WM QRS West Midlands Quality Review Service

NHS

Care of Adults with Long-Term Conditions

Care of Children & Young People with Diabetes

North East Birmingham & Solihull Health Economy

Visit Date: 14th, 15th, 16th & 17th January 2013 Report Date: May 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 14th, 15th, 16th & 17th January 2013. The purpose of the visit was to review compliance with West Midlands Quality Review Service (WMQRS) Quality Standards for:

- Care of People with Long-term Conditions, Version 1.1, 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 North East Birmingham & Solihull health economy. Appendix 2 contains the details of compliance with each of the standards and the percentage of standards met.

NORTH EAST BIRMINGHAM AND SOLIHULL HEALTH ECONOMY

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

- Birmingham Community Healthcare NHS Trust
- Heart of England NHS Foundation Trust
- NHS Birmingham CrossCity Clinical Commissioning Group (CCG)
- NHS Birmingham South Central Clinical Commissioning Group
- NHS Solihull 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. Individual organisations are responsible for taking action and monitoring progress through their usual governance mechanisms. Commissioners have responsibility for supporting quality improvement across the whole patient

pathway. The nominated lead commissioner in relation to services provided by Heart of England NHS Foundation Trust is NHS Solihull CCG. The nominated lead commissioner for Birmingham Community Healthcare NHS Trust is NHS Birmingham South Central CCG. The nominated lead commissioner for out of hours GP services, walk-in centres and primary care centres is NHS Birmingham CrossCity CCG. 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 www.wmqrs.nhs.uk

Acknowledgments

West Midlands Quality Review Service would like to thank the staff and service users and carers of North East Birmingham & Solihull 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

This review covered North and East Birmingham and Solihull. In some ways this area worked as three health economies with different pathways for the care of people with long-term conditions in each area. The area included some excellent services. The care of people with long-term conditions was generally being considered an important strategic priority and several services were exploring new models of service delivery. There were, however, a few services about which reviewers were seriously concerned.

Good Practice

1 In Solihull, a 'Frailty Board' involving the local authority, Heart of England NHS Foundation Trust acute and community services, medicines management staff, the CCG quality team and '*LINKS*' was working to improve integrated care of people with multiple long-term conditions. This Board had overseen the development of a commissioning strategy, commissioning intentions and a good service specification. There was GP leadership of this work and a 'frailty register' was in development. Implementation of the agreed specification was in progress.

Concerns

1 **Care of people with chronic neurological conditions**

The care of people with chronic neurological conditions did not appear to be a priority for commissioners or providers. Out-patient care, a small rehabilitation service and some input to in-patient care was provided by neurology services at Heart of England NHS Foundation Trust. Specialist nursing support for people with multiple sclerosis or Parkinson's Disease was provided by Birmingham Community Healthcare NHS Trust. Some patients, especially from Solihull, were referred to neurologists at University Hospitals Birmingham NHS Foundation Trust. Services for people with epilepsy did not meet NICE guidance (see section of this report relating to care of people with chronic neurological conditions for further detail). There was no overall strategy for the development of services and no clarity about future commissioning intentions. As a result, some patients from the health economy had access to only a limited range of services. Pathways of care were not clear and mechanisms for integrated working between the services that were available were not defined. (See chronic neurological conditions section of this report for more detail on this issue.)

2 **Integration of services within Birmingham**

Integrated multi-disciplinary teams (IMTs) were developing as the focus of care for people with multiple long-term conditions in Birmingham. Links between these services and the community-based teams for COPD, heart failure, diabetes, Parkinson's Disease and multiple sclerosis (provided by Birmingham Community Healthcare NHS Trust and covering the whole of Birmingham) appeared to work reasonably.

Links between community and hospital-based condition-specific specialist teams were variable (for example, between hospital and heart failure teams) and appeared to depend on personal relationships rather than organisational arrangements. Opportunities for improving the quality of services through effective joint working, including cover for absences, did not appear to be being taken. Reviewers saw examples of duplication and poor communication between some services.

Links between hospital-based condition-specific specialist teams and IMTs were also variable and there was little evidence of effective communication and integrated working.

Further Consideration

1 As described above, the care of people with single long-term conditions was not well coordinated in Birmingham. Discussions on integration of care for people with multiple long-term conditions who may be in contact with several services did not appear to have started. Further work on this may be helpful.

2 Reviewers were told about delays in hospital discharge of Birmingham residents, especially for people needing palliative care and those with learning disabilities. In the time available reviewers were not able to investigate this issue and its impact on the care of people with long-term conditions in detail.

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PRIMARY CARE

NHS BIRMINGHAM CROSSCITY CLINICAL COMMISSIONING GROUP
NHS BIRMINGHAM SOUTH CENTRAL CLINICAL COMMISSIONING GROUP

This section of the report is also included in the South and Central Birmingham health economy report.

General Comments and Achievements

GPs were able to put 'special notes' directly on the Badger GP out of hours IT system so that out of hours staff could be alerted to ongoing issues relating to the care of the patient.

Immediate Risks: No immediate risks were identified.

Concerns

1 In Birmingham CrossCity Clinical Commissioning Group area there was no structured GP primary care education programme. One part of the area had previously run protected learning time.

Further Consideration

1 Some GPs who met reviewers were concerned about the amount of information about services which was sent to them. Others appeared not to be aware of services that were available. An easy to use directory or guide to local services was not yet available.

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

3 The timeliness of results of anti-coagulant testing was slower in the independent primary care service which Birmingham GPs were expected to access than in the hospital service. As a result, GPs and patients were accessing the hospital-based service as results were available more quickly. This issue may merit further investigation.

NHS SOLIHULL CLINICAL COMMISSIONING GROUP

No specific issues relating to primary care in Solihull were identified. Related points are included in the health economy and commissioning sections of this report.

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HEART OF ENGLAND NHS FOUNDATION TRUST

General Comments and Achievements

Services for children and young people with diabetes at Heart of England NHS Foundation Trust were valued and appreciated by parents. Good progress had been made on integrating the previously separate teams at Good Hope Hospital (GHH) and Birmingham Heartlands Hospital (BHH) and ensuring consistency of care. Staff were enthusiastic and committed to providing good care for patients.

Good Practice

1 Clinical guidelines were very well-presented, updated annually and had been agreed by clinicians on both hospital sites and were easily accessible at both hospitals.

2 A 'walk-in' podiatry clinic was available at Good Hope Hospital which enabled easy access for children and young people and helped to avoid multiple visits to hospital.

3 Retinopathy screening was available on site at Birmingham Heartlands Hospital. This was particularly useful for ensuring that patients who had missed appointments in the regional screening programme were screened.

4 Nursing clinical notes were well organised on both sites. All contacts with the child or young person and their family were documented and an effective 'contact sheet' summarised the patient journey.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Low Staffing Levels**

Staffing levels were insufficient for the number of patients. A total of 420 children and young people with diabetes from Birmingham, Solihull and South Staffordshire were receiving care across the three sites, in addition to a number of clinics in South Staffordshire. At the time of the review there were 0.55 w.t.e. consultants allocated to this work, 4.7 w.t.e paediatric diabetes specialist nurses (PDSNs) and 0.2 w.t.e. dietitian support. Staffing levels were lower than recommended levels and were not sufficient for the service to achieve *Best Practice Tariff.*

Reviewers were particularly concerned about the low level of dietician staffing; weight reduction plans were limited because of the shortage of dietetic support and nurses were taking on some of the work which would normally be undertaken by dietitians, especially in relation to carbohydrate counting. Psychological support was available to patients at Birmingham Heartlands Hospital. Good Hope Hospital patients were referred to child and adolescent mental health services if they needed psychological help. Staffing levels were stretched even further because clinics were provided on five different sites. Weekly clinics were held at Good Hope Hospital and Birmingham Heartlands Hospital and monthly clinics at Lichfield, Tamworth and Solihull**.** A business case for additional staffing had been produced but had not been approved at the time of the review and future funding was still unclear.

2 **Follow-up after Diagnosis**

The service offered only three contacts in the first week after diagnosis, after which parents could contact the service for advice. This arrangement did not meet the expected daily contact for the first week.

3 **Local Network Group**

There was no Trust or health economy group with responsibility for driving improvements in services for children and young people with diabetes, including supporting achievement of *Best Practice Tariff.*

Further Consideration

1 A more structured approach to on-going education for patients and carers may be helpful, especially at Birmingham Heartlands Hospital.

2 The information pack that was handed out to newly diagnosed patients did not always contain the same information. Reviewers considered it might be appropriate to be consistent across both sites.

3 Further discussion and consideration of some of the feedback from parents who met the visiting team may be helpful; in particular, parents said that they often had to phone several nurses at Good Hope Hospital whereas the arrangements for contacting a specialist nurse at Birmingham Heartlands Hospital were easier. Also parents reported variability in the telephone advice given by ward staff outside normal working hours.

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COMMUNITY LONG-TERM CONDITIONS SERVICES

BIRMINGHAM COMMUNITY HEALTHCARE NHS TRUST

General Comments and Achievements

Integrated multi-disciplinary teams (IMTs) had been in place since April 2012 providing community-based care for people with long-term conditions. These teams comprised clinical case managers, district nursing and domiciliary therapy services. The IMTs worked closely with specialist community-based services for people with diabetes, heart failure and COPD. There was also a Birmingham city-wide Single Point of Access (SPA) and a Rapid Response Service (RRS), 8am to 10pm. A telemonitoring service centre was based at the SPA.

Staff in the IMTs were committed and coping with the change of organisational arrangement and the implications for their roles. Patients who met the visiting team were appreciative of the care they received.

Good Practice

1 The 'Single Point of Access' was well organised and staffed by clinicians with appropriate competences. All urgent calls were managed by a clinician rather than a call handler at all times (24/7). Clinicians who were handling calls had a good understanding of the services which were available.

2 A Fatigue, Anxiety and Breathlessness service had been piloted and then implemented, based at the John Taylor Hospice. This service was run by the hospice multi-disciplinary team and community COPD specialist nurses. Four programmes had run in 2012 and two more were planned for 2013. This service had been evaluated at the end of the pilot and had been shown to be effective in developing participants' competence and confidence in self-management.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Clinical Leadership**

The clinical leadership of the IMTs was not clear. It was therefore not clear who within the teams had responsibility for development of clinical guidelines and policies, and for the monitoring and quality assurance of clinical care.

2 **Documented Guidelines and Policies**

Several of the expected clinical guidelines were not yet in place, including guidelines on diagnosis, monitoring and management, and management of chronic complications. Reviewers were particularly concerned because the Advanced Nurse Practitioners in the RRS were making diagnoses on patients referred to the service.

Further Consideration

1 Capacity limitations within the IMTs and Rapid Response Service were limiting their ability to work with acute Trusts on 'supported discharge'. It may be helpful to review the extent of this problem, for example through some 'capacity and demand' work.

2 Integration with condition-specific specialist teams and care of people with multiple long-term conditions: See health economy section of this report.

3 IT systems were not integrated between the acute and community Trust, although community staff could see results and letters from the hospital services. Hospital-based staff could not see information about care being delivered by community-based services. Further development of IT support to mobile working was being considered at the time of the review visit.

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SOLIHULL COMMUNITY VIRTUAL WARDS – HEART OF ENGLAND NHS FOUNDATION TRUST

General Comments and Achievements

Community health services in Solihull were part of an 'Integrated Care Partnership' hosted by Heart of England NHS Foundation Trust. Commitment to integrated working was clearly evident and community services had good links with both Solihull and Birmingham Heartlands Hospital. The three Virtual Wards in Solihull were an important part of the Integrated Care Partnership, with a particular emphasis on multi-disciplinary assessment and case management with the aim of delivering care closer to home, reducing unplanned admissions to hospital and reducing length of hospital stays as much as possible.

Staffing of the Virtual Wards comprised a ward clerk, community matrons, staff nurse, health care assistant, social worker, pharmacist and physiotherapist. Social worker, pharmacist and physiotherapy posts were shared across the teams with each team having 0.6, 0.3 and 0.5 w.t.e. respectively.

Risk stratification was used as the basis for referral to the Virtual Ward. A Joint Outcomes Framework had been agreed with the Local Authority which combined the NHS Outcomes Framework, Adult Social Care Outcomes Framework and Public Health Outcomes Framework.

Reviewers were impressed by many aspects of the work of the Virtual Wards, including the level of expertise among the staff, their commitment to improving patient care, the good communication which was clearly evident and the robust clinical leadership. The model of care was being reviewed and improved on an ongoing basis, for example, following audit evidence from their clinical case load, dementia services had been re-established as part of the integrated team. Integration of IAPT ('Improving Access to Psychological Therapy') services into the Virtual Ward was also being piloted at the time of the review.

Good Practice

1 The multi-disciplinary Virtual Wards had social workers as part of their permanent staffing establishment.

2 A pharmacist was part of each Virtual Ward team and an 'Interface Formulary' across primary and secondary care was in place.

3 A 'Carer's Strain Index' tool was being used which improved awareness of carers' needs across the whole team.

4 Support from drug and alcohol detoxification and health trainers were easily accessible for patients of the Virtual Wards.

5 A community matron was specifically working with care homes delivering training and education for the care home staff. Members of the Virtual Ward team provided education for domiciliary care agencies on a quarterly basis.

Immediate Risks: No immediate risks were identified.

Concerns: No concerns were identified.

Further Consideration

1 Further education of staff around continuing health care arrangements may be helpful.

2 It may be helpful to review whether the emphasis on enabling self-management by patients of the Virtual Ward could be increased. It may also be helpful to consider whether patient engagement and feedback mechanisms could be strengthened.

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SPECIALIST CARE OF ADULTS WITH DIABETES

The services providing specialist care for adults with diabetes described in this report were provided by Heart of England NHS Foundation Trust. These comprised hospital-based teams at Good Hope Hospital and Birmingham Heartlands Hospital, and integrated community and hospital care at Solihull. Community-based specialist diabetes services for Birmingham were provided by Birmingham Community Healthcare NHS Trust and the review of this service is included in the South and Central Birmingham health economy review report.

HEART OF ENGLAND NHS FOUNDATION TRUST – GOOD HOPE HOSPITAL

General Comments and Achievements

Specialist services for people with diabetes at Good Hope Hospital were run by a multi-disciplinary team who worked well together, including good involvement of secretarial staff. Reviewers saw clear evidence of good care of patients with diabetes and the patients who met the reviewers were very appreciative of the care they received. Patients were able access advice from the diabetic specialist nurses and specialist midwife in a variety of ways, including by email, text and telephone.

The team had strong leadership and was committed to improving services for people with diabetes. Reviewers found several examples of good practice and innovative developments. A diabetic foot clinic was run at Good Hope Hospital and patients had access to more specialised services at Birmingham Heartlands Hospital. Three diabetes specialist nurses had specific responsibility for in-patients and were supporting diabetes training for nursing staff. There was a good programme of development of link nurses and 'Diabetes Champions' on medical wards and a robust framework of training for nursing staff. A pilot of remote blood glucose monitoring of all in-patients with diabetes was taking place. This allowed data on all in-patients to be accessed centrally by the diabetes team. Clinical staff had good knowledge and awareness of the number of patients and the resulting workload for the team.

Good Practice

1 Transition guidelines were comprehensive and there was a clear policy of transition from paediatric to adult services. Patients saw adult and paediatric consultants together twice before their transfer to adult care.

2 Arrangements for care of women with gestational diabetes were particularly good. A midwife with particular interest in the care of diabetes in pregnancy was available and able to perform ultrasound scans. There was an extensive range of high quality patient information and good clinical guidelines were in use.

3 There was good cooperation between the metabolic clinic and pathology laboratory in relation to cardiovascular risk reduction. When metabolic consultants saw abnormal data they acted on it through the metabolic clinic, which was next door to diabetic clinic, or by writing to the patient's GP.

4 A weekly diabetes in-patient multi-disciplinary meeting reviewed the care of in-patients with more complex needs. This meeting was chaired by a diabetes consultant and was well-attended by a range of other disciplines.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Limited Dietician Support**

Dietician support was available only for patients on insulin pumps. Other patients with more complex needs, including pregnant patients with diabetes did not have access to specialist dietetic support and advice.

2 **Training of Surgical Ward Nursing Staff**

Nursing staff on surgical wards had not had specific training in the care of people with diabetes, including peri-operative care. Data on Diabetes Champions and achievement of the training programme was not separated at ward level. This was particularly important because of the number of medical 'outliers' on surgical wards. Patients who met the visiting team also expressed some concerns about their care while on surgical wards.

3 **Diabetic Foot Team**

A multi-disciplinary diabetic foot team was not yet functioning effectively at Good Hope Hospital at all times. Vascular surgeon opinion was available at clinics held at Good Hope Hospital but these had become less frequent and patients were sometimes required to travel to Birmingham Heartlands Hospital for a vascular opinion.

Further Consideration

1 Individualised, personalised care planning was not yet firmly embedded. The orange book care plan was not routinely used and individualised targets were not clearly identified. Review letters to GPs did not consistently include all relevant information about the patient's care. Diabetes-related parameters were discussed and reported in the GP letters but these did not give an overview of the patients' needs. For example, blood pressure and cholesterol were not mentioned in some of the letters seen by reviewers.

2 Patients who met the visiting team were not aware of the Trust policy on self-administration of insulin while in hospital. Greater publicity of this policy may be helpful.

3 Urgent review by a member of the specialist team was not available at weekends. Cover by a medical on call consultant was available.

4 The ophthalmology service provided good, holistic care for people with diabetes but did not have access to community screening data for the local population.

5 The opportunities for emphasising the prevention of diabetes may benefit from further consideration. In particular, reviewers suggested that identifying and targeting patients with high HbA1c may identify people at high risk of diabetes who may benefit from support for lifestyle change.

6 Links with community dietetics services did not appear well developed. There may also be opportunities for accessing dietetic support through the community diabetes service.

7 Criteria for discharge from the specialist service were not documented and diabetes specialist nurses may be providing ongoing support for people who could be managed in primary care.

8 Some guidance and pathway documents did not have dates and other appropriate version control.

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HEART OF ENGLAND NHS FOUNDATION TRUST – BIRMINGHAM HEARTLANDS HOSPITAL

General Comments and Achievements

The reviewers considered that the specialist services for people with diabetes at Birmingham Heartlands Hospital were excellent. Patients who met reviewers were very appreciative of the standard of care they received. The service had strong leadership and staff appeared passionate about their role and about improving the services offered. There was very good multi-disciplinary working. The service was based in excellent facilities which enhanced patient care. The retinopathy service had achieved a 76% take up, which exceeded the level stipulated in the contract. There was a high level of quality assurance within the service and the team had achieved excellent results from the 'Nine Basic Steps' programme. The specialist 'ABC' pharmacy-led clinics had improved patients' clinical parameters, including blood pressure, HbA1c levels and cholesterol levels. The service offered a wide range of specialist clinics for patients from across north and east Birmingham and Solihull, and regional services for people with cystic fibrosis or neuropathy. Specialist lipid and weight management clinics were also available. The out-patient clinics offered two urgent appointment slots each day.

Good Practice

1 Nurses carried a pocket-size 'safety manual'. This provided clear information and a focus on patient care and safety.

2 Foot care for people with diabetes was very well organised. A strong multi-disciplinary team was made up of consultant diabetologists, vascular surgeons, podiatrists, orthotic services, tissue viability team, microbiology, specialist nurses and imaging and representatives from all these disciplines attended multi-disciplinary meetings. Podiatry clinics were held daily Monday to Friday. Weekly clinics were run by the consultant diabetologist and there was a monthly joint clinic with the vascular surgeon.

3 The integrated pathway for the management of diabetic ketoacidosis was well-developed and offered early discharge with support from the diabetes specialist nurses.

4 Ward 9, the main ward for people with diabetes, had achieved a high level of compliance with the 15 Step Challenge, including 100% against the infection control point.

Immediate Risks: No immediate risks were identified.

Concerns: No concerns were identified.

Further Consideration

1 Roll-out of the 'EDITH' education programme for people on insulin pumps to other hospitals within the Trust may be helpful.

2 The team had undertaken some excellent preventative work in local schools in Saltley and in local mosques. It may be helpful to consider how this work is evaluated and wider implications identified.

3 There was no overall training plan or competence framework covering competences expected for roles within the service. Some nursing staff were self-funding diabetes training and development courses.

4 Reviewers noted that plans were in place to roll-out the Ward Champion programme, in place at Good Hope Hospital only at the time of the review, to Birmingham Heartlands and Solihull Hospitals.

5 Incorporation of Royal College of Obstetricians and Gynaecologists guidance on preconception and early use of vitamin D into guidelines may be helpful, especially because of the number of South Asian patients using the service.

6 Greater integration with community diabetes services for Birmingham may be helpful. The community-based consultant did one clinic per week at the Trust but it was not clear how integration between the work of the hospital-based and community service happened in practice.

7 Further work with primary care on using risk stratification information to identify and support patients at high risk of hospital admission may help to improve patient care and avoid admissions.

8 Reviewers suggested that, as part of the 'Nine Basic Steps' programme, priority should be given to encouraging patients to stop smoking. At the time of the review only 44% of patients had their smoking cessation status recorded.

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HEART OF ENGLAND NHS FOUNDATION TRUST – SOLIHULL COMMUNITY and HOSPITAL SERVICE

General Comments and Achievements

Specialist care for people with diabetes in Solihull was provided by a multi-disciplinary Community Diabetes Team. Consultant diabetologists provided care for in-patients, out-patient clinics and community-based clinics. Diabetes specialist nurses attended out-patient clinics held at Solihull Hospital (SH). Plans were in place for a move to more integrated care with greater coordination between primary, community and secondary care services and this vision was supported by all staff who met the visiting team.

The Community Diabetes Service was highly committed and enthusiastic about improving care for people with diabetes. Very good community dietetic support was available. Patients were highly appreciative of the support and care they received. The service was proactive in its approach to communication with general practices and community services. There was a clear specification for the service and clear roles in supporting GP practices and health care professionals working in community services, and providing direct care for patients who were newly diagnosed or not responding to general practice interventions.

The antenatal services for patients with diabetes were also well-organised and patient-focussed, and provided good information for patients.

Good Practice

1 The 'XPERT' patient education programme for people with diabetes was well-attended, with good sharing of knowledge. Patients' evaluations showed that this had helped them to improve the management of their diabetes.

2 A 'Principles of Delegation' system was in use which risk-stratified patients and ensured that they were seen by the most appropriate clinician.

3 A community-based weight reduction clinic was running and available to patients across the health economy.

Immediate Risks: See Trust-wide section of this report in relation to critical care at Solihull Hospital.

Concerns

1 **Management of Patients with Diabetic Ketoacidosis**

In addition to the lack of access to high dependency care (see Trust-wide section of this report), the documented pathway for the management of patients with diabetic ketoacidosis was long and complex. Reviewers were told that, as a result, staff from the Medical Admissions Unit would contact the diabetes consultants when a patient with diabetic ketoacidosis was admitted rather than following the documented pathway. These consultants were sometimes in clinic or not on site and could not respond immediately.

2 **Ward 18 Low Nurse Staffing Levels**

Ward 18 served as the main ward for admission of patients with diabetes. Nurse staffing levels were low for the number and dependency of the patients admitted, especially because patients with diabetic ketoacidosis were admitted to the ward because of the lack of on-site access to high dependency care. Three registered nurses and three health care assistants were on duty for 30 beds which reviewers considered was insufficient given that high dependency care was being provided on the ward. At the time

of the review the ward manager was managing another ward in addition to ward 18. (NB. This issue links with the Immediate Risk identified in the Trust-wide section of this report.)

Some ward staff were having difficulty with the recently purchased blood glucometers. This meant that it was difficult to record an urgent blood sugar quickly.

3 **Ward 18 Environment**

The environment on ward 18 was not welcoming and did not provide appropriate privacy and dignity for patients. The beds were in what had previously been a day room which had minimal space between the beds and patients were on full view to the adjacent bay and ward corridor. The ward environment was cluttered and dark.

Further Consideration

1 The diabetic specialist nurses covered all three sites and there was very little support for in-patients on the Solihull site due to the workload. Specialist nurses within the community were also becoming involved in social and palliative care issues which was minimising the time available for care for their patient group.

2 Reviewers noted that plans were in place to roll-out the Ward Champion programme, in place at Good Hope Hospital only at the time of the review, to Birmingham Heartlands and Solihull Hospitals.

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SPECIALIST CARE OF PEOPLE WITH COPD INCLUDING PULMONARY REHABILITATION

HEART OF ENGLAND NHS FOUNDATION TRUST – GOOD HOPE HOSPITAL and BIRMINGHAM COMMUNITY HEALTHCARE NHS TRUST

General Comments, Achievements and Good Practice

Reviewers were impressed by the welcoming and friendly approach of the team providing specialist care for people with COPD at Good Hope Hospital, despite the considerable pressure under which staff were working. The team was focussed on providing good patient care and good communication between team members was apparent. The commitment to maintaining the service, despite the very heavy workload, was commended. The clinical team was aware of the risks inherent in their low staffing levels and that, as a consequence, their time was focussed on clinical work and little time remained for management issues and service development. Good progress had been made on implementing integrated working with other services serving patients from South Staffordshire and the team provided outreach clinics in the local communities there.

In the 12 months to October 2012, 842 patients with COPD were admitted to Good Hope Hospital with an average length of stay of 6.0 days and a 28 day re-admission rate of 27%. Staffing at the time of the review comprised two full time respiratory consultants and 1.6 w.t.e. respiratory specialist nurses.

Immediate Risks

1 At the time of the review, Good Hope Hospital COPD service (and other respiratory services) had only two respiratory consultants. Only one respiratory consultant was available at times of annual or other leave. A third post had been vacant for approximately 15 months, although a new post-holder was due to start at the Trust in March 2013. Reviewers considered that the workload for three consultants was high and, with only two consultants, was so high that there was potential for error and patients may not be receiving the specialist respiratory care that they need. Contingency plans in the event of the unplanned absence of either consultant were not apparent. The workload pressures were made worse because one consultant did not have a secretary at the time of the review visit.

The Trust's response to this issue is given below[1].

Concerns

1 Reviewers were seriously concerned about the specialist service for people with COPD at Good Hope Hospital for a combination of reasons, in addition to the immediate risk (see above):

a. **Consultant staffing**

Even when three consultant posts were filled, consultant staffing appeared low for the population served, especially because of the small number of junior medical staff. (On the day of the visit there was only one non-consultant doctor on the respiratory ward.) The hospital provided care for approximately 400,000 population and admitted about 1,500 respiratory patients per year.

b. **Other staffing**

Only one secretary was available for the respiratory service.

c. **Service development**

Many of the expected Quality Standards were not yet met, including those relating to training and competence development, personalised care planning, encouraging self-management, guidelines, data collection, audit and service improvement. Reviewers were not surprised by this given the pressure under which staff were working. Reviewers noted the relatively long length of stay and increasing re-admission rates and considered that these may be a sign of a service under considerable pressure.

d. **Pulmonary rehabilitation frequency**

Pulmonary rehabilitation sessions were held only once a week at Good Hope Hospital rather than the expected twice weekly programme.

Further Consideration

1 Greater cooperation between Good Hope Hospital and Birmingham Heartlands Hospital may be helpful in supporting the service at Good Hope Hospital and helping its development. See also health economy section of this report in relation to integration with community services.

2 Conversations with patients were not recorded within their care plan. Further development of written information for patients would also be helpful.

3 See Birmingham Heartlands Hospital section of this report (further consideration 7) for other issues relating to pulmonary rehabilitation.

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HEART OF ENGLAND NHS FOUNDATION TRUST – HEARTLANDS HOSPITAL and BIRMINGHAM COMMUNITY HEALTHCARE NHS TRUST

General Comments and Achievements

The specialist COPD service at Birmingham Heartlands Hospital was provided be an enthusiastic and forward-looking team. In the 12 months to October 2012 there were 723 admissions to Birmingham Heartlands Hospital of patients with COPD with an average length of stay of 7.7 days and a 28 day re-admission rate of 22%. A multi-disciplinary respiratory clinic for COPD patients had 'rapid access' slots available with the aim of avoiding admissions. Pulmonary rehabilitation was provided at Heartlands Hospital and some community locations.

[1] Trust response to Immediate Risk: Following the review, additional cover was introduced on the medical on-call rota. Additional support for clinics was offered by consultants from Birmingham Heartlands Hospital. An additional consultant was due to start work in March 2013. Medical secretarial cover was also introduced.

The COPD service had strong clinical leadership and well-informed specialist nurses and nursing sisters on the respiratory ward. The team was committed to several service improvement initiatives, including involvement with the NHS lung improvement project on admission and discharge care bundles. Work on improving the effectiveness of out-patient services was also taking place. Several audits had been undertaken and the service was aware of the proportion of patients with self-management plans and the proportion who had had a post-exacerbation review. There were 2.8 w.t.e. specialist nurses, who covered in-patients at Birmingham Heartlands Hospital and outpatients, home oxygen service, bronchiectasis and COPD services across Heartlands and Solihull Hospitals. (Support for in-patients at Solihull Hospital came from the Solihull community respiratory team.)

In-patient and out-patient non-invasive ventilation was provided for all patients of Heart of England NHS Trust with good physiotherapy involvement. The respiratory ward had capacity for up to 11 patients on non-invasive ventilation. A physiotherapist was on call overnight for patients needing non-invasive ventilation. Reviewers were impressed by the detailed knowledge of all staff providing non-invasive ventilation.

Good Practice

1 The home oxygen and review service was well-organised, including a weekly clinic. There was no waiting list for the service and patients were seen in the next clinic following their referral.

2 A respiratory consultant was on call at all times and all in-patients saw a respiratory consultant within 24 hours of admission. Respiratory middle-grade doctors were available for 12 hours each day.

3 The service operated a system of open referral for 12 months after discharge. During this time patients could re-refer themselves without going through their GP. The 'traffic light' system told patients when their symptoms indicated that action should be taken.

4 Out-patient clinics issued FP10 prescriptions and, because there was a retail chemist on site, patients could collect their prescription and then go back to the out-patient clinic with any queries or to have their inhaler technique checked. Patients were therefore also able to obtain their medication quickly with no delay in getting and starting medication.

5 Discharge letters were very well structured. They used a proforma but had space for free text. The letters covered all relevant information including spirometry, medication, smoking, relevant tests and investigations, and information from respiratory nurse specialists. Discharge letters were given to the patients with a copy for the GP but were immediately available on the '*ICare'* system and so could be accessed by the patient's GP immediately. Discharge letters were available quickly when a patient was ready for discharge. Discharge letters were also clear about arrangements for formal reviews.

6 The service was one of 20 hospitals participating in the national British Thoracic Society improvement project on admission and discharge care bundles.

7 Fatigue, Anxiety and Breathlessness service: See Community LTC services section of this report.

Immediate Risks: No immediate risks were identified.

Concerns: No concerns were identified.

Further Consideration

1 Arrangements for annual review of patients with COPD were not robust. The hospital service did a post-discharge review which was communicated to the GP. Patients in ongoing contact with the service were also reviewed in out-patients. GP annual reviews were undertaken but were not communicated to the specialist team.

2 See health economy section of this report in relation to integration with community services. Further work on integrated care of people with multiple long-term conditions may also be helpful.

3 British Lung Foundation information leaflets were available for patients to look at but the service did not have funding to provide these for patients. Further work on patient information, and on enabling and encouraging self-management, may be helpful.

4 Work was taking place on identifying patients with repeated admissions. Further work with primary care on identifying and interventions for patients at high risk of admission may be helpful.

5 There was no early supportive discharge service specifically for patients with respiratory disease / COPD in the area covered by the previous Birmingham East and North PCT. Early supported discharge was available in the previous Heart of Birmingham and Solihull PCTs. It may be helpful to look at whether enhancing the respiratory skills available, either within the existing services or as a separate team, could speed up discharge from hospital for patients from the previous Birmingham East and North PCT area.

6 The service's own audit had identified that only 19% of patients had a self-management plan. Further attention in this area could ensure that all patients had a care plan, including a self-management plan and patient identified goals.

7 Pulmonary rehabilitation:

a. Patients usually waited about 12 weeks to start pulmonary rehabilitation, rather than the expected standard of 10 weeks.

b. There was no clear system of discharge from pulmonary rehabilitation and it appeared that some patients may have continued to use the service for long periods of time. This may explain the relatively low number of people completing rehabilitation programmes. Reviewers noted that maintenance rehabilitation sessions were offered to patients using Birmingham Heartlands Hospital but not to North Birmingham or Solihull patients. Structured arrangements for discharge to a less health-care intensive maintenance programme may be helpful.

c. See also Good Hope Hospital section of this report for concerns about frequency of pulmonary rehabilitation at Good Hope Hospital.

8 Consultants were keen to be involved in discussions about contracts for the service and ways in which contractual agreements could be changed to improve the care of people with COPD.

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HEART OF ENGLAND NHS FOUNDATION TRUST – SOLIHULL COMMUNITY AND HOSPITAL SERVICES

General Comments and Achievements

Specialist services for people from Solihull were provided by a hospital-based team and a community respiratory team. In the 12 months to October 2012 there were 497 admissions of patients with COPD to Solihull Hospital with an average length of stay of 6.2 days and a 28 day readmission rate of 20%. Activity may have increased since October 2012 as additional wards had been opened for medical patients at Solihull Hospital.

The community respiratory team provided nurse-led clinics at two community locations, home visits and pulmonary rehabilitation at two other locations. Specialist nurses from the community team also provided specialist advice for patients admitted to Solihull Hospital with COPD and participated in multi-disciplinary clinics at Solihull Hospital. The expected 'take on' rate for pulmonary rehabilitation of two new patients per week was not happening at the time of the review because of an increase in the number of house-bound patients and patients with more complex needs being cared for by the team.

Reviewers were particularly impressed by the organisation of the pulmonary rehabilitation service where patient satisfaction was high and there was good evidence of the effectiveness of the programme.

A Rapid Access Day Service (RADS) was starting at the end of January 2013 which would bring together many of the available services in one location with the aim of improving accessibility and avoiding admission to hospital wherever possible.

Good Practice

1 A very clear and comprehensive *'My COPD'* booklet provided information for patients and supported self-management.

Immediate Risks:

See Trust-wide section of this report in relation to access to critical care. This issue was particularly relevant to patients with COPD who needed non-invasive ventilation.

Concerns

1 **Low Staffing Levels – Hospital-Based Service**

A respiratory consultant was available on site at Solihull Hospital on Mondays to Wednesdays each week. There was nominal respiratory consultant cover on Thursdays and Fridays but this consultant was often not available on site and cover was provided by general physicians from the acute medical unit. Effective cover for absences of both consultants was not available. A relatively low proportion of patients with COPD were being cared for by staff with specialist respiratory competences, especially since additional medical wards had been opened at Solihull Hospital.

Further Consideration

1 Waiting times for pulmonary rehabilitation service sometimes went above 10 weeks. These should be kept under review to ensure patients do not wait longer than 10 weeks for rehabilitation. The team was aware of this issue and was working to address it.

2 Patient information about COPD was not available on the respiratory ward. As part of the work to improve patient information it may also be helpful to consider additional information on prescription 'season tickets' and the availability of spiritual support. Women aged less than 45 years could be referred to a specialist clinic but there did not appear to be any patient information targeted at this patient group.

3 Arrangements for involving the respiratory lead consultant in the decisions about services at Solihull Hospital may benefit from review. Although this consultant had a leadership role, there were limited opportunities to influence decisions or alter the way in which care was delivered.

4 Formalising the arrangements for identifying and recording patient-identified goals may be helpful.

5 The community respiratory team was providing in-reach specialist nursing support to the respiratory ward at Solihull Hospital. A review of whether staffing is sufficient for this may be helpful. This should be considered in the context of the relatively low nurse staffing on the respiratory ward, the relatively high proportion of patients with respiratory diseases being cared for on non-respiratory wards and occasional long waiting times for pulmonary rehabilitation.

6 The community respiratory team reported that 'did not attend' and non-completion rates for pulmonary rehabilitation had increased. Further work on understanding the reasons for this change may help to improve these rates in future.

7 Urgent review within 24 hours was not yet available in Solihull. This was planned to improve when the 'Respiratory Ambulatory Day Service' commenced at the end of January 2013, following which urgent review within 24 hours would be available on four days a week.

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SPECIALIST CARE OF PEOPLE WITH HEART FAILURE

HEART OF ENGLAND NHS FOUNDATION TRUST: GOOD HOPE HOSPITAL, BIRMINGHAM HEARTLANDS HOSPITAL. SOLIHULL HOSPITAL AND SOLIHULL COMMUNITY HEART FAILURE SERVICE and BIRMINGHAM COMMUNITY HEALTHCARE NHS TRUST

General Comments and Achievements

Services for people with heart failure were well organised throughout the health economy and the patients who met the visiting team were very appreciative of the care they received. Pathways of care were clearly documented in all three hospitals and areas served by the Trust. Pathways were slightly different in each area but these differences were well understood. Team members were enthusiastic and committed. Teams on each hospital site worked well together and there were good links with the Solihull community heart failure service. There were also good links between sites with effective use of resources to avoid duplication where appropriate. Urgent review within 24 hours by a member of the specialist team was possible on the Birmingham Heartlands Hospital site. Data were submitted to the National Heart Failure Audit including, since 2012, data from Good Hope Hospital. A total of 1,347 patients were admitted with a primary diagnosis of heart failure in 2011/12 (GHH 507; BHH 503 and SH 336), with an average length of stay of 11.8 days and a 28 day readmission rate of 17%.

Community heart failure specialist nurses for Birmingham were managed by Birmingham Community Healthcare NHS Trust (6.4 w.t.e. for the whole of Birmingham).

The community heart failure service in Solihull was well organised and welcoming. Patients appreciated the easy access to care provided by the service.

Good Practice

1 Provision of heart failure device therapy was particularly well organised. Indications for device therapy were considered for all patients. Patients who were possibly appropriate were discussed at multi-disciplinary meetings on each hospital site. Implantation of devices was undertaken at Good Hope Hospital for all Trust patients with good patient support available. Facilities for implantation of devices were good, including good imaging to optimise device therapy. Arrangements for deactivation of devices were clear and work on a network-wide protocol for device deactivation was taking place.

2 Imaging support for patients with heart failure was excellent. 'One stop' heart failure assessment was achieved through protected echocardiography 'slots' on the day of clinic attendance. Immediate reporting was available. Urgent echocardiography was available within a day and routine investigations within one week. All echocardiographs were stored on PACS and could be easily accessed. The echocardiography service at Birmingham Heartlands Hospital was led by technicians who had specific competences in dobutamine stress echocardiography. Full Doppler echocardiography, dobutamine stress echocardiography, 3-D echocardiography and cardiac MRI were available on all three hospital sites. Non-invasive CT coronary angiography was available at Good Hope and Birmingham Heartlands Hospitals.

3 The acute medical admissions units at Birmingham Heartlands Hospital had dedicated cardiac beds staffed by nurses with specialist cardiac competences. Arrangements for nurse-led discharge from these beds were in place. Staff rotation between these beds and the cardiac wards was organised.

4 A heart failure database contained details of all patients with heart failure. GPs and community staff had access to the information on this database.

5 Links with palliative care were very strong. Palliative care was available for all patients with heart failure and collaboration with local palliative care consultants and hospices was good. Clear protocols for referral to hospices were available.

6 Guidance on the management of acute heart failure was clearly written and the guidelines included an implementation 'sign-off' list, thus ensuring all relevant parties were involved and committed to follow the guidelines.

7 Solihull community heart failure service: The referral pathway was clear and good use was being made of risk stratification information. The community team was working closely with the *Virtual Ward,* including some joint visits with the care manager and specialist nurse. Good communication and sharing of information with general practices was also apparent, including use of risk stratification information. Good use was being made of the British Heart Foundation competence framework for nursing staff.

Immediate Risks: See Trust-wide section of this report in relation to critical care at Solihull Hospital.

Concerns

1 **Specialist Nurse Workload – Good Hope Hospital**

The workload of the specialist nurse at Good Hope Hospital was very high. This nurse provided support to all Trust patients with devices as well as support for in-patients with heart failure at Good Hope Hospital. (Workload was expected to be 20% devices and 80% heart failure but, in practice, care of patients with devices could take up a greater proportion of time.) Cover for absences was available from another clinical nurse specialist but reviewers were told that, in practice, the heart failure specialist nurse was often phoned when not on duty. Specialist nurses from South Staffordshire attended out-patient clinics at which most South Staffordshire patients attended and community-based heart failure nurses would attend out-patient clinics with their patients whenever possible. Overall, however, it was felt that too great a workload and responsibility fell on one person with limited backup.

2 **Cardiac Rehabilitation**

Cardiac rehabilitation was not commissioned for patients with heart failure.

3 **Integration with Birmingham Community Services**

Integration between Birmingham community heart failure specialist nurses and hospital-based teams did not appear to be working effectively. Some duplication and a lack of effective communication were noted by reviewers. Particular examples were that hospital-based nurse specialists were undertaking initial home visits on discharge from acute services, whereas community staff said that they should be carrying out this role. Criteria for referral to community heart failure nurses were not clearly defined. Community heart failure nurses were all nurse prescribers but the service did not have an agreed approach to using this expertise. Arrangements for cover for absences were not clearly defined and did not take advantage of the specialist nurse resources available. Community staff were expected to cover hospital clinics but a reciprocal arrangement was not in place. Community staff had been told that their notes could not be included in the Heart of England NHS Foundation Trust notes because of filing issues. Community specialist nurses had good links with community long-term condition teams for the care of people with multiple long-term conditions but the hospital-based service did not have an agreed approach to using these links. Leadership of the heart failure specialist nurses was not clearly defined and did not cover all the specialist nursing resources available.

Further Consideration

1 Arrangements for six monthly review of patients with heart failure were not robust. GPs and community services could see information about reviews undertaken by the hospital service but hospital-based teams could not see information about reviews in primary care or community services. It was not always clear who was taking the lead role in the six monthly review.

2 Emergency access to psychological support was available but there was no direct referral to psychological support for other patients. Referral for psychological support from the GP was available.

3 The accuracy of data on the heart failure database may benefit from review. Reviewers were given some examples of data which were incorrect because of limitations in the database. The team was aware of this issue and was working on possible solutions.

4 Some staff in the Birmingham heart failure community team said that they were not able to access results of investigations which they had requested. Reviewers were also told that all community staff could see results of investigations. Further investigation of this issue should ascertain and communicate the accurate position.

5 Criteria for discharge from the hospital-based service may benefit from review. From the information available to reviewers it appeared that some patients were continuing to attend the hospital for follow-up when this could appropriately have been undertaken in primary care or by community services. (See also concern (above) about integration of services.)

6 Urgent review by a member of the specialist team was not available within 24 hours seven days a week at Good Hope Hospital or in Solihull. Options for accessing reviews at Birmingham Heartlands Hospital at weekends may benefit from further consideration.

7 Serum natriuretic peptide testing was not available for patients being seen in hospital-based services. GPs did have access to this diagnostic test although it was not clear that it was routinely used in the diagnosis of heart failure.

8 The development of a heart failure support group was being considered and reviewers supported this development, as well as other approaches to involving patients and carers in decisions about the management of the services.

9 Good heart failure multi-disciplinary team meetings were run on each hospital site. It may be possible to use these meetings as the basis for service-level 'review and learning' (QS JN-798) which would avoid the need for additional meetings and enable communication with all relevant staff.

10 Ward and specialist nurse staffing levels were lower at Good Hope Hospital than at Birmingham Heartlands and Solihull Hospitals. It was not clear to reviewers that this disparity was justified by the workload, the complexity of patient need or the services provided.

11 Plans for cardiology consultants and /or heart failure specialist nurses to identify patients with heart failure on non-cardiac wards were being considered. It will be important to ensure that any new arrangements apply to all three hospitals in the Trust.

12 See also the health economy section of this report in relation to the care of people with multiple long-term conditions.

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Specialist Care of People with Chronic Neurological Conditions

HEART OF ENGLAND NHS FOUNDATION TRUST: GOOD HOPE HOSPITAL, BIRMINGHAM HEARTLANDS HOSPITAL. SOLIHULL HOSPITAL and BIRMINGHAM COMMUNITY HEALTHCARE NHS TRUST

General Comments and Achievements

Specialist services for people with chronic neurological conditions were provided by a team at Heart of England NHS Foundation Trust, linking with Birmingham Community Healthcare NHS Trust staff and services at University Hospitals Birmingham NHS Foundation Trust. Consultant staffing at the time of the review was 4.2 w.t.e., which included one locum consultant on 0.2 w.t.e. provided from University Hospitals Birmingham NHS Foundation Trust through a service level agreement. Twenty seven out-patient clinics per week were run. A specialist nurse for people with multiple sclerosis was available from UHB who ran a monthly clinic at Solihull Hospital. Four Parkinson's Disease specialist nurses from Birmingham Community Healthcare NHS Trust covered the whole of

Birmingham, including running community clinics. 'The Hub', a small rehabilitation service for people with chronic neurological conditions, was based at Birmingham Heartlands Hospital.

At the time of the review, waiting times for a consultant neurologist out-patient appointment were six weeks at Birmingham Heartlands Hospital, six to eight weeks at Solihull Hospital and 13 weeks at Good Hope Hospital. Capacity and demand work had indicated the need for additional out-patient sessions at Good Hope Hospital. Some patients, especially from Solihull, were referred to neurologists at University Hospitals Birmingham NHS Foundation Trust. Neuro-physiology was accessed at City Hospital (Sandwell and West Birmingham NHS Trust) and UHB although a business case for an in-house service was being developed.

Patients needing in-patient care were admitted onto general medical wards. Urgent review by a neurologist was available Monday to Friday 9am to 5pm. Reviewers did not visit medical wards as part of this review.

Staff providing the services were enthusiastic and committed. There was good awareness of the difficulties facing the service. GPs were able to requests investigations via the radiology electronic referral system with the imaging department making some decisions about the most appropriate investigation to perform. A hydrotherapy pool staffed by physiotherapists was available on each hospital site.

Patients who met the visiting team appreciated the care they received and commented that they had seen improvements in the services available at Heart of England NHS Foundation Trust, and improved liaison with services at University Hospitals Birmingham NHS Foundation Trust.

Good Practice

1 A prescribing pharmacist attended clinics for people with Parkinson's Disease. Good links with social care and voluntary organisations were also evident in the community clinics run by the Birmingham Community Healthcare NHS Trust.

2 The 'Hub' rehabilitation facility was providing good multi-disciplinary support for people with chronic neurological conditions.

3 Clinics for people with multiple sclerosis in Solihull were run by a nurse from University Hospitals Birmingham NHS Foundation Trust and a support worker from the Multiple Sclerosis Society was also available in the clinic.

Immediate Risks: No immediate risks were identified

Concerns

1 **NICE Guidance on Care of People with Epilepsy**

NICE guidance on the care of people with epilepsy was not being followed. Guidelines and information for primary care encouraging referral of people with their first seizure was not in place. A Trust protocol for referral to the neurology department was in place in the A&E departments for people presenting with their first seizure. Specialist nurse support for people with epilepsy was not in place across the health economy and there was a limited amount of information available for patients and carers although reviewers were told that information was given to patients and carers as part of their out-patient appointments.

2 **Care Planning and Review**

Robust arrangements for personalised care planning and review of patients at least annually were not in place although individual care plans were incorporated into clinic letters. Reviews may have taken place in primary care but, if so, information from these reviews was not communicated to the specialist team. Little patient information was available. The pathway of care for people with multiple sclerosis or Parkinson's Disease was fairly clear but there was no clear pathway of care for people with epilepsy or those with other chronic neurological conditions, although arrangements for referral for neurophysiology and neuro-radiology were covered in clinic letters.

3 **Clinical Guidelines**

Clinical guidelines expected by the Quality Standards were not documented. Overall, the pathways of care for patients with Parkinson's Disease or multiple sclerosis were clear but pathways for other chronic neurological conditions, including epilepsy, were not clearly defined, other than A&E guidelines for referral of people with first seizure.

4 **'Out of Hours' Cover**

Consultant neurologists were not on call outside normal working hours. Patients were cared for in general medical beds and arrangements for accessing advice in an emergency outside normal working hours were not clear. There was a service level agreement with University Hospitals Birmingham NHS Foundation Trust for neurology referrals covering the provision of advice and support outside normal working hours. Reviewers were told, however, that this functioned effectively only for patients who had been seen by a neurologist and not for referrals from general medical teams.

5 **Data Collection**

The number and types of patient for whom the service was commissioned, the activity being delivered, and the extent of unmet need were not clear.

6 **Service Strategy**

The strategy for the future development of the service was not clear. Individual members of staff had ideas about developments they wished to make but it was unclear if these were supported by the Trust or by commissioners. A clear service specification was not available and robust monitoring arrangements were not in place.

Further Consideration

1 Only three patients were in 'The Hub' day hospital at the time of the review although reviewers were told that sessions for people with Parkinson's Disease were more fully utilised. It may be helpful to review whether more patients would benefit from this service.

2 Information about patients did not appear to be being shared between community and hospital-based staff, and so the latest information may not always be available when a patient is seen.

3 Arrangements for liaison with the multiple sclerosis specialist nurse from University Hospital Birmingham NHS Foundation Trust may benefit from further discussion in order to resolve operation problems, such as lack of notification about cancellation of patients.

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TRUST-WIDE

BIRMINGHAM COMMUNITY HEALTHCARE NHS TRUST

This section of the report is also included in the South and Central Birmingham Health Economy Report.

General Comments and Achievements

Birmingham Community Healthcare NHS Trust had been in existence for under two years at the time of the review. Services had been transferred from several different providers and work to establish service remits and pathways was ongoing. Good progress was being made with establishing the Integrated multi-disciplinary teams (IMTs) and Single Point of Access (SPA) for community services.

Several points of relevance to the Trust are covered in the health economy section of this report.

Good Practice

1 The Trust had a high number of non-medical prescribers with good governance of non-medical prescribing. The pharmacy team had a dedicated lead for non-medical prescribing.

2 Motivational interviewing and training was widely available within the Trust

Immediate Risks: No immediate risks were identified.

Concerns

1 **Clinical Leadership**

As described in the Community LTC Services section of this report, with the exception of neurological rehabilitation, arrangements for clinical leadership of services were not clear.

2 **Staff Competences**

Generic competence frameworks for groups of staff were being developed at the time of the review. Mandatory training was in place although it was not clear that systems for monitoring uptake of mandatory training were robust. In several services, competences for specific roles undertaken by staff were not clear and this report gives some examples were reviewers were concerned about this. Several staff were not able to describe the Trust's arrangements for mentoring and clinical supervision.

3 **Guidelines and Protocols**

Clinical guidelines and protocols were generally not documented. Some staff said that they used NICE guidance but there were no examples where NICE guidance had been localised to show how it would be implemented locally. Some staff said that they used PCT guidelines but relevant guidelines could not be found on PCT websites.

4 **IT and Care Records**

Several different IT systems were in use and patients could have multiple care records in the community – as well as hospital and primary care records. A mixture of paper, electronic and faxes were used for communication between services. It was not clear that community-based healthcare professionals would have access to up to date clinical information about the patients for whom they were caring, including results of diagnostic tests.

Further Consideration

1 Further work on communication between middle management and operational staff may be helpful. Reviewers came across several examples where middle managers' views of how services worked were different from those of operational staff. Some operational staff were not clear about Trust systems, including those for training and supervision. Reviewers commented that the management structure appeared to have many layers and the different responsibilities for each layer were not apparent.

2 Reviewers were told that reciprocal arrangements were not in place for providing care for Birmingham GPs' patients who were resident outside Birmingham. If this is correct, further consideration should be given to establishing these arrangements with neighbouring areas.

3 Medicines management were well organised and linked well with some clinical teams. Reviewers were told that some services did not have medicines management support as part of their service specification. Further work to ensure an appropriate level of medicines management support is available to all clinical services may be helpful.

HEART OF ENGLAND NHS FOUNDATION TRUST

General Comments and Achievements

Hospital-based services at Good Hope Hospital and Birmingham Heartlands Hospital, and both community and hospital services for Solihull, were provided by Heart of England NHS Foundation Trust. Reviewers were pleased to see the involvement of consultants in the care of older people and social workers in the initial assessment of people admitted as emergencies.

Good Practice

1 The Trust-wide '*I Care'* system enabled good access to clinical information for hospital staff, community-based staff and GPs.

2 Imaging services were well organised and provided good support to the care of people with long-term conditions. Further detail is given in the condition-specific sections of this report.

3 Consultant clinics for diabetes and COPD at Birmingham Heartlands Hospital had two urgent 'slots' each day so that urgent review was available and admission to hospital avoided whenever possible.

Immediate Risks

1 **Solihull Hospital – Critical Care**

Critical care was not available on site for patients admitted as emergencies to Solihull Hospital. This issue relates to all acute admissions, including those of people with long-term conditions, and arose during discussion of access to non-invasive ventilation. Reviewers were told that, since October 2012, the Critical Care Unit at Solihull Hospital had not been admitting patients. An Outreach Nurse was normally available 24/7 at Solihull Hospital. During October and November 2012 an additional nurse with critical care skills had been available on site which had allowed a critical care bed to be opened in an emergency. The additional nurse had then been withdrawn and, occasionally, the Outreach Nurse had been required to work at Birmingham Heartlands Hospital, leaving no nurse with critical care skills at Solihull Hospital. Reviewers were also concerned that patients admitted with diabetic keto-acidosis were being cared for on a general medical ward without access to appropriate monitoring or appropriate levels of nursing care. A protocol had been agreed for transfer to a critical care bed within four hours of the decision by the referring consultant that critical care was needed. Reviewers were told that this timescale was not always achieved and there were sometimes differences of view between referring consultants and critical care consultants about the need for transfer to critical care. Some incidents had been reported and the Trust was considering opening three high dependency beds at Solihull Hospital. Reviewers considered this issue was an immediate risk because of the undifferentiated medical emergency 'take' at Solihull Hospital, especially in the weeks before the review when additional medical beds had been opened.

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

Concerns:

1 Integration with Birmingham community services: See health economy section of this report

2 Reviewers were concerned about the disparity in staffing levels across the three areas served by the Trust. Staffing levels did not appear to relate to workload, the complexity of patient need or the services provided. In general, medical and specialist nurse staffing levels at Birmingham Heartlands Hospital were significantly higher than those at Good Hope Hospital. Medical staffing levels at Solihull were lower but there was more support available from community specialist nursing staff.

[2] Trust response to immediate risk: Three high dependency beds were opened at Solihull Hospital from 21st January 2013.

Further Consideration

1 Diabetes training for ward staff on surgical wards at Good Hope Hospital: See diabetes section of this report.

2 Smoking cessation support to in-patients was not evident. Reviewers were told that patients could be referred to community-based smoking cessation services. It may be helpful to consider whether greater support could be given to patients so they could use their hospital admission as a trigger for giving up smoking.

3 Some staff were concerned about difficulties in access to historical investigations and results as some older notes had not been scanned into the '*ICare'* system.

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COMMISSIONING

NHS BIRMINGHAM CROSSCITY CLINICAL COMMISSIONING GROUP
NHS BIRMINGHAM SOUTH CENTRAL CLINICAL COMMISSIONING GROUP

This section of the report is also included in the South and Central Birmingham Health Economy Report.

General Comments and Achievements

The newly formed Birmingham CrossCity and Birmingham South Central Clinical Commissioning Groups (CCGs) had many opportunities for improving the care of people with long-term conditions, including opportunities for joint commissioning. A complex mix of services had been inherited and both CCGs realised the need for simplification. A prioritisation exercise had started.

Reviewers commented that improving services for people with long-term conditions was going to require strong leadership, drive and direction from CCGs, especially because of the number of large and disparate provider Trusts in the city. The benefits which could accrue were great but the organisational barriers which may be encountered should not be under-estimated.

Immediate Risks: No immediate risks were identified.

Concerns

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

Service for people with chronic neurological conditions were not fully reviewed. There did not appear to be an overall commissioning strategy for these services. An extensive service was commissioned from University Hospitals Birmingham NHS Foundation Trust (UHB). A more limited service, with no in-patient provision, was commissioned from Heart of England NHS Foundation Trust (HEFT). Parkinson's Disease specialist nurses were commissioned from Birmingham Community Healthcare NHS Trust and linked in different ways with hospital-based services at UHB, HEFT and Sandwell and West Birmingham Hospitals NHS Trust. Patient pathways and waiting times varied depending on the provider to whom patients were referred. There were no specialist nurses for people with epilepsy. Reviewers were told that times to be seen after a first seizure varied from six to thirteen weeks and ongoing care of people with epilepsy was largely the responsibility of primary care.

Specialist rehabilitation was commissioned from Birmingham Community Healthcare NHS Trust. Operational links with services in the rest of the West Midlands were in place, but there were no formalised pathways or arrangements for shared care. Whether services were meeting the needs of populations across the West Midlands was not clear and activity levels at different services, related to need, did not appear to have been analysed. Non-specialist rehabilitation was not specifically commissioned and it appeared that access depended on whether the patient's GP thought to refer them.

Ensuring services met the needs of people with chronic neurological conditions, and that NICE guidance was fully implemented, did not appear to be a priority for commissioners.

2 **Young People with Diabetes**

Arrangements for young people with diabetes to transfer to the care of adult services were not clear. The age guidelines for transfer were not clear and there were joint clinics between adult and children's services were not yet in place. There was no local network for driving improvements to the care of children and young people with diabetes and these services did not appear to link with the newly formed Birmingham diabetes network.

3 **Cardiac Rehabilitation**

Cardiac rehabilitation was not commissioned for people with heart failure. Some patients were occasionally able to access this service but this was exceptional rather than the norm.

4 **Specifications**

Reviewers were presented with lots of service specifications. For many, it was not clear whether these related to all or part of Birmingham and whether they were current or historical. The relationship between the service specifications and the services reviewed was opaque. Referral and discharge criteria were not specified in several specifications.

Further Consideration

1 Joint CCG arrangements for monitoring the quality of services for people with long-term conditions, including mechanisms for addressing issues identified in this report, were in the early stages of development. It will be important to ensure that implementation of these arrangements continues.

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

See also 'All Commissioners' section below.

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NHS SOLIHULL CLINICAL COMMISSIONING GROUP

General Comments and Achievements

Considerable work had taken place to improve the care of Solihull people with long-term conditions. Community services had been established with clear specifications. These were working closely with hospital-based services and plans for even greater integration were being discussed. There were good relationships with individual practices and a positive approach to driving improvements in care was evident.

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

Good Practice

1 'Frailty' Board and its work: See health economy section of this report.

2 Arrangements for monitoring primary care of people with long-term conditions were well developed. These included risk stratification information sent to practices monthly, feedback on patients who were admitted and their length of stay in hospital, half a day of pharmacist time in each practice to support improvements in care, information for practices on their prevalence of long-term conditions and monitoring of key performance indicators.

Immediate Risks: No immediate risks were identified.

Concerns

1 See health economy section of this report in relation to the care of people with chronic neurological conditions.

2 Cardiac rehabilitation was not commissioned for people with heart failure.

3 There was no local network or equivalent group taking forward improvements in services for children and young people with diabetes.

Further Consideration

1 Work was underway reviewing the key performance indicators for services. Reviewers encouraged continuation of this work.

2 The arrangements for pathway review and learning may benefit from review. It was not clear that systematic arrangements for review and learning across the whole pathway, including primary care, were in place and some issues were raised with reviewers about the handling of incidents and near misses.

3 It was not clear to reviewers how Solihull commissioners were linking with other commissioners of hospital services used by Solihull residents, in particular, those at Heart of England NHS Foundation Trust.

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

See also 'All Commissioners' section below.

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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 and are not repeated in South and Central Birmingham Health Economy Report:

Immediate Risks:

1 Solihull Hospital – Access Critical Care**:** See Trust wide section of the report and associated footnote.

Concerns:

1 Specialist Care of Children and Young People with Diabetes: Staffing; Follow-up post diagnosis

2 Community Long Term Conditions services: Clinical leadership

3 Specialist Care of People with COPD: Staffing; Service development; Pulmonary rehabilitation capacity

4 Specialist Care of People with Diabetes: Dietetic staffing; Training of ward staff; Management of diabetes ketoacidosis; Integration

4 Specialist Care of People with Heart Failure: Staff workload; Integration

5 Specialist Care of People with Chronic Neurological Conditions: NICE epilepsy guidance; Care planning and review; Out of hours cover

APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Executive Lead

Eamonn Kelly	Chief Executive	West Mercia Cluster

Visiting Team

Jacqueline Barnes	Associate Director of Nursing, Quality & Safety	Arden NHS Cluster
Julie Bent	Clinical Nurse Specialist - Multiple Sclerosis	Walsall Healthcare NHS Trust
Pam Bojczuk	User Representative	Local Commissioning Advocate Rep for Epilepsy Action
Dr Manjari Bollu	General Practitioner	Coventry - Forum Health Centre
Jenny Borley	Lead Nurse - Heart Failure	The Royal Wolverhampton Hospitals NHS Trust
Dave De Santis	User Representative	
June De Santis	User Representative	
Tina Fletcher	Heart Failure Nurse Specialist	Walsall Healthcare NHS Trust
Maxine Fowler	User Rep	Multiple Sclerosis Society
Dr Colin Gelder	Respiratory Consultant	University Hospitals Coventry & Warwickshire NHS Trust
Wendy Godwin	Programme Manager for Planned & Unscheduled Care	Walsall Healthcare NHS Trust
Joanne Gutteridge	LTC Commissioning Project Lead	NHS Dudley Clinical Commissioning Group
Dr Mary Heber	Consultant Cardiologist	Shrewsbury and Telford Hospitals NHS Trust
Jane Holmes	Community Matron	Staffordshire & Stoke on Trent Partnership NHS Trust
Liz Hudson	Paediatric Diabetes Nurse Specialist	Sandwell & West Birmingham Hospitals NHS Trust

Karen Joseph	Practice Manager	Sherbourne Medical Centre
Lucy Jukes	Advanced Respiratory Physiologist / Pulmonary Rehab Coordinator	Walsall Healthcare NHS Trust
Samuel Keong	Group Manager - Ambulatory Services	University Hospitals Coventry & Warwickshire NHS Trust
Dr Melanie Kershaw	Paediatric Endocrinologist	Birmingham Children's Hospital NHS Foundation Trust
Dominic Leadbetter	Project Manager – Planned Care	NHS Walsall PCT
Dr Jo Leahy	General Practitioner and Board Member	Telford &Wrekin CCG
Delia McCarthy	COPD Specialist Nurse	University Hospitals Coventry & Warwickshire NHS Trust
Joanne Moult	Children's Diabetes Nurse	University Hospital of North Staffordshire NHS Trust
Dr Rajiv Nair	Consultant Physician	George Eliot Hospital NHS Trust
Gillian Owen	Advanced Physiotherapist for COPD team and Emergency Portals	University Hospital of North Staffordshire NHS Trust
Dr Vinod Patel	Consultant Diabetologist	George Eliot Hospital NHS Trust
Carole Roberson	Professional Practice Facilitator for District Nursing/District Nurse Team Leader	Worcestershire Health & Care NHS Trust
Lorna Rowes	Dietician	Sandwell & West Birmingham Hospitals NHS Trust
Dr Jacob Samuel	Consultant Paediatrician	Burton Hospitals NHS Foundation Trust
Fiona Shalley	Lead Nurse Community COPD Service	University Hospitals Coventry & Warwickshire NHS Trust
Dr Gaurav Tewary	General Practitioner	Coventry - Copsewood Medical Centre
Dr Antony Thomas	Consultant Neurologist	University Hospitals Coventry & Warwickshire NHS Trust
Julie Thompson	Head Nurse for Medicine	Burton Hospitals NHS Foundation Trust
Mark Walsh	Network Director	Black Country Cardiovascular Network

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
Sharon Ensor	Director, KeyOpps Ltd	*On behalf of* West Midlands Quality Review Service
Pip Maskell	Director, KeyOpps Ltd	*On behalf of* West Midlands Quality Review Service

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APPENDIX 2 COMPLIANCE WITH THE QUALITY STANDARDS

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

Table 1 - Percentage of Quality Standards met

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

Service	Number of Applicable QS	Number of QS Met	% met
Care of Children and Young People with Diabetes			
Primary Care	3	1	33
Specialist Care of Children & Young People with Diabetes	29	18	62
Trust-Wide: Heart of England NHS Foundation Trust (HEFT)	4	3	75
Commissioning	7	0	0
Health Economy	**43**	**22**	**51**
Care of Adults with Long-Term Conditions			
Primary Care	8	6	75
Community Long-term Conditions Services (All Services)	101	63	62
Birmingham Community Healthcare NHS Trust (BCHT)	(51)	(25)	(49)
Solihull Community Virtual Ward (HEFT)	(50)	(38)	(76)
Specialist Care of Adults with Diabetes (All Services)	177	119	67
Good Hope Hospital (HEFT)	(59)	(35)	(59)
Birmingham Heartlands Hospital (HEFT)	(59)	(43)	(73)
Solihull Community and Hospital Service (HEFT)	(59)	(41)	(69)
Specialist Care of People with COPD (All Services)	298	181	61
Good Hope Hospital (HEFT) & BCHT	(56)	(11)	(20)
Birmingham Heartlands Hospital (HEFT) & BCHT	(56)	(38)	(68)
Solihull Community and Hospital Service (HEFT)	(56)	(36)	(64)
Pulmonary Rehabilitation – Good Hope Hospital and Birmingham Heartlands Hospital (HEFT) & BCHT	(65)	(45)	(69)
Pulmonary Rehabilitation – Solihull (HEFT)	(65)	(51)	(78)
Specialist Care of People with Heart Failure (All Services)	113	72	64
Good Hope Hospital, Birmingham Heartlands Hospital, Community Heart Failure Service (HEFT) & BCHT	(57)	(35)	(61)

Service	Number of Applicable QS	Number of QS Met	% met
Solihull Hospital and Community (HEFT)	(56)	(37)	(66)
Specialist Care of People with Chronic Neurological Conditions – HEFT & BCHT	58	25	43
Trust-Wide: Heart of England NHS Foundation Trust	7	3	43
Commissioning	12	8	67
Health Economy	**774**	**477**	**62**

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