Good

Birmingham Community Healthcare NHS Trust

Quality Report

3 Priestley Wharf,
Holt Street,
Birmingham,
B7 4BN
Tel: 0121 466 6000
Website: bhamcommunity.nhs.uk

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Core services inspected	CQC registered location	CQC location ID
Adult Long Term Conditions	Birmingham Community Healthcare NHS Trust Headquarters	RYWZ3
Children's and Family Services	Birmingham Community Healthcare NHS Trust Headquarters	RYWZ3
Children's and Family Services	Edgewood Road Respite Care Unit	RYW77
Inpatient Services	Moseley Hall Hospital	RYWX1
Inpatient Services	West Heath Hospital	RYW24
Inpatient Services	Norman Power Centre	RYWK5
Inpatient Services	Community Unit 29	RYW02
Inpatient Services	Perry Tree Centre	RYW04
Inpatient Services	Community Unit 27	RYW01
Inpatient Services	Inpatient Services	RYWY9
End of Life Services	Sheldon Unit	RYW22
End of Life Services	Birmingham Community Healthcare NHS Trust Headquarters	RYWZ3
Other Services	Elliot lodge	RYWX9
Other Services	Sayer House	RYWY1
Other Services	Kingswood Drive	RYWF7

Summary of findings

Other Services	The Bungalow	RYWX6
Other Services	Birmingham Community Healthcare NHS Trust Headquarters	RYWZ3
Other Services	Other Services	RYW21

This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for community health services at this provider	Good 
Are services safe?	Good 
Are services effective?	Good 
Are services caring?	Good 
Are services responsive?	Good 
Are services well-led?	Good 

Summary of findings

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Overall summary

We found that the provider was performing at a level which led to a judgement of Good. Services were safe, staff reported incidents and near misses and learning took place. The majority of services had sufficient staff though there were a number of vacancies across most teams, especially administrative staff, which were impacting on the delivery of services. Staff received suitable training and supervision.

Services were delivered using evidence based practice, and were delivered through multidisciplinary teams utilising care pathways. The majority of premises were fit for purpose and equipment was available for staff to access in the community.

Staff were caring and compassionate, and we saw some excellent examples of care especially in end of life services. The majority of services were responsive to the needs of patients, and there were innovative examples of care delivery. However there were some services, particularly in dental and children and family services where services were not as responsive as they should be.

The trust is well led, with an accessible and visible executive team, especially the chief executive and executive nurse. Governance systems and processes are in place and there is performance and quality management information available. Quality is high on the trusts agenda.

Summary of findings

The five questions we ask about the services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We judged services to be safe at the time of our inspection. Systems and processes were in place to report incidents, accidents and near misses, and there was evidence of learning though this varied across different services. Infection prevention measures were effective; staff actively washed their hands and were bare below their elbows in clinical areas. Some concerns were identified in dental services, related to decontamination processes, but the trust were aware of these and were taking action.

The majority of facilities were in a good state of repair, though there were one of two concerns regarding the timeliness of action by the estates department. There were some trip hazards and unlocked facilities that could have posed a risk in the intermediate care units. Medicines were managed effectively, safeguarding policies and training were effective and records were well maintained. Record keeping was good, though some concerns were identified with the quality of records on some inpatient wards.

There were some concerns regarding staffing levels, clinical staff from a range of services indicated that there were not enough administrative staff which required them to cover these duties. Data from the trust indicated they were within safe staffing levels. Vacancies existed in many community teams; some had been filled with temporary staff, some of whom had been in a temporary position for many months.

Major incident plans were in place though staff from adult and children's services and inpatient units indicated that they had not received any training.

Are services effective?

Good

Over all the effectiveness of services was good. The majority of staff used national guidelines to provide care, and in some cases this was being recognised nationally. The use of national guidelines was more limited across inpatient units with some concerns regarding the provision of guidelines for stroke care. Pain relief medication was provided as required, with anticipatory prescribing in end of life care.

Patients nutritional and hydration care was appropriately managed, and there were a range of patient outcome measures identified across teams, the majority being positive; though inpatient services would benefit from further development in this area.

Summary of findings

Staff took part in audit activity, and there was a comprehensive array of performance and quality information available, though not all clinical teams had access at present. Staff were competent to deliver services, and the majority had access to performance assessments, supervision and mandatory and professional training, though some gaps did exist.

Overall access to equipment was good, and the majority of premises were of good quality.

Multi-disciplinary team working took place across teams both within Birmingham Community Healthcare NHS Trust and with staff from other organisations. Pathways were utilised though there were concerns from staff in children and family services about the effectiveness of transitional arrangements between children's and adults services.

Are services caring?

Good

Staff were caring and compassionate towards their patients and families, and sought to respect their dignity at all times. We observed and found some excellent care in end of life services, including nursing staff verifying expected deaths, and seeking to meet all the needs of their patients, including understanding and taking into account difference in cultural need.

The majority of patients were involved in decisions about their care, and staff sought to take the time to explain to patients about their care to ensure patients could fully consent to their treatments.

Staff provided emotional support for patients, and we discussed a range of support that staff in end of life services had provided to patients and their families including their approach to involving parents individually depending on their emotional state, open visiting on the Sheldon Unit and writing to employers to support parents care effectively for their children.

Are services responsive to people's needs?

Good

The majority of services were responsive to the needs of patients, though there were concerns regarding some services for children, young people and their families. A range of services were provided to meet the needs of people and staff endeavoured to provide flexible services as close to people's homes as possible.

The single point of access service provided a range of interventions that prevented around 200 people a week requiring hospital admission. Although most services provided care within the agreed

Summary of findings

time frames, some children's services, and in particular speech and language services had had long waiting times, and whilst they were reducing still exceeded the expected timeframe. Other delays were also noted with some dental services.

The trust handled complaints appropriately, and sought a variety of ways in which to gain feedback and handle complaints.

Are services well-led?

Good

Overall the provider was a well led organisation, with an open and supportive culture. The executive team, and chief executive and executive nurse in particular were well known amongst staff, and made time to visit with staff to hear their views of the organisation. The chief executive took the opportunity to communicate with staff in a variety of ways including video blogs, and there was a dedicated email address for the chief executive for staff to provide feedback.

There was a trust vision and values in place, the values had been developed in conjunction with staff, though at the time of the inspection knowledge varied across the staff groups that we interviewed.

There were appropriate governance and performance management structures in place that extended corporately down into the divisions. Performance and safety information is available to staff and is shared in a variety of ways. Continuous improvement of these systems takes place for example the development of Gel Solutions that will provide all staff with 'live' information on performance and quality indicators. The trust had also developed its own essential care indicators as quality measures. There was some concern regarding the visibility of other senior directorate managers, and some staff were more familiar with the executive staff than their own directorate leadership.

Patients, staff and members of the public were engaged by the trust, and there was evidence of improving patient satisfaction from surveys and the Family and Friends test.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Dr Cheryl Crocker, Director of Quality and Patient Safety, Nottingham North and East Clinical Commissioning Group

Head of Inspection: Adam Brown, Care Quality Commission

The team included CQC inspectors, and a variety of specialists; School Nurse, Health Visitor, GP, Dentist, Nurses, Therapists, Senior Managers, and 'experts by experience'. Experts by experience have personal experience of using or caring for someone who uses the type of service we were inspecting.

Why we carried out this inspection

Birmingham Community Healthcare NHS Trust was inspected as part of the second pilot phase of the new inspection process we are introducing for community health services. The information we hold and gathered about the provider was used to inform the services we looked at during the inspection and the specific questions we asked.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection team always looks at the following core service areas at each inspection:

1. Community services for children and families – this includes universal services such as health visiting and school nursing, and more specialist community children's services.
2. Community services for adults with long-term conditions – this includes district nursing services, specialist community long-term conditions services and community rehabilitation services.
3. Services for adults requiring community inpatient services
4. Community services for people receiving end-of-life care.

Before visiting, we reviewed a range of information we hold about Birmingham Community Healthcare NHS Trust and asked other organisations to share what they knew about the provider. We carried out an announced visit between 23 and 27 June 2014. During our visit we held focus groups with a range of staff (district nurses, health visitors and allied health professionals). We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We visited 46 locations which included 13 community inpatient facilities and the dental hospital. The remaining locations included various community facilities. We carried out an unannounced visit on 27 June to one of the inpatient units.

Information about the provider

Birmingham Community Healthcare NHS Trust delivers community-based healthcare to people of all ages across Birmingham, covering a population of approximately one million people and a geographical area of 103 square miles across Birmingham, Sandwell, Dudley and Walsall. It also delivers Specialist Rehabilitation services and services at Birmingham Dental Hospital for the people of the wider West Midlands region, including Warwickshire,

Summary of findings

Staffordshire, Worcestershire, Shropshire and Herefordshire. The Birmingham Community Healthcare NHS Trust learning disability service works across Birmingham, in which 23,800 (2.3 per cent of the 1.1 million population) have a learning disability.

The trust delivers services in people's homes, primary care premises and as well as from the following main sites, of which some are community inpatient facilities:

- In Northfield: Edgewood Road Children's Centre, West Heath Hospital and Sheldon Nursing Home.
- In Kings Norton: Sayer House, Elliott Lodge, Kingswood Drive.
- In Ladywood: Birmingham Community Healthcare NHS Trust Headquarters, HMP Prison Winson Green, Birmingham Dental Hospital and Norman Power.
- In Hodge Hill: The Bungalow, Community Unit 29.
- In Moseley: Moseley Hall Hospital
- In Erdington : Perry Tree Centre
- In Yardley: Ann Marie Howes Centre
- In Sutton Coldfield: Community Unit 27

The trust provides community and specialist NHS services across Birmingham and the West Midlands and employs 4,845 staff (established posts at March 2014).

What people who use the provider's services say

Patient and carer feedback was positive. The majority of patients through surveys rated the services they received positively and would recommend the service to others. The main concern from people who used services was often waiting times to access certain services. Feedback from patients and relatives during the inspection was positive and staff were praised for their caring and compassionate nature. Outcomes from the Family and Friends test demonstrated the improving picture across the trust.

Good practice

- Podiatry service, where staff had used NICE guidance to identify ways of reducing unnecessary referrals. This had reduced the number of major amputations from diabetic/vascular complications.
- Pain management, staff introduced single sex interpreted group therapy sessions tailored to minority groups who previously had not engaged with the service.
- Chronic Kidney Disease, by working closely with GP's and acute services, staff had provided support and guidance to enable people to self-manage their conditions preventing people reaching crisis and needing hospital care. The neighbouring acute hospital had re-deployed staff who had been dealing with crisis patients due to the fall in admissions.
- There were examples of excellent multi-disciplinary working at Allen's Croft Children's Centre hosting awareness events in partnership with local and national organisations.
- The provision of just in time medication boxes to ensure that patients pain relief could be maintained in the community
- Nurses undertaking verification of expected deaths to reduce further distress to families
- The quality of care and extra steps that staff across end of life services carried out to support patients and their families.
- On-going work to provide dental services to specific groups of patients, often with complex needs.
- Combined community dental services provided cognitive behaviour therapy (CBT) to anxious patients in order to help them overcome their long-term anxieties.

Summary of findings

Areas for improvement

Action the provider MUST or SHOULD take to improve

- Appropriate decontamination processes and infection prevention audits should be put in place to demonstrate improvement in practice.
- The trust should engage staff in understanding the available performance information, and where necessary develop appropriate outcomes measures and audit programmes.
- Further action should be taken to ensure that access times are reduced where they in excess of referral to treatment time targets.
- The trust should work with partners to ensure that transition between childhood and adults services is effective and reduces unnecessary anxiety in young people and their parents or carers.
- The trust should improve the telephone system at the Birmingham Dental Hospital in order for patients to be able to access clinics and appointments information in a timely manner.
- The trust should complete recruitment processes to fill vacancies across the organisation including administrative support staff.
- The trust should address and mitigate the risks identified with the R4 patients' record system in combined community dental services.
- The trust should ensure that it has effective health and safety measures in place, including the storage of medical gases, management of clinical waste, removal of out of date stock and ensure that any chemicals are stored appropriately, and 'out of bounds' areas are appropriately secured.
- The trust should ensure that staff are aware of and utilise the Deprivation of Liberty Safeguards are effectively in a person's best interests and in compliance with legal requirements.
- The trust should consider the nature of the environment in residential learning disability settings and ensure whilst they meet infection control standards, they reflect a home environment.
- The trust should ensure that repairs and maintenance to equipment and facilities is carried out within acceptable timeframes across the learning disability services.
- The trust should ensure that all staff are aware of their roles and responsibilities with regard major incidents.
- The trust should provide suitable and sufficient IT training so that staff are competent to use the new information and records systems as they are introduced.
- The trust should ensure that learning following serious untoward and never events is shared across all areas of the organisation.
- The trust should ensure that the quality of record keeping is improved and that audits accurately reflect practice. This should include staff compliance with the deteriorating patient policy to ensure staff are recognising and managing patient deterioration confidently and competently. Records need to provide adequate evidence for the whole staff team to provide care.
- The trust should ensure that all staff who provide care in the rehabilitation of stroke patients have received appropriate training.
- Care should be delivered using best practice and guidance across all inpatient services, and should involve the patient and their family.
- The trust should ensure staff attendance at mandatory training and ensure all staff received appropriate supervision.
- The trust should review its 24 hour working practices across inpatient units to assure itself that patient flow is as effective as possible.
- The trust should review the national clinical guidance for stroke care to provide assurance that care delivery meets the ongoing needs of the patient and their family or carer.
- Put in place benchmarking against other wards within the service, to increase opportunities for learning across inpatient services.

Birmingham Community Healthcare NHS Trust

Detailed findings

Good

Are services safe?

By safe, we mean that people are protected from abuse * and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

We judged services to be safe at the time of our inspection. Systems and processes were in place to report incidents, accidents and near misses, and there was evidence of learning though this varied across different services. Infection prevention measures were effective; staff actively washed their hands and were bare below their elbows in clinical areas. Some concerns were identified in dental services, related to decontamination processes, but the trust were aware of these and were taking action.

The majority of facilities were in a good state of repair, though there were one of two concerns regarding the timeliness of action by the estates department. There were some trip hazards and unlocked facilities that could have posed a risk in the intermediate care units. Medicines were managed effectively, safeguarding policies and training were effective and records were well maintained. Record keeping was good, though some concerns were identified with the quality of records on some inpatient wards.

There were some concerns regarding staffing levels, clinical staff from a range of services indicated that there were not enough administrative staff which required them to cover these duties. Data from the trust indicated they were within safe staffing levels. Vacancies existed in many community teams; some had been filled with temporary staff, some of whom had been in a temporary position for many months.

Major incident plans were in place though staff from adult and children's services and inpatient units indicated that they had not received any training.

Our findings

Incidents, reporting and learning

Services were judged to be safe at the time of the inspection. There was a reporting system, Datix, which staff were aware of and evidence of sharing and learning from incidents took place, though this varied somewhat on the intermediate care units. There had been a recent never event in community dental services, a wrong tooth was extracted. Staff within that service were aware of the event and had shared learning and made improvements since

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the event. However staff in other parts of the trust did not have an awareness of the incident and which elements of the learning could be applied to their practice even if not directly linked to dental services.

The trust utilised essential care indicators as part of its risk reporting, and had developed an IT based system to allow all staff to access performance and clinical information called 'Gel Solutions'. This had been developed from a predecessor organisation and was being rolled out across the trust. At the time of the inspection whist we observed the potential impact the system could have, few staff reported to CQC that they were aware of the system. The trusts Quality Governance and Risk Committee was the main reporting structure to the board, met regularly with evidence demonstrating incidents were discussed and learning disseminated.

Other safety thermometer data including falls with harm, venous thromboembolism rates and patients with who develop a urinary tract infection who have an indwelling catheter, whilst fluctuating on occasions were all below the England average.

Between December 2012 and March 2014 the trust reported 443 serious incidents. Of these 386 related to grade 3 or 4 pressure ulcer development, and 313 (of the 443) occurred in peoples own homes. Of the 313 occurring in patients own homes, 309 related to pressure sores, and the remaining 4 related to two drug errors, a safeguarding incident and one classified as 'other'. In September 2012 as a result of the high numbers of pressure sores being reported the trust had introduced an initiative designed to reduce the number of serious pressure sores by identifying them at an earlier stage and preventing them developing. The initiative saw a 30% fall in the number of grade 3 and 4 pressure sores in the first month. Incidents of new pressure sores continued to fall and were below the national average. In April 2013 the numbers began to rise. Analysis of the increase identified that the impetus had gone from the project. It was re-launched along with staff training both within the trust and to external care providers and as a result with two exceptions of June and November 2013 the reported incidents have continued to be below the national average.

Cleanliness, infection control and hygiene

The majority of premises we visited during the inspection were clean and well maintained. Staff working at the dental hospital told us that it was a challenge to keep the building clean due to the age of the building, and there had recently been a deep clean of the building. New premises to replace Birmingham Dental Hospital are currently being built and should open in 2015.

The majority of staff were observed washing their hands before and after patient treatments, and were observed using personal protective equipment such as gloves and aprons.

We observed some inappropriate storage of nutritional supplements on the floor in some learning disability services, and there were concerns regarding the decontamination of dental instruments, mainly at Birmingham Dental Hospital. Some instruments had been returned from the decontamination company with bacteria present following decontamination and sterilisation; however this was within the agreed contractual limits. This was a known risk, and had been the subject of discussion between the trust, external contractor and the Pan West Midlands Decontamination Consortium Group.

We saw a range of infection prevention audits that had taken place, individual units scored well against these, and the information was displayed on public notice boards. Recent patient led assessments of the care environment at nine locations of the trust since April 2013 have scored them at 96.32 for cleanliness.

Maintenance of environment and equipment

There was a mixture of new and old buildings in use across the trust. In general the buildings were kept in an appropriate state of repair, and equipment was either single use or maintained according to agreed policy; though some concerns were identified in children and family services.

In community services for adults with long term conditions, we observed how a safety alert from the Medicines and Healthcare Regulatory Agency regarding a potentially defective piece of equipment was discussed at a team handover. The device was commonly issued to people who received care at home. All staff confirmed that the device in question was not one which was in use by any of their patients. Staff were able to name the devices in use in their area.

Some concern was raised with us by staff regarding the timeliness of repairs carried out by the estates department. Suction tubing in one dental services treatment room in a community clinic was damaged and awaiting repair, and in

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learning disability services, we saw evidence of faults reported some nine months earlier to the estates department that still required repair. Some areas within the inpatient wards were not secured appropriately, which could pose a danger to patients or the public, some trip hazards, were identified and some gels and dressings were out of date.

Medicines

We judged that medicines were stored and administered correctly where appropriate. Controlled drugs were all stored correctly and medication administration records we reviewed all indicated that medicines were administered appropriately.

Medication audits had taken place with errors recorded and learning shared with staff. Fridge temperatures were mostly recorded daily and the temperatures were within the recommended ranges to ensure that medicines remained effective. However; at one or two locations we found that ambient room temperature readings were high or not recorded and the rooms were used to store medicines, including emergency medicines, and had limited ventilation.

Both on the Sheldon Unit and in the community, nurses had trained to take on the additional role of a medication prescriber for end of life services. Systems were in place to support the nurses and for additional checks to be made on prescriptions. In end of life services additional medication boxes were available to patients to ensure that they did not run out of medicines for example at weekends.

Safeguarding

There were appropriate policies in place to manage safeguarding for adults and children's services across the trust. Training was provided; the numbers of staff who had received training varied across core services but averaged around 90% of applicable staff.

There was a safeguarding lead for the trust and appropriate systems in place to report to the board current levels of safeguarding concerns and action taken. Staff we spoke with were able to describe different types of abuse and potential abuse and how they would report it. We identified concerns from some staff regarding children's safeguarding referrals to the local children's safeguarding teams where they felt there had been a lack of action taken to address the concerns they had raised. We brought this to the attention of the chief executive who took immediate action to raise these concerns with the chair of the local children's safeguarding board.

Records

The majority of records we reviewed were paper based. The trust was rolling out a new computer system which staff told us was meant to reduce the amount of paper records and improve information flow. The computer system had been introduced in April 2014 and was still undergoing updates and improvements. The initial introduction of this system had caused frustration and difficulty for staff, who felt that the preparation and training had not been sufficient.

There were concerns expressed regarding the R4 patient records system in dental services with regard to its reliability. The trust was aware of this and were working to improve the reliability of it.

During our inspection we reviewed a range of patient records, most of the records were well organised and information was easy to access. Records contained a detailed assessment of the needs of patients.

However within inpatient services the quality of records varied, there were concerns particularly on the intermediate care units regarding the completeness of assessment and planning records.

Lone and remote working

The trust had a lone workers policy in place, and staff we interviewed stated that they followed these. The majority of staff operated a buddy system to ensure that colleagues were aware of the location. In end of life services we were told that risk assessments of families were undertaken, and information from associated authorities such as the police and local authorities was used to identify potential high risk families who presented risks to staff safety.

Some staff told us of ID cards that contained emergency communication devices that they could use to indicate they were in difficulty; however staff told us they tended not to use these as they considered their training and other systems more effective. In learning disability services staff working in the community were not issued with individual mobile phones or with personal alarms. One manager told us that each community team had a mobile phone that could be used by any member of the team if required.

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Managers told us they relied on staff to use their personal mobile phones to communicate with office bases or to return to their base to liaise with other members of the multidisciplinary team.

Adaptation of safety systems for care in different settings

Risk assessments carried out tended to reflect the setting in which care was being delivered for example in a community facility, patients own home or inpatient facility. Teams operated local risk assessments to reflect the type of services and where they were being delivered. Systems were in place to monitor and respond to risk. Staffing levels and skill mix supported safe practice in the areas we inspected and that risk assessments had been conducted to ensure staff and patient safety.

The dental service offered a domiciliary (home visiting) service for those who were not able to attend the surgeries, for example people who were housebound because they were infirm, or had profound disabilities. Staff told us there were procedures which they followed to ensure patients were assessed for their suitability to receive domiciliary dental services and that domiciliary visits were planned to maintain safe provision of dental services in patients' homes and staff safety.

Some health and safety risks to people with cognitive impairment, or living with dementia, had not been fully considered on one ward at West Heath Hospital and the intermediate care units. For example, some cleaning products were not stored securely in cupboards and as noted above some were kept under a sink in one unit.

Assessing and responding to patient risk

Services had in place individual risk assessments for treatments they carried out, and to recognise changes in patient conditions. For example, in the dental hospital systems were in place to provide sedation either through inhalation or intravenously, with appropriate patient assessments prior to this. End of life services had systems in place to assess the clinical needs of patients whose condition was worsening and ensure that they received prompt medical care.

Speech and language therapists (SLT) had introduced a telephone triage system. Patient conditions were categorised as urgent, moderate or routine and were seen according to the severity of their condition. Staff made periodic telephone calls to them to ensure that the information they had was correct and to discuss the person's current situation. Advice was given on how the patient could control their symptoms whilst waiting for a full assessment. Where patients reported a deterioration or additional symptoms staff were able to change their category to reflect the risk. Staff produced information which demonstrated that urgent cases were seen within two weeks, moderate cases within four weeks and routine cases with eight weeks.

Inpatient services used the Modified Early Warning Score (MEWS), to record routine physiological observations such as blood pressure, temperature and heart rate, and monitor a patient's clinical condition. This was used as part of a "track-and-trigger" system whereby an increasing score triggered an escalated response. However in some cases we identified a lack of recording and assessment which had impacted on the quality of care for some patients.

Staffing levels and caseload

Staff absence levels for the trust had been consistently higher than the average across England. Sickness absence rates at Birmingham Community Healthcare NHS Trust were above the average for community provider trusts in 2012-2013 at 5.67%. The average for community trusts was 4.7% and for the NHS across England 4.2%.

Absence rates for adult and communities and children and family services for June 2013 to May 2014 were 6.1% and 4.9% respectively, which was higher than 4.7% England average. The trust had an initiative in place "the health and wellbeing pilot" this was to drive down the staff absence rates.

Maintaining safe staffing levels was an area in which the trust performed higher than their target of 85%. Documents supplied by the trust showed that 92% of the time, they achieved the minimum number of staff to maintain patient safety within the trust. However the 2013 staff survey indicated that 53% of staff felt that there was not enough staff in the organisation for them to do their jobs properly.

Whilst the majority of staff indicated that there were sufficient numbers of staff for the level of service they provided there were exceptions to this. Community learning disability staff had vacancies though recruitment was taking place at the time of the inspection. However staffing numbers in one community nursing team had reduced from six to four and there were no plans to recruit to the vacancies despite an increasing workload.

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Staff levels and skill mix were acceptable within inpatient facilities. Some staff on the intermediate care units told us of staffing level concerns at the weekends, when there was no catering staff available to prepare breakfasts and also when staff went out to accompany patients for hospital appointments.

Caseloads were high in health visiting, and currently above the Community Practitioners and Health Visitors Association (CPHVA) recommendations. The trust was in the middle of a programme to recruit additional health visitors as part of National Health Visitor Implementation Plan, with the intention of increasing recruitment from 156 to 270 whole time equivalent by April 2015.

We were informed that there were vacancies for dentists and dental nurses at the Birmingham Dental Hospital. Staff told us the recruitment processes had been slow and they felt the planning and management of staff recruitment at the Birmingham Dental Hospital had not always been completed in a timely way. Staff told us there were not always enough dental nurses to provide a dental nurse dedicated to every dentist or student dentist working in different clinics at the hospital. Senior dental services directorate staff confirmed recruitment was on-going for both dentists and dental nurses at the Birmingham Dental Hospital. Where there were gaps in staffing, current staff worked overtime shifts, bank and agency staff were also used to address staffing levels. The dental services directorate team also confirmed there were vacancies in the medical secretary's team at the Birmingham Dental Hospital.

A number of different services indicated that there was a lack of administrative staff, and that clinical staff had to take on these duties which impacted on their care delivery time.

Deprivation of Liberty safeguards

Staff had received training in relation to the Mental Capacity Act, and Deprivation of Liberty Standards. As at March 2014 95% of staff across the trust had received the basic awareness training that included both Mental Capacity Act, and Deprivation of Liberty Standards. However, staff understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards in learning disability services was variable.

Throughout our inspection of learning disability services, we met patients who, under the recent Supreme Court Ruling, were possibly being deprived of their liberty (inappropriately restricted of their freedom). For example we met patients who had been assessed as lacking capacity to make decisions and consent to care, who required continuous supervision and control and were not free to leave the premises. When we looked at the care records for these people we found that assessments had not been made in relation to DoLS, and that applications had not been made to authorise DoLS within residential or respite Learning disability services. We spoke with senior managers about this and they responded immediately with an action plan to review and update all patient records in relation to this.

Managing anticipated risks

We identified a range risk assessments in place across the core services we inspected for example fire risk assessments, falls risk assessments and plans in place to manage outbreaks of infectious diseases for example swine flu and other pandemics. The lack of person centred care planning for people with cognitive impairment or dementia was identified on the trusts board assurance framework as a quality priority for 2014-2015.

In children's services plans were in place to manage the risk of changes in demand and long waiting lists. For example occupational therapy (OT) had accessed locum staff that were competent with paediatric OT care and treatment, to manage the increased demand on the service. Health visitors had access to bank staff that were familiar with the service in the event of busy periods or staff sickness.

Major incident awareness and training

In community services, for adults with long term conditions, staff had an understanding of major incident plans. Staff were aware of how to access major incident plans, but believed they would be instructed by managers and team leaders if a major incident occurred. Staff we spoke with in both adult and children's services had not undertaken specific training in relation to major incidents.

The trust had a lock down policy for dealing with major incidents in learning disability services. There were plans in place to respond to and manage unexpected emergency situations. We saw that there were risk assessments in place, for example in relation to fire. Staff had received fire safety training and were able to explain what they would do in an emergency. Plans had been discussed with other teams and staff in these teams were able to tell us their role in supporting services in an emergency. Staff told us that

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fire drills took place every six months in residential settings and we saw evidence of this in records. The staff we spoke with were aware of escalation procedures if a risk was identified. However, we did not identify any personal emergency evacuation plans for patients with limited mobility.

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary of findings

Over all the effectiveness of services was good. The majority of staff used national guidelines to provide care, and in some cases this was being recognised nationally. The use of national guidelines was more limited across inpatient units with some concerns regarding the provision of guidelines for stroke care. Pain relief medication was provided as required, with anticipatory prescribing in end of life care.

Patients nutritional and hydration care was appropriately managed, and there were a range of patient outcome measures identified across teams, the majority being positive; though inpatient services would benefit from further development in this area.

Staff took part in audit activity, and there was a comprehensive array of performance and quality information available, though not all clinical teams had access at present. Staff were competent to deliver services, and the majority had access to performance assessments, supervision and mandatory and professional training, though some gaps did exist.

Overall access to equipment was good, and the majority of premises were of good quality.

Multi-disciplinary team working took place across teams both within Birmingham Community Healthcare NHS Trust and with staff from other organisations. Pathways were utilised though there were concerns from staff in children and family services about the effectiveness of transitional arrangements between children's and adults services.

Our findings

Evidence based care and treatment

Staff used evidence based guidance and policy to deliver care to patients across the organisation, though this was not always the case across inpatient wards. Guidance included that published by the National Institute for Health and Care Excellence (NICE), and the Gold Standards Framework for end of life care. There was a lack of guidance available for the provision of stroke care to patients across many inpatient wards.

There were limitations in the use of some rehabilitation measures for example the 10 Meter Walking Test and the Timed Up and Go test to assess the patient's mobility and the Tinetti Performance Oriented Mobility Assessment designed to measure balance (including fall risk) and gait function. Records we viewed across a variety of inpatient settings did not always provide clear treatment plans for various professional groups to follow.

In community services for adults with long term conditions, podiatry services had used published NICE guidance to steer their review of the referral system. This had made an impact in reducing the number of inappropriate referrals and freeing up their time to deal with more appropriate cases. The practice had been highlighted by NICE as an example of how guidance could be used to improve services; NICE had produced a poster based on the model used at Birmingham Community Healthcare NHS Trust.

In children's services, health visitors gave out Bookstart packs to children at home visits in line with the national early intervention and cultural access programme for every child. Physiotherapy and speech and language (SLT) services had developed their own assessment tool based on risk, impact, benefit of treatment and level of child ability.

Pain relief

Medication was prescribed as appropriate for the management of pain relief for patients receiving care across the trusts' services. In end of life services, anticipatory prescribing took place to ensure that patients did not experience any delays in pain relief. Staff assessed the effectiveness of the pain relief medication using a tool developed by the World Health Organisation.

Appropriate pain management guidelines were in place, and we observed for example in children's, young people and family services, that staff used the pain management care plans and administered liquid analgesia to children. We did note, and staff confirmed that no paediatric specific medication training was provided to staff.

Nutrition and hydration

Nutrition and hydration assessments were completed for the majority of patients where it was appropriate to do so. Swallowing assessments were carried out by SLT staff in the community. In learning disability services, malnutrition

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universal screening tools were used to undertake weekly assessments for patients. A variety of menu choices were available for patients, and patients who required support were helped in a caring manner.

In one of the inpatient community units, risk assessments in patient notes were mostly completed but there were some omissions and inaccuracies which had not been noted or corrected by subsequent records by nursing staff. We found one patient had the wrong height recorded which meant that the risk assessment for nutrition indicated the need for increased calorific intake and was having food supplements. The inaccuracy was not noted for a number of weeks until a dietician checked the records.

The infant feeding team and health visitors promoted and audited the number of breastfed babies in the area. Breast feeding initiation was low at 68.1% compared to 74.6% nationally. Breastfeeding prevalence at 6-8 weeks averaged 52.6% between September 2013 and March 2014, higher than the national average of 49%. Initiatives such as weekly breastfeeding workshops and peer support groups had been developed to promote breastfeeding. Quinton Lane Health Visiting Team had designed a pictorial mood booklet due to be released which could be used to overcome language barriers.

Patient outcomes

There were a number of activities undertaken by staff to assess the outcomes of treatment for patients who used their services.

The majority of patients we spoke with across dental services were satisfied with their treatment. We noted that staff at the dental hospital used the World Health Organisation's surgical safety check list and this was audited quarterly. The latest results for completeness of recording ranging from 93-100%.

In end of life services staff no longer used the Liverpool Care Pathway, and had researched and implemented the Supportive Care Plan. The aim of the care plan was to support people who had a life limiting diagnosis to preserve their quality of life, in this final phase. The Supportive Care Plan was comprehensive and took into account the best practice in end of life, by being personalised to the patient, taking into account their current emotional and mental status and family expectations.

Children and their families mostly achieved their preferred place of dying. Data showed for the four quarters of 2013 83% died in their preferred place. Notably in quarter three 100% achieved this.

Some patient outcome measures were in place across inpatient settings though this wasn't consistent. For example at Moseley Hall Hospital, one ward was taking part in data collection for the UK Specialist Rehabilitation Outcomes Collaborative (UKROC) database. Staff had access to the essential care indicators, which were being used to compare services and there was some benchmarking at meetings for clinical effectiveness.

In adult community services, the podiatry team demonstrated how through a combination of early intervention and innovative application of NICE guidance they had reduced the need for major amputations (above the ankle) to 0.7 annually per 1000 population, significantly lower than the national average of 0.9 per 1000. Chronic kidney disease (CKD) clinics had raised the profile of the disease with GP's in the community. Staff had run virtual clinics with GP's identifying patients who may already have or be at risk of developing CKD. Clinics ran at different locations on different days and patients were able to choose the most appropriate location or day on which to attend. Follow-up visits for patients who had difficulty travelling were conducted in their home.

Many of the children's and family services used the Strengths and Difficulties Questionnaire (SDQ) (a behavioural screening questionnaire) as part of the initial assessment and again at the end of the clinical programme. Although outcomes could be seen on an individual basis, no service audited the questionnaire to demonstrate outcomes at service level or evaluate interventions. The trust had identified this as an area requiring improvement and therefore, the development of outcomes was registered on the divisional plan for 2014-2015.

One of the trust's CQUIN projects was to encourage early identification of grade 2 pressure ulcers to provide effective treatment to prevent these progressing to grade 3 or 4 pressure ulcers. The trust's Quality Account reported that each quarterly target was achieved.

Performance information

Performance information was available to staff via the Gel Solutions IT system, however at the time of our inspection

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this was relatively new, not all clinical areas had access to the service and few staff we spoke with were aware of it. The system however had the potential to provide a rich source of performance information about both staffing performance as well as the trusts essential care indicators which gave measures of clinical performance for all staff to access.

For example the reporting tool provided a regular update into the level of harm free care and essential care. In May 2014 for example Hall Green Community Team achieved 95.5% in both harm free and the essential care indicators, though further work was noted as required for patient observation, which was scored at 80%. In addition to this each division had its own RAG (red, amber, green) rated score card, which included a wide range of patient outcome measures including healthcare acquired infection rates and waiting time information.

Staff took part in a variety of clinical audits, and we observed staff discussing and sharing the outcomes of the audits, and how learning could be implemented in practice. For example the in-depth analysis of referrals to podiatric services identified how much time was being spent dealing with inappropriate referrals. The team identified how they could be more effective if they could prevent incorrect referrals being made. By providing guidance to GP's and the public and other healthcare professionals they were able to signpost people who did not require their services to more appropriate services including private nail care services.

Across the inpatient units, the majority of wards displayed performance information on public notices boards, and staff used the essential care indicators including harm free care data to measure their performance. Staff did indicate that inpatient units would benefit from additional performance indicators including for rehabilitation.

District nurse teams used live data to assess capacity and caseloads. This had enabled them to identify deficiencies with skill mix of staff. Because the teams worked geographically there were times when highly skilled staff were completing less demanding work whilst neighbouring areas were unable to provide timely responses to patients because nurses with the skills required were not on duty. As a result teams had been brought together in clusters enabling an exchange of staff if required to ensure patients received the most appropriate level of care with the least delay possible.

During 2013-2014 the Commissioning for Quality and Innovation (CQUIN) target of 200 common assessment framework assessments being initiated by the children and families service was exceeded. There were 342 assessments initiated by the division and 265 of those were initiated by the health visitor service (the common assessment framework (CAF) is a national approach to providing a way of assessing children with additional needs, with the purpose to initiate and support early intervention).

Competent staff

Induction processes were in place, and staff had access to training and professional development. The majority of staff told us that they had access to training, performance reviews and mandatory training, though this varied across the organisation. Overall in the last staff survey, 78% of staff felt that they received job relevant training; this was down from 81% the previous year. Staff working on inpatient units indicated that they had received mandatory training but were not able to access specialist training in stroke care, learning disability and dementia care.

The percentage of staff who had received a performance review varied, in May 2014 in adults and communities, 78% of staff had received an appraisal against a target of 90%, whilst 82% of staff had undertaken mandatory training against a target of 85%. Overall for the inpatients' service, 72% of staff had completed the trusts' mandatory training in April 2014, against the trust target of 85%. The trust had recognised this area as needing action and wards had action plans in place to address this issue.

In children's and family services, health visitors had 'shut down days', where clinical supervision and discussion of challenging cases took place to share clinical skills and knowledge. Physiotherapy and occupational therapy (OT) had journal clubs and rotational staff posts, some shared with Birmingham Children's Hospital NHS Foundation Trust (BCH) and others with adult services to ensure staff were competent in a variety of clinical areas.

The majority of staff stated that they had access to supervision on a 1 to 1 or group perspective; however this was not the case for the falls in adult's community service or on a number of the inpatient units.

Staff in dental services reported that they were supported and encouraged to attend training, including mandatory training and specialist training related to their individual roles. Records confirmed that most staff were up to date

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with their mandatory training. Staff told us they participated in continuing professional development, (CPD) in line with General Dental Council (GDC) requirements, and were actively encouraged to take part in audits and further professional development. Staff confirmed they attended annual appraisals with their line managers. All of the staff we spoke with at the dental hospital and community dental services clinics told us learning and development was a high priority within the directorate and they felt they had benefitted from the training opportunities provided by the trust.

Use of equipment and facilities

The majority of facilities that we inspected as part of the inspection were fit for purpose, though storage space on some inpatient wards was limited. In children's and family services, services were colourful, interactive and a pleasant environment for children and young people. There were good children's facilities within services, including a sensory room at Bacchus Road Child Development Centre (CDC). There were multiple in and out door play areas for children across the service catering for different ages and abilities.

The services for people with a learning disability whist being well designed were very clinical in nature. In essence these settings were people's homes, and had recently had carpets removed and walls painted a very neutral colour. In two of the services we visited dining chairs were very heavy and without arms, which we observed made them very difficult to manoeuvre for both patients and staff.

Community services did not raise any concern with access to equipment for patients, with staff reporting that they had access to equipment as they required it.

Telemedicine

Some telemedicine systems were in place, mainly in adult community services. Community respiratory teams used telemedicine systems. Staff we spoke with described how the system was effective and reduced clinic visits and reduced patient anxiety as they could input information and receive feedback without having to book appointments, travel or wait to see professionals and if an issue was identified the response was fast and effective.

Multi-disciplinary working and working with others

Multi-disciplinary team (MDT) working took place across all the teams and services that we inspected. Both inpatient and community end of life teams worked with a range of other MDT team members, including local hospices, and community health and social care staff. The community children's teams worked with a range of other professionals, including respite care workers, play workers, occupational therapists, physiotherapist, psychologists, dieticians and speech and language therapists and hospices and charities. This was not the case at the Sheldon unit, where staff predominantly worked with local hospices and dieticians. We could not establish any evidence that staff worked with psychologists, physiotherapists or other allied health professionals.

Staff within the dental services directorate worked in partnership with other primary and specialised dental services to ensure an effective and patient focused service. Staff we spoke with were able to explain the procedures for screening and making referrals to other specialists outside of the community dental service.

Within children's and family services, Allen's Croft Children's Centre had been chosen to launch the Royal Society for the Prevention of Accidents' first ever Family Safety Week in March 2014. The centre was chosen as an outstanding example of a multi-agency partnership working, with early year's education services provided by Birmingham City Council (BCC) alongside specialist paediatric healthcare services delivered by Birmingham Community Healthcare NHS Trust (BCHC) and other NHS colleagues in the dedicated centre. Staff did raise some concerns regarding difficulties accessing, referring to, and communicating with social services and Child and Adolescent Mental Health Services (CAMHS). They felt this delayed appropriate care.

At West Heath Hospital, weekly MDTs were held and included summary of medical issues, management plans were discussed and future issues, outcomes and expectations identified. A doctor told us that the focus of the ward was on the best interests of the patients and the quality of care. They had had excellent opportunities to learn, and were well supported and had gained better insight into other team members contributions to the MDT approach.

Staff in adult community services described the single point of access (SPA) system where all referrals were recorded and passed on to the relevant teams this included referrals from outside the trust such as GP's and care homes; the system was nominated for a national award in 2013.

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Co-ordinated integrated care pathways

There were examples of effective integrated care pathways being used across a number of different services. In learning disability services, pathways anticipated care needs and had been developed by the multidisciplinary team and were patient and family focused. We saw that patients were supported by members of the multi-disciplinary team who worked together to ensure care was integrated.

In end of life services, care was provided by Gold Standard Framework procedures which were GP led but involved multi-disciplinary teams from the community prioritising assessment and care to reduce pain and anxiety for people approaching the end of life.

However, in services for children, young people and families, there were few transition pathways across children and families services and occupational therapists, physiotherapists and health visitors told us that they had concerns for those young people who were due to transfer into adult services. Some services had started to implement transition arrangements such as a pilot scheme in physiotherapy and joint child and adult clinics in attention-deficit hyperactivity disorder services.

The local Child and Adolescent Mental Health Services (CAMHS) was provided by a different provider and staff reported this service now had stricter referral criteria and had declined a number of the trust's referrals. Some delays were reported in referrals to social services due to the capacity and demand on the local authority. Health visitors told us that they had met with social care services to discuss these concerns and improve relationships but that there continued to be a lack of communication between the services and that this was very time consuming to resolve.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary of findings

Staff were caring and compassionate towards their patients and families, and sought to respect their dignity at all times. We observed and found some excellent care in end of life services, including nursing staff verifying expected deaths, and seeking to meet all the needs of their patients, including understanding and taking into account difference in cultural need.

The majority of patients were involved in decisions about their care, and staff sought to take the time to explain to patients about their care to ensure patients could fully consent to their treatments.

Staff provided emotional support for patients, and we discussed a range of support that staff in end of life services had provided to patients and their families including their approach to involving parents individually depending on their emotional state, open visiting on the Sheldon Unit and writing to employers to support parents care effectively for their children.

Our findings

Compassionate care

Overwhelmingly patients were cared for by compassionate staff. Patients, children, young people and families that we spoke with were positive in their praise for the caring nature of staff, though some patient feedback at the dental hospital and intermediate care units indicated that this was not universally the case.

We observed staff delivering care and they did so demonstrating that they had the best interests of the patients at the heart of their care. We noted that one member of the community palliative care team had won the Lord Mayors award for compassionate, outstanding and exceptional service.

At the Children's Respite Care Unit at Edgewood Road care records had 'All about me' sheets that discussed the child's needs, preferences and dislikes. We witnessed staff tailor care to meet the individual needs of children. Parents told us that there was constant communication between staff and themselves regarding their child's care and treatment.

Dignity and respect

Staff treated patients and their relatives with dignity and respect. We observed staff maintaining patients' dignity when carrying out clinical activities. Staff took into account the cultural needs of patients, for example how staff in end of life services observed cultural differences, and included within their care planning the effects of religious festivals which required fasting and the impact that this would have on both patient and their carers.

Patient understanding and involvement

Patients told us and we observed staff involving patients, children, young people and their families in decisions about their treatment. In learning disability services, staff used a variety of communication methods in order to support patients to make decisions. Families of patients who used learning disability services told us they were always consulted regarding decisions.

On inpatient units the majority of patients were involved in their care, though patients on one of the intermediate care units were not always aware of whom their named nurse was. On one of the community units patients were not consistently involved in meetings to discuss their plan of care or discharge arrangements.

We saw evidence in dental services of appropriate consent to treatment, and in end of life services effective do not attempt cardiopulmonary resuscitation (DNACPR) decision making and recording including the involvement of patients and family members.

In adult services we spoke with a patient visiting the chronic kidney disease (CKD) clinic who told us about their treatment. After a sudden illness they had been admitted to hospital and later discharged, they had been seen by several health professionals and were referred to the CKD clinic. They told us that it was only when they spoke with the staff at the clinic that anyone had actually spent time to explain what the medical condition was and how it could impact on their life. They now had an understanding of how to reduce the impact of their condition and could plan for the future.

Emotional support

We identified a range of support for patient's emotional well-being. The looked after children's service used the Warwick-Edinburgh Mental-Being Scale to measure children's mental wellbeing and provide support. There was an emotional health nurse to support children and to

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

promote health and wellbeing of all school age children. They were able to offer six direct sessions with a child to emotionally support the child through matters such as bereavement, self-harm and depression.

In end of life services, staff had undertaken additional training to be able to undertake verification of death which supported families at a time of heightened emotion. This was an area in which the trust is one of few organisations that have the ability to support relatives to this level by having trained nursing staff verifying expected deaths. This meant that staff that knew the patient and families and had had time to build a relationship were able to complete this task. The one bereaved family we spoke to told us they greatly appreciated this and to have had a GP out of hours at that time who they did not know would have added to their distress.

On the neurological rehabilitation ward, there was good access to a clinical psychologist and there were quiet areas for discussion with patients and relatives.

Staff providing community dental services had undertaken cognitive behaviour therapy (CBT) training to help anxious patients overcome their anxieties related to their dental treatments. CBT was delivered by trained dental nurses who had completed additional training in CBT techniques. CBT therapy was used to improve the longer term needs of patients who were extremely anxious about their dental health care.

Promotion of self-care

We observed staff providing advice and guidance on self-care throughout the inspection, some of this was general lifestyle advice, other more specific to the individual needs of a particular client group.

In children's services the occupational therapy satisfaction survey for August to September 2013 indicated that 94% of parents and carers undertook prevention activities in the home environment and that this had a positive impact on their child and helped them to understand their child's illness.

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

Summary of findings

The majority of services were responsive to the needs of patients, though there were concerns regarding some services for children, young people and their families. A range of services were provided to meet the needs of people and staff endeavoured to provide flexible services as close to people's homes as possible.

The single point of access service provided a range of interventions that prevented around 200 people a week requiring hospital admission. Although most services provided care within the agreed time frames, some children's services, and in particular speech and language services had had long waiting times, and whilst they were reducing still exceeded the expected timeframe. Other delays were also noted with some dental services.

The trust handled complaints appropriately, and sought a variety of ways in which to gain feedback and handle complaints.

Our findings

Service planning and delivery to meet the needs of different people

Staff across the trust endeavoured to ensure services were planned to meet the needs of their diverse populations. This was achieved across a range of services though concern remained in learning disability services as it was unclear what the long term commissioning arrangements were going to be for that service.

Staff in combined community dental services provided services across a wide range of settings, including secure units and prisons in the local region. Services were also provided to patients in their own homes when required and for patients who were homeless or had no fixed abode. Dental services for people who were homeless were provided by a dedicated team of dentist and dental nurse, though at present staff numbers were limited to two and there were no contingency plans in place should these staff not be at work.

Across inpatient services, we observed an integrated approach to care delivery across wards involving nursing staff, therapists, medical staff and pharmacy and a commitment to facilitating a timely, safe and person-centred discharge for the patient. Home assessments were conducted with the patient, relative and a member of the multidisciplinary team before discharge to assess the need for equipment or further community support after discharge. However there was limited activity for some patients on the community units.

Staff across children's and family services provided a range of health promotion activities across Birmingham to reflect a range of need for the location population. For example health campaigns to tackle alcohol misuse were implemented by school nurse students, young people's health advisors and child safeguarding leads; as hospital stays due to alcohol related issues in Birmingham for under 18s were higher than the England average. Workshops took place in schools and we observed health visitors discuss the principles of the 'Who's in Charge?' campaign, which raises awareness of babies and children suffering serious harm after their parents drink too much alcohol at home.

In community adult services pain clinics ran single sex sessions with interpreters to meet the cultural needs of the community. Care pathways had been adapted to reflect the cultural differences; staff had recognised that western ideas and phrases were lost when talking to people who did not speak English. There were some concerns expressed regarding the lack of seven day working which impacted on the responsiveness of some services.

Learning disability services within the trust had experienced a period of change. Some services had recently been decommissioned and the future of others was still undecided at the time of our visit. These commissioning decisions impacted on planning for the future within these services. The trust had a published vision for learning disability services; however staff told us that they found it difficult to plan for the future because there was doubt about whether services would be re-commissioned. However despite this staff endeavoured to provide a service that met the needs of its patient group including the provision of suitable activities, information in appropriate formats and the provision of female only carers where appropriate.

In end of life services the community children's nursing and palliative team worked closely with commissioners to identify areas of additional resource. Two new palliative care nurses were due to start; this was because the service had shown they were over delivering.

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

Access to care as close to home as possible

The majority of community services were delivered from people's homes or from community centres across Birmingham to allow flexible access to services. Inpatient services were delivered from a range of locations across the city and the majority of patients were admitted close to their home location.

The single point of access into adult community services was helping around 200 people each week to stay at home for treatment and out of hospital. The service received around 500 calls each week. A rapid response service with integrated multidisciplinary teams, helped to shift the emphasis away from acute hospital care and towards community settings. Clinicians staffed the phone line 24 hours a day and directed care to the community service as appropriate.

In addition to this additional flexibility has been developed in community nursing services. Community nurses were now part of 43 integrated multidisciplinary teams across the city - working closely and flexibly with therapists, social workers and case managers to provide care that allows patients, particularly frail elderly people, to retain their independence at home.

Across dental services, where treatment could be offered at a local facility patients were offered this option to ensure it was as close to their home as possible. Some dental services were offered in the patient's own homes if it was practical to do so and the patient was unable to visit a clinic.

Access to the right care at the right time

The trust met the majority of its referral to treatment times targets, however, there were delays in patients accessing treatment within the 18 weeks for orthodontic and paediatric patients at Birmingham Dental Hospital. We noted that paediatric dental services had failed to achieve the target for 95% of all referrals to be seen within 18 weeks since September 2013. Orthodontic services had breached the 18 week non-admitted pathway since January 2014. We were told the breaches within orthodontics and paediatrics at Birmingham Dental Hospital were due to lack of capacity.

There were a range of concerns regarding access in children's and family services. Waiting time for an initial assessment for SLT services were between seven and eight months and there was a further wait of up to twelve months for therapy. The trust had recently received funding which had reduced waiting times from 102 weeks to 48. This had reduced further to 44 weeks at the time of our inspection with a forward plan to reduce to 18 weeks by March 2015. The SLT satisfaction survey (November-December 2013) had over 50 comments from respondents regarding the long waiting times. Waiting times had been an on-going problem for over 2 years.

At one location, the waiting time had been reduced from 12 months, and the current waiting list we saw indicated that there was a 33 week wait for social communication groups, a 14 week wait for global development assessments and a 2 week wait for early developmental assessments and intervention pathway. Occupational therapy services had reduced waiting times from 52 weeks and now offered appointment by 37 weeks. This improvement was a result of the implementation of occasional Saturday clinics, offering staff overtime and the employment of locums. There were three locums working in the service during our inspection, one had been with the service for 18 months, yet we were told no plans were in place to recruit permanent staff.

The majority of inpatient services provided services that met the needs of patients; however the lack of 7 day working by some therapy staff meant that assessment targets were not always being met.

In adult services, though some patients indicated that they believed that they had had to wait a long time for treatment, data indicated that the trust met its access targets. There had been some delays to service delivery during the implementation of the new records management system which had impacted on service delivery, but staff had carried out additional clinics to compensate for this.

Within learning disability services, waiting times for referrals to psychology, physiotherapy and occupational therapy were all approximately 12 weeks which was less than the 18 week target. We saw evidence from the trust that in September 2013, 100% of patients referred were seen within the 18 week target with 95% being seen for the year to date at the time of the inspection.

Flexible community services

Staff endeavoured to provide services flexible to the needs of their population. A range of services were provided, some of which have already been described in this report,

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

but including the provision of virtual chronic kidney disease clinics, held with GP's to identify potential patients who could be monitored by their GP and referred to a specialist clinic when necessary; and a monthly late night drop in health visitor clinic for parents and children at Hodge Hill Primary Care Centre. Staff also provided quick response (QR) codes for young people to access information about services in the form of an animated You Tube video that the service had provided.

Meeting the needs of individuals

There was a range of services that helped to meet the needs of individuals across services, and these have been described within this report. These include for example the provision of same sex pain clinics, CBT services for patient anxious about dental treatments, and evidence based podiatry services that have improved outcomes for patients.

Translation services were available from both an in-house team of interpreters as well as an external company; this included British sign language. In inpatient facilities nutritional requirements were met through a range of menu options and in end of life services preferences were maintained in the kitchens at Sheldon Unit to ensure patients received food that they liked.

The majority of facilities across dental services were adequate, though wheel chair access was more restricted at the Central Clinic Dudley. Some concerns existed regarding the telephone system at the dental hospital. The telephony system at the Birmingham Dental Hospital was causing frustration for patients who were unable to get through on the phone to make appointments. There were limited resources available at the centres we visit for children and young people, other than magazines, with the exception of Oldbury Health Centre.

Moving between services

There were a range of pathways in place that allowed patients to move between services, though some concerns were raised with us with regard to the transition of children through to adult services from children and families services.

Respite services were available in learning disability services, this included multiagency discussion and joint working to ensure the smooth admission and discharge of patients before and after respite care. The patients and their families using learning disability services had been involved throughout their care pathways and their wishes had been considered. A transition pack had been developed to support young people as they moved from children's to adult services. Patients had a document explaining their preferences and wishes should they be transferred to an acute hospital. A qualified nurse would always accompany the transfer of patients requiring acute care and a health care assistant could stay with the patient at the acute hospital should this be required.

Complaints handling and learning from feedback

We observed information for patients or their carers on how to make complaints and access to patient advice and liaison services. The trust managed feedback on the NHS Choices web site effectively offering people who raised concerns the opportunity to discuss their concerns further.

The trust undertook the Friends and Family Test (FFT) which seeks to find out whether patients would recommend their care to friends and family (there is no current requirement for community trusts to adopt the Family and Friends Test). The trust wide net promoter values increased from 68 (in Jan/Feb 2014) to 78 during March/April 2014. The percentage of patients reporting overall satisfaction (very good/excellent) increased very slightly from 80.53 to 81.07% during this period. The Net Promoter Score (NPS) for inpatients' services in March 2014 was 70, against the trust wide score of 75. Maximum scores of 100 were achieved by four wards.

A range of action from the Family and Friends Test were included in the commissioning for quality and innovation targets agreed with the trusts commissioners, including developments for staff, for example significant work was carried out to reduce work – related stress; resilience toolbox training and Be Well Roadshows were organised for staff at various sites. As a result, responses to the question "If a relative needed treatment would they be happy with the standard of care?" showed an improvement of 11% from 56% to 67%.

The trust had received 192 complaints in 2013-2014, the majority of which were in community services. Some services for example end of life and learning disability services received very few complaints. Patients and their relatives in these services would often have a conversation with staff if they were not happy and problems would be dealt with before they became big issues.

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

Across different clinical services we saw 'You said, We did' displays that outlined issues that had been raised and action that staff had taken to resolve the issue.

The looked after children's service had a touch screen questionnaire, designed by 1000 children and young people in Birmingham schools, for children to complete.

Feedback from this showed that children did not know what to expect when coming to the service. As a result the service added a Quick Response Code to the information children receive prior to assessments, this meant that children could access via electronic devices information about the service.

Are services well-led?

Good

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary of findings

Instructions

Overall the provider was a well led organisation, with an open and supportive culture. The executive team, and chief executive and executive nurse in particular were well known amongst staff, and made time to visit with staff to hear their views of the organisation. The chief executive took the opportunity to communicate with staff in a variety of ways including video blogs, and there was a dedicated email address for the chief executive for staff to provide feedback.

There was a trust vision and values in place, the values had been developed in conjunction with staff, though at the time of the inspection knowledge varied across the staff groups that we interviewed.

There were appropriate governance and performance management structures in place that extended corporately down into the divisions. Performance and safety information is available to staff and is shared in a variety of ways. Continuous improvement of these systems takes place for example the development of Gel Solutions that will provide all staff with 'live' information on performance and quality indicators. The trust had also developed its own essential care indicators as quality measures. There was some concern regarding the visibility of other senior directorate managers, and some staff were more familiar with the executive staff than their own directorate leadership.

Patients, staff and members of the public were engaged by the trust, and there was evidence of improving patient satisfaction from surveys and the Family and Friends test.

Our findings

Instructions

Vision and strategy for this service

There was a trust vision and articulated values in place, and directorate strategies were in place or in development at the time of our inspection. Staff knowledge of the trusts vision and values varied. Some staff were able to quote the values and the '6C's' 'Care, Commitment, Communication, Compassion, Competence and Courage' which the organisation promotes, but not all staff were fully engaged in this.

Whilst there was a vision for learning disability services, there were concerns regarding the future as commissioning intentions were not clear. There was a vision for dental services, which included the relocation in 2015 to a new build and the integration of the hospital and community services. This was causing some concern for staff, but staff did acknowledge that they were being kept informed of developments.

The trust had consulted widely on their quality priorities for 2014-2015 with their stakeholders, including staff and the public members. Consultation took place from December 2013 through to the end of January 2014. The agreed quality priorities for 2014-2015 were continuous implementation of the Safety Thermometer, safe staffing, measuring clinical outcomes, care planning, patient experience and information technology.

Governance, risk management and quality measurement

Governance structures were in place at a corporate level which were mirrored down into the divisions. The main quality group was the Quality Governance and Risk Board Committee. This met monthly and discussed performance as well as risk and quality. The trust had also developed a performance management structure with associated staff and governance structure.

The Performance and Programmes Management Board linked into the Quality Governance and Risk Board Committee. Performance management staff linked into the individual divisions, and provided project management support to deliver service transformation and cash releasing efficiency savings (CRES). All CRES programmes had evaluation built into them to review the impact on the quality of care before during and after implementation and staff were involved in the development of programmes.

The trust achieved level 1 of the NHS Litigation Authority's risk management standards in November 2012, and assessed themselves against the Department of Health's Information Governance policies and standards and were rated as satisfactory.

Are services well-led?

Good

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

In 2013-2014 Birmingham Community Healthcare NHS Trust participated in 100 per cent of applicable national clinical audits and 100 per cent of national confidential enquiries of the national clinical audits and national confidential enquiries.

There was a comprehensive risk reporting system across the trust which included divisional RAG rated score cards, and access for some staff to Gel Solutions a continuously updated information system that allow staff to view a range of clinical and performance indicators, including staff sickness and absence, essential care indicators and other data. At the time of our inspection few staff were aware of this, but it was being rolled out across teams. Where staff did not have access to this, we were told that they had regular staff meetings where information was shared including performance and risk.

The trust implemented a Safety Express in 2013 to help monitor quality of services and compliance with care pathways. The system was used to assess the four areas identified by the department of health's safer care programme, no needless pressure ulcers, no needless harm from falls, no needless harm from catheters and no needless blood clots. In adult services they achieved over 95% harm free care during 2013-2014.

Incident reporting and analysis at local level was well embedded into team meetings and handover sessions. Some staff expressed how difficult the Datix reporting system was to complete, but stated that this had not prevented them reporting incidents.

Regular audits of services were conducted; clinical practice teachers reviewed five sets of randomly selected patient notes each month in each service area, feeding back to or arranging guidance or additional training to staff as appropriate. Annual audits were completed of each service and results fed back through team meetings. A clinical practice teacher was present during a handover meeting we observed. We saw how topics which were raised were expanded upon and identified as areas for further learning, during our observation palliative care systems were discussed and the clinical practice teacher identified that this would be a good area to include in clinical supervision meetings.

Leadership of this service

Leadership locally and across the trust was strong. Staff locally were aware of their line managers, and many staff were aware of who the executive team were. Members of the executive team frequently visited with staff across the organisation though acknowledged that with an organisation as diverse as Birmingham Community Healthcare NHS Trust this was hard to achieve with all services. The majority of staff valued the effort made by the executive team and welcomed the various messages that the chief executive in particular sent round. Some staff did not feel as engaged with the organisation, and considered their loyalties lay more with their team rather than the trust as an entity.

Staff told us about the trusts Values in Practice (VIP) awards and how these recognised innovative and dedicated practice. The complex care team at Barbara Hart House had won an award for 'quality and innovation' with the VIP awards in July 2013. All nominees had their names displayed in the front entrance of the trusts headquarters building.

Culture within this service

Staff believed there was an open and supportive culture across the organisation. They were encouraged to report incidents, accidents and near misses and felt comfortable to raise concerns with their managers; staff were proud to work for their service.

On one intermediate care unit, staff told us there had been a closed culture and that they had not always been consulted and engaged in the development of the unit, but this had been recognised and plans were in place to improve the team cohesiveness. We saw plans were in place to facilitate enhanced team working and team building.

Public and staff engagement

The trust board invited people who had used their services to talk about their experience. We spoke to a bereaved family who had been given the opportunity to do this. It had been arranged by one of the senior staff in community children's nursing and palliative team. We spoke to this member of staff too, who thought it was very enlightening for the trust to understand the families experience and the level of commitment the staff offered.

The chief executive and executive nurse had a particularly strong presence amongst many staff, and produced video

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logs and other means of communication with staff across the organisation. Staff told us that they received information in staff briefings about developments across the trust.

The trust had begun a 'Patient Experience Forum'. The role of the forum was to examine, discuss and challenge, members' experience, reports and information the trust has on patient experience. This programme engaged people who were using the trusts services. There was a staff survey in 2013 with an associated action plan for improvements that encouraged staff to be part of local development. There was a weekly trust e-newsletter and monthly newspaper to keep staff informed about recent trust news and information reminders about matters such as dignity and safeguarding.

Public feedback was collected for individual services. The community children's nurses collected feedback which demonstrated that 89% of service users were likely or extremely likely to recommend the service to friends and family and that 68% felt the service they received was excellent. The SLT service collected feedback between November and December 2013. It demonstrated that 81% of services users were likely or extremely likely to recommend the service to friends and family, however there were multiple negative comments regarding the waiting time for appointments.

The attention-deficit hyperactivity disorder service collected face to face feedback from young people, parents and carers between November and December 2013. Twenty three young people completed the survey that showed 78% were likely or extremely likely to recommend the service to friends and family and 96% rated the service as good, very good or excellent. Each of the 28 parents and carers respondents said they were likely or extremely likely to recommend the service to friends and family.

Within learning disability services, people who used services and their relatives were encouraged to give feedback on their experiences. Residential and respite services held regular carers' meetings and we saw minutes of these meetings. A large number of families participated in these groups. The families of respite and community services patients had organised a petition which led the commissioners to extend some services for an additional 12 months.

The trust had engaged with staff and public to reduce serious pressure sores by identifying sores earlier, and preventing them occurring by effective management and advice. The SSKIN initiative was launched in 2012 with training and guidance to staff along with publicity and information to the public and wider health community. Statistics provided by the trust show that there was a 30% reduction in the number of serious grade 3 and 4 pressure sores within after only one month. However, in April 2013 the numbers of serious pressure sores had started to rise. Analysis of potential causes for the increase identified that the impetus had gone out of the initiative and in order to regain the commitment of staff. The trust re-launched the initiative in May 2013 with a pressure ulcer prevention week. Staff training was re-visited and resources made available along with promotional items to raise the profile. In order to ensure continued commitment by staff repeat training has embedded in the process.

The trust is accredited with Investors in People and has attained their silver award standard.

Innovation, improvement and sustainability

We identified a range of developments and innovations across the organisations. In learning disability services, there was a project called Profound and Multiple Learning disability pathways (PMLD). This was being developed though multidisciplinary teamwork, to identify the population of people who present with PMLD in Birmingham and map the patient's journey through Learning Disability services. The group had made significant progress in developing a PMLD checklist from which people with PMLD could be identified, a PMLD database which had been developed. The group had also agreed that people with PMLD should receive a lifelong service and had developed a baseline assessment tool to be used when a patient entered the service and a service model which included care co-ordination and regular reviews. At the time of our visit this pathway was at the point of implementation.

The SLT teams in adult services had produced guidance to GP's, care homes and public on how to deal with swallowing problems which did not require SLT intervention. This meant people were not put on waiting lists to see specialist staff only to be told that their condition is not something which the team deal with. The

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team also introduced a telephone triage system which enabled people who were on the waiting list to receive general advice about their condition and interim measures they could take whilst waiting for a full assessment.

The trust had undertaken support activities for carers of people with dementia. They undertook an audit of all inpatients in 2013-2014 and found that of 1100 patients screened for dementia, 27% (over 300) were identified as having a possible diagnosis of dementia. Nearly 600 staff undertook dementia training and 141 carers had received carer support to help them identify support organisations. This was a commissioning for quality and innovation (CQUIN) initiative to improve services to patients. The trust and the commissioning body agreed the project which resulted in improved patient outcomes. The trust met the target.

During the winter of 2013-2014 the trust delivered a range of initiatives in conjunction with partners to improve the flow of patients from hospitals back out into the community. The trust developed discharge hubs where multidisciplinary teams were based, who could speed up the discharge process for patents with complex needs. On average an additional 20 patients were discharged per week. The programme was judged as successful and is now provided seven days a week and the trust is expanding the service to its own inpatient units to improve discharge processes from its own inpatient facilities.