

# Care of Adults with Long-Term Conditions

## South and Central Birmingham Health Economy

Visit Date: 29<sup>th</sup>, 30<sup>th</sup> and 31<sup>st</sup> January 2013

Report Date: May 2013

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## INTRODUCTION

This report presents the findings of the review of the care of people with long-term conditions which took place on 29<sup>th</sup>, 30<sup>th</sup> and 31<sup>st</sup> January 2013. The purpose of the visit was to review compliance with West Midlands Quality Review Service (WMQRS) Quality Standards for:

- Care of People with Long-term Conditions, Version 1.1, August 2012

and the following national standards:

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

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

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

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

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

## SOUTH AND CENTRAL BIRMINGHAM HEALTH ECONOMY

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

- Birmingham Community Healthcare NHS Trust
- NHS Birmingham South Central Clinical Commissioning Group (CCG)
- NHS Birmingham CrossCity Clinical Commissioning Group
- NHS Sandwell and West Birmingham Clinical Commissioning Group
- Midlands and East Specialised Commissioning Group

Most of the issues identified by quality reviews can be resolved by providers' and commissioners' own governance arrangements. Many can be tackled by the use of appropriate service improvement approaches. Individual organisations are responsible for taking action and monitoring progress through their usual governance mechanisms. Commissioners have responsibility for supporting quality improvement across the whole patient pathway. The nominated lead commissioner for Birmingham Community Healthcare NHS Trust is NHS Birmingham South Central CCG. The nominated lead commissioner for out of hours GP services, walk-in centres and primary care centres is NHS Birmingham CrossCity CCG. When addressing issues identified in this report, commissioners

are expected to cooperate with each other and, where appropriate, with NHS England Birmingham, Solihull and the Black Country Local Area Team commissioners of primary care and specialised services.

## **SOUTH AND CENTRAL BIRMINGHAM**

This report differs from those for other health economies in the 2012/13 WMQRS review programme for a number of reasons:

- University Hospitals Birmingham NHS Foundation Trust chose not to participate in this review and so this report does not include any information about services provided by that Trust for south and central Birmingham residents with long-term conditions. This report therefore gives only a partial view of the pathway of care for people with long-term conditions. Specialist services for people with heart failure, diabetes and COPD provided by University Hospitals Birmingham NHS Trust for Birmingham residents are not included. The Trust's neurology services link with several parts of the West Midlands and so their omission from the review process was a particular loss.
- This report brings together Trust-wide conclusions relating to Birmingham Community Healthcare NHS Trust, whose services link with north, east and west Birmingham as well as south and central Birmingham. From a provider perspective, the report should be read together with reports relating to a) North East Birmingham and Solihull, and b) Sandwell and West Birmingham.
- This report includes the review of rehabilitation services for people with chronic neurological conditions provided by Birmingham Community Healthcare NHS Trust, which provides care for people from across the West Midlands and beyond.
- Birmingham CrossCity and Birmingham South Central Clinical Commissioning Groups commission services from a wide range of providers across Birmingham. This report brings together reviewers' conclusions about the commissioning of services.
- The findings of the review of services for children and young people with diabetes provided by Birmingham Children's Hospital NHS Foundation Trust are given in a separate report.

## **ABOUT WEST MIDLANDS QUALITY REVIEW SERVICE**

WMQRS was set up as a collaborative venture by NHS organisations in the West Midlands to help improve the quality of health services by developing evidence-based Quality Standards, carrying out developmental and supportive quality reviews - often through peer review visits, producing comparative information on the quality of services and providing development and learning for all involved.

Expected outcomes are better quality, safety and clinical outcomes, better patient and carer experience, organisations with better information about the quality of clinical services, and organisations with more confidence and competence in reviewing the quality of clinical services. More detail about the work of WMQRS is available on [www.wmQRS.nhs.uk](http://www.wmQRS.nhs.uk)

## **ACKNOWLEDGMENTS**

West Midlands Quality Review Service would like to thank the staff and service users and carers of South and Central Birmingham health economy for their hard work in preparing for the review and for their kindness and helpfulness during the course of the visit. Thanks are also due to the visiting team and their employing organisations for the time and expertise they contributed to this review.

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# CARE OF PEOPLE WITH LONG-TERM CONDITIONS

## HEALTH ECONOMY

### General Comments and Achievements

This review took place at a time of significant organisational change for Birmingham's health services. Birmingham Community Healthcare NHS Trust had been in existence for less than two years and Birmingham CrossCity and South Central Clinical Commissioning Groups had only recently been formed. The organisation of services therefore largely reflected decisions of predecessor organisations. Many of these decisions fitted well with the previous organisational structures. Viewed from the perspective of the new organisations, some decisions about services fitted less well. Changes in personnel also meant that some of the history may have been lost – which may have been interpreted by reviewers as 'a lack of clarity'. The conclusions of this report should be viewed in this context and should not be taken as critical of either the new or predecessor organisational structures.

Good progress was being made with establishing the Single Point of Access (SPA) services and Birmingham-wide Integrated Multi-disciplinary Teams (IMTs) focussing on the care of people with multiple long-term conditions.

A diabetes network had been established which was working with all providers to drive improvements in the care of people with diabetes. The heart and stroke network was bringing organisations together, including to address the care of people with heart failure. Arrangements for driving coordination and improvement of services for people with COPD were less clear and reviewers were told about both a respiratory network and a primary care COPD meeting.

### Concerns

#### 1 Variation and Integration

The lasting impression from this review was of variation in services and a lack of integration. Some services covered some parts of Birmingham and not others and some hours of availability varied across the city. Pathways of care were not clear and were usually not supported by robust guidelines and protocols. Integration between services appeared to depend on relationships between individuals, rather than on clear, structured organisational arrangements. Whether a patient's GP was aware that a service existed was a key determinant of whether patients were referred – a view supported by some of the patients who met the visiting team.

#### 2 Condition-Specific Services - Service Model

Birmingham Community Healthcare NHS Trust was commissioned to run small community services for respiratory diseases (including COPD), heart disease (including heart failure) and Parkinson's Disease. The Trust also provided a larger community diabetes service. Capacity in the small community services was stretched with, for example, 6.4 w.t.e. heart failure nurses covered Birmingham (except for south Birmingham), including liaison with four acute hospitals.

The community respiratory team worked to three different service-specifications with a different model in place in south Birmingham. In central and west Birmingham the service included respiratory nurse specialist, respiratory physiotherapists, a GP with a special interest and health care support workers provided pulmonary rehabilitation, a primary care respiratory clinic and a respiratory outreach service. In north and east Birmingham nurse-led clinics and supported discharge were provided. A total of 10.2 w.t.e. clinical staff plus some GP sessions covered the whole of Birmingham. A revised Birmingham Community Healthcare NHS Trust respiratory service specification for the whole service was due to commence from April 2013.

Parkinson's Disease Nursing was provided by 3.6 w.t.e. nurses who supported patients across Birmingham and Solihull.

Links between these community-based services and hospital-based services were variable and reviewers saw examples of duplication and a lack of effective joint working. Most of the community-based nurses were nurse prescribers but it was not clear that these skills were being fully used. Apart from the diabetes service, teams were well-provided with administrative and managerial support. Reviewers were concerned that the service model for these services did not reflect the best use of resources and was unsustainable. Reviewers suggested that consideration should be given to integration of hospital and community condition-specific specialist services for people with COPD, heart failure and Parkinson's Disease.

Similar issues were apparent in relation to diabetes and effective liaison between the community-based service and hospital services was not seen. The community-based specialist service covered some parts of the city, others had Local Enhanced Services available and some had neither. A variety of structured diabetes education programmes was available. These issues were, however, being addressed by the newly formed diabetes network.

### **3 Out of Hours Services**

The way in which Birmingham's out of hours services were organised was complex and different people had different views on the services which were available and how the patient pathway worked for each area of the city. GP out of hours services were provided by two providers, one of which also provided out of hours district nursing for part of the city. A community rapid response service was available between 8am and 10pm. It was not clear that out of hours services had access to the latest clinical information about patients. Also, out of hours services did not generally have access to the admission avoidance services or hospital-based rapid review services without referral back to the patient's GP. Access to equipment services over the weekend had not been available prior to the review. This service had been re-tendered and reviewers hoped that this issue had been addressed. Feedback to GPs was through a mixture of electronic communication and faxes and reviewers were told there were sometimes problems because fax machines were not turned on. Arrangements for monitoring the quality of out of hours services were not clear. Reviewers concluded that it must be very difficult for patients, GPs and hospital services to understand the services which were available and the patchy, uncoordinated nature of the services must be resulting in some patients being admitted to, or staying in, hospital when they could be cared for at home.

#### **Further Consideration**

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

Issues relating to the commissioning of services for people with chronic neurological conditions are described in the commissioning section of this report. Addressing these issues will require cooperation and collaboration across the health economy.

##### **2 A Joint Strategic Needs Assessment had been undertaken and some service specifications contained information about population need. In general, data on service activity and how this related to population need were rarely evident through this review. Reviewers were given anecdotal information on problems (for example, comments about problems with district nursing caseload in some parts of the city) where quantitative analysis may be helpful to clarify the nature and extent of the issue.**

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## PRIMARY CARE

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

*(This section of the report is also included in the North East Birmingham Health Economy Report).*

#### General Comments and Achievements

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

**Immediate Risks:** No immediate risks were identified.

#### Concerns

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

#### Further Consideration

- 1 Some GPs who met reviewers were concerned about the amount of information about services which was sent to them. Others appeared not to be aware of services that were available. An easy to use directory or guide to local services was not yet available.
- 2 Arrangements for ensuring all practices were following up women with gestational diabetes were unclear. An audit of whether practices had implemented prompts or recalls for these women may be helpful.
- 3 The timeliness of results of anti-coagulant testing was slower in the independent primary care service which Birmingham GPs were expected to access than in the hospital service. As a result, GPs and patients were accessing the hospital-based service as results were available more quickly. This issue may merit further investigation.

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## COMMUNITY LONG-TERM CONDITIONS SERVICES

### BIRMINGHAM COMMUNITY HEALTHCARE NHS TRUST<sup>1</sup>

#### General Comments and Achievements

Integrated Multi-disciplinary Teams (IMTs) for central, west and south Birmingham were reviewed as part of this visit. (See North East Birmingham and Solihull Health Economy Report in relation to teams in north and east Birmingham). These teams provided clinical case management, district nursing and domiciliary therapies. Some teams also had allocated social workers. The Single Point of Access (SPA) service and the Rapid Response Service (RRS) were also reviewed. The SPA service had the option of call-handler or clinical triage. Specialist therapy services could be accessed by each IMT. The teams were enthusiastic and were bringing staff together who had previously worked in different settings and progress was being made on establishing standardised systems and processes. Integration with mental health services was being piloted in one area.

Patients and carers who met the visiting team were very appreciative of the services offered and particularly liked having a named contact. Patients and carers had several good ideas about the future development of services, including options for out-of-hours access and exercise groups. Patients had some concerns about the introduction of telehealth.

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<sup>1</sup> In August 2012 it was agreed that Birmingham Community Healthcare NHS Trust's heart failure, cardiac rehabilitation and specialist respiratory services would be reviewed along with condition-specific services in north, east and west Birmingham. The general conclusions for these services are given in the health economy section of this report.

## Good Practice

- 1 The SPA service had a good pathway for clinician to clinician communication. This pathway was usually staffed by advanced practitioners (although it was not clear that this level of staffing was being sustained at nights – see below).
- 2 The respiratory team received ‘Blackberry’ alerts if a patient on their caseload was admitted to Heart of England NHS Foundation Trust.
- 3 A ‘Fatigue, Anxiety and Breathlessness’ service had been piloted and then implemented, based at the John Taylor Hospice. This service was run by the hospice multi-disciplinary team and community COPD specialist nurses. Four programmes had run in 2012 and two more were planned for 2013. This service had been evaluated at the end of the pilot and had been shown to be effective in developing participants’ competence and confidence in self-management.
- 4 Supportive care pathway documentation included very clear clinical direction for care during the end stages of life.
- 5 Local adaption of ‘SKINN’ documentation was very clear and patient-friendly.

**Immediate Risks:** No immediate risks were identified.

## Concerns

### 1 Clinical Leadership

Arrangements for overall clinical leadership for the IMTs (and specialist services) were not clear. Formal arrangements for clinical leadership for the team were not yet in place. Clinical case managers took responsibility for individual caseloads but the arrangements for clinical leadership of the team, including ensuring development of, for example, appropriate guidelines, protocols and audit, were not clear.

### 2 Single Point of Access (SPA) Service - Nursing Cover at Night

Nursing cover for the SPA service at nights was not always available.

### 3 Staff Competences

A skills analysis was available for the clinical case managers within the IMTs but it was not clear that all staff had the competences needed for the roles which they were undertaking. The additional competences needed for their roles were not explicit. For example, clinical case managers were managing patients on non-invasive ventilation with support from the respiratory team but it was not clear that they had appropriate competences for this work. A Birmingham East and North competence framework was available but it was not clear if this was being implemented in all teams. This issue also applied to staff in the community specialist teams, where the evidence presented suggested that very few had degree-level qualifications, and where staff were not effectively linked with specialist condition-specific teams.

### 4 Equipment Supply at Weekends

At the time of the review, IMTs did not have access to an equipment supply service at weekends. In particular, large equipment such as beds and mattresses was not available at weekends. A ‘buffer stock’ of smaller equipment was kept in the IMT offices for the weekends. Equipment for patients with palliative care needs was available within four hours on weekdays but not at weekends. A new contract had just been awarded but staff who met the visiting team were not clear whether the new arrangements would include supply of equipment at weekends.

### 5 Documented Guidelines and Policies

Several of the expected clinical guidelines were not yet in place, including guidelines on diagnosis, monitoring and management of chronic complications. Reviewers were particularly concerned because the

Advanced Nurse Practitioners in the RRS were making diagnoses on patients referred to the service. Some staff said that they were using PCT guidelines but these could not be found on the relevant websites.

### Further Consideration

- 1 IMTs and specialist services used a separate version of the same care record. Patients in contact with more than one service would therefore have more than one care record. A good Medication Review Form had been developed but not yet fully implemented, and reviewers encouraged continuation of this development.
- 2 Patients who met the visiting team had different understanding and awareness of the services available to them. They commented that the services they received appeared to depend on whether their GP was aware of what was available. Patients said that they would like to know more about services and would like this information to be updated regularly.
- 3 Informal arrangements for communication between IMTs and hospital-based condition-specific services in their area were in place and these sometimes worked well. Formal arrangements for communication and liaison between IMTs and hospital-based condition-specific services for people with long-term conditions were not yet in place. Formal arrangements for discussing the care of people with multiple long-term conditions were also not yet in place.
- 4 Staff providing home intravenous therapy came from the RRS and the IMTs. The number of staff with specialist competences in intravenous therapy appeared low for the area covered. Reviewers suggested that this should be kept under review to ensure that a member of staff with appropriate competences was always available. Formally documenting the intravenous therapy care pathway was also suggested.
- 5 A tele-monitoring service centre was being developed. Telehealth units were being purchased but reviewers did not see clear entry and exit criteria for this service. As well as documenting entry and exit criteria, data on who was using the service and their outcomes should be routinely monitored.
- 6 A 'Hospice at Home' service was being planned. The plans outlined to reviewers appeared to increase service fragmentation and reviewers wondered whether alignment of this initiative with the Trust's continuing health care team would be a more sustainable alternative.

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## SPECIALIST CARE OF ADULTS WITH DIABETES

### BIRMINGHAM COMMUNITY HEALTHCARE NHS TRUST

#### General Comments and Achievements

Staff providing the community-based specialist service for adults with diabetes were enthusiastic and keen to improve the care available for their patients. The team was facing several challenges, including combining the previous 'Heart of Birmingham' and 'Birmingham East and North' Teams. Home visits were available if necessary.

Diabetes Journal Clubs were run regularly to discuss new research and to share learning and good practice. Care plans were in place for patients with more complex needs, including those with learning disabilities and prisoners. Relationships with GP practices appeared good and links with links were being made with district nursing teams.

Letters discharging patients from the service were good. These were addressed to the patient and copied to the GP. The letters were relatively easy for patients to understand and contained diagnosis and test results.

#### Good Practice

- 1 The diabetic foot team was well developed with good access to secondary and tertiary care. Urgent problems were seen very quickly, usually the next working day. There was a good appointment system with a very low 'did not attend' rate.

**Immediate Risks:** No immediate risks were identified.

#### Concerns

##### 1 **Pre-conception and Ante-natal Care**

The team was providing some pre-conception and ante-natal care without clinical guidelines covering the care to be provided or joint clinic or shared care arrangements with a consultant obstetrician.

##### 2 **IT System:** See Trust-wide section of this report.

##### 3 **Data Collection and Audit**

The service did not have appropriate data about its work or an ongoing programme of audit. Staff were aware of the total number of contacts for the service but not the number of people it was serving, the numbers starting and completing structured education programmes, 'did not attend' rates or other data essential for managing the service. There was no programme of audit, including audit of implementation of clinical guidelines.

##### 4 **Administrative and Clerical Support**

Diabetes specialist nurses were spending up to half of their time on administrative duties because there was no administrative and clerical support available.

#### Further Consideration

- 1 The role of the service and the expected links with Integrated Multi-disciplinary Teams and hospital-based diabetes services were not clear. The team did not have a clear understanding of the needs which it was aiming to meet, did not have a focus on prevention and was not yet using risk stratification and risk profiling. The service was not providing support for patients on insulin pumps, despite some staff having competences in this area. A clear understanding of the expected role needs to be developed with commissioners and all staff need to fully understand this role.
- 2 Arrangements for ensuring diabetes specialist nursing staff were maintaining appropriate competences were not robust. Some staff said that they had not had annual appraisals and performance reviews. The Trust process for accessing relevant training may not be being implemented as reviewers were told that some staff were taking annual leave to attend relevant training.
- 3 Patients with type 2 diabetes were not all being offered structured education programmes. An in-house 'introduction to diabetes' was available and some patients accessed other programmes.

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## SPECIALIST CARE OF PEOPLE WITH CHRONIC NEUROLOGICAL CONDITIONS – REHABILITATION

### BIRMINGHAM COMMUNITY HEALTHCARE NHS TRUST

#### General Comments and Achievements

The neurological rehabilitation service provided by Birmingham Community Healthcare NHS Trust was a highly specialist service, commissioned by specialised commissioners to serve the whole of the West Midlands. The service provided out-patient, in-patient and vocational rehabilitation. There were good links with related services in the Trust, including orthotics, prosthetics and electronic equipment, wheelchair services, assistive technology, and posture and mobility services. The 32-bedded in-patient unit at Moseley Hall Hospital was a designated level 1 rehabilitation unit with strong links with the Major Trauma Centre at University Hospitals Birmingham NHS Foundation Trust. A specific multiple sclerosis rehabilitation service was available. Out-patient clinics for people with Parkinson's Disease were held at a variety of locations across Birmingham. A weekly multi-disciplinary meeting reviewed all referrals and allocated them to the most appropriate part of the West Midlands Rehabilitation Service – or referred back to local services if this was appropriate. Pathways for referral between

different parts of the specialist rehabilitation service were clearly defined and appeared to work well. A transition service supported young people needing neurological rehabilitation in their transfer to adult care.

A rehabilitation coordinator provided liaison with specialist neurology services at University Hospitals Birmingham NHS Foundation Trust. The specialist rehabilitation service also linked with local rehabilitation in-patient units in Wolverhampton, Stoke and Leamington Spa. Consultants from the service undertook out-reach work in Burton and Worcestershire.

Patients who met the visiting team were highly appreciative of the care they received. Carers had access to a carer support service and good information was available for both patients and carers. Patient transport was available for all patients attending the West Midlands Rehabilitation Service. Clinical psychology support was also available. Staff were generally enthusiastic and welcoming. Some new approaches to rehabilitation were being tried, including a Tai Chi class.

### **Good Practice**

- 1 Multi-disciplinary input to out-patient clinics was very good with all clinics having at least a consultant, nurse, physiotherapist or occupational therapist available. Patients who met the visiting team greatly appreciated this holistic approach to their care.
- 2 Self-referrals to the service were accepted. The service reviewed all referrals and then directed them appropriately.
- 3 A good Intrathecal Baclofen service was available, with good service user involvement. This included the option for a meeting with a representative of the service user group prior to the patient's operation.
- 4 The spasticity clinic had a clear, well-structured process of care planning, goal setting and review.
- 5 Out-patient clinic times were appropriate for the complexity of patients' needs, with one hour allocated for new patients and 30 minutes for a follow-up attendance.
- 6 The patient pathway for people with motor neurone disease was clear and appeared to work well. In particular, patients had good support for PEG feeding.
- 7 Arrangements for vocational rehabilitation were very good with a highly experienced team providing this service. The service was actively working with employers, with particularly good links when an individual relapsed or their condition deteriorated. There was a robust process of measuring achievement of goals and high patient satisfaction.
- 8 Liaison between Parkinson's Disease specialist nurses and palliative care services were well organised and ensured continuity of care for individuals.

### **Concerns**

#### **1 Care Planning**

The process for communicating the latest care plan to the patient and their GP was not robust. The latest care plan for outpatients was not always easily identifiable in the patient notes seen by reviewers. Patients who met the visiting team said that they did not always receive written confirmation of changes to their care plan.

#### **2 In-Patient Service**

- a. Dietician support for the in-patient service was insufficient. Only 0.2 w.t.e. dietician support was available for up to 32 patients, some of whom may have PEG feeds.
- b. Reviewers were told that patients were often transferred from University Hospitals Birmingham NHS Foundation Trust for in-patient rehabilitation without a discharge letter or other appropriate transfer of clinical information.

#### **3 IT Systems:** See Trust-wide section of this report.

## Further Consideration

- 1 Arrangements for involving patients and carers in service improvement activity and in decisions about the management of the service may benefit from review. Some feedback mechanisms were in place.
- 2 Active use of individualised expected date of discharge was not evident and, at the time of the review, the average length of stay was 60 days. Reviewers considered that there may be the potential to reduce length of stay.
- 3 The out-patient service was commissioned for a number of contacts per year. It may be helpful to review activity levels for different parts of the region and how this relates to the services available in each locality.
- 4 Although the service linked operationally with other in-patient and community rehabilitation services in the West Midlands, the role of each service and arrangements for shared care were not clearly defined. Neither providers nor commissioners seemed to have an understanding of whether services were meeting needs across the West Midlands.
- 5 The development of collaborative audit arrangements with other specialist neurological rehabilitation services may be helpful. This could enable the service to compare outcomes with similar services.
- 6 The BNRT service provided time-limited community-based rehabilitation for people with chronic neurological conditions, including stroke. Reviewers commented that younger patients with stroke may benefit from access to a longer period of rehabilitation.
- 7 The occupational therapist had limited space for the storage of equipment and, as a result, equipment was stored in the meeting room. [See also health economy section of this report in relation to equipment.]
- 8 Parkinson's Disease nurses were linking well with voluntary organisations in some parts of Birmingham but these links did not appear to be in place in south and central Birmingham areas.
- 9 Service-level website information was felt to be useful by the users and carers but they commented that it was not easy to navigate to service information and that some aspects appeared to be out of date.
- 10 A community nutrition support team was available, specialising in the care of people with Parkinson's Disease, motor neurone disease and multiple sclerosis. Consideration could be given to whether this team could also support in-patient care.
- 11 IT Systems: See Trust-wide section of this report.

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## TRUST-WIDE

### BIRMINGHAM COMMUNITY HEALTHCARE NHS TRUST

*(This section of the report is also included in the North East Birmingham Health Economy Report).*

#### General Comments and Achievements

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

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

#### Good Practice

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

- 2 Motivational interviewing and training was widely available within the Trust.

**Immediate Risks:** No immediate risks were identified.

### Concerns

- 1 **Clinical Leadership**

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

- 2 **Staff Competences**

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

- 3 **Guidelines and Protocols**

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

- 3 **IT and Care Records**

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

### Further Consideration

- 1 Further work on communication between middle management and operational staff may be helpful. Reviewers came across several examples where middle managers' views of how services worked were different from those of operational staff. Some operational staff were not clear about Trust systems, including those for training and supervision. Reviewers commented that the management structure appeared to have many layers and the different responsibilities for each layer were not apparent.
- 2 Reviewers were told that reciprocal arrangements were not in place for providing care for Birmingham GPs' patients who were resident outside Birmingham. If this is correct, further consideration should be given to establishing these arrangements with neighbouring areas.
- 3 Medicines management were well organised and linked well with some clinical teams. Reviewers were told that some services did not have medicines management support as part of their service specification. Further work to ensure an appropriate level of medicines management support is available to all clinical services may be helpful.

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## COMMISSIONING

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

*(This section of the report is also included in the North East Birmingham Health Economy Report).*

#### General Comments and Achievements

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

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

**Immediate Risks:** No immediate risks were identified.

#### Concerns

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

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

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

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

##### 2 Young People with Diabetes

Arrangements for young people with diabetes to transfer to the care of adult services were not clear. The age guidelines for transfer were not clear although there were some joint clinics between adult and children's services with University Hospitals Birmingham NHS Foundation Trust. There was no local network for driving improvements to the care of children and young people with diabetes and these services did not appear to link with the newly formed Birmingham diabetes network. (This concern has been included in the commissioning section of the Birmingham Children's Hospital NHS Foundation Trust report.)

### 3 Cardiac Rehabilitation

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

### 4 Specifications

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

#### Further Consideration

- 1 Joint CCG arrangements for monitoring the quality of services for people with long-term conditions, including mechanisms for addressing issues identified in this report, were in the early stages of development. It will be important to ensure that implementation of these arrangements continues.
- 2 The care of people with more common chronic neurological conditions is described in this report. Less common neurological problems, when considered together, affect a significant number of people. Services for this group of patients are usually less well organised than those for people with more common conditions and further consideration should be given to whether local services are meeting their needs.

See also 'All Commissioners' section below.

#### ALL COMMISSIONERS

The issues identified in the 'health economy', 'primary care', and provider sections of this report will require the attention of commissioners. The following points are specifically drawn to the attention of commissioners and are not repeated in North East Birmingham Health Economy Report:

#### Other Concerns Identified

- 1 Community Long Term Conditions services: Leadership; SPA staffing; Access to equipment.
- 2 Specialist Care of People with Diabetes: Preconception and antenatal care; Staff competences; Administrative support.
- 3 Specialist Care of People with Chronic Neurological Conditions: Care planning; Dietician staffing; Inpatient service.

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## APPENDIX 1 MEMBERSHIP OF VISITING TEAM

### Executive Lead

Simon Hairsnape	Chief Operating Officer	Redditch & Bromsgrove CCG
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### Visiting Team

Dr Mona Arora	General Practitioner	North Staffordshire Clinical Commissioning Group
Yvonne Brown	Community Matron	Coventry and Warwickshire Partnership NHS Trust
Dr Fiona Campbell	Consultant Paediatrician	Leeds Teaching Hospitals NHS Trust
Adele Dean	Clinical Quality Manager	West Midlands Ambulance Service NHS Trust
Dr Julie Edge	Consultant in Paediatric Diabetes	Oxford University Hospitals NHS Trust
Ben Ellis	Physiotherapy Team Lead	Walsall Healthcare NHS Trust
Sian Finn	Self Care Programmes Manager	West Mercia Cluster
Wendy Godwin	Programme Manager for Planned & Unscheduled Care	Walsall Clinical Commissioning Group
Bie Grobet	General Manager- Integrated Adult Services	South Warwickshire NHS Foundation Trust
Chris Groves	Service User	Rheumatology User Group
Joanne Gutteridge	LTC Commissioning Project Lead	NHS Dudley Clinical Commissioning Group
Jane Haest	Paediatric Diabetes Nurse Specialist	Oxford University Hospitals NHS Trust
Frances Hanson	Paediatric Diabetes Dietician	Leeds Teaching Hospitals NHS Trust
Clair Huckerby	Pharmaceutical Adviser	NHS Dudley PCT
Dr Alexander Joseph	Rehabilitation Consultant; Walsall Healthcare NHS Trust	The Royal Wolverhampton Hospitals NHS Trust
Karen Joseph	Practice Manager	Sherbourne Medical Centre

Dr Raveendra Katamaneni	General Practitioner	Solihull PCT
Joe Myatt	Clinical Nurse Specialist Diabetes	Walsall Healthcare NHS Trust
Dr Chioma Eliezar Okirie	Consultant in Neurological Rehabilitation	University Hospitals Coventry & Warwickshire NHS Trust
Dr Vinod Patel	Consultant Diabetologist	George Eliot Hospital NHS Trust
Dr Ash Reynolds	Clinical Psychologist	Black Country Partnership NHS Foundation Trust
Gill Salt	Lead Paediatric Diabetes Nurse Specialist	The Royal Wolverhampton Hospitals NHS Trust
Dr John Scanlon	Consultant Paediatrician	Worcestershire Acute Hospitals NHS Trust
Sally Thompson	Multiple Sclerosis Nurse Specialist	Sandwell & West Birmingham Hospitals NHS Trust
Dr Venugopal Yuvaraj	General Practitioner	The John Kelso Practice

#### **WMQRS Team**

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

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## APPENDIX 2 COMPLIANCE WITH THE QUALITY STANDARDS

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

**Table 1 - Percentage of Quality Standards met**

Details of compliance with individual Quality Standards can be found in the appendix document for this report. Compliance with the standards for Specialist Care of Children & Young People with Diabetes is detailed in the Birmingham Children's Hospital NHS Foundation Trust report.

Service	Number of Applicable QS	Number of QS Met	% met
<b>Care of Children and Young People with Diabetes</b>			
Primary Care	3	1	33
Specialist Care of Children & Young People with Diabetes	29	20	69
Commissioning	7	0	0
<b>Health Economy</b>	<b>39</b>	<b>21</b>	<b>54</b>
<b>Care of Adults with Long-Term Conditions</b>			
Primary Care	8	1	13
Community Long-term Conditions Services	52	21	40
Specialist Care of Adults with Diabetes	58	35	60
Specialist Care of People with COPD	58	21	36
Specialist Care of People with Heart Failure	57	27	47
Specialist Care of People with Chronic Neurological Conditions (All Services)	165	102	62
West Midlands Rehabilitation Service	(56)	(35)	(63)
Moseley Hall In-patients	(55)	(33)	(60)
Community Parkinson's Disease Team	(54)	(34)	(63)
Commissioning	12	4	33
<b>Health Economy</b>	<b>410</b>	<b>211</b>	<b>51</b>

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