WM QRS West Midlands Quality Review Service

NHS

Care of Adults with Long-Term Conditions

Care of Children & Young People with Diabetes

Sandwell & West Birmingham Health Economy

Visit Date: 5th, 6th, 7th & 8th February 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 5th, 6th, 7th & 8th February 2013. The purpose of the visit was to review compliance with West Midlands Quality Review Service (WMQRS) Quality Standards for:

- Care of People with Long-term Conditions, Version 1.1, August 2012
- Care of Children and Young People with Diabetes, Version 1.2, June 2012

and the following national standards:

- Pulmonary Rehabilitation Service Specification, Department of Health, August 2012
- British Association of Cardiovascular Prevention and Rehabilitation, Standards and Core Components for Cardiovascular Disease Prevention and Rehabilitation, March 2012

This visit was organised by WMQRS on behalf of the West Midlands Long-term Conditions Care Pathway Group.

The aim of the standards and the review programme is to help providers and commissioners of services to improve clinical outcomes and service users' and carers' experiences by improving the quality of services. The report also gives external assurance of the care within the Health Economy which can be used as part of organisations' Quality Accounts. For commissioners, the report gives assurance of the quality of services commissioned and identifies areas where developments may be needed.

Care of people with long-term conditions was chosen as the main WMQRS review programme for 2012/13 for a variety of reasons. Six out of 10 adults report having a long-term condition that cannot currently be cured and the majority aged over 65 have two or more long-term conditions. Eighty per cent of primary care consultations and two thirds of emergency hospital admissions are related to long-term conditions. The Operating Framework for the NHS in England 2012/13 gave priority to improving the care of people with long-term conditions. Most services for people with long-term conditions had not previously been subject to external quality assurance. The focus brought to these services by the Quality Standards and peer review visits was therefore new for many staff involved in the care of people with long-term conditions. This review programme has given the opportunity for highlighting good practice and sharing this with others across the West Midlands, as well as identifying areas where action is needed by providers and commissioners.

The report reflects the situation at the time of the visit. The text of this report identifies the main issues raised during the course of the visit. Appendix 1 lists the visiting ream which reviewed the services at Sandwell & West Birmingham health economy. Appendix 2 contains the details of compliance with each of the standards and the percentage of standards met.

SANDWELL AND WEST BIRMINGHAM HEALTH ECONOMY

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

- Sandwell and West Birmingham Hospitals NHS Trust: provides hospital services for Sandwell and West Birmingham and community services for Sandwell
- Birmingham Community Healthcare NHS Trust
- Sandwell and West Birmingham Clinical Commissioning Group (CCG)
- Birmingham South and Central Clinical Commissioning Group
- Birmingham CrossCity 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 for Sandwell and West Birmingham Hospitals NHS Trust is Sandwell and West Birmingham CCG. The nominated lead commissioner for Birmingham Community Healthcare NHS Trust is Birmingham South and Central CCG. The nominated lead commissioner for out of hours GP services, walk-in centres and primary care centres in West Birmingham is 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.

Services provided by Birmingham Community Healthcare NHS Trust were reviewed as part of the reviews of North East Birmingham and Solihull, and South and Central Birmingham. This report therefore does not include the findings related to Integrated Multi-Disciplinary Teams, Rapid Response Service, Community Diabetes Service and services for people with chronic neurological conditions which are provided for residents of West Birmingham by Birmingham Community Healthcare NHS Trust. These findings are in the South and Central Birmingham health economy report, available on the WMQRS website www.wmqrs.nhs.uk

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 Sandwell & West Birmingham 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

The Sandwell and West Birmingham health economy has a long history of partnerships through the *Right Care – Right Here* programme. At the time of the review, these plans were being re-visited and reviewed with the newly formed Sandwell and West Birmingham Clinical Commissioning Group. Working relationships between social care and health care appeared to be operating well, especially in Sandwell. Considerable work had taken place on the development of personalised health budgets, including a pilot of personalised budgets for people with multiple sclerosis. The new 'iCare' service in Sandwell also demonstrated effective integration of health and social care services.

This review found many individual teams who were caring for their patients and very committed to providing good services. Reviewers were impressed that the 'SystmOne' IT system was used by community staff and 60% of GP practices. This meant that information about patients could be easily shared between community staff and GPs.

The health economy was already achieving the requirements of *Best Practice Tariff* for services for children and young people with diabetes.

Concerns

1 **Strategy for the Care of People with Long-Term Conditions**

The health economy's strategy for the care of people with long-term conditions was not yet clear. Several service specifications were available, some developed by Heart of Birmingham PCT and Sandwell PCT. Some of these had not yet been implemented. In general, reviewers found a lack of clarity about patient pathways and individual service's roles within the pathway. Criteria for referral to and discharge from condition-specific services for people with long-term conditions were usually not clear, and reviewers found several examples of services continuing to provide care for patients who could have been discharged to primary care. Effective integration between hospital and community-based services was also not yet evident. Reviewers saw little evidence of use of data to understand what services were doing and for planning service changes. Reviewers concluded that the health economy had real opportunities to significantly improve the care of people with long-term conditions through stream-lining patient pathways and improving coordination of care. Clear processes involving patients and carers, providers and commissioners will be needed in order to realise these benefits.

2 **Care planning and reviews**

A common finding in the services for adults which were reviewed was that robust, personalised care planning was not yet embedded. Review of care plans could take place in primary care, community services or hospital-based services – or all three – with little coordination or sharing of the information gained at the reviews.

3 **Access to psychological support**

Difficulty with access to psychological support for people with long-term conditions was identified specifically in the diabetes and chronic neurological conditions reviews. Patients could be referred to the 'RAID' team at City Hospital for urgent support and GP referral to psychological support services was available. Neither of these options led to psychological support from someone with specialist expertise in the care of people with particular long-term conditions.

Further Consideration

1 Reviewers suggested that there were particular opportunities for integration of hospital and community-based condition-specific teams in order to streamline patient pathways and make better use of resources. This was starting to be discussed in Sandwell but not yet with Birmingham community-based services where operational links were working less well.

2 Reviewers saw little evidence of collaboration between teams at Sandwell and City Hospitals. Some cover for absences was provided cross-site but the opportunities for sharing, for example, the development of patient information, clinical guidelines, operational policies, data collection and audit, and staff training did not appear to be being taken.

3 Arrangements for integrated care for people with multiple long-term conditions, including integration between condition-specific services and community long-term conditions services were not yet in place. This could be considered as part of the development of the future strategy. Reviewers were told that, for people with multiple long-term conditions, it could be difficult to identify the person responsible for case managing their care and a more coordinated approach to case management could improve admission avoidance.

4 Some patients and staff who met reviewers mentioned difficulties with access to interpreters, especially for Chinese speakers.

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PRIMARY CARE

SANDWELL & WEST BIRMINGHAM CLINICAL COMMISSIONING GROUP

Concerns

1 Use of serum natriuretic peptide testing: See care of people with heart failure section of this report.

Further Consideration

1 'Special patient notes' could be identified to the out of hours services but reviewers were told that this was not used routinely for patients with long-term conditions. Also, out of hours services were not aware of some of the services which were available to avoid admission to hospital and may not have access to these.

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

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SPECIALIST CARE OF CHILDREN & YOUNG PEOPLE WITH DIABETES

SANDWELL & WEST BIRMINGHAM NHS TRUST

General Comments and Achievements

Good care for children and young people with diabetes was provided by a committed team who had worked hard with commissioners to develop a quality service. The requirements of *Best Practice Tariff* were already being achieved due to robust service organisation. There was also good collection of data to support management of the service. The service had strong leadership and a forward-looking approach was apparent throughout the service, including in education programmes. The service was appreciated and highly praised by the parents and patients who met the visiting team.

Good Practice

1 A good 'Management of Children with Medical Needs in Schools' policy was available which included a good section on collaborative working between the diabetes team and local education team. This was particularly clear about roles and responsibilities.

2 Diabetes-specific psycho-social meetings were held monthly to discuss the care of patients with particular psycho-social needs.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Staffing levels – Paediatric Diabetes Specialist Nurse and Dietician**

Paediatric diabetes specialist nurse (PDSN) staffing levels were slightly below the recommended level. At the time of the review 2 w.t.e. PDSNs and one bank nurse session were caring for 170 patients compared with a recommended ratio of 1:70. A staffing review had been undertaken and had identified the need and funding for an additional PDSN. At the time of the review there was 0.5 w.t.e. dietetic support for the service. Reviewers were unclear how this level of dietetic support could adequately provide the support for the clinics and reviews needed to meet *Best Practice Tariff.*

Further Consideration

1 Reviewers identified a problem with incorrect filing in patients' notes. An audit of all patients' notes was completed to resolve this issue during the course of the visit. The service should ensure that all staff involved in filing notes are reminded of the importance of correct filing. An audit of general paediatric notes may also be necessary to assure the Trust that this is not a more widespread problem.

2 The arrangements for 24/7 advice met the relevant Quality Standard but some of the families who met the visiting team expressed dissatisfaction with the level of specialist expertise available. Further discussion with families may help to identify any particular problems or issues.

3 Ward link nurses had been identified shortly before the review. More involvement of these nurses with the work of the paediatric diabetes team may be helpful to make sure that they have the ongoing understanding and awareness needed for their role.

4 Some documents seen by reviewers did not have implementation or review dates. Patient information had a very good document control process but this did not appear to be being applied to clinical guidelines.

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COMMUNITY LONG-TERM CONDITIONS SERVICES

See South and Central Birmingham health economy review report in relation to Integrated Multi-Disciplinary Teams in West Birmingham.

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST – SANDWELL COMMUNITY SERVICES

General Comments and Achievements

The Sandwell community long-term conditions (LTC) team was based in the Lyng Health and Social Care Centre. This is a health living centre in the centre of West Bromwich. The community LTC service was well-run with an enthusiastic team with staff who were passionate about providing good quality care for patients. Rehabilitation and therapy services were co-located which enabled a good multi-disciplinary approach to patient care. Community-based condition-specific specialist nurses also worked from the centre which helped to coordinate the care of people with multiple long-term conditions. The community LTC team had come together relatively recently and some aspects of the service organisation were still under development. A good system of a named lead for

each patient was already in place. Several nurses were nurse prescribers and a good range of patient group directives was in place. Further development of community matron roles and the 'virtual ward' concept were still under discussion. The 'SystmOne' IT system enabled easy access to patients' notes and supported multi-disciplinary working within the team. GPs who used 'SystmOne' had good access to the same clinical information.

Good Practice

1 The LYNG Centre provided the opportunity for a range of disciplines to work together and supported team working and communication, and was resulting in improvements to the quality of care and patient outcomes.

2 IT system: See health economy section of this report.

Immediate Risks: No immediate risks were identified.

Concerns: No concerns were identified.

See sections relating to condition-specific services for people with diabetes, COPD, heart failure and chronic neurological conditions for issues relating to community-based specialist nursing staff.

Further Consideration

1 Arrangements for communication with GP practices which are not using 'SystmOne' may benefit from review. It appeared that changes to patients' care plan may not be communicated as quickly and there may be more difficulty in accessing results of investigations and clinical letters. The potential for stream-lining processes for these practices should be considered.

2 Mechanisms for using patient feedback to inform future service developments and for involving patients in decisions about the organisation of the service may benefit from further consideration and development.

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SPECIALIST CARE OF ADULTS WITH DIABETES

SANDWELL & WEST BIRMINGHAM NHS TRUST

General Comments and Achievements

The teams providing specialist care for people with diabetes at City and Sandwell Hospitals and in the community in Sandwell were hard-working, with friendly and dedicated staff. Both teams were innovative and wanted to improve patient care. All patients who met reviewers were pleased with the care they received. The Sandwell Hospital team was particularly enthusiastic and morale among this team appeared to be high. All patients seen were very pleased with the service the team provided. Patients had a named care-coordinator in the community and those cared for by the community team had a single community care coordinator, even if they had multiple conditions.

'Think Glucose' referral mechanisms and triage arrangements were robust. Reviewers were also impressed by the pathway of care for people with diabetes and foot problems. At Sandwell Hospital a specialist nurse for people with learning disabilities had a particular interest in the care of people with learning disabilities and diabetes and provided additional support for these patients.

Good Practice

1 Several regular joint clinics with primary care were held.

2 There was good evidence of robust audit, including SWOT analyses which were discussed at Departmental meetings on both sites.

3 The Sandwell Hospital team used a particularly good "How's my diabetes test" letter to patients.

4 Sandwell Hospital had also implemented a system of cards which prompted junior doctors about the need to access opportunities for learning about diabetes.

5 IT system: See health economy section of this report.

Immediate Risks: No immediate risks were identified.

Concerns

1 Access to psychological support: See health economy section of this report.

Further Consideration

1 Links with the Birmingham community diabetes service (provided by Birmingham Community Healthcare NHS Trust) were not evident. Further integration between the Sandwell acute and community-based specialist diabetes services may also be helpful. For example, insulin pump therapy was provided by both Sandwell services and patients appeared to be managed differently in the two services. Also, the number of patients on pump therapy appeared low; reviewers were told that only 50 people were on pump therapy across Sandwell and West Birmingham**.**

2 One specialist dietician covered both City and Sandwell Hospital sites and cover for absences was from general dieticians and ward-based dieticians. Staff were also concerned that vacancies were not being filled and it was sometimes difficult to obtain approval for CPD activities. Diabetes specialist nurses were occasionally required to cover general nursing duties at times of bed crises which depleted the time available for their specialist nurse role.

3 The arrangements for care of diabetes patients on in-patient wards may benefit from review. Dedicated wards for people with diabetes were not available which made it difficult for staff to offer urgent patient review at weekends. Additional training for ward staff may also be helpful.

4 Annual reviews were carried out in primary care and it was not clear that the specialist service was always informed about the outcomes of these reviews. Involvement of the specialist team in annual reviews of patients under their care should be considered.

5 A website was available about the Sandwell service but some patients were not aware of this. It may be helpful to add the website details to patient and GP letter.

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SPECIALIST CARE OF PEOPLE WITH COPD INCLUDING PULMONARY REHABILITATION

SANDWELL & WEST BIRMINGHAM NHS TRUST

General Comments and Achievements

Specialist care for people with COPD was provided by hospital-based teams at City and Sandwell Hospitals, linking with community-based respiratory teams in West Birmingham (provided by Birmingham Community Healthcare NHS Trust) and Sandwell (part of Sandwell and West Birmingham Hospitals NHS Trust). The Sandwell and West Birmingham Hospital Trust teams were well-motivated staff with good coordination and multi-disciplinary working. There was evidence of good leadership, including strong GP leadership, a clear strategic direction and good liaison with primary care services. Considerable progress had been made on reducing non-elective admissions for people with respiratory disease (reduced by 61%). Length of stay had also reduced following implementation of the outreach programme and improved out-patient services. The new to follow-up ratio in out-patients had been kept low (1:1.78) through the development of community services and close work with GPs. Patient feedback about the care received was very good.

Good Practice

1 Pulmonary rehabilitation services were well-organised and were seeing patients quickly. Completion rates were high (79% in Birmingham and 72% in Sandwell). In general, patients were able to start rehabilitation within one week of referral.

2 The home oxygen service was well-organised, including good links with the heart failure team.

3 Community services were making good use of pictograms and interpreters. This was resulting in improved patient experience and compliance, and contributing to the reduction in emergency admissions.

4 The team kept a good supply of equipments such as masks, nebulisers and commodes so that patients could be discharged at weekends without delays.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Ward Staffing Levels and Competences**

Reviewers were seriously concerned about the levels of nurse staffing and associated competences for the in-patient services at both City and Sandwell Hospitals.

At City Hospital, respiratory patients were nursed on mixed gastroenterology and respiratory wards. It was not clear that nurses had the appropriate specialist competences in both gastroenterology and respiratory care. The City Hospital service had only 1.9 w.t.e. respiratory specialist nurses for a large number of admissions (634 admissions with respiratory disease in the year before the review.

At Sandwell Hospital, patients were nursed on a mixed gastroenterology, cardiac and respiratory ward. It was not clear that nursing staff had appropriate specialist competences in all three areas.

The Trust was aware of the problems associated with the situation at the time of the review. A training programme was in place and a senior nurse met ward managers fortnightly to review whether any adverse incidents had arisen due to the lack of competences. No incidents had been identified since September 2012.

Also, between 25 and 50% of respiratory patients were being nursed on non-respiratory wards. Respiratory nurses were actively trying to admit patients from the medical admissions units to respiratory beds

Occupational therapy staffing levels at Sandwell were low with one occupational therapist covering all respiratory patients (29 at the time of the review).

2 **Care Pathway, Care Plans and Reviews**

Arrangements for follow up and review of care plans were not robust. The case notes seen by reviewers had no evidence of formal reviews of care plans. The care pathway for patients was not clearly documented, including links between hospital and community services. (A Sandwell community respiratory pathway was documented.)

Further Consideration

1 Guidelines covering discharge from hospital and management of COPD in primary care were not evident.

2 The COPD team did not appear to have easy access to respiratory-specific data on hospital readmissions, hospital mortality, complaints and significant events, or to be using this information in improving local services. Also, neither service had a robust rolling programme of clinical audit. In Sandwell, some charts had been produced but it was not clear what these were showing due to insufficient labelling.

3 Training of the Trust respiratory specialist nurses in spirometry may be worth considering. At the time of the review, pulmonary physiologists were called in whenever spirometry was needed.

4 Arrangements to support patients in stopping smoking may benefit from review. Smoking cessation services were available by referral but there did not appear to be a focus within the hospital for ensuring appropriate patients were identified and referrals made.

5 At the time of the review, an informal breathlessness clinic was run but without any specific clinic or appointment times. A clinic had run previously but was no longer commissioned. Clarification of the status of the clinic and formalising its arrangements should be considered.

6 Some of the expected guidelines were not yet in place, including those relating to tele-monitoring and discharge from the service. In Sandwell community services, it was not clear who is responsible for patients who self-refer.

7 It may be helpful to formalise the arrangements for identification of patients admitted as emergencies who may benefit from the care of staff with specialist respiratory competences, including those admitted through A&E and the acute medical unit.

8 The health economy did not yet have a formal mechanism or group involving commissioners and providers with responsibility for driving improvements in the care of people with COPD, or other respiratory diseases. The future strategy for the development of services was not clear. Also, risk stratification information was not yet being used across the care pathway to try and prevent admission.

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Specialist Care of People with Heart Failure

SANDWELL & WEST BIRMINGHAM NHS TRUST

General Comments and Achievements

This review looked at hospital-based teams at City and Sandwell Hospitals and the community service in Sandwell. The City Hospital service linked with community heart failure services provided by Birmingham Community Healthcare NHS Trust. (Issues relating to this service are given in the South and Central Birmingham health economy report.) The two Sandwell services did communicate with each other to discuss the care of individual patients and further integration of services was being considered. Although the City Hospital team was aware of the community service, there was no regular communication between the hospital and community-based services, apart from some communication between hospital and community-based heart failure specialist nurses. Community heart failure clinics took place in several locations in Sandwell and two locations in West Birmingham. There was one acute heart failure specialist nurse at each hospital site and each provided cover for absences of the other.

Patients were highly appreciative of the support which they received and, in particular, the support available from the heart failure specialist nurses. They were particularly grateful for the rapid response they received when they contact heart failure specialist nurses.

At both City and Sandwell Hospitals the cardiology wards and day care units were clean and well organised and good cardiac rehabilitation facilities were available.

Good Practice

1 **Cardiac physiology service at City Hospital**

The cardiac physiology service at City Hospital was provided by welcoming and attentive staff and one member of staff had a particular interest in heart failure. The service environment was good and very neat and tidy. Systems and processes were robust and clear, and results were available very quickly. There was good liaison with heart failure specialist nurses and other members of the heart failure team. An 'app' facility was available on mobile phones, which allowed the heart failure specialist nurses to access cardiac

physiology results. All patients implanted devices were given a credit card-sized 'business card' with information about their device.

2 **Support for patients with palliative care needs**

Both acute heart failure specialist nurses had additional training in palliative care. At Sandwell, one palliative care nurse was specifically allocated to the care of non-cancer patients. In Sandwell all community heart failure nurses also had palliative care training and staff had liaised with the local palliative care team to provide a range of hospice facilities locally at '*The Bungalow'*.

Immediate Risks: No immediate risks were identified.

Concerns

Reviewers were seriously concerned about services for people with heart failure for a combination of reasons:

1 **Clinical Guidelines and Protocols**

Few clinical guidelines were available and one guideline that was available was out of date (2004). Staff said that they used NICE guidance and Map of Medicine but these had not been localised to show how they would be implemented locally.

2 **Patient Pathway**

The patient pathway for people with heart failure was not clear. There was little documentation about the pathway and some of the documentation that was available was out of date. Regular formal multi-disciplinary clinical meetings to discuss the care of people with heart failure did not take place at either City or Sandwell Hospitals. The referral pathway and referral criteria were not clear and it appeared that the patient pathway may depend on who was on duty at the time. At City Hospital the consultant regularly visited the acute medical unit to identify patients with potential heart failure but this did not always appear to be a formal arrangement or coordinated with acute medical unit processes. Effective liaison was not in place between the City Hospital service and community-based heart failure nurses. Criteria and arrangements for discharge from the specialist team were not clear at City Hospital and it appeared that patients may be remaining within the care of the specialist team longer than necessary. Sandwell Hospital did have clear discharge criteria (RAG rating) but patients could re-access the service at any time. Patients who met reviewers said that they preferred to contact the heart failure specialist nurses rather than their GP and so, in practice, patients were not effectively discharged. Data on the number of referrals, hospital admissions and discharges from the services were not clear and did not appear to be being used to manage the services.

3 **Care Plans and Six Monthly Reviews**

Care plans were not formalised and did not include patient-identified goals. Treatment plans were documented in clinic letters. Six monthly reviews were expected to be undertaken by GPs but there was no communication of the outcome of these reviews to the specialist team. Specialist teams' caseloads were reviewed every six months. 'Active' patients had a face to face review; if patients were stable then the review took place by telephone. It was not clear that all relevant clinical information was gathered by these telephone reviews or how these related to the reviews carried out by the GP.

4 **Staffing**

a. At the time of the review two of the four consultants with a particular interest in heart failure were about to leave the Trust. This will add to the pressure on the remaining consultants, even if locums are appointed. This is a particular problem because the systems and processes used, especially at City Hospital, were very labour-intensive and consumed a lot of consultants' time.

b. The available heart failure specialist nurse resource was not equitably spread across the service. Approximately 1.5 w.t.e. community nurses were available for west Birmingham. One acute heart failure nurse was based on each hospital site with limited cross cover for absences. The Sandwell

community services had seven w.t.e. heart failure specialist nurses and one health care assistant and were split into three regions; one nurse had a caseload of 361 patients. The systems and processes used were labour-intensive for the hospital-based specialist nurses and the specialist nursing resource was not yet working effectively together.

c. Acute heart failure specialist nurses were providing a 24/7 service through 'goodwill'. Sandwell community heart failure specialist nurses were regularly working from 8am to 8pm. All the heart failure specialist nurses were answering telephone calls from patients outside of these times and when they were not on duty.

5 **Use of serum natriuretic peptide testing**

Serum natriuretic peptide testing was not routinely used as part of the diagnostic pathway, as recommended by NICE guidance. Reviewers were told that this was not used by all GPs, partly because samples had to be sent to a different laboratory.

Further Consideration

1 Urgent review by a member of the specialist team within 24 hours was not usually available at weekends (other than on a 'goodwill' basis from specialist nurses). Specialist nurses provided a Monday to Friday service. A consultant with an interest in heart failure was sometimes on call at weekends but this was not guaranteed. Patients could be seen for urgent review in the City Hospital day hospital on Mondays to Fridays but the arrangements for accessing this service were not clear and reviewers were not certain that primary care clinicians were aware of this option.

2 Ward nursing staff on the cardiac wards appeared to rely heavily on the acute heart failure nurses. Further consideration should be given to the potential for developing additional heart failure specific competences among the ward staff. Ward staff mentioned particularly their wish for additional training in fluid management in patients with heart failure.

3 Arrangements for coordinating care for people with multiple long-term conditions were not yet in place. A specialist nursing forum was in existence but this did not specifically consider services for people with long-term conditions.

4 Reviewers considered that a needs assessment, clarification of the pathway that is commissioned and an analysis of the staffing needed to deliver this pathway, including allied health professional staffing, would be helpful. The pathway clarification would need to include discussion of criteria for discharge back to primary care and the appropriateness of the easy self-referral back which was evident at the time of the review. As part of the service re-design, staff rotation between community and acute services could be considered and new consultant appointments in the near future may also provide the opportunity to review the way in which heart failure services are working in the Trust.

5 The leadership of the teams, especially at City Hospital, may need support to help them take a more strategic approach to the improvement of the service. The staff on both sites who met reviewers were very operationally focussed and may not have insight into the need for service re-design and the potential benefits which this could deliver.

6 Serum natriuretic peptide testing was not available for patients being seen in hospital-based services.

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SPECIALIST CARE OF PEOPLE WITH CHRONIC NEUROLOGICAL CONDITIONS

SANDWELL & WEST BIRMINGHAM NHS TRUST

General Comments and Achievements

At the time of the review, a consultant-led neurology service was based at City Hospital. There were plans for the service to move to Sandwell Hospital in the near future so that the co-location with stroke services could be maintained. Two specialist nurses were available for people with multiple sclerosis. People with motor neurone disease were usually referred to the service at University Hospitals Birmingham NHS Foundation Trust.

In Sandwell, a newly established *iCare* team included two specialist nurses with particular expertise in Parkinson's Disease and multiple sclerosis respectively. An additional Parkinson's Disease specialist nurse was being recruited. West Birmingham was also served by Parkinson's Disease and multiple sclerosis specialist nurses from Birmingham Community Healthcare NHS Trust. The report relating to the Birmingham community service is given in the South and Central Birmingham health economy report.

Sandwell and West Birmingham Hospitals NHS Trust also provided a nurse-led headache service which was following up approximately 1000 patients a year, some of whom had been under the care of the service for up to 10 years. This service had an active research agenda.

In-patient rehabilitation beds at City Hospital provided the facility for active rehabilitation prior to discharge.

Patient feedback about the services provided by Sandwell and West Birmingham Hospitals NHS Trust was very positive. Staff were enthusiastic and positive about the move of in-patient services to Sandwell Hospital. Reviewers were also impressed by the RAID mental health liaison service at City Hospital and the discharge nurse who worked with the neurology ward, including following up patients' care when appropriate.

Good Practice

1 The neuro-physiology service provided a six-day a week service. Timely access to investigations was available. There was a good range of information covering neuro-physiology investigations available in both leaflet form and on the website.

2 Rehabilitation assistants on the in-patient ward worked with patients in group sessions, supported nurses in washing and dressing, supported physiotherapists during treatment sessions and led group sessions aimed at cognitive function.

3 The multiple sclerosis service was provided by two specialist nurses who provided very good support for their patients. Patients who met reviewers said that they "didn't feel like a patient - but felt like a person". The specialist nurses integrated well with community-based staff.

4 Non-invasive ventilation was available, especially for people with motor neurone disease.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Access to Psychology Services:** See health economy section of this report

2 **Care for People with Epilepsy**

Specialist nursing support was not available for people with epilepsy, indicating that NICE guidance on the care of people with epilepsy had not been implemented in full. People with epilepsy were seen by consultants or cared for in primary care. Some of the patients who met reviewers were unhappy with the level of expertise relating to epilepsy in their primary care services.

3 **Guidelines and Protocols**

Few clinical guidelines were available. Staff said that they used NICE guidance and Map of Medicine but these had not been localised to show how they would be implemented locally.

4 **Access to equipment**

Delays in access to equipment were leading to delays in discharge from City hospital and rehabilitation. Reviewers were told of particular delays in the availability of specialist wheelchairs.

Further Consideration

1 The Trust was providing a nurse-led headache service, significance aspects of which NICE guidance suggests should be provided in primary care. Reviewers were told, however, that the service had reduced non-headache waiting times for neurology appointments and cut the cost of imaging because of the nurse-led diagnostic process. The headache service did not have discharge guidelines and some patients had been attending for over 10 years. The development of discharge criteria and guidelines may be helpful.

2 The development of a local network (or equivalent group) may help to clarify the strategic direction for services for people with chronic neurological conditions. This may also help to build and improve links between hospital-based, community-based and primary care services. Community-based therapy services could be linked into such a group which could also look at the coordination of services for people with less complex rehabilitation needs.

3 There was no overarching competence framework showing the competences expected for different roles in the service, including the condition-specific competences for specialist nursing and ward staff.

4 Reviewers were told of a number of operational problems. It may be helpful to review the mechanisms for addressing such issues to ensure these are robust. Examples raised at the time of the visit were use of dictaphones by administrative staff and problems of tapes going missing, delays in coordinating discharges of people with more complex needs, out of date letter-heading, and availability of disease-modifying therapy following changes in consultants, shortages of some medications resulting in alterations of medications for people with Parkinson's Disease.

5 Effective liaison with Parkinson's Disease community-based specialist nurses in Birmingham was not in place. Referral could be made to these nurses but they no longer attended clinics or met with the hospital-based team. In Sandwell, the Community Parkinson's disease nurse was linked to the 'iCare' service, the nurse had a caseload of 397 and was only able to see patients with more complex needs, although the Trust was recruiting another Parkinson's Disease nurse.

6 Reviewers did not see a clear staffing framework for the move to Sandwell Hospital. It may therefore be helpful to keep staffing levels under review in order to check that the new staffing is appropriate.

7 Multiple sclerosis specialist nurses were doing lots of home visits (100 in 2011). It was not clear that home visits were the most effective use of available specialist nursing time. It was also not clear that home visits and telephone support were commissioned or counted in activity levels.

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TRUST-WIDE

SANDWELL & WEST BIRMINGHAM NHS TRUST

General Comments and Achievements

Reviewers met many committed staff and saw several examples of good practice during the visit to Sandwell and West Birmingham. In particular, there was a good process of matching the Trust strategy and service strategies with training and education programmes. Completion of mandatory training was high (89%) and workforce needs

were clearly related to ongoing training and development. The Trust had an active programme of 'Listening into Action'.

Good Practice

1 Robust medicines management arrangements were in place within Sandwell and West Birmingham Hospitals NHS Trust. Reviewers were particularly impressed by the good process for managing nurse prescribing. There were over 80 nurse prescribers in the Sandwell community services. These nurses attended regular meetings and their prescribing was audited annually. If the audit showed any problem with prescribing the nurse was suspended from being a nurse prescriber until further investigation had taken place. Medication reviews took place on the acute medical admissions unit on Mondays to Saturdays.

2 **The electronic bed monitoring system** provided a very clear 'snapshot' of in-patients within the Trust. This system made good use of expected date of discharge and linked with patient transport systems.

Concerns

1 **Clinical guidelines and policies**

Few clinical guidelines were available and some of those that were available were out of date. Staff said that they used NICE guidance and Map of Medicine but these had not been localised to show how they would be implemented locally. The Trust was exploring the possibility of adopting the West Mercia clinical guidelines.

2 **IT systems**

Different IT systems were in use in hospital and community services which did not communicate with each other. Plans for bringing these together were not apparent. As a result, clinical staff did not always have all the latest clinical information available to them when they saw patients.

3 **Off duty contact with specialist nurses**

Specialist nurses in several services were being contacted by patients when they were not on duty.

Further Consideration

1 Reviewers saw little evidence of collection and reporting of activity of community services.

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COMMISSIONING

SANDWELL & WEST BIRMINGHAM CLINICAL COMMISSIONING GROUP

General Comments and Achievements

At the time of the review, Sandwell and West Birmingham CCG had recently been formed. Strategies and commissioning plans had been inherited from two PCTs and the CCG was seeking to review these and bring them together. Care of people with long-term conditions had been identified as one of the CCG top priorities and the CCG management structure was being reviewed to see if it reflected this. Reviewers were told of a number of service specifications but it was not clear that these were fully implemented. The CCG was, however, going through a systematic process of review of service specifications, starting with care of people with diabetes. A process had been developed for palliative and end of life care and the CCG planned to use this process for other long-term conditions.

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

Concerns

1 **Strategy for the care of people with long-term conditions:** See health economy section of this report.

2 **Care planning and reviews:** See health economy section of this report.

3 **Implementation of NICE guidance**

This report identifies that NICE guidance on the care of people with a) heart failure and b) epilepsy has not yet been fully implemented.

4 **Access to psychological support:** See health economy section of this report.

Further Consideration

1 Sandwell and West Birmingham Hospitals NHS Trust was providing a nurse-led headache service, significance aspects of which NICE guidance suggests should be provided in primary care.

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.

ALL COMMISSIONERS

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:

Other Concerns Identified

1 Specialist Care of Children and Young People with Diabetes: Staffing.

2 Specialist Care of People with COPD: Ward staffing and competences; Care planning and care pathways.

3 Specialist Care of People with Heart Failure: Care pathway; Care planning and review; Staffing; Access to serum natriuretic peptide testing.

4 Specialist Care of People with Chronic Neurological Conditions: Access to equipment.

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APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Executive Lead

Paul Tulley	Chief Operating Officer	Shropshire County Clinical Commissioning Group

Visiting Team

Marie Adams	Physiotherapist	Heart of England NHS Foundation Trust
Dr Mona Arora	General Practitioner	North Staffordshire Clinical Commissioning Group
Dr Prithwish Banerjee	Consultant Cardiologist and Lead for Heart Failure	University Hospitals Coventry & Warwickshire NHS Trust
Dr James Beattie	Consultant Cardiologist	Heart of England NHS Foundation Trust
Helen Bladon	Diabetes Service Lead	Walsall Healthcare NHS Trust
Jenny Chapman	User Representative	Diabetes UK
Helen Charters	Specialist Stroke Nurse, Community Stroke Team	Staffordshire & Stoke on Trent Partnership NHS Trust
Neil Davies	Practice Manager	Dr Machin & Partners GP Practice, Sheldon
Dr Roland Etti	Consultant Neurologist	The Dudley Group NHS Foundation Trust
Wendy Godwin	Programme Manager for Planned & Unscheduled Care	Walsall Clinical Commissioning Group
Dr Raveendra Katamaneni	General Practitioner	Solihull PCT
Deborah McCausland	Paediatric Diabetes Specialist Nurse	Walsall Healthcare NHS Trust
Dr Kathryn McCrea	Consultant Paediatrician	Shrewsbury & Telford Hospitals NHS Trust
Dr Harmesh Moudgil	Consultant Respiratory Physician	Shrewsbury & Telford Hospitals NHS Trust
Dr Binoj Nair	General Practitioner	Peterloo Medical Centre
Dr Nisha Pargass	Consultant Paediatrician	The Royal Wolverhampton Hospitals NHS Trust

Gill Salt	Lead Paediatric Diabetes Nurse Specialist	The Royal Wolverhampton Hospitals NHS Trust
Dr Ravinder Sandhu	GP Partner/Trainer	NHS Walsall PCT
Steve Sharples	User Representative	
Dr Ateeq Syed	Diabetes Consultant	Heart of England NHS Foundation Trust
Angela Turner	Clinical Quality Improvement Advisor	NHS Telford & Wrekin
Helen Wylie	Nurse Practitioner	Lisle Court Medical Centre
Dr Venugopal Yuvaraj	General Practitioner	The John Kelso Practice

Observers

Manuela Quaresma	Researcher	Cancer Research UK Cancer Survival Group, London School of Hygiene and Tropical Medicine
Dr Purushottam Desai	Consultant Cardiologist	University Hospitals Birmingham NHS Foundation Trust

WMQRS Team

Jane Eminson	Acting Director	West Midlands Quality Review Service
Sarah Broomhead	Quality Manager	West Midlands Quality Review Service
Sue McIldowie	Long Term Conditions Programme Support	West Midlands Quality Review Service
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	3	100
Specialist Care of Children & Young People with Diabetes	29	25	86
Trust-Wide: Sandwell & West Birmingham NHS Trust	4	4	100
Commissioning	7	7	100
Health Economy	**43**	**39**	**91**
Care of Adults with Long-Term Conditions			
Primary Care	8	1	13
Community Long-term Conditions Services	52	35	67
Specialist Care of Adults with Diabetes	59	44	75
Specialist Care of People with COPD	56	25	45
Specialist Care of People with Heart Failure	57	20	35
Specialist Care of People with Chronic Neurological Conditions	58	24	41
Trust-Wide: Sandwell & West Birmingham NHS Trust	7	3	43
Commissioning	12	4	33
Health Economy	**309**	**156**	**50**

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