WM QRS West Midlands Quality Review Service

NHS

Reviews of Mental Health Services, Health Services for People with Learning Disabilities, Dementia Services and Care of Vulnerable Adults in Acute Hospitals

Birmingham and Solihull Health Economy

Visit Date: 5th, 6th, 7th, 8th, 11th, 12th, 13th & 14th July 2011 and 26th, 27th September 20011

Report Date: November 2011

Images courtesy of NHS Photo Library and Sandwell & West Birmingham NHS Trust

INDEX

Introduction ... **3**
Health Economy ... **5**
Mental Health Services ... **6**
Trust-Wide ... 6
Primary Care-Based Psychological Therapies ... 9
Specialist Mental Health Services ... 10
Birmingham & Solihull Early Intervention Services ... 10
Birmingham & Solihull Community Mental Health Teams (CMHTs) ... 12
Birmingham & Solihull Acute Care Service ... 14
Birmingham & Solihull Home Treatment Teams ... 14
Birmingham And Solihull In-Patient Services ... 15
Birmingham & Solihull Assertive Outreach Services ... 16
Commissioning ... 17
Dementia ... **18**
Memory Services ... 18
Commissioning ... 20
Health Services for People with Learning Disabilities ... **21**
Primary Care ... 21
Specialist Learning Disabilities Services ... 21
Birmingham Community Healthcare NHS Trust ... 21
Community Services ... 22
Short Break And Day Services - Hob Moor Rd ... 22
Short Break & Day Services – Kingswood Drive ... 23
In-Patient Unit – Birmingham Community Assessment And Treatment Service (BCATS) ... 23
In-Patient Unit – Sayer House ... 24
In-Patient Unit - Tessall Lane ... 25
In-Patient Unit – Handsworth Wood ... 25
Commissioning ... 26
Care of Vulnerable Adults in Acute Hospitals ... **28**
Acute Trust-Wide and Clinical Areas ... 28
Heart Of England NHS Foundation Trust ... 28
Birmingham Women's NHS Foundation Trust ... 30
Royal Orthopaedic Hospital NHS Foundation Trust ... 31
Sandwell & West Birmingham Hospitals NHS Trust ... 32
University Hospitals Birmingham NHS Foundation Trust ... 33
Commissioning ... 34
Appendix 1 Membership of Visiting Team ... **35**
Appendix 2 Compliance with the Quality Standards ... **38**

Compliance tables for Appendix 2 can be found in a separate document

INTRODUCTION

ABOUT WEST MIDLANDS QUALITY REVIEW SERVICE

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 http://www.wmqi.westmidlands.nhs.uk/wmqrs/.

This report presents the findings of the review of mental health services, health services for people with learning disabilities, dementia services and care of vulnerable adults in acute hospitals which took place on 5th, 6th, 7th, 8th, 11th, 12th, 13th & 14th July 2011. A meeting with service users with learning disabilities and their carers was held in July 2011. The review of health services for people with learning disabilities in Birmingham took place on 26th and 27th September 2011. These were announced visits with the dates agreed approximately six months in advance.

The purpose of the visit was to review compliance with WMQRS Quality Standards for:

- Mental Health Services, Version 1, February 2011
- Health Services for People with Learning Disabilities, Version 1.1, December 2010
- Dementia Services, Version 1, February 2011
- Care of Vulnerable Adults in Acute Hospitals, Version 1.1, December 2010

These visits were organised by WMQRS on behalf of the following Care Pathway Groups: West Midlands Mental Health Care Pathway Group, West Midlands People with Learning Disabilities Care Pathway Group and West Midlands Dementia Care Pathway Group.

The purpose of these 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.

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

ACKNOWLEDGMENTS

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

Key Points

1 This review covered mental health services, dementia services and care of vulnerable adults in acute hospitals across Birmingham and Solihull. Health services for people with learning disabilities in Birmingham were reviewed. Solihull health services for people with learning disabilities are covered by the Coventry and Warwickshire health economy report, available on the WMQRS website: http://www.wmqi.westmidlands.nhs.uk/wmqrs/. Reviewers of mental health and dementia services were aware that the review concentrated on Birmingham services and differences in Solihull may not have been fully explored and a further review specifically of Solihull services has been offered.

2 Across the health economy, reviewers were concerned about a lack of integration between health and social care at an operational level. Social workers were no longer based with mental health or learning disability teams and difficulties and delays in accessing social workers with appropriate expertise were being experienced. Integration between health and social care at a commissioning level was good.

3 Reviewers identified several opportunities for redesign of mental health services and suggested that the therapeutic contribution of some of the day and in-patient services provided by Birmingham and Solihull Mental Health NHS Foundation Trust should be reviewed to see whether service users' needs could more appropriately be met through other models of service provision.

4 The review of Birmingham and Solihull health economy identified many examples of good practice and all staff were committed to improving services for local residents. Reviewers were particularly impressed by the Zinnia Centre and the staff training passport at Birmingham and Solihull Mental Health NHS Foundation Trust. There were several examples of work to ensure that the physical health needs of service users were met and good collaboration with *'Youthspace'* and development of the Early Intervention and Assertive Outreach services. Reviewers also found generally good information for service users and carers.

5 Concerns were raised, however, about aspects of staff training, unclear care pathways, governance and safeguarding within Birmingham and Solihull Mental Health NHS Foundation Trust. Reviewers were also struck by the variability of services within the Trust with some excellent services but others where this good practice had not yet been adopted.

6 Specific concerns were raised about staffing levels and service capacity within the IAPT service, resulting in some long waiting times, and about working hours and staff caseloads for the Crisis Resolution / Home Treatment teams. Reviewers were also concerned about diagnosis and assessment process for people with dementia.

7 Health services for people with learning disabilities were provided by Birmingham Community Healthcare NHS Trust. There were many good aspects of the services provided but reviewers were concerned about a lack of clear policies and guidelines in several areas and about difficulty accessing GPs for some people with learning disabilities.

8 The reviews of care of vulnerable adults in acute hospitals found a mixture of good practice and some concerns in each of the hospitals visited. All were actively working to improving the identification of and care for vulnerable adults.

Return to *Index*

HEALTH ECONOMY

General Comments and Achievements

A Partnership Board was operational and recognised the need to reduce variability in services.

For most services, the Trust evidence provided and the clinical staff who met the visiting team were from Birmingham. Reviewers were not confident that they had fully reviewed differences between Solihull and Birmingham and this report may not, therefore, give a full picture of Solihull mental health and dementia services. As a result, the Birmingham and Solihull health economy has been offered an additional peer review visit to Solihull. Any future review programme should allow additional time specifically to consider Solihull services.

Concerns

1 **Health and social care integration**

Most of the Birmingham services reviewed commented on the lack of integration of health and social care. Social workers were no longer based with the mental health teams. Most services reported delays in accessing social care assessments, delays in access to social care and the loss of service-specific expertise as referrals were handled by generic social workers. Joint assessments were not in place. Staff reported that these difficulties were getting worse. Reviewers were concerned that the benefits of the joint commissioning structure and Section 75 agreement between commissioners were not being realised because of the separation of operational health and social care staff.

Further Consideration

1 **Commissioned services – opportunities for redesign**

The number of day services and non-acute beds provided by the Birmingham and Solihull Mental Health NHS Foundation Trust appeared high for the population served. These services were not reviewed. Issues of a lack of focus on social integration and recovery are identified within this report (see CMHT section) and may also apply to day services and non-acute beds. Reviewers suggested that Commissioners and the Trust look together at the therapeutic contribution being made by these services and whether a third sector social care provided model – with health input – may more appropriately meet service users' needs.

Some staff within the Birmingham and Solihull Mental Health NHS Foundation Trust were concerned that residential and day alternatives to admission were being reduced and that service users did not have easy access to appropriate housing and rehabilitation facilities. They reported that this was resulting in a longer length of stay on acute in-patient wards. These concerns should be considered as part of any review of the configuration of services.

2 **Solihull services**

Because of the lack of emphasis on Solihull mental health and dementia services during this review (see health economy general comments and achievements above), the health economy may wish to undertake additional quality assurance of Solihull services and an additional WMQRS review specifically to Solihull services has been offered.

Return to *Index*

Mental Health Services

Trust-Wide

BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST

General Comments and Achievements

WMQRS staff were aware that communication about the organisation of the review had not been ideal and, as a result, some teams had short notice of the review and were unsure what information to prepare and who needed to meet the reviewers. This report should be read with this in mind. The visiting team considered, however, that their main conclusions would be unlikely to change with additional information. Some of the less important issues, for example, those identified as for 'further consideration', may have been different had additional information been available.

At the time of the visit the Birmingham and Solihull Mental Health NHS Foundation Trust was going through a management restructuring and was addressing a significant financial deficit. The Trust was part-way through implementing an Estates Strategy which aimed to reduce the number of bases from which staff operated. Pharmacy services were well-organised and providing good support to clinical teams.

Immediate Risk: See Crisis Resolution Home Treatment Service

Good Practice

1. Reviewers were very impressed by the Zinnia Centre. A range of services (in-patient, CMHT, crisis, assertive outreach) were based together and so communication between them was easy. There was good evidence that recovery-focussed care plans were implemented. The Unit had been very carefully planned with service user, carer and local community involvement in the design of the building. There were many examples of attention to small details which improved responsiveness to users' and carers' needs and made it easier for staff to work.

2. There were several examples of work to ensure that the physical health needs of service users were met.

3. '*Youthspace'* was an excellent example of collaborative working and responsiveness to the needs of young people.

4. A good Training Passport identified whether individual members of staff had undertaken statutory and mandatory training.

5. There were several examples of good information for service users and carers. A good range of numbered Trust-wide information leaflets were in use across all services reviewed. A good poster raised awareness of care plans. Good mechanisms for receiving feedback from service users and carers had been developed, including 'User Voice' which was linked to PALS, electronic feedback stations, mystery shoppers, creative arts programmes, seminars and information-sharing service user forums. (See, however, Trust-wide 'further consideration' about actions taken as a result of feedback.)

Concerns

1 **Staff training**

The expected statutory and mandatory training for registered and un-registered staff was in place and monitored monthly. Monitoring information showed high levels of achievement in some areas but low in others, including equality and diversity. There were no competence frameworks showing the training expected for specific roles in individual services and no evidence of staff having achieved the expected competences. The skill mix within some services may also benefit from review as there appeared to be a relatively low proportion of registered staff. Reviewers noted that a new head of training and development had recently been appointed.

2 **Care Pathways**

Pathways of care were disjointed in several services with unclear criteria for referral, multiple access routes, multiple pathways and unclear discharge criteria. Good working relationships overcame this problem in some services but these were often individual dependent. Robust pathways were not in place across all services and service users' and carers' experiences may therefore depend on which member of staff they see and where they live. More detail of this issue is given in the service-specific section of this report.

3 **Governance**

Reviewers were concerned about several issues relating to clinical governance within the Trust:

a. Staff reported that the issue of long shifts identified in this report as an immediate risk for the Home Treatment Teams had been identified as a risk previously but no action had been taken.

b. The Dementia Services section of this report includes a serious concern about implementation of NICE guidance.

c. Reviewers were given examples of attitudes and practice which did not appear to be being actively managed, including concerns raised by service users and carers about a lack of action in response to issues raised.

The Trust was aware of the need to improve governance processes but the pace of change appeared slow.

4 **Safeguarding**

The Trust Safeguarding Policy was being revised at the time of the visit, partly in response to the CQC Review of Compliance (February 2011). Reviewers were assured that social care staff had robust arrangements for handling safeguarding issues. Reviewers were concerned that safeguarding was seen as a social care responsibility and the contribution of health service staff to safeguarding was not understood. Although a new policy had been ratified in early July 2011, several other aspects of the CQC report action plan had not yet been implemented. NB. This issue links with the Trust-wide concern above about the lack of data on completion of statutory and mandatory training.

Further Consideration

1 **Clinical Guidelines**

Services were not yet clear which care pathways they were expected to offer. Staff could access a range of guidelines, including NICE guidance, through the Trust website. Guidelines had not been localised to reflect local circumstances. This issue is identified as for 'further consideration' at this stage but will be of concern

at any future review visits as progress should have been made by then. This issue also has implications for audit as, until clinical guidelines are in place, their implementation locally cannot be audited.

2 **Inconsistency in Trust services**

The overall impression of mental health and dementia services for Birmingham and Solihull was of variability. Some services were excellent but this good practice was not implemented throughout the Trust. Information for service users, including information in other languages, was not available in all the services visited. Many pilots were underway but the mechanisms for evaluation and, if appropriate, roll-out did not appear robust. In some services reviewers commented on the lack of a focus on recovery and rehabilitation (see service-specific reports for details). Relatively little emphasis on personalisation and personal budgets was evident. These appeared to be seen as a social care function with no role for health services.

3 **Two-way Communication with Senior Management**

As part of the management re-structuring, mechanisms for two-way communication between staff and senior management may benefit from review. Reviewers were struck by an apparent disconnection between individual services and the Trust senior management. Several staff commented that issues were addressed on the basis of 'who shouts loudest' and that they did not have mechanisms to influence senior management. Staff also said that some managers were listened to whereas others were not. Reviewers were also struck by differences in managers' insight into the problems faced by their services. Some had a good understanding with appropriate plans for the service whereas others appeared to have little insight and therefore plans for improvement were not robust.

4 **Service user involvement**

There were many ways for service users to give feedback on their experiences of care (see Trust-wide good practice section of this report). Several Birmingham service users, including those who were involved in Trust-wide groups and mechanisms, reported, however, that action was not taken on issues raised. (NB. This issue was raised by service users and not by carers. Carers who met the visiting team were satisfied with the way in which issues were handled. This issue also did not apply to Solihull where service users who met the visiting team were very positive about the services they received.) Reports from the 'mystery shopper' programme were reported to the Trust Governance Committee but minutes available showed that actions were still 'red' after three years. The mechanisms for follow up did not appear to be robust.

5 **Medical Staff – Integration with Service Teams**

With the exception of the Home Treatment teams and some CMHTs, medical staff appeared relatively distant from the services with which they worked. Medical staff had a management structure separate from the operational structure for the rest of the Trust. Arrangements for multi-disciplinary management of services, involving medical as well as other staff, were not generally evident. This issue was a concern for dementia services.

6 **Pilots**: Many pilots were underway but the mechanisms for evaluation and, if appropriate, roll-out did not appear robust.

7 **Management Restructure:** The management restructuring was being welcomed by some staff, especially nursing staff. It will be important to ensure that progress with improving service delivery is not delayed due to this restructuring.

8 **Transition:** Reviewers were given some examples of difficulties in transition of some young people with complex needs from CAMHS to *Youthspace* and adult services. Reviewers did not have the opportunity to fully investigate this issue.

9 **Information Technology:** A new IT system was being introduced and some staff were concerned about the length of time being taken on data entry.

Return to *Index*

PRIMARY CARE-BASED PSYCHOLOGICAL THERAPIES

Primary care-based psychological therapy (IAPT) services for Birmingham were reviewed during this visit. Services for Solihull were reviewed as part of the Coventry and Warwickshire health economy review. The report of this visit is available on the WMQRS website: www.wmqi.westmidlands.nhs.uk/wmqrs.

General Comments and Achievements

IAPT services were provided by a committed team which was working hard to improve the care provided. The service had been running for only three months in the current form. (Some services had been provided since 2008 but had recently been re-tendered.) The service was therefore not yet fully developed, although good progress was being made towards meeting the service specification. Good managerial supervision arrangements were in place.

Reviewers met senior staff but were not able to meet other staff from the service. Reviewers' conclusions and this section of the report therefore cannot be taken as providing the same level of assurance of other WMQRS reviews.

Good Practice

1 The service includes a 'step 4A', provided by staff with a higher level of clinical expertise. This reduces the gap between primary and secondary mental health care and will enable more clients to be seen in primary care.

2 A Partnership Manager within the IAPT service supported communication with and engagement of GPs.

Immediate Risks: None

Concerns

1 **Staffing Levels and Service Capacity**

The service had approximately half the recommended number of staff for the population served. Approximately 20,000 referrals per year would be expected for the population but the service was seeing only about 12,000. Some staff had very high caseloads and waiting times in some parts of the service were long. Reviewers were told that waiting times varied between one day (Heart of Birmingham) and four months (South Birmingham). Little administrative and clerical support was available which increased the pressure on clinical staff. In some areas the service was having difficulty securing access to suitable premises, which was adding to delays in seeing clients.

Further Consideration

1 Reviewers saw little evidence of feedback from service users being used to improve the service provided. As the service develops, this aspect may benefit from further attention.

2 Pre-printed therapy resources may reduce staff time and effort in producing resources for each service user.

3 Informal links with CMHTs were in place for patients stepping up and stepping down the patient pathway. Formalising the expected communication and arrangements may ensure that this transition always happens in a consistent and timely manner as the current system appeared very dependent on individuals.

4 The service uses telephone screening of all referrals (GPs can request a face to face appointment). This should increase the number of appropriate referrals which are seen face to face, which is particularly important because of the pressure on staff. A follow-up audit of those who were screened out, covering the service user experience and what happened subsequently, may be helpful to confirm the sensitivity and specificity of the screening process. The advice given to those who are 'screened out' and the information for GPs about these patients may also benefit from review.

5 Each part of the service had a set staffing establishment with no apparent flexibility to move staff to meet fluctuations in the number of referrals or increasing waiting times. Greater flexibility in the use of staff may be helpful.

6 Difficulties in securing appropriate facilities for seeing clients were being experienced and will need ongoing management attention.

Return to *Index*

SPECIALIST MENTAL HEALTH SERVICES

BIRMINGHAM & SOLIHULL EARLY INTERVENTION SERVICES

These services were provided in collaboration with *Fairbridge* through the *Youthspace* initiative. Four Early Intervention teams were reviewed who were providing care for a total of approximately 600 clients. Early Intervention teams provided care for young people aged 16 to 25 with a first episode of psychosis.

General Comments and Achievements

Staff providing this service were passionate about improving their service for young people. They had good insight into the issues which needed to be addressed and were thinking innovatively about ways to achieve the necessary changes. Reviewers were impressed with the many examples of age-appropriate good practice within the service and were impressed with the team's inclusion of social recovery into their practice. Reviewers were not able to see any Early Intervention service users and carers and were aware that the team had had little time to prepare for the review. Reviewers' conclusions and this section of the report therefore cannot be taken as providing the same level of assurance of other WMQRS reviews.

Good Practice

1 An age-appropriate service was provided for people aged 14 to 35. The service was actively and successfully working to reduce the duration of untreated psychosis and reduce stigma for this group.

2 Very innovative ways of engaging with service users were being used, including *Facebook, Twitter,* work with local radios and work with some local communities.

3 The service had an innovative collaboration with the youth service provided by Fairbridge. This allowed the service to reach into job centres and many other youth services.

4 Effective collaboration with the COMPASS substance misuse service was in place to ensure appropriate care was provided for people with dual diagnoses. COMPASS provided training and one day each week of support for the Early Intervention service. COMPASS was also actively involved with the Early Intervention strategy and service planning.

5 The Early Intervention service had a very strong research base with a good record of completed and ongoing research studies and publications.

Immediate Risks: None

Concerns

1 **Clinical guidelines, data collection and audit**

Reviewers did not find evidence of clinical guidelines for care cluster 10 or data collection about the service's activity and outcomes. As a result, a systematic programme of audit of implementation of clinical guidelines was not in place.

2 **Delayed discharges**

Some clients had been with the service for well over the expected three year maximum. As a result, the service was having difficulty finding the capacity to see new referrals and delays in seeing new referrals were resulting. Reviewers were told that work was in progress to review individual care coordinator case loads in line with the move towards a recovery focus.

3 **Long duration of untreated psychosis in CMHTs**

Evidence was provided of long durations of untreated psychosis in young people aged 18 and over referred directly to CMHTs. Although young people were referred through *YouthSpace,* those aged 18 and over were also being referred directly to CMHTs. The referral pathway was not clear and robust mechanisms for re-directing young people from CMHTs to the Early Intervention service were not in place. The Trust IT system could be used systematically to identify people on care cluster 10 in other services but this information was not being routinely monitored and acted upon.

4 **Staff Training:** See Trust-wide section of this report

Further Consideration

1 Corporate arrangements for review of, and learning from, positive feedback, complaints, outcomes, incidents and 'near misses' were in place but there was less evidence of multi-disciplinary review and learning within the Early Intervention service. Reviewers suggested that it may be helpful to strengthen this aspect of the service's work.

2 The service had relatively little administrative and clerical support and, as a result, clinical staff were spending time on duties which could have been undertaken by administrative staff. The introduction of electronic notes may also impact on administrative and clerical time needed for the service.

3 Some parts of the service were caring for large numbers of clients from specific communities. For example, over 60% of service users in one team were from black and minority ethnic communities. The service was also aware of the different needs of some groups, for example, Irish and Chinese young people. This may give the opportunity for the development of specific expertise and more specialist provision – resulting in a service which is more responsive to the needs of different cultural and ethnic groups within Birmingham and Solihull.

4 One occupational therapist covered all four Early Intervention services and occupational therapy input to care planning and therapeutic interventions was therefore limited. Further consideration of the skill mix within the service may increase the multi-disciplinary input to the care provided.

BIRMINGHAM & SOLIHULL COMMUNITY MENTAL HEALTH TEAMS (CMHTs)

General Comments and Achievements

All of the staff from Community Mental Health Teams who met reviewers were positive and enthusiastic. Reviewers visited the Ten Acres team and were impressed by the environment and the good information for service users which was available. Some examples of very good practice were seen during the review. The overall impression, however, was of a 'patchy' service, excellent in parts but without robust arrangements for ensuring the best possible care was provided to all service users. Some CMHTs were beginning to work together in order to share skills and expertise. The newly appointed Programme Director for CMHTs was aware of the issues to be addressed. The management challenge in implementing changes across all CMHTs in Birmingham and Solihull should not be underestimated. Joint work with commissioners may be helpful in ensuring the expected changes are clearly prioritised and implementation monitored.

A good range of psychological interventions was available and there was active psychology input into all the teams reviewed. Occupational therapy and psychology clinical leadership was strong. Consultant psychiatrists were an integral part of all CMHTs. In Solihull, social workers were integrated with CMHTs.

Good Practice

1 Consultant psychiatrists were actively involved in the work and leadership of the teams, with each having links to a group of general practices. All service users had an explicit prioritisation of their need for access to a psychiatrist. One consultant had allocated time for seeing urgent referrals at the end of each day.

2 See also Trust-wide section of this report relating to the Zinnia Centre.

Immediate Risks: None

Concerns

1 **Care Pathways and Models of Care**

Reviewers were concerned that, with some exceptions, the care pathways and models of care were not actively focussed on social inclusion and recovery. Referrals came from many different sources and arrangements for handling and allocating of referrals varied between and within the teams. There was no apparent pathway-based reason for the different allocation decisions. Reviewers were told that in some teams the manager allocated referrals, in others there was multi-disciplinary discussion and, in some, the consultant decided on the allocation. Several examples of delays of up to three weeks in allocation of a Care Coordinator were given, including examples of people being admitted while waiting for a Care

Coordinator. Variable contact with Care Coordinators during in-patient stays and home treatment team episodes was also reported.

The Trust policy on care planning was implemented to a variable extent. Care pathways which embedded social inclusion and recovery into the assessment, care planning and discharge process were not evident. The therapeutic interventions being delivered by the teams were not always clear. Although reviewers were impressed by the medical prioritisation system (see good practice), they identified the potential for this to encourage a medical rather than multi-disciplinary response. Large depot clinics were still running which, for many service users, may more appropriately be provided in primary care. Clear arrangements for clients to re-access care at times of difficulty were not evident. Some teams were struggling with their workload and some staff were proud of the resulting emphasis on crisis management. A few staff realised that better services could be provided by changing the model and focus of their work but this insight was not widespread.

The staffing structures supported this rather traditional approach to care. Teams were relatively well staffed with medical and psychology staff and more senior nurses had been trained to deliver certain interventions. Little use was made of support workers and occupational therapy staffing was variable. One team had no access to occupational therapy expertise.

2 **Links with social workers (Birmingham only)**

Social workers were not an integral part of CMHTs and access to social workers was by referral to generic social care services. This contributed to the lack of a focus on social integration and recovery (see above), meant that integrated pathways of care could not be provided and led to delays in access to social care. In practice, information sharing arrangements between CMHTs and social work staff were not clear and some staff were not aware of the Birmingham information-sharing agreement. Personalisation and individual budgets were seen as the responsibility of social workers and, as a result, did not have a high profile within the work of CMHTs.

3 **Adult Safeguarding:** See Trust-wide section of this report.

4 **Long duration of untreated psychosis in young people:** See Early Intervention Service section of this report.

5 **Staff Training:** See Trust-wide section of this report

Further Consideration

1 **Clinical Guidelines:** See Trust-wide section of this report.

1 Several pilots were taking place, including a well-researched LES pilot of shared care with GPs. The process by which pilots were evaluated, decisions about roll-out made, and changes become embedded in all services was not clear. It will be important that this is addressed as part of the proposed service redesign to ensure that all service users have access to the best possible care.

2 Reviewers were told that most referrals were from GPs with relatively few from other sources. Reviewers did not see data on the different sources of referral but, if this is the case (which would fit with points made above about the medically-led approach to care), further work with other agencies on referral pathways may streamline the journey to care for service users.

3 Although some joint work had taken place with the substance misuse service COMPASS, it was not clear that CMHTs saw the care of people with dual diagnosis as ‘core business’. Reviewers were told that people

with substance misuse problems were usually referred to COMPASS rather than remaining within the CMHT.

4 As part of the planned service redesign work, consideration should be given to the arrangements for multi-disciplinary professional leadership within each team in order to support the development of a strong multi-disciplinary approach to the development of the service.

5 The Trust policy on management supervision was not consistently implemented within the CMHTs.

6 Work was starting on the development of specialist expertise in the care of people with Autistic Spectrum Condition and reviewers supported the continuation of this work.

BIRMINGHAM & SOLIHULL ACUTE CARE SERVICE

BIRMINGHAM & SOLIHULL HOME TREATMENT TEAMS

General Comments and Achievements

Service users gave good feedback about the care they received through a variety of mechanisms. Staff were positive and enthusiastic and there was a good 'team-spirit' within the service. Good health promotion work was taking place with a range of activities available aimed at reducing stigma. A good range of audits had been undertaken, including audit of the storage of drugs. Information sharing agreements were well understood. Good links with forensic and liaison services were in place.

Good Practice

1 A good CPA workbook for Care Coordinators was in use.

2 A comprehensive physical health check resource pack was in use.

Immediate Risks:

1 **Crisis Resolution / Home Treatment Teams – Working Hours**

Staff within the Crisis Resolution / Home Treatment Teams were working for excessive periods without adequate rest. Reviewers were told that, on a regular basis, staff were working a late shift, on call at night and then on duty again the next day. Because of the high on-call demands, staff could be working through much of the night; the verbal information given to reviewers was that more than once a week staff were up until at least 2am or 3am. Staff reported that the issue had been identified as a risk for several years.

Concerns

1 **Staff Training:** See Trust-wide section of this report

2 **Staff Caseloads**

Several Crisis Resolution Home Treatment Team staff had caseloads of 40 to 50 people compared with the caseload of 25 on which staffing levels were based. There was no upper limit on the caseload for an individual member of staff.

Further Consideration

1 **Clinical Guidelines:** See Trust-wide section of this report.

2 **Access to in-patient beds**

Staff within the CRHT teams were concerned about difficulties in access to in-patient beds. They reported that, although various protocols governed the work of the Emergency Care Team, in practice beds were allocated on the basis of 'who shouts loudest'. In-patient staff reported that that the Emergency Care Team worked well in managing access to beds and the Trust provided an audit of the management of in-patient beds which showed few problems. Further discussion with in-patient services about the CRHTs' perspective on the admission process may be helpful.

3 Delays in the response of Care Coordinators and a lack of regular contact from Care Coordinators were reported. (See also CMHT section of this report: Care pathways and models of care.)

4 Staff were concerned that residential and day alternatives to admission were being reduced and that service users did not have easy access to appropriate housing and rehabilitation facilities. They reported that this was resulting in a longer length of stay on in-patient wards. Reviewers were not able to investigate this issue fully and further health economy work on this may be helpful. (See also health economy section of this report.)

BIRMINGHAM AND SOLIHULL IN-PATIENT SERVICES

General Comments and Achievements

Reviewers visited in-patient wards Oleaster, Barbary and the Zinnia Centre. Other in-patient facilities were not visited. The facilities and environment at all three sites was excellent. All were new builds and provided a calm therapeutic setting. Staff were welcoming and enthusiastic at all sites. Wards were running good activities programmes and reviewers were told that length of stay had reduced since the new facilities were operational. It was also reported that staff sickness had reduced. One female ward was running a pilot of 'caring for carers'.

Good Practice:

1 Zinnia Centre: See Trust-wide section of this report.

2 Very good leaflets about medication were easily available.

3 Birmingham City University student nurses had placements with the user involvement team in order to improve their understanding of user and carer involvement.

4 A 'Care Card' was given to all service users with details of their Care Coordinator and PALS services.

5 Everyone discharged from in-patient care was followed up by the home treatment team before being accepted back by CMHTs. Face-to-face handover from in-patient care to home treatment was routine.

Immediate Risks: None

Concerns

1 The visiting team was seriously concerned that, in an emergency, young people aged under 18 years were admitted to adult in-patient wards because no alternatives were available. Clear guidelines covering arrangements for care of young people aged under 18 were not in place.

2 **Staff Training:** See Trust-wide section of this report.

Further Consideration

1 Clinical guidelines for each care cluster offered by the teams had not yet been documented and robust audit of implementation of guidelines was therefore not yet in place. Some guidelines were available but were out of date.

2 On the Oleaster Unit, care plans were rather task-oriented and were not recovery-focussed.

3 **Residential and day alternatives to admission:** See Health Economy section of this report.

4 **Access to in-patient beds**

Staff within the CRHT teams were concerned about difficulties in access to in-patient beds. They reported that, although various protocols governed the work of the Emergency Care Team, in practice beds were allocated on the basis of 'who shouts loudest'. In-patient staff reported that that the Emergency Care Team worked well in managing access to beds. Reviewers suggested that audit and review of admissions involving both services may be helpful.

5 Some service users who met the visiting team were concerned that in-patient services were not sufficiently responsive to cultural needs.

BIRMINGHAM & SOLIHULL ASSERTIVE OUTREACH SERVICES

General Comments and Achievements

Assertive outreach teams were providing an impressive service, managing the care of a group of people with very complex needs in a community setting. Service users gave good feedback about the care they received through a variety of mechanisms. Staff were positive and enthusiastic and there was a good 'team-spirit' within the service. A good range of audits had been undertaken, including audit of the storage of drugs. Information sharing agreements were well understood. Good links with forensic and liaison services were in place. Leadership of the service was strong and the Service Manager was effectively bridging the gap between front-line staff and senior management in the Trust.

Good Practice

1 A member of staff within the Assertive Outreach service was employed with a primary focus on work with carers.

2 A good CPA workbook for Care Coordinators was in use.

3 A comprehensive physical health check resource pack was in use.

Immediate Risks: None

Concerns:

1 **Staff Training:** See Trust-wide section of this report

Further Consideration

1 **Clinical Guidelines:** See Trust-wide section of this report.

2 Timescales for discharge from the service were not clearly identified. It may be helpful to review these to ensure that active discharge is being pursued for all clients where this is appropriate.

Return to *Index*

COMMISSIONING

BIRMINGHAM AND SOLIHULL JOINT COMMISSIONING

General Comments and Achievements

Birmingham had an integrated commissioning unit with a section 75 agreement and joint funding for the commissioning of health and social care services. Solihull also had a section 75 agreement and integrated health and social care commissioning. Solihull had a clear commissioning strategy and a well articulated plan of actions to achieve implementation of this strategy. Commissioners undertook regular un-announced visits to services within the Trust.

Immediate Risks: None

Concerns

1 Health and social care integration: See health economy section of this report.

Further Consideration

1 Birmingham commissioners had a clear vision for the future development of services but the plans, actions and timescales required to achieve implementation of this strategy were less clear. Commissioner involvement in the Trust's financial savings plan was not apparent. Commissioners also appeared to have little involvement in proposals for improving governance arrangements. Commissioner awareness of the changes being made and progress with implementation may be helpful.

2 Both the health economy and some individual sections of this report identify potential opportunities for commissioning services which are more focussed on personalisation, social inclusion and recovery. See also health economy section of this report on opportunities for service re-design.

3 The overall impression of mental health and dementia services for Birmingham and Solihull was of variability. Some services were excellent but this good practice was not implemented throughout. Many pilots were underway but the mechanisms for evaluation and, if appropriate, roll-out did not appear robust.

Return to *Index*

Dementia

Memory Services

General Comments and Achievements

During the review of memory services provided by Birmingham and Solihull Mental Health NHS Foundation Trust, the visiting team looked in detail at the four Community Mental Health Teams (CMHT) for people aged over 65, the Birmingham Memory Assessment and Advice Service (BMAAS) and prescribing clinics. Reviewers visited one in-patient assessment ward. The Young Onset Dementia service was also reviewed although it was not always clear whether the evidence provided related to this service. It was similarly unclear whether all the evidence related to the services in Solihull and reviewers were aware that differences between Birmingham and Solihull may not have been fully explored.

The BMAAS service had been established for about a year and was still in a stage of development. This service had the potential to be a very good Memory Assessment Service if the issues identified in this report are addressed.

The STEPS team was moving away from a traditional model of day care and staff were enthusiastically embracing the associated changes. Reviewers were also interested in the adoption of a social problem approach to problem-solving whereby evidence from personality disorder services was being applied to older adult services and encouraged the evaluation of this approach.

Good Practice

1. The management of physical health was being actively promoted. Specialist nurses in infection control, diabetes and tissue viability were promoting good practice and were very involved in training other staff. A health care assistant was responsible for making sure physical health checks happened at out-patient clinics and on the in-patient ward. Physiotherapy staff played a very active role in the care of people with dementia.

Immediate Risks: None

Concerns

1. **Diagnostic and assessment process**

   Reviewers were seriously concerned about the diagnostic and assessment process for a combination of reasons:

   a. **NICE Guidance**

      NICE guidance on structural imaging (CT or MRI) prior to diagnosis was not being followed.

   b. **Competences of staff undertaking diagnosis and assessment**

      Senior practitioners (nurses and occupational therapists) led the diagnostic process as Memory Assessment Clinicians but there was no evidence that these staff had the competences needed for this work, including physical examination and medication review when this is required (for example, those described in the National Dementia Strategy (2009) and Regional Dementia Strategy (2008). Medical input to the diagnosis and assessment process was limited with only one session per week of consultant time available in BMAAS which was used for attendance at the multi-disciplinary meeting. [This concern links with that relating to staff training in the Trust-wide section of this report.]

c. **BMAAS Assessment Process**

The commissioned pathway expected that physical examination would be undertaken in primary care prior to referral with medication review and other investigations (including structural imaging) being considered at the multi-disciplinary meeting. BMAAS used an assessment recording form (client record) and the Addenbrooke's Cognitive Assessment Tool, but there were no guidelines covering the assessment process and assessment documentation did not include any detail of physical examination, medication review and other investigations. Given the expected variation in physical examinations in primary care, clinicians undertaking the assessment process should be able to undertake a physical examination when their clinical judgement indicates this is required. (See point (b) about staff competences for their roles in the assessment process.) Reviewers were also concerned that multi-disciplinary decisions about medication review and requesting of other investigations were being taken with no evidence that a specialist practitioner with appropriate competences had seen the individual concerned. Medical staff were usually, but not always, present at the multi-disciplinary discussion and these decisions were therefore sometimes taken without any medical input.

The assessment process also did not cover other aspects expected by the Quality Standards, including social care assessment, assistive technology assessment and carers' needs assessment. The service referred to other teams for these assessments when required. Reviewers were concerned that this approach did not give the expected holistic assessment, especially given the lack of integration with social care described in the health economy section of this report and the delays in response from social care (see below, concern 2).

d. **Care Pathways**

The pathway described to reviewers was that people with a possible diagnosis of dementia were referred to the Young Onset Dementia Service or BMAAS, depending on their age. The documented pathway was unclear and was not the same as the pathway described to reviewers. The documented pathway showed referrals to BMAAS, CMHTs or Prescribing Clinics depending on the choice of the GP and this pathway seemed to be being followed in practice. The Dementia Advisers, who were responsible for 'signposting' and advice, and who maintained contact with the client throughout their dementia journey, were not available to patients referred through Prescribing Clinics or CMHTs. People who had been referred more than a year ago (i.e. before the start of BMAAS) did not have a Dementia Adviser and there was no plan for ensuring they received relevant information, carers' assessments or other aspects of the service now being provided.

e. **Prescribing Clinics**

Doctors running the Prescribing Clinics were not generally involved in diagnosis, assessment or multi-disciplinary discussion. Reviewers were told that, before commencing treatment, these doctors would confirm the diagnosis on the basis of information provided. This expectation was not documented and, given the concerns above about the assessment process, reviewers considered that prescribing may be started without a robust diagnosis and assessment having been completed.

2 **Links with Social Care**

Clients who needed a social care assessment were referred to generic social workers and reviewers were told of several examples of delays in response and subsequent delays in accessing social care.

3 **Carers Needs Assessments**

Reviewers were told about several different systems for accessing carers' needs assessments. Carers of service users referred in the last year and of some in-patients would have access to a carer's assessment. The psychologist who undertook assessments of carers of in-patients was on a sabbatical and arrangements for carers' assessments during this time were not clear. The named nurse was not clear how carers' assessments would be obtained. Carers of CMHT service users could access an assessment through the Care Coordinator. It was not clear how carers of people being seen in Prescribing Clinics accessed carers' assessments. The Trust had audited carers' assessments and had showed that a low number of carers had been offered assessments.

Further Consideration

1 The ratio of registered to unregistered nursing staff on the in-patient ward appeared low (40:60 registered: unregistered during the day and 50:50 at night).

2 **Clinical Guidelines:** See Trust-wide section of this report.

3 The environment in the in-patient assessment ward was relatively clinical and reviewers, especially service user reviewers, wondered if the level of security was necessary. Although the unit was new, several aspects of the design did not appear to have taken the needs of people with dementia into account.

4 The development of more focussed support for people with dementia in care homes was being considered. Reviewers supported the continuation of this work and considered that it had the potential to reduce the use of NHS in-patient beds.

5 Formalised shared care arrangements with GPs were not in place. This was being considered as an area for development.

6 In addition to the services reviewed, Birmingham and Solihull Mental Health NHS Foundation Trust provided 70 continuing care beds for people with dementia. Reviewers were surprised that these services had not been the subject of market testing.

7 Although STEPS staff were enthusiastic about their work and an interesting range of 'classes' was available, the numbers attending the classes appeared very low and reviewers were unsure about the therapeutic interventions being offered (and therefore the rationale for NHS provision of this service).

Return to *Index*

COMMISSIONING

BIRMINGHAM AND SOLIHULL JOINT COMMISSIONING

Concerns:

Several aspects of the review of memory services at Birmingham and Solihull Mental Health NHS Foundation Trust require the attention of commissioners (see above).

Health Services for People with Learning Disabilities

Primary Care

A programme of training and development for primary care staff was run by the Health Facilitation Team.

Specialist Learning Disabilities Services

BIRMINGHAM COMMUNITY HEALTHCARE NHS TRUST

General Comments and Achievements

Reviewers met many committed and enthusiastic staff who were working hard to improve services. At the time of the review, staff were going through significant organisational change. The Trust had gained the Customer Service Excellence Standard.

Immediate Risks: None

Concerns

1 **Policies and Guidelines**

Some of the expected policies and guidelines were not available or were out of date. In some areas, several different versions of the same policy or guidelines were in use. Some policies were kept on the Trust intranet but staff were not clear what was available and did not appear confident in accessing intranet-based policies. Reviewers were told that this was because partly because of the creation of the new Trust from three different organisations.

2 **Mental Capacity Act and Deprivation of Liberty Policies**

Reviewers could not find a policy on use of the Mental Capacity Act or on Deprivation of Liberty Safeguards and staff were not aware of the Trust policies for these areas. Some staff had had appropriate training but robust arrangements for ensuring that all staff had appropriate training in these areas were not in place.

3 **Access to General Practitioners**

Service users who were in-patients, especially those who had been in-patients for long periods, did not routinely have access to a general practitioner. Reviewers were told that care for service users' physical health needs was from learning disabilities medical staff or from general acute hospitals. Annual reviews of physical health were not routine for people who had been in-patients for over a year.

4 **Access to Social Workers**

Due to reorganisation of social work within the area, social work staff were not actively engaged in planning discharges to supportive living. This was delaying discharges from some of the in-patient services.

Further Consideration

1. Service users and carers who met the visiting team expressed concern that they did not receive ongoing communication about planned changes to services. They were also worried about whether services would be available when their parents got older. Mechanisms for ongoing communication with, involvement of and feedback to service users and carers may benefit from review.

2. Access to assistive technology may benefit from review. A range of mechanisms were in place, including service users bring their own assistive technology with them. Staff were not clear about the assistive technology that was available and how to access assistive technology that may be required.

3. Some of the facilities visited were awaiting repairs and the timescale for completion of these was not clear.

4. Reviewers commented that little emphasis appeared to be being placed on personalisation and personalised budgets. Personalisation did not appear to be being actively promoted with service users and carers.

Return to *Index*

COMMUNITY SERVICES

SHORT BREAK AND DAY SERVICES - Hob Moor Rd

General Comments, Achievements and Good Practice

The short break service cared for eight service users who had access to between 42 for new clients and 60 days for existing clients respite days per year. Beds had been reduced from 12 following a review of single rooms. Service users with challenging behaviour were nursed in bungalow type accommodation linked to another bungalow type accommodation for people with complex physical needs at the other. Staff seemed committed and knowledgeable about the service. The service had a longstanding carer involvement group which met every two months. Interactive work with several clients was observed. Reflexology was available one day a week.

The Day Centre provided a day services for the whole of Birmingham. Clients could attend between one and five days per week depending on the assessment of their needs. Staff collected clients from homes, which provided an opportunity for interaction with carers. Reviewers were introduced to service users and support workers.

Immediate Risks: None

Concerns

1. **MCA and DoLS:** See Trust-wide section of this report.

2. **Unit environment:**

   The environment of the day services was drab and in need of modernisation. Service users entered via the back entrance, which was unwelcoming. The Sensory Room had been unavailable for six months, although reviewers were told that finance to replace the unit had now been secured.

Further Consideration

1. Filing cabinets and boxes were in the corridor and a small heater was in the reflexology room. Reviewers recommended that a health and safety risk assessment of these issues is carried out.

2 Much of the information for service users and carers, and information about the service, was difficult to locate. Examples of information that was difficult to find were the user and carer feedback forms and training records

3 Staff understanding of restraint appeared variable. Some staff said restraining did not take place but breakaway techniques were used. Other staff commented that they had recently had to restrain. Further training on restraint may be helpful.

4 Limited activities were available for service users who arrived before 10.30 am.

Return to *Index*

SHORT BREAK & DAY SERVICES – Kingswood Drive

General Comments and Achievements

Service users who met the reviewing team were well cared for and happy with the service they received. Staff were enthusiastic and committed to providing a good service.

Immediate Risks: None

Concerns: None

Further Consideration

1 Service users gave feedback on their experiences but it was not clear that there was any feedback to them about actions taken and progress with implementing changes. It may be helpful to strengthen feedback to service users.

2 One of the rooms visited had a heavily stained carpet. This room was empty at the time of the review but reviewers were not assured that action would be taken before the room was used again.

IN-PATIENT UNIT – Birmingham Community Assessment and Treatment Service (BCATS)

General Comments and Achievements

This was a unit of six beds with an average length of stay of eight months. Staff were welcoming, professional, helpful and knowledgeable. Reviewers observed good interaction between service users and staff. Reviewers were able to talk to service users about their experience with BCATS.

Good Practice

1 The linked Social Worker helped to support the discharge process and was proactive about discharge, starting at the point of admission

2 Dementia booklets were available in easy read (GOLD project). These booklets contained clear and relevant information.

Immediate Risks: None

Concerns

1 **Policies and Guidelines:** See Trust-wide section of this report.

2 **MCA and DoLS:** See Trust-wide section of this report.

3 **Unit Environment**

The environment for service users and staff at BCATS was poor. The building was claustrophobic, the day room area had only one settee and a bean bag on the floor, the curtains had been removed in the day room following a ligature risk assessment and a replacement rail was awaited. Reviewers were told that some renovation work had taken place and that further redecoration was taking place. The environment was not homely and was not appropriate for service users with an average length of stay of eight months. Reviewers suggested that staff should visit other assessment units to gain ideas about ways to improve the environment until the planned new building is operational in mid-2013

Further Consideration

1 Reviewers suggested that the service should ensure that Easy-Read care plans are offered to service users. No Easy-Read care plans were included in the evidence folders and some service users were not aware that they existed.

IN-PATIENT UNIT – Sayer House

General Comments and Achievements

Sayer House was a six-bedded in-patient unit for older adults with Learning Disabilities and dementia which had recently widened its focus to caring for those with other life threatening conditions. Reviewers met staff who were very enthusiastic. Daily activities were planned and recorded and some clients accessed community activities, such as worship on Sundays. Personal development review and mandatory training were in place for staff. Reviewers met two patients who appeared comfortable and well cared for. Sayer House provided a good environment for palliative care. There was good interagency working and good continuity of care

Good Practice

1 A wall-mounted personal preferences chart meant that all staff were clear about service users' preferences

2 Nutrition scoring clearly identified service users' swallowing ability. This information clearly available for staff so they know what texture (1-3) the diet needed to be.

Immediate Risks: None

Concerns

1 **Policies and Guidelines:** See Trust-wide section of this report.

2 **MCA and DoLS:** See Trust-wide section of this report.

Further Consideration

1 Cleaning was done by nursing staff. This may not be the most appropriate use of nursing time.

2 Much of the staff training was on an in-house basis, sometimes using external trainers. The benefits of linking with other providers of similar services to access training should be considered.

IN-PATIENT UNIT - Tessall Lane

This was a step-down facility for clients with forensic needs. The accommodation was in three separate buildings. There were plans for purpose built accommodation which was projected to be available within 2 years. Staffing levels were high, including at night, as all patients were subject to restrictions. Staff communicated via walkie-talkies. Staff were enthusiastic and reviewers were told that morale and relationships with neighbours had improved. Case notes were well organised and a service user satisfaction survey had been undertaken. Service users had good legal and advocacy support and were involved and felt able to challenge plans for the building. The complaints process was available in easy read. A good range of activities was available and service users' care was being pro-actively managed.

Immediate Risks: None

Concerns

1 **Unit Environment**

Reviewers were seriously concerned that the environment of the unit was not fit for purpose. There was no ground floor accommodation and stairs were very narrow. Because of the three separate buildings, staff were heavily reliant on walkie-talkies for communication and for calling for help in an emergency. This could lead to delays in accessing support. The decoration was shabby.

2 **Access to General Practitioners:** See Trust-wide section of this report.

3 **Access to Social Work:** See Trust-wide section of this report.

Further Consideration

1 The service had a locum consultant. Interviews for a substantive post had just taken place and reviewers hoped that a substantive appointment would be made in the near future.

2 Cleaning was done by nursing staff. This may not be the most appropriate use of nursing time. The unit had no administrative support and so clinical staff were spending considerable time undertaking administrative tasks.

3 Clients told the reviewers that the use of walkie-talkies transmissions were very loud and they found this quite irritating.

IN-PATIENT UNIT – Handsworth Wood

General Comments and Achievements

This was a six-bedded in-patient unit for men, including some with forensic needs or challenging behaviour. Staff were enthusiastic. A weekly audit of medication had improved medicines management. New arrangements for review and learning had been implemented and regular multi-disciplinary meetings were in place. Clients and staff were very positive about the unit. Supportive discharge processes were evident. Clients had good access to advocacy. All documentation was archived and so it was easy to access historical information about service users and their care.

Good Practice

1 Activity planning for the forthcoming week took place each Sunday and clients were actively involved in this.

2 Very good support was available from the Health Facilitator. A lot of work had taken place to develop and implement robust care planning processes. The care plans that were reviewed were extremely comprehensive, showing interventions and outcomes and agreed with the service users. Consideration was being given to rolling out the format to other services across the Trust.

Immediate Risks: None

Concerns

1 **Policies and Guidelines:** See Trust-wide section of this report.

2 **MCA and DoLS:** See Trust-wide section of this report.

Further Consideration

1 Cleaning was done by nursing staff. This may not be the most appropriate use of nursing time. The unit had no administrative support and so clinical staff were spending considerable time undertaking administrative tasks.

2 Multi-disciplinary team meetings took place every two months. Staff commented on the usefulness of these meetings and would like them to take place at least monthly.

Return to *Index*

COMMISSIONING

BIRMINGHAM JOINT COMMISSIONING

General Comments and Achievements

The Joint Commissioning Team had a good understanding of issues which needed to be addressed. A draft Commissioning Strategy for Service for People with Learning Disabilities was being developed.

Good Practice

1 Good work on reducing out of area placements had reduced costs from an £8m overspend to an under-spend.

2 Good use was being made of 'Supporting People' lay assessors who were reviewing social and health care services.

3 Over 100 Dignity Champions had been trained, of whom 70 were people with learning disabilities.

Immediate Risks: None

Concerns

1 **Services for people with learning disabilities aged 18**

Reviewers were seriously concerned that there was an apparent gap in the commissioning of services for people with learning disabilities aged 18. Reviewers were told that services for young people were commissioned up to 17 years and 11 months and those for adult from 19 years.

2 **Access to Social Workers:** See Trust-wide section of this report.

3 A commissioning strategy was being developed and was in draft form, but did not include timescales or an action plan for implementation

Further Consideration

1 Service users and carers who met the visiting team expressed concern that they did not receive ongoing communication about planned changes to services. They were also worried about whether services would be available when their parents got older. Mechanisms for ongoing communication with, involvement of and feedback to service users and carers may benefit from review.

2 Staff who met the reviewing team were not clear who was responsible for commissioning NHS out of area placements.

3 It was not clear that staff in all services understood about assistive technology that was available and how to access this to support their clients. Further work on publicising access to assistive technology may be helpful.

4 Although joint commissioning arrangements, with section 75 agreements, were in place, reviewers saw little evidence of joint working between health and social care at an operational level. For example, the PCT and local authority had reviewed day services separately. It was not clear why this had not been done jointly given that the new model for day services would affect the same service users.

5 Commissioning of services did not appear always to take account of the holistic needs of service users. For example, reviewers were given examples of age-specific commissioning and separate commissioning to meet the mental and physical health needs of service users. Reviewers were told that this caused difficulties and delays for staff and therefore for service users.

6 The Joint Commissioning Unit has many staff with social care experience. It may be helpful to consider whether recruitment of staff with a health background, as opportunities arise, may help to improve communication with GPs and health organisations. The need for commissioning staff with specific expertise in services for people with learning disabilities may also benefit from further consideration. Reviewers commented that much of the language used in commissioning communications was complicated. Consideration of simplifying the messages, especially to GPs, may be helpful.

Return to *Index*

CARE OF VULNERABLE ADULTS IN ACUTE HOSPITALS

ACUTE TRUST-WIDE AND CLINICAL AREAS

HEART OF ENGLAND NHS FOUNDATION TRUST

During the visit, reviewers looked at Trust-wide guidelines and policies and tested their implementation in the following clinical areas:

Good Hope Hosptial: Trauma and Orthopaedics (Ward 14) Stroke & Elderly Care (Ward 24) Acute Medical Unit, Respiratory (Ward 8), Elderly Care Wards (10 & 12).

Solihull Hospital: Acute Medical Unit, Acute Medical Unit Short Stay (20a), Stroke (Ward 8) Cardiac (Ward 17), Respiratory (Ward 19), Acute Medicine/ Elderly Care, Diabetes and Gastroenterology (Ward 18), Orthopaedics (Ward 15 – Elective Patients only).

Birmingham Heartlands Hospital: Emergency Department, Renal Medicine (Ward 3), Surgical Assessment Unit (Ward 11), Trauma and Orthopaedics (Beech Ward), Elderly Care (Ward 21), Haematology/oncology (Ward 19) Elderly care short stay (Ward 30) .

General Comments and Achievements

Much work has been undertaken across the Trust in the last year. A newly appointed safeguarding adults matron and site lead nurses were in place. The adult safeguarding steering board membership and terms of reference had been revised and greater links with other agencies were being developed. A 'challenging behaviour' work-stream sub-group was looking at polices and practice around restraint, sedation and challenging behaviour. A range of nursing metrics were reported and audits had shown improvements in the delivery of some aspects of care across all hospital sites. The lead for safeguarding was very proactive and was delivering training.

Immediate Risks: None

Good Practice

1. The Acute Medical Short Stay ward was pioneering several initiatives to improve fluid and food intakes for certain groups of patients. These included
    a. Increasing the number of formal hot drink rounds during the day. In particular, patients were asked if they wished to be offered an early morning hot drink.
    b. Availability of snack boxes, which included a range of finger foods
    c. Use of coloured tableware (blue gingham table covers and blue and green crockery) to help those with dementia.
2. A Safeguarding SharePoint on the intranet had been developed and contained a wealth of information including contact numbers, publications, research and audit, policies, training and other useful information. It was an easy to access site and staff in the clinical areas found it very helpful.
3. Leadership on safeguarding and care of vulnerable adults was visible at all levels (from Board to Ward). All staff who met the visiting team were clear about who they should ask if they had queries.

4 Nursing metrics were being reported and were empowering staff to make changes and improve care. This was creating staff engagement and competition between wards.

5 A Care of the Elderly consultant worked in the Emergency Department during normal working hours in order to improve the care of older people. This initiative had avoided several admissions.

6 The first edition of a Safeguarding Newsletter had been produced in June 2011.

7 Ward 21 at Birmingham Heartlands Hospital had made several improvements to the environment, including electronic openers to help people with disabilities to access the toilets.

Concerns

1 **Care Planning**

There was evidence of inconsistency and a lack of quality control in the way care planning was undertaken on the wards visited. The approach to care planning did not optimise personalised care. The Trust was aware of this and was reviewing the documentation. On some wards, progress against care plans was documented in either the electronic ward handover or the patient's notes or duplicated in both. It was therefore not clear that the most up to date information was being communicated to staff. In one set of records reviewed the electronic handover record had not been updated for two days and the patient notes were not accessible to check whether any entries had been made (Good Hope). The use of the 're-positioning chart' was not clear: Some staff reported that a once daily record was acceptable if the patient was on an 'air bed' as they do not need re-positioning whereas care records reviewed at Solihull showed that regular re-positioning was undertaken and documented. Individualising of care plans was limited and related mainly to the risk assessment document. This would therefore cover those areas deemed at greater risk and would not include other care that may be required. An 'activity of daily living' check list was in use at Solihull but it was not clear if this document was used elsewhere in the Trust. Reviewers were told that the Trust was aware of these issues and work was underway to address them through the development and implementation of an electronic system to standardise and improve nursing assessment and care planning.

Further Consideration

1 Some staff did not appear to understand the importance of independent access to interpreters in the best interests of the patient. Examples included a lack of clarity about use of family members for interpretation and staff who were unsure whether they could be used to translate.

2 A medical lead with responsibility for safeguarding and improving the care of vulnerable adults within the Trust may help to support the lead for safeguarding and raise awareness and training among medical staff.

3 The areas visited used different ways of highlighting patients with specific needs, for example, those at risk of falls or pressure sores or those requiring help with nutrition. The Trust was in the process of implementing an electronic 'patient at a glance' screen which will enable triggers to be documented and grouped (safety bundle) and this will help communication about the care of vulnerable adults in the Trust.

4 Staff understood what to do if they had safeguarding concerns but did not appear to appreciate that their actions, and the actions of other staff, could comprise neglect. Staff responsibilities in this area were also not well understood.

5 Patient and carer information about how to raise safeguarding concerns was not easily visible. The Trust had been told that public information would be available from the Solihull and Birmingham Safeguarding Boards but little progress had been made for 18 months. The Trust was addressing this gap in information for patients and carers by developing an in-house safeguarding leaflet.

6 The number of staff who had received training in safeguarding and care of vulnerable adults was low at the time of the visit but the Trust had plans for all registered nurses to complete this training by September

2011. At the time of the visit only 23% of non-clinical staff and 31% of clinical staff had undertaken training to level 2.

7 Not all patients had easy access to a television on Ward 30. Patient bedside televisions had been removed by *Patient Line* because of lack of use.

8 Reviewers were impressed that several improvements had been developed fairly recently or were being planned and It will be important to ensure that these are followed through to full implementation. Examples included a support worker for safeguarding, implementation of new policies, implementation of the Trust dementia strategy, Safeguarding Champions, closer working with social workers, and implementing patient information and discharge planning booklets.

BIRMINGHAM WOMEN'S NHS FOUNDATION TRUST

During the visit, reviewers looked at Trust-wide guidelines and policies and tested their implementation in the following clinical areas: antenatal clinic, ward 8 (gynaecology), ward 1 (antenatal inpatients), ward 4 (postnatal care).

General Comments and Achievements

The Trust provided a good environment for women and newborn children. All staff who the reviewers met were very focussed on identifying vulnerable adults and ensuring their needs were met. Multi-disciplinary working was well developed and there were good links to child protection arrangements. Work to develop female genital mutilation service was in progress and a consultant had been appointed. The Trust had done much work on 'Listening into Action' and improving feedback from patients, including implementing real-time feedback pads. Information was available in other formats for people with visual or hearing difficulties and in other languages (CDs). The Trust intranet had lots of information with easy links to safeguarding information and national policies.

Immediate Risks: None

Good Practice

1 There was a good process for communicating the learning from incidents, including the Trust 'Risky Business' newsletter and several examples of changes of organisational policy and practice.

2 A good range of specialist roles supported the care of people with mental health problems, substance misuse, teenage pregnancies and safeguarding.

3 The resources available to support safeguarding and improving care of vulnerable adults were good with one whole-time-equivalent lead plus additional support and a medical lead with time allocated for this work.

4 The Patient Adviser and Information Service were able to produce bespoke information for patients with specific needs.

5 An attractive 'Values' logo gave a clear message about the Trust's values.

Concerns

1 The safeguarding leaflet which is taken from appendix D of the Trust Safeguarding Policy conflicts with the multi-agency policy leaflet in relation to referring suspected abuse of vulnerable adults. The flow chart implies that staff may need to confirm that abuse has taken place whereas the multi agency policy suggested escalating all concerns with no judgement required. Reviewers were told that the leaflet was not due for review until 2012.

Further Consideration

1. The safeguarding training concentrated on the care of the unborn child. It may be helpful to review whether the training programme gives sufficient emphasis to safeguarding of adults.
2. Post-induction training on safeguarding and care of vulnerable adults relied on a leaflet every three years. The Trust may wish to review whether this is sufficient, especially for senior staff in clinical areas.
3. The key performance indicators relating to safeguarding and care of vulnerable adults had not yet been defined. Complaints and incident analysis did not yet separately identify vulnerable adults.
4. A great deal of work was taking place on improving care of people with learning disabilities. A draft pathway was available and a resource folder was being developed. Reviewers encouraged continuation of this work.
5. Several guidelines and policies were in draft form, including those relating to missing people, people with learning disabilities, domestic abuse and consent. (The 2009 consent policy was being revised.) It will be important that these are finalised and fully implemented.
6. The approach to staff feedback about complaints and incidents may benefit from review. Reviewers were given examples where staff had not been told about complaints and incidents in order to save them from distress.
7. *Lorenzo* had a trigger mechanism for identifying vulnerable adults but this was not working on the day of the visit. The Trust should monitor that this does function effectively.

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST

During the visit, reviewers looked at Trust-wide guidelines and policies and tested their implementation in the following clinical areas: Wards 1, 2, pre-operative assessment clinic and out-patients department.

General Comments and Achievements

Key personnel within the Trust were enthusiastic and committed to improving the care of vulnerable adults. These staff were aware of the areas that needed to be addressed and had good plans for taking these forward. Reviewers were confident that appropriate action would be taken on safeguarding issues identified to the senior team. The Trust intranet had lots of information with easy links to safeguarding information and national policies.

Immediate Risks: None

Good Practice

1. A good multi agency safeguarding referral form was in use.
2. Posters about domestic violence were displayed in ladies toilets.

Concerns

1. **Staff training**

   Most staff in clinical areas had not yet had appropriate training on safeguarding and care of vulnerable adults. Although staff would probably react appropriately to significant abuse, reviewers were not confident that more subtle clues would be noticed and appropriate action taken, including consideration of issues which may have occurred before admission or after discharge. Staff were also not clear about their responsibilities in relation to those of other agencies.

Further Consideration

1 The management of safeguarding issues was heavily dependent on two people who had limited time for this work. Because of the lack of staff training (see above) the team was dealing with issues which may more appropriately have been managed by clinical staff. Consideration should be given to greater empowerment of clinical staff and /or increasing the time available to the safeguarding team.

2 An easily accessible 'quick reference' guide for staff may be helpful as part of building their confidence in handling safeguarding issues. This could be produced quickly and its implementation supported by the staff training programme.

3 Medical staff did not appear to be involved with work to improve the care of vulnerable adults, including improving safeguarding. Greater involvement of the Medical Lead in this work may be a helpful way to achieve engagement of other medical staff.

4 Several staff commented that the Trust was a 'low risk' organisation for safeguarding and improving the care of vulnerable adults, because the organisation did not manage an Emergency Department. There was a gap in the realisation that adults might be admitted from environments where abuse had occurred or may be being transferred on to unsafe environments. There was limited appreciation of the Trust's responsibility in these potentially unsafe situations; it seemed to be the view that either the professionals involved in care prior to admission or professionals involved in the care following discharge would pick this up. Raising awareness of the orthopaedic aspects of safeguarding and the contribution of the Trust to the care of vulnerable adults may be helpful. As part of this work, continuing to build links with the discharge planning team and with voluntary groups may be beneficial.

SANDWELL & WEST BIRMINGHAM HOSPITALS NHS TRUST

During the visit, reviewers looked at Trust-wide guidelines and policies and tested their implementation in the following clinical areas: Priory 4, Priory 3, Lyndon 4 and Priory 2 at Sandwell and D21, D24, D16, D18-MAU and A&E at City Hospital.

General Comments and Achievements

Reviewers were impressed by the approach taken by Sandwell and West Birmingham Hospitals NHS Trust to improving the care of vulnerable adults in hospital. In particular, reviewers commended the caring culture of the organisation, the scope of the work undertaken and the way in which changes had been firmly embedded into practice. Medical as well as nursing staff were engaged and committed to the changes. The "You said – we did" posters provided feedback to patients, carers and staff about changes made. Excellent minutes from the Sandwell Learning Disability Board were available in easy read format. Dementia care advice across both sites was comprehensive and staff had a good understanding of how to care for patients. At City Hospital arrangements for access to specialist advice for people with learning disabilities were robust. Staff had a good understanding of advanced care planning and reasonable adjustments.

Immediate Risks: None

Good Practice

1 Board members regularly undertook 'walk-rounds' focussing on patient experience, including safeguarding.

2 The RAID service at City Hospital provided excellent support for patients with mental health problems.

3 Involvement of relatives and carers was firmly embedded into all aspects of the organisation of services as well as in the care of individual patients.

4 An excellent Trust therapeutic observation / 'specialing' policy clearly identified the level of care required.

5 A well-publicised 'Promises' logo gave a clear message about the Trust's commitment to its patients.

Concerns

1 At the time of the visit Sandwell Hospital did not have easy access to mental health assessment or to specialist clinical advice for people with learning disabilities. A band 7 liaison psychiatric nurse had just been appointed and an advert had been placed for a band 6 nurse. Interviews were planned for the day after the visit for a lead nurse for clinical advice for people with learning disabilities.

Further Consideration

1 Many audits were being undertaken. It may be helpful to review these to ensure the most efficient approach to auditing was being undertaken.

2 Some nursing documentation may benefit from being consolidated.

3 A few policies had not yet been ratified and some did not yet reflect the latest guidance.

4 The workload and approach used by the safeguarding team should be kept under review to ensure the team does not become a 'victim of its own success' and to ensure that, wherever appropriate, responsibility is taken by operational staff in clinical areas.

5 Reviewers were impressed by the work taking place on caring for people with dementia and those with challenging behaviour, including staff training, and encouraged continuation of this approach.

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

During the visit, reviewers looked at Trust-wide guidelines and policies and tested their implementation in the following clinical areas: Trauma-410, Multi-speciality Medicine 513, 514, 515 and 516.

General Comments and Achievements

Reviewers were impressed with the new hospital and the space and privacy available on the wards. The wards that were visited had a calm and quiet ambience. Visibility in the rooms and bays were very good with plenty of natural daylight. Some wards were a bit cluttered. Patients were seen being helped with feeding and patients were observed resting in the afternoon. A range of nursing metrics was available via the ward-level 'dashboard'. The Trust dignity team included an activities coordinator and a mental health facilitator. There was good evidence of governance arrangements for safeguarding and care of the vulnerable patient. The Trust was actively working with 'hard to reach' vulnerable groups in the local community.

Immediate Risks: None

Good Practice

1 There was a strong ethos on dignity across the organisation. Examples included:

   a. The Trust ran an annual conference on dignity which was well supported and attended by a wide range of voluntary and statutory organisations.

   b. Work of the dignity team across the elderly care wards was impressive and included:

      i. 'Specialing' bags with activities for use by staff for those patients. The bags also included the Trust policy for reference and the 'about me' documentation to ensure that individual needs could be documented.

ii. Communication boxes were in place across 10 wards, these included external hearing aids for use by patients who were hard of hearing, spare batteries for hearing aids, a spectacle repair box, information on interpreters and laminated sign language sheets.

iii. The activity coordinator was very visible and was highly valued by staff and patients.

iv. The team undertook 'Dignity' visits to check completion of appropriate care plans and risk assessments and make sure that the communication boxes and 'let's respect' boxes were in place. An action plan from each visit was sent to the wards (often triggered by a complaint or comment).

c. One hundred and sixty six dignity champions were in place across the Trust.

2 Reviewers were impressed that daily real-time patient surveys were undertaken by volunteers or members of the patient information team.

3 The presentation of the nursing dashboard was clear and accessible. Ward and Directorate Reports were easily accessible.

Concerns

1 Data on the proportion of staff who had undertaken expected training in safeguarding and care of vulnerable adults were not available.

Further Consideration

1 The DoLS flow chart used a limited definition for when to refer at the beginning of the flow chart. A wider definition may help to ensure that patients are appropriately referred.

2 Several projects on safeguarding and improving the care of vulnerable adults were in progress. Arrangements for evaluation and, if applicable, roll-out of these projects were not clear. In some cases several projects were taking place at the same time and it may be difficult to determine the impact of each.

3 The Trust was working to improve accountability of nursing staff and reviewers considered that this should continue to full implementation.

4 The workload and approach used by the safeguarding team should be kept under review to ensure the team does not become a 'victim of its own success' and to ensure that, wherever appropriate, responsibility is taken by operational staff in clinical areas.

5 Reviewers identified opportunities for improving patient pathways through improved collaboration with other services, for example, services for people with learning disabilities. Mechanisms for achieving effective collaboration did not appear well-developed.

6 Information on how to raise safeguarding concerns was available on televisions only and it may be helpful to raise awareness through use of other communication routes. Mechanisms for sharing best practice and feedback on learning from incidents also appeared variable and may benefit from review.

7 Nursing dashboard information was no longer available to patients and carers in the clinical areas. Reviewers felt that wider availability of this information would be helpful.

Return to *Index*

COMMISSIONING

BIRMINGHAM and SOLIHULL CLUSTER

No specific commissioning issues were identified.

APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Nigel Barton Executive Lead	Director of Operations	Coventry & Warwickshire Partnership NHS Trust
Judith Adams	Carer Involvement Lead	Carers Count
Dr Ignasi Agell	Consultant Psychiatrist & Associate Medical Director	South Staffordshire & Shropshire Healthcare NHS Foundation Trust
Jacqueline Barnes	Director of Quality and Governance	NHS Coventry
Michael Bennett	Lead Joint Commissioning & Contracting Manager	NHS Telford & Wrekin/Telford & Wrekin Council
Claire Bonniger	Divisional Nurse Director for the Medical Division	University Hospitals Coventry and Warwickshire NHS Trust
Beverley Bulloumah	General Manager of CLDT	Sandwell PCT
Colin Burbridge	Service User	
Sam Collier	Safeguarding Vulnerable Adults & Quality Lead	NHS Warwickshire
Sandra Brennan	Director of Clinical Development and Executive Lead Nurse	NHS Worcestershire
Lisa Carroll	Nurse Consultant Acute Medicine	University Hospital of North Staffordshire NHS Trust
John Copping	Carer	Carers In Partnership
Andy Dixon-Smith	Service User	
Alison Draper	Matron for Older People/Operations Safeguarding Lead	George Eliot Hospital NHS Trust
Cheryl Etches	Director of Nursing & Midwifery	Royal Wolverhampton Hospitals NHS Trust
Dr Alan Farmer	Consultant Psychiatrist/Lead Consultant Community Business Unit	Worcestershire Health and Care NHS Trust
Margaret Greer	Named Nurse for Adult Safeguarding	University Hospitals Coventry and Warwickshire NHS Trust
Nigel Haydon	Carer	Carers In Partnership
Karen Hill	Service Co-ordinator/Matron	Coventry & Warwickshire Partnership NHS Trust
Helen Inwood	Deputy Chief Nurse	University Hospital of North Staffordshire NHS Trust
Dr Philip Jones	Senior Clinician Assertive Outreach	Worcestershire Health and Care NHS Trust
Julia Kelly	Strategic Health Facilitator	Walsall Community Health

Elizabeth Kiernan	Clinical Nurse Specialists – Older People	University Hospitals Coventry and Warwickshire NHS Trust
Dr Lesley Kilshaw	LD Consultant	Coventry & Warwickshire Partnership NHS Trust
Gillian Loweth	CPN/Memory Clinic Nurse	North Staffordshire Combined Healthcare NHS Trust
Donna Luck	Team Leader	Coventry & Warwickshire Partnership NHS Trust
Dr Ahmad Mahmood	Old Age Psychiatrist	Coventry & Warwickshire Partnership NHS Trust
Rosie Musson	Head of Quality & Innovation	Dudley & Walsall Mental Health Partnership NHS Trust
Deb Norton	Team Manager – Recovery	Coventry & Warwickshire Partnership NHS Trust
Michelle Norton	Deputy Director of Nursing	Worcestershire Acute Hospitals NHS Trust
Patrick Nyarumbu	Associate Director of Patient Experience	Mid Staffordshire NHS Foundation Trust
Yvonne O'Connor	Deputy Nursing Director	Dudley Group of Hospitals NHS Foundation Trust
Ross Palmer	Modern Matron for Orthopaedics	University Hospitals Coventry and Warwickshire NHS Trust
Bobbie Petford	IAPT Training Lead and Course Lead for Postgraduate Certificate in Low intensity Psychological Interventions in Primary Care.	Wolverhampton Healthy Minds
Dr Pijush Ray	Consultant Physician and Lean Clinician for Safeguarding Adults	University Hospitals Coventry and Warwickshire NHS Trust
Donna Smart	Service User Consultant	
Pam Smith	Matron for Neonates & Paediatrics – Safeguarding Lead	Dudley Group of Hospitals NHS Foundation Trust
Dr Sara Smith	Consultant Psychiatrist	Dudley & Walsall Mental Health Partnership NHS Trust
Diane Topham	Operational, Business and Performance Manager	NHS Herefordshire
Helen Walton	Director of Nursing	South Warwickshire NHS Foundation Trust
Lois Wilson	Clinical Team Leader	Black Country Partnership NHS Foundation Trust
Amy Wood	CR/HT South Team Leader	Worcestershire Health and Care NHS Trust
Sally Wright	Learning Disability Hospital Liaison Nurse	Worcestershire Acute Hospitals NHS Trust
Mohammed Zaman	Carer	AFSUG

WMQRS Members

Jane Eminson	Acting Director	West Midlands Quality Review Service
Sarah Broomhead	Quality Manager	West Midlands Quality Review Service
Elaine Woodward	Clinical Support: Mental Health, Dementia & Learning Disabilities Lead	West Midlands Quality Review Service
John Levy	Mental Health, Dementia & Learning Disabilities Lead	West Midlands Quality Review Service
Phil Milligan	Supporting WMQRS	

Return to *Index*

Birmingham and Solihull Health Economy

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

Service	Number of Applicable QS	Number of QS Met	% met	No. services / clinical areas reviewed
Mental Health				
Birmingham and Solihull Mental Health NHS Foundation Trust - Trust-wide	11	9	82	1
Primary Care - General Practice: Birmingham & Solihull	10	6	60	-
Primary Care-Based Psychological Therapies (Birmingham only)	30	17	57	4
Birmingham & Solihull Early Intervention Services	52	32	62	4
Birmingham & Solihull Community Mental Health Teams	52	35	67	11
Birmingham & Solihull Home Treatment Teams	56	37	66	10
Birmingham & Solihull In-Patient Services (Zinnia)	50	32	64	2 of 27
Birmingham & Solihull In-Patient Services (Oleaster)	50	31	62	
Birmingham & Solihull Assertive Outreach Services	54	40	74	8
Birmingham & Solihull Joint Commissioning	15	12	80	1
Health Economy	**380**	**251**	**66**	**-**
Dementia Services				
Dementia Primary Care	10	5	50	-
Memory Services	56	29	52	1
Birmingham & Solihull Joint Commissioning	17	13	76	1
Health Economy	**83**	**47**	**57**	

Service	Number of Applicable QS	Number of QS Met	% met	No. services / clinical areas reviewed
Health Services for People with Learning Disabilities				
Primary Care	8	6	75	-
Birmingham Community Healthcare NHS Trust:				
Short Break And Day Services - Hob Moor Rd & Kingswood Drive	46	20	43	2
In-Patient Unit - Birmingham Community Assessment And Treatment Service (BCATS)	47	21	45	4
In-Patient Unit - Sayer House	45	19	42	
In-Patient Unit - Tessall Lane	46	17	37	
In-Patient Unit - Handsworth Wood	47	21	45	
Birmingham Community Health Learning Disability Service	46	20	43	-
Birmingham Joint Commissioning	17	7	41	**-**
Health Economy	**302**	**131**	**43**	**-**
Care of Vulnerable Adults in Acute Hospitals				
Heart of England NHS Foundation Trust – Acute Trust-wide	24	18	75	-
Heart of England NHS Foundation Trust – Clinical Areas (Good Hope Hospital)	17	10	59	5
Heart of England NHS Foundation Trust – Clinical Areas (Solihull Hospital)	17	11	65	8
Heart of England NHS Foundation Trust – Clinical Areas (Birmingham Heartlands Hospital)	17	11	65	7
Birmingham Women's NHS Foundation Trust – Acute Trust-wide	24	14	58	-
Birmingham Women's NHS Foundation Trust – Clinical Areas	16	7	44	4
Royal Orthopaedic Hospital NHS Trust – Acute Trust-wide	24	14	58	-
Royal Orthopaedic Hospital NHS Trust – Clinical Areas	17	9	53	4
Sandwell & West Birmingham Hospital NHS Trust – Acute Trust-wide	24	20	83	-
Sandwell & West Birmingham Hospital NHS Trust – Clinical Areas (City Hospital)	17	15	88	6
Sandwell & West Birmingham Hospital NHS Trust – Clinical Areas (Sandwell Hospital)	17	15	88	4
University Hospitals Birmingham NHS Foundation Trust – Acute Trust-wide	24	16	67	-

Service	Number of Applicable QS	Number of QS Met	% met	No. services / clinical areas reviewed
University Hospitals Birmingham NHS Foundation Trust – Clinical Areas	17	10	59	5
Birmingham & Solihull Cluster Commissioning	3	3	100	1
Health Economy	**258**	**173**	**67**	-
TOTALS				
Birmingham and Solihull Mental Health NHS Foundation Trust	**409**	**261**	**64**	-
Birmingham Community Healthcare NHS Trust	**277**	**118**	**43**	-
Heart of England NHS Foundation Trust	**75**	**50**	**67**	-
Birmingham Women's NHS Foundation Trust	**40**	**21**	**53**	-
Royal Orthopaedic Hospital NHS Trust	**41**	**23**	**56**	-
Sandwell & West Birmingham Hospital NHS Trust	**58**	**50**	**86**	-
University Hospitals Birmingham NHS Foundation Trust	**41**	**26**	**63**	-
Birmingham and Solihull Cluster Primary Care and Commissioning*	**79**	**55**	**70**	-
Health Economy	**1023**	**602**	**59**	-

- ***NB this does not include Solihull for commissioning of health services for people with learning disabilities***

Details of compliance with individual Quality Standards are in a separate document.

Return to *Index*