Birmingham Community Healthcare NHS Trust

RYW

Adult Long Term Conditions

Quality Report

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This report describes our judgement of the quality of care provided within this core service by Adult Long Term Conditions. Where relevant we provide detail of each location or area of service visited.

Our judgement 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.

Where applicable, we have reported on each core service provided by Adult Long Term Conditions and these are brought together to inform our overall judgement of Adult Long Term Conditions

Summary of findings

Ratings

Overall rating for Adult Long Term Conditions	Good 
Are Adult Long Term Conditions safe?	Good 
Are Adult Long Term Conditions effective?	Good 
Are Adult Long Term Conditions caring?	Good 
Are Adult Long Term Conditions responsive?	Good 
Are Adult Long Term Conditions well-led?	Good 

Summary of findings

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Summary of findings

Overall summary

Services we inspected provided safe, effective, caring, responsive and well led care. Staff understood how to keep people safe and how to report incidents or concerns. Equipment and facilities were clean and well maintained. Infection prevention and control practices were embedded in how staff worked.

Services were tailored to meet people's needs and practice reflected national guidelines. Innovative working practices had been employed in many areas, such as pain management and podiatry services some of which had received national recognition.

Staff were polite, caring and compassionate. Practice was observed in a number of locations and disciplines and feedback from patients and families we spoke with was universally good.

Staff training was overseen at local and trust level. Some staff reported difficulty in training due to availability of courses, in particular manual handling training.

Patient feedback, complaints and incidents were analysed to identify themes or learning for individual or groups of staff. Learning from incidents at a local level was good, however we found that learning across departments was less well established. Never events had not been discussed in detail outside the area they occurred.

Local management in the services was good. There was an open and honest culture. Staff in some areas felt disengaged with executive level management, though understood their role and position in the trust but felt that they were not valued.

During the course of the inspection we met with 125 staff. These encounters consisted mainly of individual interviews or small groups of two or three staff within departments; we also conducted focus groups with larger groups of staff from mixed disciplines.

We spoke with 32 patients in a number of scenarios including clinics, home visits. We also received feedback from patients who had completed our comment cards.

Summary of findings

Background to the service

Community services for adults with long term conditions were part of the Birmingham Healthcare NHS Trust's adult and community division. The service provided community based specialist services to a population of 1.1million people across Birmingham.

Specialist teams included, diabetic services, coronary heart disease, chronic kidney disease, podiatry services, occupational and physical therapy services, respiratory services, speech and language therapists, pain management services, dietetics services, district nursing services and rapid response services.

The services aims were to prevent people having to be admitted to hospital or to help them rehabilitate after discharge from hospital by providing people with the knowledge, equipment and support to maintain their independence.

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

Summary of findings

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.

What people who use the provider say

Patient satisfaction surveys provided an overall satisfaction level of over 95% throughout the previous twelve months.

The NHS Families and Friends test results are used to create a net promoter score (NPS) which is used to compare results nationally. In March 2014 the NPS rating was over 60%.

We spoke with 32 patients or their families during our inspection. People told us that they were very satisfied with the service they had received. We were told that staff were very polite, friendly and caring. That they were knowledgeable and helpful.

People told us that they found services were clean and tidy, buildings and equipment were well maintained and gave them confidence in the service.

Overall people told us that they had not had to wait for excessive periods to access services. Services such as district nursing and rapid response, responded immediately with no waiting lists. Some people described having had to wait to access services but this had been explained to them so they knew what to expect. One person complained that they had waited for several months to access pain services. They said they had been promised return calls when information had been checked but the calls did not materialise. They said they believed they were only being seen now because of their own determination in repeatedly calling. However having accessed the service they had found staff to be friendly and supportive.

Good practice

- Podiatry service, where staff had used NICE guidance to identify ways of illuminating unnecessary referrals allowing them to concentrate services where their skills lay. 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.

Summary of findings

Areas for improvement

Action the provider COULD take to improve

- The trust could improve visibility and accessibility of executive and board members. Visiting clinic settings and speaking with staff and patients on an informal basis.
- The trust could improve learning, when circulating information to staff it should be clear what if any action is required in response to the information, for example on circulating never events it should be clear that departments should consider how the issues which led to the event could develop in their service and therefore how they may be prevented.

Birmingham Community Healthcare NHS Trust

Community health services for adults

Detailed findings from this inspection

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

Good

Are Adult Long Term Conditions safe?

By safe, we mean that people are protected from abuse

Summary

Community services for adults with long term conditions were judged safe at the time of our inspection. The trust collated evidence from audits, patient feedback, complaints and staff surveys to assess the quality and safety of services. We saw evidence at handover meetings of how information was cascaded between teams and senior management.

We found some information was not being used to best advantage. Learning from never events did not take place outside the area where the event had occurred. Some staff were aware of historic never events and the department they related to, but none of the services we inspected had discussed the events in detail to identify what learning may be gleaned for their own practise.

Staff had a good understanding of safeguarding policies and how to protect people from abuse. They knew how to report safeguarding issues and who to contact for advice.

Clinic areas were clean and safe and equipment was well maintained. Staff were aware of infection prevention and control procedures. Personal protective equipment was readily available and used appropriately. Medicines and medical gases were handled and stored correctly.

Medical records were updated and reflected people's current health needs. Paper records were kept securely and electronic records were password protected.

Lone worker systems and policies were in place, staff received appropriate training to help keep themselves safe.

Detailed findings

Incidents, reporting and learning

The service had well established systems for incident reporting and analysis using the Datix reporting system. Some staff told us they did not find Datix to be user friendly however they did not believe that this prevented or discouraged staff from reporting incidents.

Good

Are Adult Long Term Conditions safe?

We found that incidents were analysed at local level and learning was discussed during team meetings. We were able to observe handover and team meetings in two locations we visited and we saw how local issues were discussed and learning shared.

The majority of staff we spoke with were not aware that the trust had experienced a 'never event'. Never events are events which are avoidable if correct procedures are followed and should never happen. Many of the staff we spoke with knew very little about the incidents other than the department involved. Staff told us that they had not discussed the never events in the context of their own departments. Some staff were not aware of what a never event was even though they were involved in services which if care was not carried out correctly could result in a never event.

Between December 2012 and March 2014 the trust reported 453 serious incidents. Of these 313 were incident which had occurred in peoples own homes, 309 of which related to pressure sores. 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

All the locations we visited were clean and tidy, many of the clinics we visited were held in local community health centres, staff explained that cleaning was provided through the buildings own cleaning staff and they had always found the environment to be well looked after and had never had cause to raise issues with buildings' managers.

People who used services were all complimentary regarding the condition and cleanliness of clinics and the smart appearance of staff.

People told us that staff wore gloves and aprons when providing care and they had witnessed staff washing their hands prior to and following any examination or treatment.

We observed staff during clinic sessions and during home visits. Staff demonstrated they had an excellent understanding of infection prevention and control. We observed staff wash prior to and after care was provided, we saw appropriate use of gloves and aprons, staff described how face masks and foot protectors were available if required. During our clinic visits and home visits we were regularly shown hand cleaning gel and asked to use it. During home visits we were provided with gel by the staff we accompanied.

Maintenance of environment and equipment

Clinics we visited were based in relatively new buildings which provided professional and welcoming environments. Equipment was provided by the community centres, staff we spoke with told us the equipment was well maintained and knew who to speak with if they had any concerns.

People who used the services did not express any concerns regarding the cleanliness or operation of any equipment used during their treatment. Many smaller pieces of equipment were single use items. Sealed until use and disposed of after use.

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.

Medicines

The bulk of medicines in the community setting were personal prescriptions which people kept at home in accordance with instructions from their GP. We saw how staff reviewed people's medicines with them at clinics and when visiting their homes. This was to ensure that people had not had any changes to their medication since they were last seen, to establish if they were taking their medication as prescribed and to ensure they had suffered any adverse effects.

Good

Are Adult Long Term Conditions safe?

We did identify one concern where a visiting district nurse was not aware of the potential side effects of medication which had been recently prescribed to a patient who was already receiving other drugs which could potentially react with each other.

Oxygen cylinders which some staff carried with them on home visits had been checked and were in date.

Safeguarding

The trust had robust safeguarding policies and procedures. All staff were aware of the different types of abuse, and how to report or escalate issues. We were present when a member of staff highlighted an issue to their manager regarding a concern. A patient had been happy to describe a financial transaction which had taken place between them and other health professionals from outside the trust. The staff member was concerned that this could constitute financial abuse. The matter was discussed and the details were to be entered onto the datix system and reported to the trust safeguarding lead.

Staff had received safeguarding training at a level appropriate to their work. Trust figures showed for adult and community services and children and family services 92% of staff had received their training in safeguarding adults. People who used services told us they trusted staff and felt safe in their dealings with them.

Records

We checked a variety of records at the locations we visited. Minutes of team meetings were produced and displayed for staff to refer to, training matrix were often displayed in offices allowing staff and managers an instant overview of training needs.

We saw that confidential information was protected and kept securely when not in use. The district nurses used a 'T'card system to identify workload and calls required for the day, We saw how the cards were held in purpose built cabinets which were closed so that any visitors to the offices would not see details of calls or patients.

Patient records were held in both paper and electronic formats. 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.

We checked patient records in a number of settings both within clinics and during home visits. Patient records were undated and reviewed regularly, some records we saw had not had manual handling sections completed. In a number of cases the people whose plans we checked were present when we did so. People were happy for us to check the records. They told they were aware that the records were theirs and they could access them themselves if they wished to. People told us that staff discussed care records with them and they regularly saw staff writing in them but that they didn't read them themselves even though they knew they could.

Lone and remote working

The trust had lone worker policies and staff we spoke with told us they were aware of and understood them. Some staff described how they had been provided with ID cards which contained microchips and could be used to summon assistance if they found themselves in difficulty. Those staff who had these told us they didn't use them as they felt their training and other systems were more effective.

Staff who completed home visits had an in depth knowledge of their patients and the environments they visited, they described how they discussed new patients and any risks prior to visiting and where necessary completed accompanied visits. They were monitored by colleagues who had access to the 'T'card system and could see where individuals were meant to be. There was a buddy system in place to check on each other's welfare. Management of actual and potential aggression training was provided to staff whose role made them more vulnerable.

Adaptation of safety systems for care in different setting

The majority of services for adults with long term conditions were delivered in the patient's own home or in clinics. Staff risk assessed new patients and if necessary would visit in pairs. Security personnel were employed on the reception at some locations.

District nursing teams were developing clusters with neighbouring teams, this enabled teams to ensure appropriately skilled staff were always available to visit patients depending on assessed risk. If a member of staff with particular skills was unavailable neighbouring teams would provide cover.

Good

Are Adult Long Term Conditions safe?

Assessing and responding to patient risk

The trusts' risk register was used to monitor and target identified risk to services. Individual services used a combination of techniques to evaluate and respond to the needs of individual patients.

We saw how district nursing teams used a dependency tool to ensure that patients were prioritised according to their health needs. Staff discussed each case during handover meetings enabling priorities to be changed and identifying when other services were required.

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 statistical information which showed that on average urgent cases were seen within two weeks. Moderate cases within four weeks and routine cases with eight weeks.

Care plans contained risk assessments based on individual circumstances and need. We saw how people were advised about health risks including smoking, drinking and poor dietary choices. Falls prevention and the use of equipment such as walking aids, frames and pressure relief cushions. We saw that risk assessments were reviewed regularly and updated to reflect changes in people's health or ability.

People were able to make choices even though these may not have been the first choice of clinicians. One patient explained how they had been advised that the most effective treatment they could have would include a major amputation. They had discussed the alternatives and consequences of each treatment option and they had elected not to have the major amputation but to undergo a series of smaller operations and other treatments. Whilst this posed a risk to the person's health, they understood the decision they made and it was respected.

Staffing levels and caseload

Staffing levels were based on assessment of need and demand for services. Audits were completed to ensure staffing and service levels were appropriate over time.

Certain departments had been innovative in their approach to staffing, podiatry services had analysed their referral system and identified that large numbers of inappropriate referrals could be identified earlier and patients channelled to more appropriate services, freeing up the podiatry staff to deal with more appropriate cases.

Some disciplines had carried absences for long periods. Staff in the speech and language therapy department told us they had been without full administrative support for over twelve months. They had received partial support from administrative staff from another area, but this had constituted approximately one third of their normal cover. Staff were spending a lot of time dealing with administrative tasks instead of dealing with clients. The manager told us that staff had not reported being able to cope as a result of the introduction of the new computer systems. This was not reflected in what staff told us, they said the computer systems had only been in place since April and whilst issue had now been addressed, when it was first released the system actually caused delays.

Deprivation of Liberty safeguards

We did not see any areas within the services we inspected where people's liberty had been restricted. The service was based on the premise of assisting people to remain in the community with as much independence and freedom as their health would allow.

Staff we spoke with understood Deprivation of Liberty safeguards and were aware of the procedures to follow if restrictions were required to keep people safe.

Managing anticipated risks

Staff told us about planning which had taken place in relation to national alerts regarding swine flu and other potential large scale pandemics, and plans that were in place should these outbreaks occur.

Major incident awareness and training

Staff had an understanding of major incident plans. None of the staff who were asked had undertaken specific training in relation to major incidents. 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.

Good

Are Birmingham Community Healthcare NHS Trust effective?

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

Care was delivered using care pathways and national guidance. Patient outcomes were at the centre of care planning and the patient voice was evident in plans.

Audits were completed and feedback provided to staff through team meetings and 1 to 1 supervision.

Staff training was a priority in all areas although there were some minor discrepancies between the trust records and individual training records. Staff also complained of availability of certain courses making it difficult to attend. Induction for new staff was comprehensive and reflected best practice.

Staff were competent and confident in their roles and generally felt well supported at local level.

Detailed findings

Evidence based care and treatment

We found that care and treatment was based on national guidance and pathways of care. Staff at all levels were able to describe the care they provided and the principles on which it was based.

Patients told us they had been assessed when they first started to use the service to determine their needs. Further assessments were completed periodically and they felt involved in and at the centre of the process. Records we checked confirmed what people had told us.

Podiatry services had used published National Institute of Health and Care Excellence (NICE) guidance to steer their review of the referral system. We saw statistical evidence of how this had made a dramatic influence 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 can be used to improve services; NICE had produced a poster based on the model used at Birmingham Community Healthcare NHS Trust.

The head of podiatry services advised us that the system had been so successful they were due to present their findings and model at a national conference of the Royal College of General Practitioners.

Pain relief

We visited the pain management service and established that they followed national guidelines in respect of therapeutic and psychological treatments.

Staff used their knowledge, experience and ethnic backgrounds to identify methods of reaching harder to reach sections of the community. For example single sex group therapy sessions had been held in community centres and clinics. All staff as well as patients had been single sex; this allowed groups of people who for cultural reasons would not attend traditional sessions to receive support both from the service and from their peers.

Nutrition and hydration

Dieticians, district nurses and speech and language therapy services (SLT) all worked together to provide advice and guidance to people in the community regarding diet and health.

Swallowing assessments were completed by SLT staff who were able to explain to patients or their carers how best to prepare and present food and drinks to enable people to eat and drink well.

SLT staff explained how they had reviewed their services and liaised with other trusts regarding their practices. Staff had produced guidance for GP's, care homes and other services which helped them identify people in their care who could benefit from SLT services. The guidance also gave advice on effective methods of dealing with issues which might arise but did not require a referral to the service.

We observed staff in the community as they discussed the impact of heavy drinking or poor diet on patient's health. Staff were knowledgeable and provided information without being judgemental towards people.

Patient outcomes

Services we inspected provided care based on recognised practice and national guidelines. Some areas provided outstanding 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.

Pain management staff had introduced single sex group therapy and counselling sessions in community settings which enabled minority groups in the community access to services which they would not have used in conventional settings.

Chronic kidney disease (CKD) clinics had raised the profile of the disease with GP's in the community. They 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.

During our observation of the district nurse team handover meeting, we saw how individual cases were discussed and options for interventions including possible referrals to other specialist teams were discussed. We heard staff discuss how patients had responded well to treatments and how the techniques used might be effective on other patients with similar issues.

Performance information

Audits were completed in all services and results were analysed and shared at team and management meetings. Good practice was identified and shared as was learning at team or discipline level. 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. They demonstrated how this had reduced waiting time for their service, enabling quicker intervention and ultimately reducing the number of major amputations associated with conditions such as diabetes.

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.

Competent staff

Mandatory training was overseen at trust level. Managers and team leaders had a good overview of both mandatory and specialist training for their teams. Training matrix were used extensively some teams posting the matrix in staff offices so that everyone could identify their own training status.

Some discrepancies were found between the training matrix and actual attendance. One member of staff had completed CQUIN training but this was not reflected in the matrix because the training had not been done as part of the normal route. We also saw deficiencies in manual handling training. Staff described difficulty in arranging this training as there were too few courses available within the trust.

Staff told us that training was always discussed at team meetings, 1 to 1 meetings with their managers and at annual reviews. However staff on the falls team did not receive 1 to 1 supervision.

Staff were required to undertake continued professional development and had protected time shown in their schedules. However some staff complained that due to the high workload and their wish to provide a good service to patients the protected time was often lost in clinical activity meaning that they had to study in their own time.

We observed staff from different disciplines during their practice and interaction with patients. Staff were approachable, knowledgeable and professional.

There was clear guidance and support for new staff with a robust induction system which meant new staff were supported and mentored and monitored until they were competent. Newly qualified staff said they had found the induction process prepared them for the role and experienced staff and managers had provided support and guidance throughout.

Good

Are Birmingham Community Healthcare NHS Trust effective?

Use of equipment and facilities

Staff demonstrated their understanding of the equipment they used and its maintenance. Additional training was provided to staff in relation to the use of specialist equipment.

We heard how syringe drivers had not needed to be used for some time in one area. The team lead arranged refresher training and gave staff the opportunity to visit and observe practice with nurses from a neighbouring area in order to maintain their competence.

Facilities at the clinics we visited were relatively new, in good condition and well maintained. The facilities provided a therapeutic environment without being overbearingly clinical.

Telemedicine

Community respiratory teams used telemedicine systems. Telemedicine enabled patients to provide information on their health without having to attend clinics or have staff visit them. Data was input by the patients. The system alerted patients and staff if the data indicated a decline or issue in the patients' health. Appropriate follow-up visits or advice was then provided.

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. If an issue was identified the response was fast and effective. Staff alluded to the importance of ensuring patients understood properly how the system worked. Where people were not using the system properly it created additional work.

Multi-disciplinary working and working with others

Multi-disciplinary team working was evident through the services we inspected. Care plans indicated where staff had referred patients to other disciplines. Outcomes of the referrals were shown with guidance and information for patients. All the teams we spoke with described having good or excellent relationships with other disciplines.

The trust operated a single point of access (SPA) 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. Staff described being able to visit or call colleagues from other disciplines to discuss individual cases or to get general advice.

Co-ordinated integrated care pathways

Clinical decisions and care were based on recognised care pathways following national guidance and good practice. Schematics were displayed in some clinic areas as additional guidance for staff.

Staff were able to describe care pathways in their own disciplines and how the guidance linked care between community and hospital based care allowing patients to move between the two dependant upon need.

End of life 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.

NICE guidance had been widely adopted in the services we inspected and had been used to change practices in the podiatrist services reducing waiting times, impacting on early and preventative treatments and reduction in major amputations.

Good

Are Adult Long Term Conditions caring?

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

Summary

We observed staff from a number of disciplines and in a variety of locations including clinic and home visit consultations. We saw that staff were respectful, knowledgeable, approachable and caring.

Care and treatment was discussed fully with patients before being provided, patients were reminded when care or treatment might cause pain or discomfort and staff were supportive and encouraging in tone, speech and manner.

Staff spoke of the NHS friends and family test and how they now applied those values to their own practice. One nurse told us "I always think now, if this was my mum or dad how would I want them to be treated, and that's how I treat my patients".

Detailed findings

Compassionate care

We observed district nurses during visits to people's homes, clinicians and health care workers dealing with patients in clinical settings. Staff were friendly and knowledgeable, they took time with people assessing their current wellbeing and ascertaining what if any changes had occurred since they had last been seen. We saw that staff were gentle both in their manner and practice.

We observed staff explain treatment to people before providing care, ensuring the person understood and was happy for the treatment to be given.

Patients told us that staff fully explained their treatment and where there were options for alternatives these were fully discussed and the potential outcomes explained in terms which they understood.

Dignity and respect

We observed how staff greeted, spoke with and treated patients. Staff were respectful and polite. Staff engaged with people allowing them the freedom to talk about issues other than their health, whilst treatment was given.

Staff understood the need for confidentiality and told us they did not discuss medical conditions or issues in public areas with patients. Patients confirmed that they might have friendly conversations when being greeted by staff but clinical issues were not discussed until they were in private.

Several patients consented to members of the inspection team visiting their homes in company with staff who were attending to treat them. Staff made it clear to the patient what they were intending to do and ensured that the patients were still happy for us to be present.

People's dignity was protected by staff ensuring doors to consultation rooms were closed before discussing personal information or examining patients. During home visits staff made it clear if examinations or treatment involved intimate areas and whether it might not be appropriate for inspection team members to remain during those periods.

Patient understanding and involvement

Patients told us they were fully involved in the planning and application of their care. Patients were aware that they had care plans and how these related to their health although most told us they did not refer to the plans because they knew what was in them.

One person explained to us how they had been given the option of an operation to reduce the pain and discomfort they had but they had opted to remain at home and receive treatment from the district nurses. They told us how they had been given all the facts about the two options and that everyone had recommended the operation but they had been allowed to make the decision.

A patient visiting the chronic kidney disease clinic 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 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

Staff in all disciplines told us how they saw emotional support of their patients as a major part of their role. From understanding how telemedicine could reduce people's anxiety to supporting patients and their carers and family at the end of life.

Good

Are Adult Long Term Conditions caring?

Staff described how specialist training in areas such as dementia awareness had given them a better understanding of the issues people faced and how they could help to support people or signpost them to other services or support organisations.

Patients told us how staff had provided support and guidance both in respect of their medical conditions but also in relation to finding contact details for support groups and providing information sheets.

Promotion of self-care

Promotion of self-help and self-care was demonstrated during all encounters between staff and patients. For example we observed a district nurse explain different compression bandage types and systems to a patient. The discussion identified that the patient could benefit by having a supply of a particular bandage available to them. The patient described how on occasions the compression bandages which assisted them to maintain mobility would slip, meaning they were unable to mobilise effectively until the district nurse could attend. The additional bandage which the patient could apply would enable them to maintain mobility whilst waiting for the district nurse. We also saw how pressure cushions had been provided to patients and staff ensured they were being used appropriately, discussing the benefits with the patients.

Diet and lifestyle advice was constantly provided, but done so in a friendly and positive way, encouraging people to make healthy choices.

Patients we spoke with told us how they were encouraged to remain independent and do as much for themselves as they could. People described how they now attended group sessions and felt empowered about their condition whereas they used to “Sit at home looking at the wall”.

Good

Are Adult Long Term Conditions responsive to people's needs?

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

Summary

Services were responsive to people's needs; many areas demonstrated outstanding practise in this area. Podiatry, pain management , chronic kidney disease, speech and language therapists had all developed and introduced innovative practices to reduce waiting times and improve the responsiveness of patient experience.

Patient care was reviewed regularly and changes made according to need. Patients described how responsive staff had been and in some instances how they believed staff interventions had saved their lives.

Detailed findings

Service planning and delivery to meet the needs of different people

Peoples' care was planned in accordance with national guidelines on care pathways. Innovative systems had been adopted in some areas to enable services to engage with hard to reach minority sections of the community. The pain management service arranged group single sex sessions with interpreters. Chronic kidney disease clinic staff attended people's homes if they had difficulty attending clinics. Clinics were held on different days and in different community settings to allow people choice.

Podiatrists had introduced a referral system to a private nail clinic, this enabled people who did not require a medical intervention to source assistance with nail care and services which they could not complete themselves. This also meant that people who might progress to requiring podiatry services were being seen by a service that could identify the onset of issues and refer people back to their GP.

SLT staff had collaborated with other trusts to develop a referral process which identified which conditions were suitable for referral and which were not, they had included practical guidance on more appropriate treatment or referrals if they did not meet the SLT categories.

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 and had no concept of some of our language. An example was given of trying to explain how the different services came together like a jigsaw to provide care for people. The group had no concept of what a jigsaw was. The neuro psychologist took a number of magazine pictures and tore them into pieces, gave the pieces to the people and asked them to put them back together, then explained how those pieces represented the services and how when they came together they represented the whole.

Access to care as close to home as possible

Clinics were run from a variety of community based health centres and public buildings; in addition the trust ran clinics in neighbouring acute hospitals, enabling people a choice of services throughout the region.

Dietetic services were based in the north and central areas. Patients in the south of the region received dietetic services from a neighbouring trust. Staff told us this often caused confusion for patients who might contact them but had to be referred through the other trust for assessment and treatment which was often a slower process. The service had been contracted to the neighbouring trust because of the logistics of running clinics in the area.

Chronic kidney disease clinics were held at different locations and on different days of the week. People were able to choose which clinic and time or day suited them best. Where people had difficulty attending the clinic, routine procedures such as blood tests were carried out at people's homes.

The trust ran a rapid response community service staffed by advanced practitioner nurses. They would visit people in their homes within two hours of a referral, providing an initial intensive service to enable people to stabilise and remain in their home rather than having to be admitted to hospital.

District nurse teams had an evening service to provide care to treatment who might otherwise have needed to attend hospital.

Access to the right care at the right time

The trust was in the process of rolling out a new IT system. This had first been introduced in April 2014; and staff had identified a range of concerns. Staff who had been familiar

with other IT systems found the new system difficult to adapt to; staff who were less confident using computers and IT systems found the training had been inadequate, and the system itself did not operate correctly. All these issues had an impact on patient services. To compensate for the disruption, some clinics extended the consultation times to allow for staff having to input data; while additional clinics were also run to deal with backlogs of appointments. Some areas introduced telephone triage systems, calling people to discuss their current health giving advice over the telephone on managing their condition and where necessary upgrading their status and moving them up the waiting list if their condition had deteriorated.

Some patients described long waiting periods to access services during this period. One patient we spoke with had been referred to the pain management service in March 2014. It had taken until the third week of June to be seen. They commented that they thought they had only been seen because they had 'chased' the appointment. Trust data indicated that current waiting times were within the trust targets and people told us that once they had accessed services, it had been worth the wait.

Referral guidance to other healthcare professionals from services such as podiatrists and SLT meant people were referred when their condition was appropriate to that service. CKD virtual clinics held with GP's identified potential patients who could then be monitored by the GP and referred as necessary.

Flexible community services

Birmingham has a large multicultural community with areas of diverse culture. Many of the services we visited had gone beyond providing interpreter services and had adopted or adapted innovative working to ensure services were available to all areas of the community.

CKD clinics were held at three different sites on different days of the week. The clinics also operated at different times of day with some being available in the mornings and some in the afternoon. Patients were given the option of which combination of location, day and time best suited them. Patients were able to switch between clinic locations if they needed to and home visits were undertaken for follow-up tests to reduce the need for people with mobility issues to attend clinic locations for tests.

The pain clinic had identified a problem for women from an ethnic minority being able to engage with the service. They responded by liaising with community groups and leaders to identify the best way of engaging with the women. They set up single sex interpreter led group sessions and having identified that their usual examples of services, care and treatment would not be understood they used innovative techniques to explain to people what help was available and how to progress.

The district nursing service used a computerised dependency tool to continually assess the needs of patients and to assess workload and priorities for the teams. This and feedback within teams had identified how at times peoples skills were not being used to their best advantage. Cluster working was set up to enable a better skill mix of staff so that patients were treated by staff with the most appropriate skills and did not have to wait until staff with the required skills happened to be on duty.

Meeting the needs of individuals

The district nurse dependency tool enabled teams to prioritise workload and ensure that patients with the most urgent needs were seen before those who are less dependent.

District nurse teams operated an evening service to enable patients whose condition deteriorated to receive care and treatment where otherwise they might have to attend hospital A&E departments.

The trust operated a rapid response service who were tasked with attending referrals within two hours, the team was made up of highly skilled advanced nurse practitioners, the service aimed to stabilise people and enable them to remain at home where their care and treatment could then be undertaken by the appropriate community service. This prevented attendance at accident and emergency departments and possible admission to hospital.

Where patients were identified as nearing the end of their lives, the services engaged with GP's in the Gold Standard Framework, this supported people who wished to remain in their homes or who wished to return home to die. Staff told us how following the framework enabled all the services involved to ensure that all appropriate equipment, medication and nursing services were all identified and put in place to reduce anxiety and ensure as dignified a system for patient and family as was possible.

Good

Are Adult Long Term Conditions responsive to people's needs?

Moving between services

Care pathways were followed which enabled people with complex or multiple needs to access services both in the community and through acute services. This was demonstrated in the chronic kidney disease (CKD) clinic where patients told us of their experiences of moving between acute and community services according to their health needs.

We found excellent liaison between trust staff and other healthcare professionals. The CKD lead undertook their continued personal development training at the neighbouring acute hospital. The CKD consultants were commissioned from the acute trust enhancing the relationship. This improved communication between the services and an understanding of each other's role, which meant patients received appropriate advice when transferring between the services.

Complaints handling (for this service) and learning from feedback

Staff were aware of the trust complaints system. Staff understood what the processes involved and who to refer people to if they wished to complain and they could not resolve their issues locally.

Staff told us that they did not receive many complaints, those they did had been usually to do with late or missed visits or waiting times to access services. They said people were usually happy to discuss the situation and understood if there had been a genuine reason. These matters did not get recorded. If however people were not happy with an explanation they would be referred to the patient services department that made a formal record of the patient's complaint and assisted people to resolve their issues.

Where complaints had been made including those which had been brought to the attention of team leaders these were discussed at handover meetings and team meetings to see what could be learnt and how the issues could be avoided in the future. We observed this process during a handover meeting of one of the district nurse team. A nurse highlighted issues to the group where a patient had received a late visit and the impact this had caused because of other commitments. There was guidance in place to contact people if there was a delay in attending, however the patient concerned did not respond well to any delay, and the team discussed how this might be considered during the planning of visits.

A total of 88 complaints had been recorded across the adult's community division. Staff we spoke with told us the main areas of complaint were late or missed appointments and attitude of staff. District nursing teams had altered their allocation system to ensure that all calls were answered before the end of their shift. We were told how cluster working would add further value to the system by removing the need for patients to wait for appropriately skilled staff to be on duty. Patients we spoke with confirmed that they had rarely or never needed to raise issues and they believed staff would not let them down without good reason.

We did not see evidence of learning from issues from other disciplines or departments of the trust. Important issues had been circulated as news items in periodicals by the trust and some staff described receiving emails about incidents. We did not see a requirement or acceptance that staff should consider the issues in the context of their own services unless the issue directly related to them.

Good

Are Adult Long Term Conditions well-led?

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

Overall local management was good in the services we inspected. Some staff felt that they were not appreciated by the organisation and others were concerned about the future of their service despite having provided innovative services which had improved people's health.

Communication from and visibility of senior staff and executive officers was disjointed, staff in some services had met with executives from the trust whilst others had not. However staff worked towards the trusts vision and values of the organisation. Overall staff believed they were managed well and supported by their local managers.

Detailed findings

Vision and strategy for this service

We found variation in the level of understanding of the trust values and visions in the services we inspected. The trust values were listed as Commitment, Accessible, Responsive, Quality, Caring, and Ethical. Some staff were able to quote the values and the '6C's' 'Care, Commitment, Communication, Compassion, Competence and Courage' which the organisation promotes.

Whilst many staff could not quote the values and vision of the trust we found that their practice, attitude and commitment reflected them. Staff were committed to providing care in line with the national friends and family test.

Guidance, risk management and quality measurement

The trust implemented the 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. The services we inspected fell into the categories of adults in the community and patients in their own home. Both these areas achieved over 95% harm free care during 2013-2014.

Managers and team leaders all demonstrated a clear understanding of their role and position in the trust. They reported having regular meetings with senior staff which were evidenced by copies of meeting minutes.

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. 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.

Introduction of the new 'RIO' computer system to some disciplines caused extensive interruption to services; staff using the new system reported a disproportionate increase in workload. Staff told us that the testing of the system and the training on its use had been poorly planned. Project managers responded to feedback and adjustments to the system had for the most part been completed.

Leadership of this service

Department managers reported having a good relationship with senior managers who they found supportive and approachable. However there was varied response regarding accessibility and visibility of senior and executive staff from the perspective of other staff. The chronic kidney disease clinic which had incorporated a number of innovative practices reported that they had never been visited by a member of the board and felt more affiliation to the neighbouring acute trust where senior management had acknowledged their work than to their own.

Good

Are Adult Long Term Conditions well-led?

The trust values were embedded in the way staff approached their work. It was not clear if this was because the values had been based on what staff already did or because staff adapted their practices to the values.

Culture within this service

We found an open and honest culture. Staff were proud of their achievements and proud of their relationship with the people they cared for.

Staff did not always feel valued; an example we saw was where a member of a team had been given additional responsibilities and acted up for a temporary period. At the end of the period the staff member returned to their previous pay level but still retained the responsibilities and role of the temporary post.

Swallowing and language therapy staff reported that they had highlighted issues and had faith that their manager had escalated them but there had not been any feedback. Whilst feeling encouraged to voice concerns there was a degree of disillusionment in the process.

Public and staff engagement

The trust had a number of systems to collect and analyse feedback from the public. Patient surveys were conducted which had started to include the 'Family and Friends Test'. The test was aimed at patients and staff and asks how likely people would be to recommend that service to their friends or family. Staff explained how they received feedback from the surveys which they discussed at team meetings. We were not given examples of how the system had influenced the services we inspected, however some staff were able to describe how catering had been improved in some areas of the trust as a result of the Family and Friends test.

The trust values were publicised on the intranet and during mandatory training sessions to ensure all staff understand the importance of treating people with respect and being polite. Additional training was offered to staff whose attitude has been questioned.

The trust had a corporate patient experience team. Due to the multicultural and diverse community the trust serve they had recruited additional staff with knowledge of the cultural diversity to support the collection of information.

The trust were committed to the NHS 'making every contact count' ethos, this meant that staff took opportunities to sign post people to other services or gave guidance on diet and health in addition to completing the task at hand. We saw how this ethos had been embedded into practice when district nurses were observed providing care. General dietary needs were discussed and advice given regarding alcohol and smoking. This was done in a way which engaged the patient in conversation rather than simply passing facts and talking at them. One patient remarked, "I know it's my fault that I'm like this but the staff aren't judgemental, they just get on with it, they are lovely".

Staff surveys were conducted annually. Information from the trust showed that in 2013 there had been an increase in responses and an overall increase in staff satisfaction. The statistics provided by the trust in relation to effective communication between senior management and staff, and senior managers involving staff in important decisions had both seen a marked increase over the previous years with both areas improving by 9% however they still only achieved 34% and 31% respectively in the latest survey, this was reflected in the comments we had heard from staff.

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.

Innovation, improvement and sustainability

Remote working and new IT systems were being rolled out across the trust. Staff had reported some difficulties with early releases of the RIO computer system but there was a genuine belief that the new system would improve patient experience and safety by making information easier to find update and share.

Good

Are Adult Long Term Conditions well-led?

Continual assessment of patient outcomes within each service was provided at local and trust level by a combination of audits, patient feedback and management meetings. Staff in the CKD clinics told us that the Trust was reviewing the viability of the service as a community based service. Staff were concerned that cost of services was sometimes given more prevalence than quality although this could not be evidenced.

CKD community services were being reviewed, the service had introduced innovative practices to reduce the number of emergency admissions and enable people to manage their condition. The neighbouring acute hospital trust had previously had a full time nurse who dealt with these emergencies. The community service had reduced emergencies by such a degree that the acute hospital had been able to re-deploy their nurse. Staff were concerned that because the cost savings had been to a neighbouring provider, their own trust may not see them as cost effective. The service was being managed by a newly appointed diabetic services manager who told us that they were pursuing the issue with senior managers to end the speculation.

District nurses were concerned because they saw any reduction in support services as an increase in their own workload, they believed they coped well with the workload and had introduced cluster working to make better use of skills and specialities but felt they were now working to capacity and could not absorb any further work.

We saw innovative working in a number of disciplines. Pain management services had introduced same sex group sessions to engage with minorities in the community.

Podiatry services had interpreted NICE guidelines to enable them to reduce inappropriate referrals, freeing up time to concentrate on their core function, resulting in reduced major amputations.

SLT 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 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.