West Midlands Quality Review Service

NHS

Care of Adults with Long-Term Conditions

Care of Children & Young People with Diabetes

South Staffordshire (East) Health Economy

Visit Date: 12th, 13th and 14th February 2013 Report Date: November 2013 Version 2

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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 February 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 South Staffordshire (East) health economy. Appendix 2 contains the details of compliance with each of the standards and the percentage of standards met.

SOUTH STAFFORDSHIRE (EAST) HEALTH ECONOMY

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

- Burton Hospitals NHS Foundation Trust (BHFT)
- Staffordshire & Stoke on Trent Partnership NHS Trust (SSOTPT)
- NHS East Staffordshire Clinical Commissioning Group
- NHS South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group

Some 'outreach' clinics for South Staffordshire are also provided by Heart of England NHS Foundation Trust. 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 commissioners in relation to this report are NHS East Staffordshire and NHS South East Staffordshire & Seisdon Peninsula Clinical Commissioning Groups**.** When addressing issues identified in this report, commissioners are expected to cooperate with each other and, where appropriate, with NHS England Shropshire and Staffordshire 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 South Staffordshire (East) 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

People providing services for people with long-term conditions in the South Staffordshire (East) health economy were highly committed to the care of their patients and keen to improve the services offered. Strong primary care services underpinned the hospital and community services which were available. Reviewers were, however, concerned about several issues which were identified consistently across the health economy:

Concerns

1 **Pathways of Care and Service Integration**

In general, pathways of care for people with long-term conditions were not clearly defined and several providers and teams were involved in each pathway. Effective communication and liaison between services caring for the same group of patients was not seen, with the exception of services for people with chronic neurological conditions which were working together. East Staffordshire CCG had started developing new pathways. Integrated community long-term conditions teams were being developed by Staffordshire and Stoke on Trent Partnership NHS Trust linked with inter-agency transformation work on pathways and assessment frameworks. Sometimes informal communication was in place because of individual personal relationships or co-location of services, but formal arrangements for coordination of services within the same care pathway were not yet in place. With the number of different providers and different geographical areas involved, strong clinical and managerial leadership will be needed to ensure service integration does not stall due to organisational boundaries. The appointment of a clinical lead for each pathway, with responsibility for driving service integration and service improvement, may be helpful.

This fragmentation of services was emphasised by the number of self-assessments submitted for this review. A total of 29 self-assessments were submitted for the nine[1] topics under review.

2 **Local Networks (or equivalent)**

The health economy had few local networks (or equivalent) with responsibility for developing and improving care pathways for people with multiple long-term conditions. A Staffordshire Health Economy Forum was beginning to function and a primary care-based local respiratory forum was operational. Given the disparate organisations involved in the pathways, effective mechanisms for bringing together patients and carers, primary care, other service providers and commissioners will be essential to achieving progress.

3 **Care Planning and Review, Clinical Guidelines and Protocols, Data Collection and Audit**

a. Arrangements for holistic care planning and annual review (six monthly for people with heart failure) were generally not robust, localised clinical guidelines and protocols were mostly not documented, activity and outcome data were usually not used by teams to drive service improvements and robust audit programmes were rarely in place.

b. This finding applied both within individual services and across care pathways. There were, of course, notable exceptions such as the East Staffordshire community diabetes team guidelines but, generally, the documentation and processes to support implementation of agreed pathways was not yet in place. Patients could have multiple care plans, or none at all, and no written information following clinic visits and in-patient stays. Similarly, patients could have multiple annual (or six monthly) reviews, or none, and information from reviews was not usually communicated to other services involved in the patient's care.

[1] 1. Primary care; 2. Community LTC; 3. Children and young people with diabetes; 4 -7 Specialist care pathways for people with COPD, diabetes, heart failure and chronic neurological conditions; 8. Acute Trust-wide; 9. Commissioning.

Further Consideration

1 As part of the work on defining care pathways for people with long-term conditions, robust arrangements for coordination of care for people with multiple long-term conditions will need to be in place. These were in the process of being implemented.

2 Following the development of care pathways and clarity over the role of each service, further work on defining staff competences for roles within services may be appropriate. Reviewers were told about arrangements for mandatory training but the specialist competences expected were often not clear and it was not clear that staff had the competences appropriate for the more specialist roles which they were undertaking.

3 Work was taking place on risk stratification but reviewers were given several different interpretations of the 'top 1%' of practices' patients and the relationship to population need. Clarification of this may avoid further confusion.

4 Some GP practices did not have access to the Hospital Information System and so could not access discharge summaries and other clinical information about patients. Community, hospital and social care IT systems were not able easily to communicate, although these problems appeared to have been overcome in some locations. Ensuring IT systems support new pathways as they are developed will be important to their successful implementation.

5 Reviewers were told about some operational problems which they did not have the opportunity to explore in more detail:

a. Access to psychological support appeared difficult in some teams, with some patients being referred to Derby for psychological support.

b. Reported difficulties with patient transport included the lack of patient transport to community locations and reimbursement of costs for travel to these locations, and patients regularly arriving early or late for clinic appointments with resulting disruption to operational processes.

c. Although the District Operational Group appeared to be working well, ongoing problems with referral to district nursing services and accessing appropriate equipment were causing delays to discharge from hospital.

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PRIMARY CARE

NHS EAST STAFFORDSHIRE CLINICAL COMMISSIONING GROUP and NHS SOUTH EAST STAFFORDSHIRE & SIESDON PENINSULA CLINICAL COMMISSIONING GROUP

Further Consideration

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

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Specialist Care of Children & Young People with Diabetes

BURTON HOSPITALS NHS FOUNDATION TRUST

General Comments and Achievements

Reviewers found the service to be highly valued by patients and carers and to be patient and family-focussed. The Out of Hours and Saturday clinics, run by a committed Paediatric Diabetes Specialist Nurse (PDSN), were good examples of this focus. A business case had been approved for the recruitment of additional members of the team and reviewers considered that this was a good basis for building up the service. There were good outpatient facilities which were bright, cheerful and child-friendly.

Good Practice

1. The PDSN held regular clinics in local schools with half hour appointment slots. This arrangement provided support for children and young people without them missing their education. It was also a good means of sustaining relationships between health and education and of developing independence for young people.
2. The service had robust links with the adult service which resulted in a good transition service with young people having four meetings over two years as part of the transition to adult services.
3. The young BERTIE self-management programme was an excellent means of preparation for independent living for young people. The course included information on carbohydrate counting and insulin adjustments. It also helped young people to manage their own prescriptions and advised on lifestyle issues that would become relevant as they became more independent.

Immediate Risks: No immediate risks were identified.

Concerns

1. At the time of the review the PDSN was regularly taking phone calls from parents out of hours, including whilst on holiday. There were guidelines on the ward and registrars knew where to access them and were happy to advise any parents who rang the ward for advice. Parents rang the PDSN directly, however she normally answered and dealt with the query.
2. Staffing levels at the time of the review were insufficient for the number of patients. There was one PDSN for 116 patients compared with a recommended level of 1:70. There was no effective cover for absences of the PDSN. The service had no administrative support and clinicians were using clinical time to input audit data. There was extremely limited dietetic support and no direct access to psychological support. Staffing levels at the time of the review would not allow the service to meet *Best Practice Tariff* but a business case had been approved for the recruitment of additional staff.
3. No local network or Trust-wide group was in place.

Further Consideration

1. It may be helpful to bring together the information given to parents at the time of diagnosis into a booklet or information pack. Some parents commented that they had received a lot of information and it may have been better if it had been handed out at intervals following diagnosis, rather than all at once.
2. Development of a Personal Care Record which brings together all relevant information, including goals and insulin targets, in a standardised format may be helpful.
3. More frequent collection of patient feedback may be a useful development.
4. At the time of the review, young people started the transition process after their 17th birthday. The service may wish to consider flexibility of entry into the transition process, depending on the young person's maturity and wishes.

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COMMUNITY LONG-TERM CONDITIONS SERVICES

STAFFORDSHIRE & STOKE ON TRENT PARTNERSHIP NHS TRUST

General Comments and Achievements

Community long-term conditions services for South East Staffordshire were in transition at the time of the review. Staff were moving to integrated teams and starting to work in a more integrated way. Practice-based multi-disciplinary team meetings were planned. A 'link nurse' was based in the hospital as a focus for communication with community teams. All staff who met the reviewers had a common view of the strategy and planned developments and what this would mean for patient care.

The new teams were facing several challenges, including different IT systems and historically different processes. For example, clinical staff were undertaking a 'triage' function in some teams but not in others. They were also having to link with several different acute hospitals, including those in Dudley, Wolverhampton, Stafford, Sutton Coldfield, Burton and Derby. Arrangements for pharmacy support for the teams were not clear at the time of the visit.

Reviewers supported the model being developed and considered that this had the potential to provide very good care for people with long-term conditions. Compliance with applicable Quality Standards should also increase significantly when the new arrangements are fully implemented.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Delays in Equipment Supply and Fitting**

Reviewers were seriously concerned about access to equipment, especially large equipment such as beds and mattresses. Reviewers were told that staff had to wait up to five working days for equipment including for patients needing palliative care. This impacted on the workload of the team as staff sometimes had to 'double up' until appropriate equipment was available. Reviewers were also given at least two different versions of the system for assessment for beds and mattresses; it may be that this confusion is adding to delays. Delays in installing some equipment and fixtures were also identified and some staff were installing equipment themselves. Changes to the equipment supply arrangements were to take place from April 2013 but it was not clear if this would address the problems identified at the time of the visit. It was also not clear whether staff had identified this problem on incident reporting systems.

2 **Staff Competences**

There was no competence framework covering the competences expected for roles in the new integrated teams and it was not clear that all case managers had appropriate competences.

3 **Guidelines and Policies**

Few clinical guidelines and operational policies were documented. Staff said that they referred to NICE guidance but this was not localised to show how it would be implemented locally.

4 **Integration with Other Services**

Eight different services were being brought together into integrated teams (and self-assessed separately for this review), including District Nursing teams for East and South East, Community Matrons, Community Intervention Service (CIS), Falls , Pain Management, Rehabilitation Team South East and Community Physiotherapy team. At the time of the review, understandably, much of the focus was on internal organisational issues. Arrangements for integrated working, communication and liaison with other services were not yet in place and will need to be addressed as part of the further development of the community long-term conditions services.

Further Consideration

1. Indications (or criteria) for referral to and discharge from integrated community teams were not yet formalised but were starting to be considered. A good system of referral for rapid access to the community intervention service was in place.
2. Risk stratification using an approach based on the 'top 1%' of each practice population was being used, partly as a basis for planning the workforce needed. This approach did not take account of differences in the levels of need in different practices and so may not accurately reflect the population needs or the workforce required to meet these needs.
3. Patients' notes and referrals were paper-based. Some staff, especially allied health professions, had limited access to information about patients' medical needs and were not always sure when their patients were in hospital. In the time available, reviewers were not able to confirm arrangements for secure transmission of patient-identifiable information in these circumstances.
4. Reviewers were told by staff that the services were very short-staffed and that there was a high level of district nursing and community matron vacancies. Reviewers were also told of delays in access to district nursing support for house-bound people with diabetes and difficulties discharging patients from hospital because of delays in access to district nursing. 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. Also, the hours for which services were available were not clear. Reviewers were told that the implementation of the integrated teams would provide better cover for staff absences and vacancies. The relationship between the proposed model, its staffing and commissioners' service specifications was not clear. The Partnership Trust management team reported that vacancy levels were around 1%. Further work in this area as part of implementing the new Integrated care model may be helpful, including looking at staff understanding of expected and actual staffing levels.
5. Reviewers were told that patients were waiting up to six weeks for wheelchair repairs and between six and eight weeks for new or replacement wheelchairs. Further work to investigate this issue may be helpful.
6. A named person for case management was identified but the named person changed depending on the patient's level of need and the services with which they were in contact. It may be helpful to review, as part of the new model of care, whether this arrangement provides sufficient continuity of patient support.
7. One team was piloting involvement of a care of the elderly consultant with the work of the integrated team. Reviewers supported continuation of this work, evaluation, and roll-out if appropriate.
8. Patient transport: See health economy section of this report.

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SPECIALIST CARE OF ADULTS WITH DIABETES

BURTON HOSPITALS NHS FOUNDATION TRUST

STAFFORDSHIRE & STOKE ON TRENT PARTNERSHIP NHS TRUST

General Comments and Achievements

Specialist care for people with diabetes was provided by a hospital-based team and two community teams of diabetes specialist nurses. Diabetes specialist nurses in the community were providing a good service, including twice-weekly appointment-based evening clinics in a local supermarket. This enabled practical educational support to be provided, for example, carbohydrate counting of shopping.

Community teams covered East Staffordshire (Burton and Uttoxeter) and South East Staffordshire (Burntwood, Lichfield and Tamworth). Evidence relating to the East Staffordshire team was clearer and so both compliance with

Quality Standards and the issues identified in this report may not fully reflect arrangements in South East Staffordshire.

Medical input to the hospital team comprised three consultant diabetologists, two acute medicine consultants who were trained and accredited in diabetes and endocrinology, and one GP clinical assistant session per week. Other health care professionals within the team include a dietitian, physiotherapist, orthotist, podiatrist, assistant practitioner and health care assistants. Diabetes specialist nurse staffing comprised 2.8 w.t.e. Queens Hospital, Burton had a good multi-disciplinary foot service which included a physiotherapist, orthotist and podiatrist, with access to advice from a vascular surgeon if required.

Good Practice

1 The team provided good support for women with diabetes after the birth of a child, including post-natal glucose tolerance testing and immediate follow up.

2 One of the diabetes specialist nurses in South East Staffordshire had a specific role working with care homes.

3 The East Staffordshire community team had good guidelines - 'Fundamentals of Primary Care Specialist Diabetes Service'. These guidelines were clear about the local pathway, roles of different services within the pathway and the competences needed.

4 Good arrangements for transition from children's services were in place. Young people had four appointments over the two years after their seventeenth birthday at which both adult and paediatric clinicians were available.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Integration between Services**

Community and hospital-based services were working separately and good integration, communication and liaison between services were not evident. Also, there was no local network (or equivalent) with responsibility for driving service coordination and service improvement and involving primary care, community and hospital-based services and commissioners.

2 **Think Glucose**

'Hypo' boxes were not yet available on in-patient wards at Queen's Hospital, Burton, although there were plans for these to be implemented.

Further Consideration

1 Psychological support: See health economy section of this report.

2 Patient transport: See health economy section of this report.

3 In-patient care by staff with appropriate competences: See Trust-wide section of this report.

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SPECIALIST CARE OF PEOPLE WITH COPD, INCLUDING PULMONARY REHABILITATION

BURTON HOSPITALS NHS FOUNDATION TRUST and STAFFORDSHIRE & STOKE ON TRENT PARTNERSHIP NHS TRUST

General Comments and Achievements

Specialist care for people with COPD was provided by a hospital-based acute service and a community team which was combined with the community matron service and also included pulmonary rehabilitation. Good informal communication between these parts of the service was evident. Staff were working hard and were highly committed to the care of their patients. Patients who met the visiting team greatly appreciated the care they received and were particularly positive about care available from the community service.

Several staff were working under extreme pressure (see below) and reviewers commented that it was an achievement that non-invasive ventilation and pulmonary rehabilitation continued to be provided in these circumstances.

Good Practice

1 The 'My Usual Medication' form was a personalised, easy to use guide to patients' medication.

Immediate Risks

1 **Non-invasive ventilation**

Arrangements for the provision of non-invasive ventilation were not robust. Reviewers were particularly concerned about two aspects of this service: a) possible delays in the initiation of non-invasive ventilation and b) adequacy of nursing staffing for the care of patients needing non-invasive ventilation.

Initiation of non-invasive ventilation was undertaken by one of the four respiratory consultants if one was available at the time. (Three of the respiratory consultants were part of the medical on-call rota.) Reviewers were told that there could be delays at times when a respiratory consultant was not on call. Critical care consultants were available but were not always contacted. Respiratory consultants were sometimes contacted when not on duty.

Non-invasive ventilation was provided on Ward 3 where patients received 1:1 nursing care for the first four hours of non-invasive ventilation. Reviewers were told that, after that time, patients received the same level of nursing care as other patients on the ward. Nurse staffing levels were low for the number and dependency of patients on the ward and the ward layout meant that it was very difficult to observe patients from the nurses' station.

The Trust's response to this issue is given below.[2]

Concerns

1 **Staffing Levels**

Reviewers were concerned about several aspects of the staffing of specialist services for people with COPD:

a. Ward staffing: Low ward staffing levels on Ward 3 affected all respiratory patients (including those on non-invasive ventilation). The ward layout made it very difficult to observe patients. Because of the large number of side rooms on the ward, patients with gastro-intestinal problems were often admitted to Ward 3 for isolation. This increased the pressure on nursing staff. At the time of the review, the nurse staffing ratio was 1:7 on early and late shifts for 32 beds (including seven or eight

[2] Trust response to immediate risk: Dedicated and collaborative out of hours rota to provide advice. Dedicated time allocated to consultant job plan to allow leadership and development of the NIV service. Funding for a fourth full-time respiratory consultant. Two additional capacity beds which can be ring fenced for patients requiring NIV. Operational policy and competence based training programme for all staff developed.

side-rooms) and it was not clear that the dependency of patients had been taken into account in allocating staffing levels.

b. Hospital-based specialist nursing: There was only one hospital-based respiratory specialist nurse in acute hospital and no cover for absences. Arrangements for spirometry during her absences were not clear as ward nurses did not have appropriate competences.

c. Pulmonary rehabilitation team: Staffing was significantly reduced by vacancies, maternity and sick leave. Shortly after the review the service was to be running with only one physiotherapist. A minimum of two supervisors is expected for pulmonary rehabilitation sessions.

d. Community specialist nursing team: The community matron and specialist COPD teams were combined. Some caseloads were high due to vacancies and sick leave and, at the time of the review, there were no respiratory specialist nurses – and no community-based spirometry – in Lichfield and Tamworth.

e. Home Oxygen Service: The Home Oxygen and Review Service had been established with a 0.6 w.t.e. home oxygen nurse and no cover for absences, providing care for 142 patients on home oxygen. It was not clear how urgent requests could be responded to with this level of staffing.

f. Respiratory physiology: It was not clear that full lung function testing could be provided during absences of the head physiologist. Reviewers were told that patients were referred elsewhere if necessary but the pathways, criteria and arrangements for this were not clearly defined.

2 **Care Planning and Review, Clinical Guidelines and Protocols, Data Collection and Audit**

Care plans were not yet documented and arrangements for holistic annual review of patients cared for by the specialist team were not yet in place. Few clinical guidelines were documented and there was a lack of clarity about the patient pathway. This was a particular problem because pathways differed for East Staffordshire, South Derbyshire and South East Staffordshire. Reviewers commented that it would be difficult for anyone new to the service, or working in it on a temporary basis, to understand the patient pathways that were operational. Limited data about service activity were collected and the service did not have a robust programme of audit of implementation of clinical guidelines.

Specialist competences of staff in the community teams were not clearly documented and so it was not clear that community staff had appropriate competences for the roles they were undertaking.

3 **Pulmonary Physiology Equipment**

There was only one machine for conducting full lung-function tests. This was leading to delays in access to this service. It was not clear how the service continued at times of machine breakdown or maintenance.

Further Consideration

1 No overall clinical lead was identified for services for people with COPD in South Staffordshire (East). Reviewers suggested that identifying a clinical lead would be crucial to driving service improvements.

2 There was no local network (or equivalent) involving primary care, community and hospital-based services and commissioners with responsibility for driving service coordination and improvement.

3 When staffing levels improve, further input to primary care education programmes may be helpful in order to ensure primary care staff have and are maintaining appropriate competences in the care of people with COPD.

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Specialist Care of People with Heart Failure, including Cardiac Rehabilitation

BURTON HOSPITALS NHS FOUNDATION TRUST and STAFFORDSHIRE & STOKE ON TRENT PARTNERSHIP NHS TRUST

General Comments and Achievements

Specialist care for people with heart failure was provided by hospital-based consultants and two community teams, serving East Staffordshire and South East Staffordshire. Staff were working hard with limited resources.

The South East Staffordshire community team comprised 2 w.t.e. specialist nurses, who also covered the cardiac rehabilitation service. Support for 64 people with heart failure was provided by 0.8 w.t.e. specialist nurse and two part-time cardiac rehabilitation nurses. The nurses attended fortnightly clinics at Good Hope Hospital and Samuel Johnson Hospital, Lichfield.

The East Staffordshire community team also comprised three (2.3 w.t.e.) specialist nurses who provided care for 154 patients with heart failure. This team met monthly with the hospital-based team at Queen's Hospital, Burton. Patients from East Staffordshire who met reviewers were complimentary about the support available from the community service and the information they received. A separate team (nurse specialist, dietitian, pharmacist and exercise instructors) provided cardiac rehabilitation.

Both community teams had developed good links with palliative care.

A newly appointed consultant was keen to develop services for people with heart failure. The acting Matron for the hospital-based team had good understanding of the needs of patients with heart failure and may help to drive integration of services across the health economy.

GPs had open access to echocardiography and an invasive cardiology service had recently been developed locally.

Good Practice

1 Facilities in the new chest pain assessment centre were very good. Considerable work had been done within cardiac services to ensure patient privacy and dignity.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Diagnostic Pathway**

Echocardiography was not available within two weeks for people with suspected heart failure and a previous myocardial infarction. Rapid access multi-disciplinary assessment, as expected by NICE guidance, was not yet available.

2 **Care Planning and Review, Clinical Guidelines and Protocols, Data Collection and Audit**

Care plans were not yet documented and arrangements for holistic, six monthly review of patients cared for by the specialist team were not yet in place. Few clinical guidelines were documented and there was a lack of clarity about the patient pathway. This was a particular problem because pathways differed for East Staffordshire, South Derbyshire and South East Staffordshire. Limited data about service activity were collected and the service did not have a robust programme of audit of implementation of clinical guidelines. Reviewers commented that the number of patients under active follow up appeared low for the population served.

3 **Integration between Services**

Community and consultant services were working separately and good integration, communication and liaison between services were not evident. Patients who met the visiting team said that they had to keep chasing investigations to make sure they actually happened. Community nursing teams did not have any 'fast track' access to acute services in the event of exacerbation of patients' conditions, community teams

were not informed when their patients were in hospital, and there was no apparent coordination between echocardiography and heart failure specialist nurses.

3 **Specialist Nurse Staffing**

There was no heart failure specialist nurse in the acute Trust. Specialist nurse staffing capacity appeared low for the population served with approximately 2 w.t.e. nurses in each community team. The team in South East Staffordshire also provided cardiac rehabilitation. A survey undertaken in East Staffordshire showed that seven out of 32 patients did not receive timely face to face contact with a specialist nurse.

4 **Competences and Training Plan**

Specialist competences were not clearly documented and so it was not clear that staff had appropriate competences for the roles they were undertaking. There was no overall training plan for achieving the expected specialist competences.

Further Consideration

1. No overall clinical lead was identified for services for people with heart failure in South Staffordshire (East). Reviewers suggested that identifying a clinical lead would be crucial to driving service improvements.
2. Discussions to improve the pathway of care were in progress but it was not clear that these were coordinated. For example, reviewers heard about plans to develop a community echo-cardiography service and plans to develop an echocardiography clinic in the new heart centre. Additional echo-cardiography capacity was needed but it was not clear that anyone had an overview of the impact of these two, apparently separate, developments. A new East Staffordshire pathway of care for people with heart failure had been developed which looked very good. When the new pathway/s are clear, it will be possible to ensure that staff with appropriate competences are available for the roles expected.
3. Arrangements for patient information and support may benefit from review. It was not clear that patients were always offered the information that was available. Patients who met the visiting team commented that hospital staff gave little information and explanation of their disease. There was no support group for patients with any cardiac problem. Patients were not sent copies of their clinic letters (see Trust-wide section of this report). Reviewers were also told that patients did not have continuity of care from consultants and would often see several consultants.
4. Patients with heart failure from East Staffordshire could access cardiac rehabilitation if they wished but it was not clear that this was systematically offered to them. The service was not specifically commissioned to care for people with heart failure.

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Specialist Care of People with Chronic Neurological Conditions

BURTON HOSPITALS NHS FOUNDATION TRUST and STAFFORDSHIRE & STOKE ON TRENT PARTNERSHIP NHS TRUST

General Comments and Achievements

Specialist care for people with chronic neurological conditions was provided by a consultant-led service at Queen's Hospital, Burton and two rehabilitation teams;

a. the Adult Ability Team in Burton was an interdisciplinary team including two specialist nurses, one for people with Parkinson's Disease and the other for people with multiple sclerosis and

b. the General Rehabilitation Service serving Lichfield and Tamworth.

Both rehabilitation services cared for people with a wide range of chronic neurological conditions. Good leadership was evident in the rehabilitation teams and the services worked hard to keep patients out of hospital.

There were two specialist nurses, one for people with Parkinson's Disease and the other for people with multiple sclerosis or motor neurone disease who covered the South East Staffordshire area. Patients who met the visiting team were pleased with the services and appreciative of the care they received.

The Adult Ability Team provided an impressive, innovative service. Patients with progressive neurological conditions were supported well and there was particular focus on fatigue management and research. Patients could access respite beds at Barton. Multiple sclerosis and Parkinson's Disease specialist nurses were integral to the team and had good links with the acute Trust.

The South East Staffordshire service was a general rehabilitation service based at Sir Robert Peel (Tamworth) and Samuel Johnson (Lichfield) Community Hospitals. This was an integrated service involving physiotherapy, occupational therapy and speech and language therapy. One of the physiotherapists had specific expertise in the care of people with neurological conditions. Links with specialist nurses for people with chronic neurological conditions were also in place and the rehabilitation team provided cover when the specialist nurses were away. The community falls team was also based at Sir Robert Peel Hospital which helped communication with this team and links with the consultant in care of frail older people. The service also linked with the early discharge team for the Burntwood, Lichfield and Tamworth area and with voluntary sector organisations. A good range of education and self-management programmes was offered and the service was able to be very flexible in meeting patients' needs. A good, clear pathway was in place. Staff had experience of caring for people with neurological conditions and people with a wide spectrum of conditions were accepted. (Only adults with cerebral palsy were not covered by the referral criteria.) Reviewers were told that 75% of patients referred to the service had a neurological problem.

The consultant-led neurology service at Queen's Hospital, Burton, comprising two consultant neurologists, a Trust specialty doctor and secretarial support, was working hard to meet the needs of patients with limited resources. Clear pathways of care were being developed and there was a strong focus on patient-orientated goals. A monthly multi-disciplinary clinic was held, involving specialist nurses and staff from the Adult Ability team. Rehabilitation service staff were able easily to put patients on the list for multi-disciplinary team discussion. One session of neuro-radiology was available, provided from University Hospitals Leicester. Patients needing consideration of disease modifying therapy were referred to Queen's Medical Centre, Nottingham.

Good Practice

1. A good 'Epilepsy First Fit Flow Chart' was used in the Emergency Department. This was very clear and set out well the responsibilities of Emergency Department staff.
2. A clear pathway for ambulatory care for people with recurrent seizures was in use.
3. The Adult Ability Team provided good, integrated care for people with progressive neurological conditions. There was a strong focus on keeping people out of hospital and good links with the hospital-based service for discussion of patients' needs. Vocational support and home visits were also provided.
4. The South East Staffordshire Rehabilitation Service provided a holistic multi-disciplinary approach to meeting the needs of the local population and good, integrated working with other local community-based services was evident.

Immediate Risks: No immediate risks were identified.

Concerns

1. **Care of People with Epilepsy**

   No specialist nurse was available to support people with epilepsy and NICE guidance on the care of people with epilepsy was therefore not fully implemented.

2 **Guidelines and Protocols**

Clinical guidelines and protocols were not yet documented in the hospital-based service. Staff said they referred to NICE guidance but this had not been localised to show how it would be implemented locally. New pathways were, however, being developed.

Further Consideration

1 Support for people with other chronic neurological conditions was not always available.

2 Limited evidence of the competences of staff providing services for people with chronic neurological conditions was available. Staff appeared to have undertaken appropriate training but there was not a clear framework of competences expected and whether these were achieved.

3 It may be helpful to consider whether nurse prescribing would be a useful addition to the range of services offered.

4 The rehabilitation services did not have access to medicines management advice which could enhance the multi-disciplinary input to the care offered.

5 Reviewers did not see much use of activity data and caseload numbers for management and planning improvements to the services offered. For example, the Adult Ability Team was regularly doing urgent visits which impacted on routine activity – but this activity and its implications did not appear to be being analysed.

6 Carers who met the visiting team were not clear about the support available in different areas of the health economy, including for carers of people with cerebral palsy.

7 A large number of separate teams and services were involved in the care of people with chronic neurological conditions, including two rehabilitation services, two specialist nursing services, a hospital-based service in Burton, support from Leicester, referral to Nottingham and some links with Birmingham for the care of people with motor neurone disease. Services were working together despite this fragmentation, especially in East Staffordshire. It may be helpful to consider whether the current organisational and managerial arrangements optimise patient care, including patient pathways, patient flow, communication and integration, and whether any changes are needed.

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TRUST-WIDE

STAFFORDSHIRE & STOKE ON TRENT PARTNERSHIP NHS TRUST

Trust-wide comments relating to Staffordshire and Stoke on Trent Partnership Trust are given in the report of the South Staffordshire (West) peer review visit. This report is available on the WMQRS website***:* www.wmqrs.nhs.uk**

BURTON HOSPITALS NHS FOUNDATION TRUST

General Comments and Achievements

Good pharmacy support was available for the Trust's services. A very good leaflet on self-administration had been developed. This was being piloted on two wards and there were plans to roll out the initiative to other wards following evaluation. Good medicines management support was available for patients and medicines reconciliation was undertaken for all in-patients.

Good Practice

1 The electronic records system within the Trust provided excellent access to all clinical information (although links with the IT systems used in the community services were not yet possible).

Immediate Risks: No immediate risks were identified.

Concerns: See health economy section of this report.

Further Consideration

1. Clinic and discharge letters were not copied to patients. Patients therefore may not have up to date information about their condition and care plan.
2. The Trust's document control policy applied to organisational policies but did not appear to cover clinical guidelines. As a result some guidelines seen by reviewers did not have appropriate document control.

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COMMISSIONING

NHS EAST STAFFORDSHIRE 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 points are specifically drawn to the attention of commissioners:

General Comments and Achievements

The representatives of NHS East Staffordshire Clinical Commissioning Group who met the visiting team were very well-informed about local services for the care of people with long-term conditions and had good plans for improvements to these services. Reviewers were impressed that a social care commissioner was seen as part of the team.

Good Practice

1. A 'Medicines in Care Homes' project was running, linked to the management of COPD and QOF arrangements. The project was aimed at reviewing medicines management in care homes and identifying system errors which may cause medication problems. Patients on several medications, including medicines with a high potential for harm, were identified for a clinical review by a practice-based pharmacist. A report of the visit and any recommendations was provided to the care home and clinical issues were raised with the GP.

Immediate Risks: No immediate risks were identified.

Concerns: See health economy section of this report.

Further Consideration

1. Cardiac rehabilitation was not specifically commissioned for people with heart failure. Patients could access this service if they wished but it was not clear that it was systematically offered to them.

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NHS SOUTH EAST STAFFORDSHIRE & SEISDON PENINSULA 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 points are specifically drawn to the attention of commissioners:

General Comments and Achievements

Care of people with long-term conditions had been identified as a priority for NHS South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group. This CCG commissioned services from several acute providers and from South Staffordshire and Stoke on Trent Partnership NHS Trust but was not the lead commissioner for any of these organisations. The CCG was, however, actively involved in Clinical Quality Review Meetings for all these

providers. Work had been undertaken relating to care of people with diabetes, where about 80 people were using tele-health, and people with chronic neurological conditions (excluding epilepsy).

Immediate Risks: No immediate risks were identified.

Concerns: See health economy section of this report.

Further Consideration

See also 'All Commissioners' section below.

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ALL COMMISSIONERS

Other Immediate Risk and Concerns Identified

The issues identified in the 'health economy', 'primary care', and provider sections of this report will require the attention of commissioners. The following points are specifically drawn to the attention of commissioners:

Immediate Risks:

1. Specialist Care of People with COPD - Non-invasive ventilation: See COPD section of the report and associated footnote.

Concerns:

1. Specialist Care of Children and Young People with Diabetes: Staffing; Local Network
2. Community Long Term Conditions Services: Access to equipment; Staffing and staff competences; Integration
3. Specialist Care of People with Diabetes: Integration
4. Specialist Care of People with COPD: Staffing; Care planning, Data and audit; Pulmonary physiology equipment
5. Specialist Care of People with Heart Failure: Pathway; Care planning, Data and audit; Integration; Nurse staffing and competences
6. Specialist Care of People with Chronic Neurological Conditions: NICE Epilepsy Guidance

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Appendix 1 Membership of Visiting Team

Executive Lead

Dr Dawn Moody	General Practitioner	North Staffordshire Clinical Commissioning Group

Visiting Team

Dr Manjari Bollu	General Practitioner	Coventry - Forum Health Centre
Neil Davies	Practice Manager	Dr Machin & Partners GP Practice, Sheldon
Adele Dean	Clinical Quality Manager	West Midlands Ambulance Service NHS Trust
John Grayland	Senior Strategy and Redesign Manager - LTC	NHS Birmingham East & North PCT
Chris Groves	Service User	Rheumatology User Group
Wendy Hampshire	Locality Manager Adult Services	South Warwickshire NHS Foundation Trust
Karen Joseph	Practice Manager	Sherbourne Medical Centre
Sharon Letissier	Multiple Sclerosis Nurse Specialist	University Hospitals Birmingham NHS Foundation Trust
Jamie Maxwell	Clinical Governance Lead	University Hospital of North Staffordshire NHS Trust
Sarah Millard	Heart Failure Specialist Nurse	The Royal Wolverhampton Hospitals NHS Trust
Dr Murthy Narasimha	Consultant Physician - Diabetes + Endocrine	University Hospitals Coventry & Warwickshire NHS Trust
Sheila Page	Clinical Nurse Specialist Diabetes	Walsall Healthcare NHS Trust
Dr David Parr	Consultant Respiratory Physician & Clinical Director, Cardio-Thoracic Division	University Hospitals Coventry & Warwickshire NHS Trust
Dr Sanjiv Petkar	Consultant Cardiologist/Electrophysiologist	The Royal Wolverhampton Hospitals NHS Trust
Dr Parakkal Raffeeq	Consultant Paediatrician	University Hospital of North Staffordshire NHS Trust

Dr Ash Reynolds	Clinical Psychologist	Black Country Partnership NHS Foundation Trust
Jane Smith	Head of Nursing	Worcestershire Acute Hospitals NHS Trust
Angela Turner	Clinical Quality Improvement Advisor	NHS Telford & Wrekin
Mark Weston	Paediatric Diabetes Specialist Nurse	Wye Valley NHS Trust

WMQRS Team

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

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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	6	4	67
NHS East Staffordshire CCG	(3)	(3)	(100)
NHS South East Staffordshire & Seisdon Peninsula CCG	(3)	(1)	(33)
Specialist Care of Children & Young People with Diabetes: BHFT	29	15	52
Trust-Wide: BHFT	4	2	50
Commissioning	14	7	50
NHS East Staffordshire CCG	(7)	(5)	(71)
NHS South East Staffordshire & Seisdon Peninsula CCG	(7)	(2)	(29)
Health Economy	**53**	**28**	**53**
Care of Adults with Long-Term Conditions			
Primary Care	16	9	56
NHS East Staffordshire CCG	(8)	(4)	(50)
NHS South East Staffordshire & Seisdon Peninsula CCG	(8)	(5)	(63)
Community Long-term Conditions Services: SSOTPT	52	13	25
Specialist Care of Adults with Diabetes: BHFT & SSOTPT	58	25	43
Specialist Care of People with COPD: BHFT & SSOTPT	58	17	29
Specialist Care of People with Heart Failure (All Services)	171	50	29
Heart Failure: SSOTPT (South East)	(57)	(15)	(26)
Heart Failure: SSOTPT (East)	(57)	(16)	(28)
Heart Failure: BHFT	(57)	(19)	(33)
Specialist Care of People with Chronic Neurological Conditions (All Services)	166	90	54
Queen's Hospital (BHFT)	(58)	(29)	(50)

Service	Number of Applicable QS	Number of QS Met	% met
Adult Ability Team (East Staffordshire)	(54)	(33)	(61)
Rehabilitation Team, MS/MND & Parkinson's Nurse Specialist (South East Staffordshire)	(54)	(28)	(52)
Trust-Wide: BHFT	7	1	14
Commissioning	24	13	54
NHS East Staffordshire CCG	(12)	(8)	(67)
NHS South East Staffordshire & Seisdon Peninsula CCG	(12)	(5)	(42)
Health Economy	**552**	**218**	**39**

Abbreviations:

BHFT: Burton Hospitals NHS Foundation Trust

SSOTPT: Staffordshire & Stoke on Trent Partnership NHS Trust

MS: Multiple Sclerosis

MND: Motor Neurone Disease

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