evident and social workers did not attend practice-based or other multi-disciplinary meetings.

6 The font and print in some of the in-house patient information may benefit from review.

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SPECIALIST CARE OF ADULTS WITH DIABETES

THE ROYAL WOLVERHAMPTON NHS TRUST

General Comments and Achievements

Care for people with diabetes was provided by an integrated team comprising 6 w.t.e. consultants, 3.w.t.e Academic Teaching Fellows, 2 w.t.e specialist registrars 5.6 w.t.e diabetes specialist nurses, 4 w.t.e diabetes support nurses 0.7 w.t.e. dietitians, 1.2 w.t.e. podiatry, 4 w.t.e. clinic administrators , 2.5 w.t.e. retinal screening administration clinical administrators and 3.5 w.t.e secretarial team**.** Leadership was strong; the team was enthusiastic and good teamwork was evident. The team provided integrated care across community and hospital settings and there were good links with primary care. Patients and carers were very appreciative of the care they received. Reviewers were told that staff satisfaction rates were also high.

The service had a clear strategy for the future and had developed a good, online, integrated 'model of care' pathway, which was highly appreciated by patients and carers. The Wolverhampton Diabetes Centre 'My Diabetes Plan' (personal care plan) was comprehensive and clear.

The diabetes service IT system (Diabeta-3) could be accessed easily by community and hospital-based staff. Some issues around integration with primary care were being addressed with the IT system provider. Reviewers also found good access to 'point of care' testing and good e-modules for staff education. Progress had been made with reducing the number of major and minor limb amputations which had resulted in an amputation rate lower than the national average (Wolverhampton 0.9 per 1000; England 1.5 per 1000 for minor lower limb amputations, 0.6 per 1.0 per 1000 for major limb amputations. NHS information Centre for Health and Social Care, 2007-2010). Reviewers also noted improvement between 2011 and 2012 in the team's results in the national diabetes in-patient audit.

Insulin 'stickers' on patient notes and insulin prescription charts for in-patients had helped to reduce medication errors in relation to the use of insulin. Daily ward rounds, including at weekends, had recently been introduced and the number of patients discharged at the weekend had increased as a result. A pre-conception service for patients with diabetes was offered, although did not attend rates at these clinics were fairly high.

Good Practice

1 The clinical web portal (COBAR) identified in-patients with diabetes on all wards. This made it much easier for diabetes specialist nurses to identify and provide appropriate support to patients.

2 A television screen in the Diabetes Centre provided good education and advice for patients.

3 Primary care had the facility to refer patients for specialist advice who were at high risk of foot problems via the web-based link to the 'Diabeta3' system.

4 The service had a proactive approach to identifying patients with diabetes, especially those in high risk areas such as the Accident and Emergency department, renal clinics and Medical Admissions Unit via an IT systems check of blood sugars of all in-patients every morning.

5 'Alert' charts on the end of patients' beds were used effectively to identify patients at risk of medication errors, falls or pressure ulcers. These alerts also identified if assistance with eating and drinking was required. Charts seen by reviewers were 'ticked' for each patient.

Immediate Risks: No immediate risks were identified

Concerns: No concerns were identified.

Further Consideration

1 'Link nurses' or 'ward champions' to drive improvements in the care of people with diabetes were not identified. Competences needed by ward staff were not yet clearly identified. Reviewers considered that the establishment of 'link nurses' would enable specialist team staff to concentrate on other aspects of service improvement.

2 Work was taking place with the ambulance service on the care of people with severe hypoglycaemia. Plans were in place for a service whereby patients were not admitted and were treated at home wherever possible. Reviewers supported continuation of this work

3 Dietitian staffing levels were low (0.7 w.t.e.) and there was no cover for absences. Reviewers were not clear how this level of dietitian support could achieve all the clinics and work that was indicated on the self-assessment. Increased dietitian support may also help patients to achieve good glycaemia control and prevent complications in the future.

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Specialist Care of People with COPD, including Pulmonary Rehabilitation

THE ROYAL WOLVERHAMPTON NHS TRUST

General Comments and Achievements

A well-integrated team provided hospital and community-based specialist care for people with COPD, including expert diagnosis and treatment, quality assured spirometry, oxygen assessments and monitoring, patient education and advice, pulmonary rehabilitation in several centres across Wolverhampton and rapid access 'hot' clinics. The team comprised 8 p.a. sessions of a consultant, 5.22 w.t.e specialist respiratory nurses, 2.7 w.t.e. health care assistants, 1.w.t.e. cystic fibrosis specialist nurse, 2.4 w.t.e. lung cancer nurse specialist. Good links with community matrons and the Hospital at Home team were in place. There were also good links with palliative care services and a number of mechanisms to identify and support patients nearing the end of life. The service was well-organised with good, clear documentation. The team had good pharmacy support and access to cognitive behaviour therapy through the hospice-based physiotherapist. The team was using risk-stratification information to target support for patients at high risk of admission.

A good, well-organised pulmonary rehabilitation service was also provided. Waiting times for pulmonary rehabilitation had been reduced from 19 to 10 weeks through integrating staff with the cardiac rehabilitation service. A good, clear patient-held diary was used in the rehabilitation service.

All staff were committed and enthusiastic and patients who met the visiting team were highly appreciative of the care they received. The team had a particularly good understanding of the number of patients being cared for by

the specialist team, the number diagnosed in primary care and the 43% 'gap' between the expected and diagnosed prevalence of COPD.

Good Practice

1 A very good competence framework was available showing the competences expected for different members of the team.

2 Good arrangements for proactive identification of patients were in place. A respiratory consultant (7/7) and respiratory nurse (5/7) did a ward round of Medical Admissions Unit daily. If patients with respiratory needs were transferred to a non-respiratory ward then the respiratory specialist nurses continued monitor their care and give advice to the patients.

3 The RAINBOW network (Respiratory Action Network for The Benefit of Wolverhampton) involved the GP with a special interest in respiratory diseases, consultants, specialist nurses, community matrons, consultant nurse for long-term conditions, commissioner, home oxygen service and review (HOSAR) lead, pulmonary rehabilitation lead, respiratory directorate and community provider services managers, palliative care consultant, information services officer, lead for marketing, senior respiratory technicians and specialist therapist. This network was providing direction and support for improving the care for people with COPD. Everyone involved was well aware of the issues which needed to be addressed. All information was 'branded' using the RAINBOW branding. This was an example of good health economy-wide cooperation which had developed out of the local lung improvement project.

4 The Home Oxygen Assessment and Review Service (HOSAR) was well-organised with clear pathways of care, including a pathway for taking people off oxygen. All clinical staff undertook an e-learning mandatory training module about oxygen with an on-line assessment tool. There were robust arrangements for prescribing of oxygen on respiratory ward and in the community. A hospital oxygen prescription charts included a 'target oxygen' level. The HOSAR nurse had visited each general practice in order to increase awareness and ensure appropriateness of referrals. A good 'alert' card was given to all patients.

5 A respiratory clinic 'hot' clinic was held between 12 noon and 1pm on Mondays to Fridays. Acute medicine and A&E consultants, GPs and community matrons could refer to this clinic. Selected patients (following multi-disciplinary team discussion) were also issued open access passports so that they can self- refer to the 'hot' clinic.

6 Robust multi-disciplinary meeting arrangements were in place. The COPD team, community matrons and palliative care team attended a fortnightly multi-disciplinary meeting. Patients re-admitted within 30 days were automatically discussed at this meeting.

7 The integrated team had 'paperless' patient notes. There was a good proforma for data capture and history-taking which made it very easy for staff to find information.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Non-Invasive Ventilation**

There were only four ventilators on the respiratory ward for patients needing non-invasive ventilation. Previously, when more than four patients needed non-invasive ventilation they had been transferred to critical care but reductions in critical care capacity had reduced the availability of this option. Reviewers considered that this was insufficient capacity for non-invasive ventilation for the number of patients who may benefit from this intervention. January 2013 had been a particular problem with 105 admissions of patients with COPD. As a result there may be delays in providing non-invasive ventilation and the possibility some patients who may benefit were not be offered this service. Non-invasive ventilation was initiated in one side-room on the respiratory ward where patients stayed until they were stable. Nursing staff with competences in non-invasive ventilation were sometimes moved from the respiratory ward which made it

difficult quickly to increase capacity when a patient was admitted. Reviewers were told that a business case for increasing capacity on the respiratory ward from four to eight patients was being considered.

2 **Pulmonary Physiology Equipment and Staffing**

Only one machine for measuring lung volumes and gas transfer was available and staffing of this service was insufficient. Three respiratory consultants had been appointed without any increase in physiology staffing or equipment. At the time of the review there was a nine week waiting time for consultant referrals for pulmonary physiology (six weeks for GP referrals).

Further Consideration

1 The Home Oxygen Assessment and Review Service (HOSAR) did not have the facility to measure blood gases in patients' homes and no option to review patients in their homes if they were not able to attend hospital. The service was aware of this issue and was submitting a business case for an additional physiologist.

2 Pulmonary rehabilitation referral criteria from primary care may benefit from review. Reviewers were told that 33% of patients referred were unsuitable for the service. Spirometry and diagnosis was not always undertaken prior to referral and the referral criteria were not clear in the evidence available to reviewers. Also, the pulmonary rehabilitation service was not routinely calculating the BMI for all patients. This may help to identify patients with particular nutritional needs.

3 The service was starting to offer spirometry training to primary care staff and reviewers encouraged continued work in this area.

4 A standardised screening tool for patients suffering from anxiety and depression was not in use. This may be helpful, especially to ensure that cognitive behavioural therapy is targeted at patients at greatest need.

5 Despite all of the interventions available, re-admission rates were relatively high. Ongoing monitoring and work to understand the reasons for this will be needed.

6 Patients with COPD who had been admitted to hospital were automatically offered a follow-up out-patient appointment. Reviewers were unsure whether this was the best use of resources and whether follow up by specialist nurses could be more appropriate.

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SPECIALIST CARE OF PEOPLE WITH HEART FAILURE

THE ROYAL WOLVERHAMPTON NHS TRUST

General Comments and Achievements

Specialist care for people with heart failure was provided by a multi-disciplinary team, involving a lead cardiologist, specialist nursing team (6.8 w.t.e.) and administrative support (2 w.t.e.). This team linked closely with the cardiac rehabilitation service. The specialist nursing team was very well-organised with good teamwork, good succession planning, and integration of community and hospital-based care. A good competency document was in place and four of the team were non-medical prescribers. All members of the heart failure team were enthusiastic and keen to improve the service offered. Good facilities were available in the Heart and Lung Centre. Patients who met the visiting team greatly appreciated the care that they received.

Achievements of the team included individualised education and symptom review consultation, the development of hospital and community clinics at seven different locations, use of assistive technology and a good hospital 'in-reach' service. Good joint working was in place with community matrons and the virtual ward, district nurses, palliative care and other services. The service had a strong emphasis on education and had developed teaching packages for Foundation Year1 / 2 doctors, newly qualified nurses, GPs and practice nurses. Links with competence frameworks for district nurses and community matrons had also been made.

A good cardiac rehabilitation service was run by very committed and enthusiastic staff. The service was highly appreciated by the patients that the reviewers met and they felt that it gave them confidence, quality of life improvement and peer support. Staff also felt well supported by other clinical staff such as cardiac registrar and the consultant cardiologist.

Good Practice

1 The integrated team-working and good links with other services was an impressive achievement. Reviewers were particularly impressed that heart failure specialist nurses worked in different parts of the service in rotation.

2 Key rings and fridge magnets gave service information and contact details and were offered to all patients. A hand-held patient diary was comprehensive and clear. It supported self-monitoring and also helped to ensure patient safety when medication was changed over the telephone.

3 The cardiac rehabilitation service used a very good initial and ongoing assessment tool. This was thorough and comprehensive and supported ongoing 'bench-marking' against expected goals.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Regular Review**

Patients under the care of the specialist time did not have a six monthly review within the service. Patients' GPs were contacted but it was not clear that these reviews were taking place in primary care and there was no communication about the outcome of the review back to the specialist team.

Further Consideration

1 It may be helpful to review whether all patients are being offered the available patient information at appropriate stages in their patient journey (or, possibly, explicitly to link patient information to the patient pathway).

2 Multi-disciplinary meetings involving the whole team were not yet in place and the team did not come together for review and learning. The team had identified dates for team meetings to take place later in the year.

3 Some of the clinical guidelines were still in draft form. It may also be helpful to bring the guidelines together into an easily accessible 'folder'. Similarly, it may be helpful to make the heart failure pathway more easily accessible.

4 The service that was reviewed was not commissioned to care for people with diastolic heart failure and preserved ejection fraction and it was not clear how these patients were managed. Discussions with commissioners on this issue need to continue.

5 The heart failure pathway included 'step-down' to primary care with the option of self-referral back to the service. Patients who met the reviewers were not aware of the self-referral option.

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SPECIALIST CARE OF PEOPLE WITH CHRONIC NEUROLOGICAL CONDITIONS

THE ROYAL WOLVERHAMPTON NHS TRUST

General Comments and Achievements

Services for people with chronic neurological conditions in Wolverhampton comprised an acute neurology service and a specialist inpatient rehabilitation ward plus a community neurological rehabilitation team based at West Park Rehabilitation Hospital. People with spinal injuries were referred to Robert Jones and Agnes Hunt

(Orthopaedic) Hospital, Oswestry. Those with motor neurone disease were generally cared for by the neurology service and referred to the tertiary service at University Hospitals Birmingham NHS Foundation Trust as required. Those needing more complex specialist rehabilitation (ACT, FES, IBT pump) were referred to the West Midlands Rehabilitation Service in Birmingham.

The acute service was staffed by 2.6 w.t.e. consultants, which included a 1.0 w.t.e. vacancy, and a locum consultant neurophysiologist. The neurophysiology service supported Shropshire and Dudley as well as Wolverhampton. Clinical nurse specialists (1.6 w.t.e. – including 0.6 w.t.e. vacancy) provided care of people with multiple sclerosis, providing home visits as well as acute support. A Parkinson's disease specialist nurse was also available but did not meet the reviewing team. One consultant specialising in care of older people also had a special interest in Parkinson's disease but did not meet the reviewing team. Acute neurology beds were not available in Wolverhampton. Consultants were employed by University Hospitals Birmingham NHS Foundation Trust and worked in Birmingham on Fridays in order to take part in multi-disciplinary and other meetings. Advice was available from Birmingham at all times. The multiple sclerosis nurse linked with the 'Hospital at Home Team' for the provision of intravenous steroid therapy. Patients commented positively on the support they received from the multiple sclerosis specialist nurse and the neuro-psychologist.

In 2012/13 a total of 469 people were referred for neurological rehabilitation and the ongoing caseload of the community neurological rehabilitation team (CNRT) was 408 at the time of the review. Staff were highly committed and enthusiastic and patients were very appreciative of the care offered by the team. The establishment of the community neurological rehabilitation team included 1.0 w.t.e. consultant covering the services at Walsall and Wolverhampton. The post covering Wolverhampton was vacant at the time of the review and the Walsall consultant was covering the whole service with one Trust doctor at West Park Hospital. The 10 bedded in-patient rehabilitation unit at West Park Rehabilitation Hospital admitted approximately 60 patients per year and was achieving the standards for a level 2a in-patient specialist rehabilitation service. A 0.4 w.t.e. neuro-psychologist and 0.5 w.t.e. psychology assistant was available, covering in-patient and out-patient rehabilitation services. A service for people with chronic fatigue was also run from West Park Hospital. Specialist clinics were provided for people with spasticity, brain injury and amputations.

Good Practice

1 Reviewers were particularly impressed by the neurological rehabilitation service. A good multi-disciplinary team was available including a social worker and neuro-psychologist. The team had a holistic approach to rehabilitation including management of symptoms and drug therapy, vocational rehabilitation, support for leisure pursuits and personal dignity. The team cared for people with a wide range of conditions, including those with stroke, head injuries and chronic fatigue syndrome. A multi-disciplinary meeting was held weekly to discuss the care of in-patients. This meeting was well-organised with a comprehensive approach to assessment against internationally validated outcome measures. 'Live' data collection to the UK Rehabilitation Outcomes Collaborative (UKROC) database was in place. This service had recently been commissioned to provide care for people in the Seisdon area as well as Wolverhampton.

2 A good wheelchair service was available with short waiting times for all patients and the capacity to see urgent referrals more quickly. Wheelchairs could also be supplied for people with a short-term need as well as those needing longer-term equipment.

3 Patients with Guillain-Barré Syndrome were jointly managed with the respiratory service with good arrangements for liaison and communication about all aspects of the patients' care.

4 The neurophysiology service had access to a portable EEG machine which could also be used for home-based investigations.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Consultant Staffing Levels**

The rehabilitation consultant was covering both Walsall and Wolverhampton services. The second post had been advertised. There was also 1.0 w.t.e. consultant neurologist vacancy in the acute service. This situation was particularly difficult because of the low level of middle grade medical staff in the acute service. GPs who met the visiting team were concerned about long waiting times for an out-patient appointment.

5 **Implementation of NICE Guidance for People with Epilepsy**

There was no specialist nurse available to support people with epilepsy. Guidelines on the management of epilepsy were not in place. An audit of care in the Accident and Emergency department showed that people with epilepsy were not being treated according to NICE guidance, including patients not being referred to a neurologist. Consideration was being given to using the acute consultant vacancy to recruit a consultant with a particular interest in epilepsy.

6 **Local Availability of Services**

Out-patients seen by a consultant neurologist who needed a diagnostic lumbar puncture were required to attend the Queen Elizabeth Hospital, Birmingham for this investigation. Patients with multiple sclerosis who required dose-modifying therapy were referred to Birmingham for assessment and then referred back to Wolverhampton for treatment. They then had to go to Birmingham again for annual reviews. Patients therefore had to travel to Birmingham for services which could be provided locally.

7 **Guidelines and Protocols**

Few local clinical guidelines and protocols were documented. Access to NICE guidance was available but this guidance had not been localised to show how it would be implemented locally.

8 **Care Planning and Reviews**

Robust arrangements for care planning and holistic annual review were not evident in the acute service. In the acute service, patients seen as out-patients did not have care plans and were not copied into clinic letters. Arrangements for annual review of patients seen in the acute service were not clear and reviewers were told that a formal review process was not commissioned. (Patients in the rehabilitation service did have personalised goal-setting and received very clear, well-worded clinic letters from the consultant.)

9 **Patient Information**

Little written patient information was available in the acute service although patients were verbally told about websites where they could access relevant information. This was of particular concern for people with epilepsy where no specialist nurse was available to provide support.

Further Consideration

1 Although reviewers were told that one clinical lead and one manager had responsibility for the services, effective clinical and managerial coordination of the acute and community parts of the service was not yet evident. Improving links and communication between acute and community parts of the service may benefit from further attention.

2 There was no competence framework or training plan detailing the competences expected for staff in the service. Staff who met the reviewers had had appropriate training.

3 A user and carer group to provide feedback on the service was not yet in place. Patients could feedback via the Patient Advice and Liaison Service (PALS). Carers who met the reviewing team commented that they would welcome additional support and a forum specifically to discuss carers' needs.

4 Work was taking place on developing links with local palliative care services for people with motor neurone disease. Reviewers supported continuation of this work.

5 Follow-up of the recommendations of the audit of first seizures will need to be taken into account as part of work on implementation of NICE guidance for care of people with epilepsy

6 The rehabilitation service may be able to make greater use of the UKROC data which are being collected. Exploring the use of the 'live' data collection for service management and service improvement could be an exemplar to other services.

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TRUST-WIDE

THE ROYAL WOLVERHAMPTON NHS TRUST

General Comments and Achievements

The Royal Wolverhampton 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:

Pharmacy services had a clear system of monitoring and following up prescribing errors. Good pharmacy support was available to patients and there were clear arrangements for pharmacy support to specialist teams (with the exception of acute neurology services). Medicines reconciliation was undertaken on admission. Plans to link hospital and GP prescribing systems were being discussed.

Training and education services were well-organised with good systems for monitoring mandatory training and good arrangements for linking needs assessment with role-specific training plans. Medical and non-medical staff were included in the monitoring and planning arrangements.

All staff who met the visiting team were clear about the use of 'Datix' for recording incidents and about systems for feedback on incidents reported.

Reviewers were also told of good links with hospital social workers, including care packages routinely kept open for two weeks and contact with the hospital social work lead before packages were closed. This enabled flexibility if minor changes or a short extension was needed. There was a social work presence in the Accident and Emergency department from 9am to 5pm and access to 24 non-medical community resource beds where patients could stay for up to 72 hours without charge. These beds could be used as alternatives to admission.

Good Practice

1 The coding of all deaths within hospital was verified by the consultant responsible for the patient.

2 Very good document control was evident on every leaflet and on guidelines. There was a clear schedule of updating patient leaflets, clinical guidelines and policies.

3 The discharge summaries included a clear plan which was specific about responsibility for different actions. Hospital pharmacists contributed directly to discharge summaries.

Concerns

1 Services for people with chronic neurological conditions: See health economy section of this report.

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COMMISSIONING

NHS WOLVERHAMPTON 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

Clinical Commissioning Group representatives had good understanding of the issues to be addressed, even though some had been in post for relatively short periods of time.

Concerns

1 Services for people with chronic neurological conditions: See health economy section of this report.

2 Specialist services for people with heart failure were not commissioned to undertake six monthly holistic reviews (in line with NICE guidance). Also, specialist care for people with diastolic heart failure not commissioned.

See also 'All Commissioners' section below.

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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: Follow-up post diagnosis; OOH arrangements

2 Specialist Care of People with COPD: Access to NIV; Pulmonary physiology equipment and staffing

4 Specialist Care of People with Heart Failure: Arrangements for six monthly review

5 Specialist Care of People with Chronic Neurological Conditions: Consultant staffing levels; NICE epilepsy guidance; Access to local services; Care planning and reviews; Patient information.

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APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Executive Lead

Sandy Brown	Nurse Director	West Midlands Ambulance Service NHS Trust

Visiting Team

Dr Chizo Agwu	Consultant Paediatrician	Sandwell & West Birmingham Hospitals NHS Trust
Dr Martin Allen	Consultant Physician -Respiratory Medicine (RPD)	University Hospital of North Staffordshire NHS Trust
Dr Mona Arora	General Practitioner	North Staffordshire Clinical Commissioning Group
Dr Alexandra Ball	Consultant in Neuro rehabilitation medicine	University Hospital of North Staffordshire NHS Trust
Dr Ansu Basu	Consultant Physician and Endocrinologist	Sandwell & West Birmingham Hospitals NHS Trust
Helen Bladon	Diabetes Service Lead	Walsall Healthcare NHS Trust
Pam Bojczuk	User Representative	Local Commissioning Advocate Representative for Epilepsy Action
Helen Charters	Specialist Stroke Nurse, Community Stroke Team	Staffordshire & Stoke on Trent Partnership NHS Trust
Linda Hill	Senior Physiotherapist	Heart of England NHS Foundation Trust
Nicola Humphrey	COPD Lead Nurse	Walsall Healthcare NHS Trust
Jane Humphries	Diabetes Nurse	Burton Hospitals NHS Foundation Trust
Sue Lear	Service Redesign and Innovation	Arden Commissioning Support
Annette Logan	Lead Parkinson's Disease Nurse Specialist	Mid Staffordshire NHS Foundation Trust
Elizabeth Malpass	Community Matron/Case Manager	Staffordshire & Stoke on Trent Partnership NHS Trust

Dr Sushma Manthri	General Practitioner	NHS Walsall: Coalpool Surgery; Harden Health Centre
Daniel Meiring	Head of CRM	Sandwell & West Birmingham Hospitals NHS Trust
Dr Dawn Moody	General Practitioner	North Staffordshire Clinical Commissioning Group
Dr David Nicholl	Consultant Neurologist	University Hospitals Birmingham NHS Foundation Trust
Jennifer Sech	Community Practice Educator - District Nursing	Staffordshire & Stoke on Trent Partnership NHS Trust
Manisha Sharma	Cardiovascular Disease & Cancer Prevention Programme Lead	Solihull Public Health
Dr Binoy Skaria	Consultant Cardiologist	Heart of England NHS Foundation Trust
Alison Webb	Community Practice Educator	Staffordshire & Stoke on Trent Partnership NHS Trust
Karen Whitehead	Paediatric Diabetes Specialist Nurse	Mid Staffordshire NHS Foundation Trust
Helen Wylie	Nurse Practitioner	Lisle Court Medical Centre
Dr Venugopal Yuvaraj	General Practitioner	The John Kelso Practice

Observer

Dr Jyothi Srinivas	Specialist Paediatric Registrar	Birmingham Children's Hospital NHS Foundation Trust

WMQRS Team

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

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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	18	62
Trust-Wide: The Royal Wolverhampton NHS Trust	4	2	50
Commissioning	7	5	71
Health Economy	**43**	**28**	**65**
Care of Adults with Long-Term Conditions			
Primary Care	8	8	100
Community Long-term Conditions Services	52	30	58
Specialist Care of Adults with Diabetes	59	54	92
Specialist Care of People with COPD (All Services)	120	103	86
COPD	(55)	(49)	(89)
Pulmonary Rehabilitation	(65)	(54)	(83)
Specialist Care of People with Heart Failure (All Services)	82	61	74
Heart Failure	(57)	(36)	(63)
Cardiac Rehabilitation	(25)	(25)	(100)
Specialist Care of People with Chronic Neurological Conditions (All Services)	116	46	40
Acute Service	(58)	(20)	34
Rehabilitation including Multiple Sclerosis & Parkinson's Disease	(58)	(26)	45
Trust-Wide: The Royal Wolverhampton NHS Trust	7	6	86
Commissioning	12	10	83
Health Economy	**456**	**318**	**70**

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