WM QRS West Midlands Quality Review Service

NHS

Transfer from Acute Hospital Care and Intermediate Care

East Staffordshire Health and Social Care Economy

Visit Date: 20th and 21st January 2015 Report Date: May 2015

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INTRODUCTION

This report presents the findings of the review of services for the transfer of care from acute hospital and intermediate care services that took place on 20th and 21st January 2015. The purpose of the visit was to review compliance with the following West Midlands Quality Review Service (WMQRS) Quality Standards:

- Transfer from Acute Hospital Care and Intermediate Care, V1 August 2014

The aim of the standards and the review programme is to help providers and commissioners of services to improve clinical outcomes and service users' and carers' experiences by improving the quality of services. The report also gives external assurance of the care 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 team that reviewed the services in East Staffordshire. Appendix 2 contains the details of compliance with each of the standards and the percentage of standards met.

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

- Burton Hospitals NHS Foundation Trust
- Staffordshire and Stoke on Trent Partnership NHS Trust
- East Staffordshire Clinical Commissioning Group
- South Staffordshire and Seisdon Clinical Commissioning Group

Social care is fundamental to the pathway for transfer from acute hospital care and intermediate care and some aspects of this report cover providers and commissioners of social care in North Staffordshire and Stoke on Trent or jointly provided or commissioned services. Actions by commissioners and providers of social care maybe required in order to address the issues identified in this report.

Most of the issues identified by quality reviews can be resolved by providers' and commissioners' own governance arrangements. Many can be tackled by the use of appropriate service improvement approaches; some require action by both health and/or local authority commissioners of services. Individual organisations are responsible for taking action and monitoring this through their usual governance mechanisms. The lead commissioner for the service concerned is responsible for ensuring action plans are in place and monitoring their implementation, liaising, as appropriate, with other commissioners, including commissioners of primary care. The lead commissioner in relation to this report is East Staffordshire Clinical Commissioning Group.

ABOUT WEST MIDLANDS QUALITY REVIEW SERVICE

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

Expected outcomes are better quality, safety and clinical outcomes, better patient and carer experience, organisations with better information about the quality of clinical services, and organisations with more confidence and competence in reviewing the quality of clinical services. More detail about the work of WMQRS is available on www.wmqrs.nhs.uk

ACKNOWLEDGMENTS

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

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TRANSFER FROM ACUTE HOSPITAL CARE AND INTERMEDIATE CARE

HEALTH AND SOCIAL CARE ECONOMY

Services Reviewed

This visit reviewed the following services in the East Staffordshire health and social care economy:

Service
Primary Care
Acute Trust-wide: • Queen's Hospital, Burton (Burton Hospitals NHS Foundation Trust)
Intermediate Care: • Community Intervention Service (Staffordshire and Stoke on Trent Partnership NHS Trust) • Community Hospitals: Sir Robert Peel, Tamworth and Samuel Johnson, Lichfield (Burton Hospitals NHS Foundation Trust) • Barton under Needwood Health and Community Care Centre (Shaw Healthcare)
Commissioning: • East Staffordshire Clinical Commissioning Group • South Staffordshire and Seisdon Clinical Commissioning Group

As well as looking at relevant documentation, reviewers visited facilities, met patients, relatives and staff, and looked at case notes in the Tamworth and Lichfield Community Hospitals, in Queen's Hospital, Burton, and in the Barton under Needwood Health and Community Care Centre. Reviewers also visited Edwin House, met staff and looked at case notes for the Community Intervention Service. Detail of compliance with Quality Standards was not reviewed for Barton under Needwood Health and Community Care Centre or for South Staffordshire and Seisdon Clinical Commissioning Group.

Some issues crossed the whole patient pathway and are described in this 'health and social care economy' section of the report.

General Comments

This was the first of the West Midlands peer review visits looking at 'Transfer from Acute Hospital Care and Intermediate Care' and took place soon after a very pressured Christmas and New Year period for acute hospital staff. The health and social care economy should be commended for having managed the visit in these circumstances. As this was a first visit using new Standards, levels of compliance with Quality Standards are likely to be lower than the levels for health and social care economies that are reviewed later in the programme. This should not be of concern so long as progress continues to be made towards achieving all applicable Quality Standards.

Reviewers also commented on the accuracy of the self-assessments provided by the health and social care economy, the welcoming attitude of staff and their good and innovative ideas for improving local services.

'Care Home Select' was being used effectively to support discharge from hospital (acute and community), including to research options for achieving discharge. Staffordshire and Stoke on Trent Partnership Trust (SSoTP)

was working with West Midlands Ambulance Service on the implementation of 'Emergency Care Plans' with the aim of reducing inappropriate admissions.

Good Practice

1 Medicines reconciliation was well implemented in all Burton Hospitals NHS Foundation Trust services visited by reviewers. Prescribing pharmacists were available on all sites and took a proactive approach to medicines reconciliation, including writing in patients' hospital notes

Immediate Risks: No immediate risks were identified.

Concerns

1 **Availability of domiciliary care packages**

Reviewers heard from several sources about difficulties and delays in the availability of domiciliary care packages. This was resulting in delays in transfer home from acute wards, community hospitals and the Community Intervention Service (CIS). Reviewers were told that care packages were sometimes not available until later in the day, which made achieving 'home for lunch' difficult. Significant capacity (approx. 150 hours of care) within 'Living Independently Staffordshire' (LIS) was taken up by people waiting for maintenance domiciliary care packages and, as a result, the available capacity for intermediate care/re-ablement was severely reduced.

Further Consideration

1 **Domiciliary care packages**

Reviewers were told, but were unable to confirm, that the problems in availability of domiciliary care packages arose because only two providers were commissioned to provide domiciliary care, and these providers had difficulty retaining staff because carers were not paid for their travel time. Travel can make up a significant part of the day, especially in rural areas, and actual pay was therefore less than could be earned in local supermarkets.

Within the time available reviewers were not able to quantify the extent of problems in transfer home resulting from the lack of availability of domiciliary care packages. Reviewers suggested that this study should be undertaken in the near future so that an impact assessment of domiciliary care commissioning decisions could be made.

2 **Transfer from acute hospital to intermediate care**

Reviewers considered that several aspects of the transfer from Queen's Hospital to intermediate care services may benefit from further consideration:

a. Criteria were in place for intermediate care provided by the Community Intervention Service (CIS), Living Independently Staffordshire (LIS), commissioned intermediate care beds from independent providers and the community hospitals in Lichfield and Tamworth. Reviewers were told that the criteria were not implemented consistently in Sir Robert Peel Community Hospital. Reviewers also saw some evidence of hospital staff considering community hospitals as the 'default' option. On the day of the acute hospital visit, reviewers saw patients waiting for community hospital beds when reviewers considered that they could have been transferred home with support from the CIS or LIS. There may also be the potential for further development of links between the Emergency Department and the CIS, as Emergency Department staff appeared unaware of the availability of the CIS or the range of therapies offered. Decisions to transfer patients to community hospitals appeared to be taken without knowledge of the availability of beds or the likely length of the wait for a bed.

b. 'Trusted assessors' were not yet in place. Some staff said that the Discharge Liaison Team were 'trusted assessors' but, in practice, it appeared that the CIS team came into hospital to make their own assessments, local GPs decided on whether patients could be admitted to Sir Robert Peel Community Hospital, and a telephone discussion took place with staff at Samuel Johnson Community

Hospital. Care home staff came into hospital to do their own assessment. Reviewers were told of delays in transfer of care while patients waited for a care home assessment even though Social Services would fund placements until a full assessment had been completed. Some staff did not appear to be aware of this agreement. Reviewers considered that implementing a 'trusted assessor' model could reduce delays and reduce multiple assessments.

c. Administration of the waiting lists for the Lichfield and Tamworth community hospitals was well organised, but the arrangements for clinical review were less clear. Reviewers considered that some patients waiting for a community hospital bed may have improved sufficiently to go straight home with support from the CIS or LIS, but would still be transferred to a community hospital because this was what had been planned initially. Responsibility for the active rehabilitation of patients waiting for community hospital beds was also not clear. Reviewers saw patients waiting for a community hospital bed who did not have a clear 'rehabilitation plan'. Processes for reviewing the need for a community hospital bed were also not evident.

d. The waiting list model in the Lichfield and Tamworth Community Hospitals was different from that at Barton under Needwood, which did not allow a waiting list and so could be used for admission avoidance or diversion from the Emergency Department or Acute Admissions Unit. The benefits of the different waiting list models may be worthy of further consideration.

3 **Intermediate care**

Reviewers considered that the following aspects of intermediate care services may benefit from further consideration:

a. Reviewers considered that the range of intermediate care provided by the community hospitals could be enhanced, in particular through the provision of more 'sub-acute' therapies. Reviewers observed that several of the patients in Samuel Johnson Community Hospital appeared to be waiting for care home or continuing healthcare placements with some very long lengths of stay, and that many of the patients at Barton under Needwood Health and Community Care Centre could have been cared for at home with community support. Sub-acute care (for example, intravenous antibiotics, PEG and nasogastric feeding, or deep vein thrombosis treatment) was available from the CIS but not in the community hospitals, although Samuel Johnson had recently started caring for patients on intravenous antibiotics and there were plans for staff at Sir Robert Peel to receive training in this. The CIS cared for patients from East Staffordshire only and so patients from some other areas did not, in practice, have access to sub-acute care outside the acute hospital.

b. Arrangements for the care of patients with a new PEG feed (rather than an established PEG) were not clear, and reviewers heard several different versions of where these patients could receive care. Arrangements for the care of patients needing VAC therapy were also unclear. Clarifying these arrangements, including, if necessary, training appropriate carers (family and paid) and community-based staff, may be helpful.

4 **'Patient Passport'**

Several 'patient passports' were in use but none of these appeared to function effectively as a 'passport' (i.e. to contain information about a patient and their care that could be easily transferred to another care setting). Community services had a yellow folder containing comprehensive information about the patient and their care but reviewers were told that this did not usually go with the patient into hospital because the folder 'got lost'. The Lichfield and Tamworth community hospitals had a yellow discharge folder into which information relevant to the patient's transfer home was placed. There did not, however, appear to be any standardisation of the information put into the folder. Queen's Hospital used an electronic 'patient passport' that was not accessible by the community hospitals, the CIS, community services or primary care. The 'patient passport' was written in lay language but did not appear to be shared with the patient or their carers.

5 **Shared learning**

Arrangements for shared learning from Serious Incidents were in place. Arrangements for shared learning across the 'transfer from acute hospital care and intermediate care' pathway, including from incidents, 'near misses', good practice, complaints and suggestions, were not yet in place. Reviewers suggested that introducing 'shared learning' for this pathway could help to drive improvements.

6 **Other issues**

The following issues also came to reviewers' attention:

a. Social care assessments were not yet available within 24 hours of request because social services staff had not yet introduced 'seven day working'.

b. Reviewers were told that most care homes would accept a maximum of two patients per day and would not exceed this number, even for patients who had been admitted to hospital from the care home. Reviewers suggested that commissioning levers could be used to address this issue, especially for people transferring back to the home from which they had been admitted.

c. The system for counting 'delayed transfers of care' for patients transferring to community hospitals was not clear and it appeared that 'the clock started again' on admission to a community hospital, with a new Section 2 form being submitted. If this is correct, data on delayed transfers of care may be underestimating the true picture.

d. Reviewers were told that some district nurses would not change tubes on PEG feeds for patients discharged from hospital until the GP had visited the patient.

e. Several examples of operational problems, delays in patient transport and problems with links with NSL (provider of a non-emergency patient transport service) were brought to reviewers' attention. It may be helpful either to establish a forum for relevant staff to talk to NSL or to involve NSL in the 'shared learning' arrangements (see above).

f. Arrangements for accessing *Age UK* and other voluntary sector services may benefit from review. Reviewers were told that these services had previously had a presence in Queen's Hospital but that this link had been lost.

g. Throughout the visit, arrangements for transfer home for people from the Uttoxeter area were unclear. In the time available reviewers were not able to establish whether this was because services were not available in that area or because services were available but staff were unaware of them.

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PRIMARY CARE

Primary care is involved in several aspects of this report. Specific issues related to primary care that were identified during this review visit were:

Concerns

1 **Medical responsibility: Community Intervention Service, Concern 1**

It was not clear who was taking medical responsibility for patients of the CIS. GPs who referred patients directly to the service took medical responsibility for their patients. Commissioner representatives who met the visiting team said that GPs also took medical responsibility for patients transferred home with support from the CIS. GPs who met the visiting team said that GPs did not have this responsibility. In practice, it appeared that arrangements depended on who was the patient's GP, with some GPs being prepared to accept medical responsibility and others not. The arrangements also appeared to depend on the patient's medication. Reviewers were told that some patients were transferred to the CIS with medication that could

be prescribed only by consultants. These patients sometimes had to be re-admitted in order to have changes to their medication.

Further Consideration

1 **Transfer from acute hospital to intermediate care : Health and Social care economy, Further Consideration 2**

Reviewers considered that several aspects of the transfer from Queen's Hospital to intermediate care services may benefit from further consideration:

a. Criteria were in place for intermediate care provided by the Community Intervention Service (CIS), Living Independently Staffordshire (LIS), commissioned intermediate care beds from independent providers and the community hospitals in Lichfield and Tamworth. Reviewers were told that the criteria were not implemented consistently in Sir Robert Peel Community Hospital. Reviewers also saw some evidence of hospital staff considering community hospitals as the 'default' option. On the day of the acute hospital visit, reviewers saw patients waiting for community hospital beds when reviewers considered that they could have been transferred home with support from the CIS or LIS. There may also be the potential for further development of links between the Emergency Department and the CIS, as Emergency Department staff appeared unaware of the availability of the CIS or the range of therapies offered. Decisions to transfer patients to community hospitals appeared to be taken without knowledge of the availability of beds or the likely length of the wait for a bed.

b. 'Trusted assessors' were not yet in place. Some staff said that the Discharge Liaison Team were 'trusted assessors' but, in practice, it appeared that the CIS team came into hospital to make their own assessments, local GPs decided on whether patients could be admitted to Sir Robert Peel Community Hospital, and a telephone discussion took place with staff at Samuel Johnson Community Hospital. Care home staff came into hospital to do their own assessment. Reviewers were told of delays in transfer of care while patients waited for a care home assessment even though Social Services would fund placements until a full assessment had been completed. Some staff did not appear to be aware of this agreement. Reviewers considered that implementing a 'trusted assessor' model could reduce delays and reduce multiple assessments.

c. Administration of the waiting lists for the Lichfield and Tamworth community hospitals was well organised, but the arrangements for clinical review were less clear. Reviewers considered that some patients waiting for a community hospital bed may have improved sufficiently to go straight home with support from the CIS or LIS, but would still be transferred to a community hospital because this was what had been planned initially. Responsibility for the active rehabilitation of patients waiting for community hospital beds was also not clear. Reviewers saw patients waiting for a community hospital bed who did not have a clear 'rehabilitation plan'. Processes for reviewing the need for a community hospital bed were also not evident.

d. The waiting list model in the Lichfield and Tamworth Community Hospitals was different from that at Barton under Needwood, which did not allow a waiting list and so could be used for admission avoidance or diversion from the Emergency Department or Acute Admissions Unit. The benefits of the different waiting list models may be worthy of further consideration.

2 **'Transfer of care' letters: Acute hospital, Further Consideration 1**

Arrangements for documenting the transfer of care from the acute hospital may benefit from review. Some of the medical discharge letters had little detail of the acute care the patients had received. The 'nursing discharge' section was completed on Ward 5 and was sent to the GP by the ward clerk, but it was not clear that this was standard practice across Queen's Hospital. Nursing and medical discharge letters were sent separately. Medical discharge letters were either emailed or posted to GPs (arrangements varied) and were not copied to the patient or given to them to take home. Nursing discharge documentation (short and long versions) was taken home by the patient. Ward staff tried to contact GPs by telephone about patients who

were frequently admitted to hospital or were at high risk of re-admission, but they did not always manage to speak to the GPs.

3 **Sir Robert Peel Community Hospital: Further Consideration 1**

Consistency of medical input: Four practices cared for their own patients while they were in Sir Robert Peel Community Hospital, whereas other patients were under the care of a GP who visited the hospital every lunchtime. Reviewers were told of inconsistent decision-making, including inconsistent interpretation of the criteria for admission. It may be helpful to look at this in more detail in order to understand the impact on individual patient care as well as on the use of resources.

ADMISSION AVOIDANCE

Admission avoidance was provided by the Community Intervention Service and, if a bed was available, by the Barton under Needwood Health and Community Care Centre. Reviewers' findings in relation to both services are given below.

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ACUTE HOSPITAL

QUEEN'S HOSPITAL, BURTON (BURTON HOSPITALS NHS FOUNDATION TRUST)

Queen's Hospital, Burton provided acute hospital services comprising an Emergency Department, an Acute Assessment Ward, a Short-stay Unit and 12 further wards for medicine, care of older people and surgical and orthopaedic pathways. (Maternity, neonatal and paediatric services were outside the scope of this review.)

General Comments and Achievements

Reviewers were impressed with many aspects of the care provided at Queen's Hospital, Burton. 'Board rounds' were well established in all wards of the hospital. Weekly meetings reviewed the care of patients with over six days' length of stay. An Advanced Nurse Practitioner (ANP) 'Frailty Assessment' process had been implemented across the acute hospital, and the Trust was auditing whether implementation of the process reduced lengths of stay in hospital. Allied health professionals were working well together, were providing a seven day service (although with reduced staffing levels) and had good links with the discharge team. Plans for rotation of allied health professionals between acute and community posts were also being developed.

Good Practice

1 Good educational materials and tools had been developed for training staff on transfer of care from the acute wards.

2 Frailty screening took place in the Emergency Department. For patients identified as 'frail', the Frailty Team undertook a **c**omprehensive geriatric assessment and actively managed the patients' care for the first 72 hours of their admission, wherever they were in the hospital. Care was then handed over to whichever team (hospital or community) was providing ongoing care for the patient. The Frailty Team was proactive and flexible.

3 The 'Board Round' in Ward 5 (respiratory ward) was particularly impressive. A discharge liaison nurse was attached to the ward, and links with the Community Intervention Service appeared to work particularly well. In the week before the visit 29 patients had been discharged from the ward. The Ward Sister was proactive and provided good leadership. Consultants, junior doctors and therapists all attended the Board Round. The workload for the day was agreed and doctors did not normally leave the ward until the actions allocated to them had been completed.

4 Pharmacy-related timescales were particularly good, with prescribing to pharmacy verification usually taking place in less than one hour.

5 A 'front door pilot' was being tried. The Discharge Team included a 'rapid access assessor' who would bring the carer in to meet the patient. The 'rapid access assessor' and the future carer then completed all documentation together. This significantly reduced duplication from the patient's perspective and meant that the patient had met the person who would be looking after them when they came out of hospital.

6 A 'Trauma Board' electronic tool was in use. This allowed the team to go through all trauma-related admissions, ensure handover from the on-call team and agree prioritisation for theatre lists. The Trauma Coordinator was actively managing the care of patients with trauma. The 'Trauma Board' was led by consultants but attended by junior doctors and used as a teaching session for them.

Immediate Risks: No immediate risks were identified.

Concerns: No concerns were identified.

Further Consideration

1 **'Transfer of care' letters**

Arrangements for documenting the transfer of care from the acute hospital may benefit from review. Some of the medical discharge letters had little detail of the acute care the patients had received. The 'nursing discharge' section was completed on Ward 5 and was sent to the GP by the ward clerk, but it was not clear that this was standard practice across Queen's Hospital. Nursing and medical discharge letters were sent separately. Medical discharge letters were either emailed or posted to GPs (arrangements varied) and were not copied to the patient or given to them to take home. Nursing discharge documentation (short and long versions) was taken home by the patient. Ward staff tried to contact GPs by telephone about patients who were frequently admitted to hospital or were at high risk of re-admission, but they did not always manage to speak to the GPs.

2 **Transfer of Care Plan**

Patients' electronic records included their 'transfer of care plan'. It was not clear how patients and carers saw and agreed the content of this plan, or how they knew what was being considered. The ward white board identified who was involved in discussions about the transfer of care, including the expected date of discharge, and this may have been communicated verbally to patients and carers.

3 **Discharge Team**

The Discharge Team had no administrative support, and clinical time was clearly being used for administrative work. Reviewers considered this was not the best use of the resources available. The Discharge Team had compiled a directory of local voluntary organisations offering care, and reviewers suggested that this could usefully be made available to ward staff who were unaware of its existence.

4 **Frailty Team**

The Frailty Team did not include a social worker. The team could access social work support but it was not an integral part of the team. Reviewers considered that including a social worker within the team could significantly improve its effectiveness. The team felt they were hindered by a shortage of consultant geriatricians. Reviewers considered that more innovative and creative models may need to be explored in order to attract new consultants.

5 **Carers' support**

The Frailty Team was aware of local carers' support groups and other mechanisms for accessing support for carers. Other staff within the hospital were less aware of the available support for carers. Reviewers suggested that appropriate posters and information about carers' support may be helpful for staff and for carers themselves.

6 **Other issues**

a. Queen's Hospital did not hold a 'buffer stock' of equipment for Leicestershire patients. Equipment for Leicestershire patients was therefore given out and then collected by Trust staff. This appeared a poor use of staff time, and reviewers suggested further discussions with Leicestershire about a 'buffer stock' of equipment.

b. Reviewers were told of some operational issues in relation to prescribing, including 'drugs to take out' being dispensed but the patient not being discharged. More shared learning between ward and pharmacy staff may help such issues to be addressed by the staff involved.

c. Advanced Nurse Practitioners (ANPs) in the Frailty Team did not have authority to discharge patients from Queen's Hospital. Reviewers suggested that introducing 'criteria' or 'event'-led discharge by ANPs would be helpful.

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INTERMEDIATE CARE

COMMUNITY INTERVENTION SERVICE (STAFFORDSHIRE AND STOKE ON TRENT PARTNERSHIP NHS TRUST)

General Comments and Achievements

East Staffs Community Intervention Service (CIS) provided services in Burton, Uttoxeter and surrounding villages, and supported 19 GP practices. These services were provided within Queen's Hospital, intermediate care beds and community settings. The team provided intensive rapid response to meet both medical and social needs for patients over the age of 16. Hospital cover was available Monday to Friday 8.30am to 5pm and the community service was available 7am to 7pm, seven days a week.

Reviewers were highly impressed by the work of the CIS.

Good Practice

1 The CIS as a whole was considered to be an example of good practice. The service provided integrated health and social care and was fully integrated across professional disciplines, including social work, nursing, physiotherapy, occupational therapy, and staff with particular expertise in the care of people with mental health problems. A robust intravenous therapy service was provided, including for people with chest infections, cellulitis and urinary tract infections. Staffing levels were appropriate for the service provided, and role development had been taken forward creatively; for example, the introduction of band 4 assistant practitioners in order to help staff retention. Staff had access to laptops so patient updates could be communicated quickly and easily. The inspirational and knowledgeable leadership of the team had been key to these achievements (although this was a fixed term appointment and more permanent arrangements were not clear.)

Immediate Risks: No immediate risks were identified.

Concerns

1 **Medical responsibility**

It was not clear who was taking medical responsibility for patients of the CIS. GPs who referred patients directly to the service took medical responsibility for their patients. Commissioner representatives who met the visiting team said that GPs also took medical responsibility for patients transferred home with support from the CIS. GPs who met the visiting team said that GPs did not have this responsibility. In practice, it appeared that arrangements depended on who was the patient's GP, with some GPs being prepared to accept medical responsibility and others not. The arrangements also appeared to depend on the patient's medication. Reviewers were told that some patients were transferred to the CIS with medication that could

be prescribed only by consultants. These patients sometimes had to be re-admitted in order to have changes to their medication.

2 **Clinical guidelines**

Clinical guidelines specific to the CIS, including for the intravenous antibiotic pathway, were not yet documented. Some Trust guidelines were available but these were not usually in a format or detail appropriate for the CIS. As a result, it was not always clear who was responsible for implementing different aspects of care.

Further Consideration

1 Staff training on the care of people with PEG feeds was in progress and reviewers encouraged continuation of this.

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SIR ROPERT PEEL AND SAMUEL JOHNSON COMMUNITY HOSPITALS (BURTON HOSPITALS NHS FOUNDATION TRUST)

Sir Robert Peel Community Hospital, Tamworth provided intermediate care in a 24-bedded ward. Samuel Johnson Community Hospital, Lichfield had two wards (Anna and Darwin Wards). These usually ran at 23 beds, but three additional beds on each ward were opened in December 2014 to support capacity and flow. Out-patient and minor injuries services were available at both hospitals. Samuel Johnson Community Hospital also provided a midwife-led birthing unit, whereas Sir Robert Peel Community Hospital had an operating theatre and a day case ward.

General Comments and Achievements

Intermediate care in both Community Hospitals was mainly led by nurses and therapists, with all staff working hard to provide care that was as good as possible. Board rounds took place daily in both Sir Robert Peel and Samuel Johnson Community Hospitals. Weekly meetings reviewed the care of patients with over six days' length of stay. Admission criteria were flexed when capacity at Queen's Hospital was on higher levels of escalation. A Frailty Screening Tool had recently been introduced. Prior to leaving the community hospitals, patients were given a yellow folder with relevant information about services and their future care. Patients at high risk of re-admission were given emergency contact numbers for social care. A discharge nurse (18 hours per week) worked across both community hospitals facilitating the transfer of patients with more complex needs.

Good Practice

1 The 'patient at a glance' whiteboards had a flap that ensured confidentiality of patients' names.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Access to Therapies**

a. Physiotherapy and Occupational Therapy

Physiotherapy and occupational therapy were available from Monday to Friday and Saturday morning only. This meant that active rehabilitation and discharge from the community hospitals made little progress at weekends.

b. Dietetics and Speech and Language Therapy

At Samuel Johnson Community Hospital the dietician was in the hospital on Tuesdays, and the speech and language therapist on Wednesday and Fridays. At Sir Robert Peel Community Hospital both services were available five days a week but by referral only, with no time allocated for their work in

the community hospitals. The lack of easy availability of these therapies delayed patient pathways and impacted adversely on multi-disciplinary rehabilitation and re-ablement for patients.

Further Consideration

1 Social workers were present at 'Board Rounds' on some days but not every day. Reviewers were told of delays of more than 72 hours in allocating a social worker after completion of the Section 2 form.

2 Use of the day rooms may benefit from review. At Sir Robert Peel Community Hospital the day room appeared to be a storage area and was not set up to support active rehabilitation of patients. On the day of the review visit many of the patients at Samuel Johnson Community Hospital were too dependent to make use of the day room.

3 Staff did not have full access to the Queen's Hospital electronic patient records. Some staff had read-only access but could not update patients' records. Electronic prescribing records were transcribed onto paper when patients were admitted to the community hospitals, which was labour intensive and could lead to transcription errors. Community hospital records were not scanned into the Queen's Hospital system, and so information on patients' stays in the community hospital was not accessible to acute hospital staff. The Trust had plans to address this issue within the next two years.

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SIR ROBERT PEEL COMMUNITY HOSPITAL, TAMWORTH (BURTON HOSPITALS NHS FOUNDATION TRUST)

General Comments and Achievements

Sir Robert Peel Community Hospital had a relaxed and friendly atmosphere. Open visiting arrangements were in place, and reviewers were told that this made communication with relatives easier. The team was planning to start offering intravenous therapy. Medical responsibility for patients was taken by GPs, but there was good access to consultant opinion for appropriate patients.

Good Practice

1 Care planning and goal setting were well-organised, and started as soon as the patient was admitted to the community hospital. Both the patient and their family were actively involved in the development of care plans and goals.

Further Consideration

1 Consistency of medical input: Four practices cared for their own patients while they were in Sir Robert Peel Community Hospital, whereas other patients were under the care of a GP who visited the hospital every lunchtime. Reviewers were told of inconsistent decision-making, including inconsistent interpretation of the criteria for admission. It may be helpful to look at this in more detail in order to understand the impact on individual patient care as well as on the use of resources.

2 Sir Robert Peel Community Hospital had pharmacy prescribers but no nurse prescribers. Introduction of nurse prescribers may help to avoid delays while waiting for the GP or pharmacist to arrive.

3 Although care plans were very good, they did not identify the role of staff who had agreed the plan. It may be helpful to add this information to the plan.

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SAMUEL JOHNSON COMMUNITY HOSPITAL, LICHFIELD (BURTON HOSPITALS NHS FOUNDATION TRUST)

General Comments and Achievements

A consultant geriatrician attended one day each week and a staff grade doctor was available on weekdays. Both nurse and pharmacist prescribers were available. Several developments had been implemented, including the

introduction of intravenous therapy. Work was also being undertaken to improve communication with patients and relatives, following concerns identified in a recent patient experience survey.

On the day of the visit the acuity of the patients was high, with many requiring support to mobilise with the use of hoists. It appeared to reviewers that many patients were awaiting a long-term care placement and, in practice, were not receiving intermediate care.

Good Practice

1 Staff phoned relatives when patients were ready to leave the hospital so that relatives did not have to wait around in the hospital.

2 Both nurse and pharmacy prescribers were available.

3 Dementia liaison nurses were actively working with patients and as part of the multi-disciplinary team.

Concerns

1 **Patient Records and Care Plans**

Some patients' records and care plans seen by reviewers had been photocopied many times and were barely legible. Patients' records were not in any logical order. No care plans were evident in the notes seen by reviewers. Reviewers also saw no evidence of patient and carer involvement in care planning and goal setting.

2 **Patients' length of stay**

On the day of the visit the length of stay of most of the patients in Samuel Johnson Community Hospital exceeded 10 days. Nine of the 23 patients on Anna Ward had been in the Community Hospital for over 50 days. Only three patients on Darwin Ward had lengths of stay in single figures, and nine of the 25 on Darwin Ward had complex needs. The majority of patients were in bed, and reviewers saw little evidence of active rehabilitation or of making the environment and care as home-like as possible for long-stay patients. Reviewers commented that staff appeared to accept the long lengths of stay as normal.

3 **Nurse Staffing – Darwin Ward**

Nurse staffing levels on Darwin Ward had been increased shortly before the review, but the ward was still heavily reliant on temporary staff. Twenty-five shifts per week were covered by temporary staff. Staffing levels for 26 beds (including three 'winter pressure' beds) were:

Early: four registered / three non-registered; Late: three registered / three non-registered; Nights: two registered / two non-registered.

Staffing for the night shift appeared low in relation to the acuity of the patients on the ward. A supervisory Sister was available Monday to Friday only.

Further Consideration

1 It may be helpful to introduce a review meeting later in the day in order to identify whether actions agreed in the morning board round had been completed and whether further action was needed. This system appeared to be working well in Sir Robert Peel Community Hospital.

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BARTON UNDER NEEDWOOD HEALTH AND COMMUNITY CARE CENTRE – SHAW HEALTHCARE

General Comments and Achievements

The Barton under Needwood Health and Community Care Centre (Shaw Healthcare) provided seven intermediate care and two palliative care beds, commissioned by East Staffordshire Clinical Commissioning Group. Four respite beds were also available. Only patients of low dependency were admitted, and patients stayed for a maximum of

six weeks. Physiotherapy and occupational therapy input was provided by South Staffordshire and Stoke on Trent Partnership NHS Trust. Good team-working was evident and roles and responsibilities were clearly identified. Care plans were 'patient-centred' and care was adapted to meet the changing needs of patients. If a bed was available, patients were admitted in order to avoid an acute admission.

Good Practice

1 Care was coordinated by a Band 4 physiotherapy assistant from Staffordshire and Stoke on Trent Partnership NHS Trust who acted as a 'Care Navigator' for patients.

2 A good therapy leaflet was available, which provided relevant information for patients and staff.

3 Patients and carers were clearly involved in developing and agreeing care plans. Nursing care plans were individualised and included an appropriate range of assessments and also 'life maps'.

Immediate Risks: No immediate risks were identified.

Concerns: No concerns were identified.

Further Consideration

Reviewers were told that delays in obtaining oxygen concentrators meant that patients were sometimes admitted to Queen's Hospital just to access oxygen.

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COMMISSIONING

General Comments and Achievements

East Staffordshire Clinical Commissioning Group (CCG) commissioned the acute hospital parts of the 'transfer from acute hospital care and intermediate care' pathway, with South Staffordshire and Seisdon CCG commissioning community hospital beds. South Staffordshire and Seisdon CCG was working on de-commissioning and re-commissioning community bed services.

Immediate Risks: No immediate risks were identified.

Concerns

Concerns identified elsewhere in this report will require the involvement of commissioners to ensure they are addressed:

1 Availability of domiciliary care packages: See health and social care economy section of this report.

2 Medical responsibility: See Community Intervention Service, Concern 1

3 Access to Therapies: See Sir Robert Peel and Samuel Johnson Community Hospitals, Concern 1

4 Patient Records and Care Plans: Samuel Johnson Community Hospital, Concern 1

5 Patients' length of stay: Samuel Johnson Community Hospital, Concern 2

6 Nurse Staffing – Darwin Ward: See Samuel Johnson Community Hospital, Concern 3

Further Consideration

1 Reviewers commented that commissioners did not appear to be actively involved in supporting providers in addressing issues, especially those involving multiple providers or those that crossed the whole patient pathway. In reviewers' experience, a more involved approach from commissioners could be helpful for these circumstances.

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APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Visiting Team

Ann Carey	Divisional Director of Nursing - Medicine	Worcestershire Acute Hospitals NHS Trust
Amanda Futers	Clinical Nurse Specialist Older Adults	University Hospital of North Staffordshire NHS Trust
Dr Simon Harlin	GP Lead, Frail Elderly Pathway	Walsall Healthcare NHS Trust
Gina Jones	Community Matron	Coventry & Warwickshire Partnership NHS Trust
Marcelle Rollings	Divisional Clinical Pathways Lead/NMP Lead	Black Country Partnership NHS Foundation Trust
Judith Whalley	Patient Representative	

Observer

Andy Matthews	Patient Representative	

WMQRS Team

Jane Eminson	Acting Director	West Midlands Quality Review Service
Sarah Broomhead	Assistant Director	West Midlands Quality Review Service
Jane Smith	Clinical Lead	West Midlands Quality Review Service

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APPENDIX 2 COMPLIANCE WITH THE QUALITY STANDARDS

Analyses of percentage compliance with the Quality Standards should be viewed with caution as they give the same weight to each of the Quality Standards. Also, the number of Quality Standards applicable to each service varies 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
Transfer from Acute Hospital Care and Intermediate Care			
Primary Care	2	0	0
Acute Hospital	23	6	26
Intermediate Care Service	66	28	42
Sir Robert Peel and Samuel Johnson Community Hospitals	(33)	(11)	(33)
Community Intervention Service	(33)	(17)	(52)
Commissioning	4	0	0
Health and Social Care Economy	**95**	**34**	**36**

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PRIMARY CARE

Ref	Standard	Met?	Comment
SA-101	**Patients at High Risk of Admission** Patients at high risk of admission to an acute hospital should have a 'Patient Passport' or equivalent patient-held record that covers: a. Diagnoses b. Allergies c. Medication d. Care package (or equivalent) e. Name and contact details of GP f. Name and contact details of main carer/s g. Advice for the patient and their carers on likely problems and what to do in an emergency h. Advice to emergency services on likely problems and recommendations for their management i. Advice for acute hospital services on the most appropriate ward (if admission is required)	N	Only those patients accessing community services had a patient passport. When patients were admitted to the acute Trust passports were not always available to staff.
SA-601	**Summary Medical Record** A summary of the patient's medical record including diagnoses, allergies, medication and agencies involved in their care should be sent with each patient referred to intermediate care or to an acute hospital for assessment or admission.	N	Summary medical records were not routinely available if patients were referred to intermediate care or to an acute hospital for assessment or admission. The CCG was working with the GPs to look at how this information might be available electronically.

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ACUTE TRUST – ALL WARDS

Ref	Standard	Met?	Comment
SM-101	**Planned Admissions** All patients awaiting a planned admission to hospital should be offered written information about arrangements for leaving the hospital and returning to their usual place of residence.	Y	The 'Your stay in hospital' booklet was very comprehensive.
SM-102	**Information about Leaving Hospital** Each ward should clearly display information for patients, carers and staff about arrangements for transfer of care on leaving the hospital, covering at least: a. The process of transfer of care b. Additional support available in the patient's usual place of residence c. Intermediate care options, criteria for accessing these and time limits on their provision (if applicable) d. How to access a discussion with medical and/or nursing staff about the patient's condition and plans for care on leaving hospital	Y	Information about leaving hospital was covered in the 'Your stay in hospital' booklet. The 'Ask Me' leaflet covered all aspects of communication. A leaflet about 'Your Rights' was also available.
SM-103	**Discussion with Families** Members of the multi-disciplinary team should be easily available to families for discussions about the patient's condition and plans for care on leaving hospital. Information on how to arrange a discussion should be clearly displayed in all ward areas.	Y	The 'Ask Me' leaflet covered multi-disciplinary teams and how families could communicate with staff and become involved in discussions and discharge planning.
SM-104	**Patients at High Risk of Re-Admission** Patients at high risk of re-admission should have their 'Patient Passport' or equivalent patient-held record (QS SA-101) updated during the course of their admission.	N	See main report

Ref	Standard	Met?	Comment
SM-196	**Transfer of Care Plan** Patients and, when appropriate, their carers should be involved in discussing and agreeing the plan for their care after leaving the hospital and should be given a written summary of their Transfer of Care Plan, which should include: a. Expected date of discharge b. Essential pre-discharge assessments c. Care after leaving the acute hospital, including self-care d. Medication required on leaving the acute hospital e. Who is taking medical responsibility for care after leaving the acute hospital f. Further investigations, treatment, rehabilitation and re-ablement to be carried out after leaving hospital, and who will arrange these, including separately identifying any of these which the GP is expected to arrange g. Possible complications and what to do if these occur, including in an emergency h. Transport i. Equipment supply or loan j. Dressings and continence aids k. Who to contact with queries or for advice l. Date by which their care should be reviewed, who is expected to undertake this review and how to access a review more quickly if required This Transfer of Care Plan should be copied to the patient's GP and to all services involved in providing after-hospital care.	N	Much of the information was on the electronic records. Patients and carers did not have a written summary of the care plan except when being discharged. From the notes and discharge letters it was not clear who would be taking over their care following their transfer to a community hospital.
SM-198	**Carers' Needs** Carers should be offered advice and written information on: a. How to access an assessment of their own needs b. Benefits available, including carers' allowance (if applicable), and how to access benefits advice c. Services available to provide support	N	Some information was available via the internet but not in other formats. Information was not clearly visible in the areas visited by reviewers. Community hospitals included information in the yellow discharge folder that was given to patients and carers on discharge.
SM-199	**Involving Patients and Carers** The service should have: a. Mechanisms for receiving regular feedback from patients and carers about transfer of care from the acute hospital b. Examples of changes made as a result of feedback and involvement of patients and carers	N	A discharge survey had been undertaken but reviewers did not see any evidence of changes made as a result. The results of the survey were displayed in the Medical Short Stay Unit.

Ref	Standard	Met?	Comment
SM-201	**Multi-Disciplinary Teams** A multi-disciplinary team to coordinate discharge planning should be available on each ward including: a. Staff with occupational therapy and physiotherapy competences with time allocated daily (7/7) for discharge planning, essential pre-discharge assessments and active pre-discharge rehabilitation b. Senior decision-maker review of patients' fitness for discharge at least daily (7/7) c. Nurse with competences in 'event-led' discharge from 9am to 8pm daily (7/7) d. Someone identified to coordinate discharge planning and preparation for discharge from 9am to 8pm daily (7/7) e. Access to social services staff available to undertake social care assessment within 24 hours of request f. Access to pharmacy services and medication 'To Take Out' available within four hours of request	N	'e' and 'f' were not met. Social care assessments within 24 hours of request were not yet possible.
SM-202	**'Trusted Assessors'** A member of staff 'trusted' and with competences to assess for local intermediate care services, including intermediate care in community hospitals, in care homes or at home, should be available to each ward daily (7/7) and able to respond on the same day to requests received by 12 noon.	N	'Trusted Assessors' processes were not yet in place. Each facility undertook assessments once referrals were received.
SM-203	**Training in Transfer of Care from the Acute Hospital** All staff, including junior medical staff, should have training in the hospital transfer of care pathway (QS SM-597), local intermediate care services (QS SM-602) and local enabling agreements (QS SZ-602).	N	Training was included in the discharge policy, but training had not taken place covering local enabling agreements since 2011.

Ref	Standard	Met?	Comment
SM-301	**Support Services** Access to the following support services should be available daily (7/7): a. Appropriate staff to undertake a home assessment within 24 hours of request b. Patient transport able to respond within four hours of request c. 'Simple' equipment available within four hours of request d. Supply of sufficient dressings and continence aids for 72 hours available within four hours of request e. All equipment, including beds and hoists, available within 24 hours of request f. 'Simple' adaptations available within 24 hours of request g. Voluntary sector 'settling home' support able to respond by the end of the next working day and continue for up to five days h. 'Simple' assistive technology available within 24 hours of request i. Medicines reconciliation (7/7)	N	Whilst access to support services was generally available, the timescales were not always met: 'a': therapist assessments were available but not for those requiring assessment by Social Services; 'e': hoists were not always available within 24 hours. Access depended on the availability of equipment from MediQuip; 'g': voluntary sector 'settling home' support agreements were being discussed with the Red Cross. Carers were signposted to the *Age UK* website for details of any other support that may be available; 'h': simple assistive technology was not available within 24 hours of request; 'i': medicines reconciliation was in place Monday - Friday only.
SM-302	**Short-Term Care at Home** Additional health and social care support should be available within four hours of request, comprising up to four visits per day for at least 72 hours after return home.	N	Provision was in place with Social Care to bridge care packages within the Community Intervention Service and Living Independently Staffordshire teams. This would normally be available within four hours, but it was dependent on the team capacity. If capacity was available then support could be arranged for up to 4 calls a day for at least 72 hours. Domiciliary care provision was not always available at short notice.
SM-499	**IT System** 'Trusted assessors' and ward-based staff responsible for coordinating discharge planning (QS SM-201) should have electronic access to: a. Health and social care records of patients from the main areas served by the hospital b. 'Patient Passports' (if electronic)	N	There was no direct access to the Social Care 'Care Director System', but information could be requested.
SM-595	**Ward and Consultant Handover** The latest version of their Transfer of Care Plan should be handed over to the new ward or consultant whenever patients are transferred to another ward within the acute hospital or to the care of another consultant and the Transfer of Care Checklist (QS SM-601) updated.	Y	Information was electronic and accessible to all areas across the Queen's Hospital site. Medical summaries and a nurse-to-nurse transfer process was in place for those transferring to the community hospitals.

Ref	Standard	Met?	Comment
SM-596	**Transfer of Care Guidelines** Transfer of care guidelines for both simple and complex discharge pathways should be in use covering at least: a. Ensuring each patient has an expected date of discharge, ideally within 12 hours of admission b. 'Event-led' discharge c. Discussion with patients and carers about the Transfer of Care Plan d. Multi-disciplinary review for complex discharges or where discharge destination is unclear, ideally within 24 hours of admission e. Single assessment process f. Transport options including patient transport service, relatives, taxis or care home transport g. Development, agreement and giving the patient, GP and, where appropriate, carers a copy of the of the Transfer of Care Plan: i. Expected date of discharge ii. Essential pre-discharge assessments iii. Care after leaving the acute hospital, including self-care iv. Medication required on leaving the acute hospital v. Who is taking medical responsibility for care after leaving the acute hospital vi. Further investigations, treatment, rehabilitation and re-ablement to be carried out after leaving hospital, and who will arrange these, including separately identifying any of these which the GP is expected to arrange vii. Possible complications and what to do if these occur, including in an emergency viii. Transport ix. Equipment supply or loan x. Dressings and continence aids xi. Who to contact with queries or for advice xii. Date by which their care should be reviewed, who is expected to undertake this review and how to access a review more quickly if required h. How to access funding decisions on specialist care not normally available in the local area i. Latest time when patients can normally be discharged home or to care homes j. Handover of the Transfer of Care Plan to services providing after-hospital care, including intermediate care services k. Informing the GP, the person taking medical responsibility for the patient and any other relevant services that the patient has left hospital, ideally within four hours of transfer of care l. Contingency plan when capacity in intermediate care services is not available	N	A single assessment process was not yet in place. The Transfer of Care Guidelines were documented as part of the Transfer Policy, but notification of the transfer of care was not fully electronic. The transfer of care plan was documented within the Nurse Discharge Plan on Meditech. There was no evidence of patients or carers being given a copy of the care plan. There were no 'event-led' discharge guidelines.

Ref	Standard	Met?	Comment
SM-597	**More Complex Transfers of Care** Guidelines should be in use covering: a. Transfer of care to other local authority or Clinical Commissioning Group areas covering at least social care assessments, intermediate care services available, patient transport and equipment supply or loan b. Transfer to a care home for long-term care c. NHS continuing care assessments and place-finding d. Liaison with palliative and end of life care services e. Patients and/or carers who do not agree a Transfer of Care Plan or who unreasonably delay their transfer of care	N	Processes were in place as part of the Decision Support Tool (DST), but were not consistently used. The guidelines were not specific about out-of-area patient transfers.
SM-601	**Ward-Level Arrangements** The following arrangements should be implemented on each ward: a. On admission: i. Requesting a Summary Medical Record from the patient's GP if this is not sent with the patient (QS SA-601) ii. Identifying agencies involved in the patient's care and, if necessary, informing them of the admission b. Availability for discussion with families (QS SM-103) c. A 'Patient at a Glance' or equivalent system so that all staff can see the patient's stage on the transfer of care pathway and actions required d. A Transfer of Care checklist (or equivalent) in each patient's notes showing their stage on the transfer of care pathway and actions required e. Updating the 'Patient Passport' (QS SA-101) for people at high risk of re-admission or issuing one if not available f. Rapid access to investigations and consultant clinics for patients following discharge (7/7) g. Local enabling agreements (QS SZ-602)	N	Points 'ai' and 'aii' were not yet in place, 'patient at a glance' boards were not yet electronic ('c'), and 'e' was not met. Commissioners told reviewers that some local enabling agreements were in place, but staff who met the reviewers were not aware of them ('g').

Ref	Standard	Met?	Comment
SM-602	**Intermediate Care** A protocol on access to local intermediate care services should be in use on each ward covering at least: a. Criteria for acceptance by each local intermediate care service and time limit for provision of the service (if applicable) b. Type of care, rehabilitation and re-ablement provided and, in particular, whether the service is able to support: i. 24/7 on-site care (community hospital or care home) ii. Overnight care (night-visiting or night sitting) iii. Intravenous therapy iv. PEG feeds v. Care for dementia or significant cognitive impairment vi. VAC therapy and other complex wound care c. 'Trusted Assessor' (QS SM-202) or other arrangements for agreement of patient suitability d. Arrangements for handover of the patient's Transfer of Care Plan	Y	There were criteria for referral and admission to the Community Intervention Service, Living Independently Staffordshire and the community hospitals. Documentation was in place to direct staff to the various services. The criteria for the community hospitals required the patients to be medically fit because of acuity and skills available. 'c': 'Trusted assessors' were not evident in any areas: apart from the CIS each service was making its own assessments, particularly on the wards.
SM-701	**Data Collection and Monitoring** Each ward should have access to data on its own performance and comparative information for other wards covering: a. Proportion of patients achieving their expected date of discharge b. Proportion of patients 'home for lunch' c. Key quality and performance indicators agreed with commissioners	Y	Data were collected on the recently implemented ALAMAC system. Once fully implemented, wards would receive feedback on data.
SM-702	**Audit** Each ward should have a rolling programme of audit of: a. Achievement of expected timescales for the patient pathway b. Patients re-admitted within 28 days who did not have a 'Patient Passport' or equivalent patient-held record c. Proportion of further investigations or follow up appointments arranged within five days of transfer from acute hospital	N	Audit as defined by the Quality Standard was not yet in place.
SM-797	**Health and Social Care Review and Learning** Each ward should have a mechanism for influencing, and receiving feedback from, the local Health and Social Care Review and Learning Group on transfer of care from acute hospitals and intermediate care (QS SZ-798).	N	The 'Systems Resilience Group' had membership from health and social care, but not from the Acute Trust.

Ref	Standard	Met?	Comment
SM-798	**Multi-disciplinary Review and Learning** Each ward should have multi-disciplinary arrangements for the reviewing of, and implementation of learning from, positive feedback, complaints, outcomes, incidents and 'near misses' relating to transfer of care from the acute hospital.	N	Multi-disciplinary review and learning on each ward as defined by the Quality Standard was not yet in place.
SM-799	**Document Control** All policies, procedures and guidelines should comply with Trust (or equivalent) document control procedures.	N	Some information seen by the reviewers lacked version control. Trust policies were clearly managed.

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INTERMEDIATE CARE SERVICE

These Quality Standards apply to intermediate care provided in community hospitals, care homes and patients' own homes.

Ref	Standard	Sir Robert Peel (RP) & Samuel Johnson (SJ) Community Hospitals		Community Intervention Service (CIS)	
		Met?	Comment	Met?	Comment
SN-101	**Service Information** Each service should offer patients and their carers written information covering: a. Organisation of the service b. Care and therapeutic interventions offered by the service c. If beds: routines, visiting times and how to get refreshments d. Staff and facilities available e. How to contact the service for help and advice, including out of hours f. Who to contact with concerns about the service g. 'After intermediate care', including information about the length of time for which the service will be provided and the options for, and process of transfer to, longer-term care (if required) h. Sources of further advice and information	Y	SJ: The Yellow folder included a range of information. RP: A wide range of appropriate information was available.	Y	Community Services supplied service information for patients via various booklets and leaflets. The literature would benefit from review to clarify any exclusion criteria and the expected length of stay for those using the service.

Ref	Standard	Sir Robert Peel (RP) & Samuel Johnson (SJ) Community Hospitals		Community Intervention Service (CIS)	
		Met?	Comment	Met?	Comment
SN-103	**Care Plan** Each patient and, where appropriate, their carer and appropriate members of the multi-disciplinary team should discuss and agree their Care Plan and should have easy access to a written record covering at least: a. Agreed goals, including life-style goals b. Self-management c. Medication d. Planned care and therapeutic interventions e. Early warning signs of problems, including acute exacerbations, and what to do if these occur f. Expected date of discharge from the service g. Name of care coordinator h. Name of doctor taking medical responsibility for their care i. Who to contact with queries or for advice j. Planned review date and how to access a review more quickly, if necessary	Y	SJ: Care plans were made up of a range of papers which were not controlled. (See main report) RP: Documentation was organised and filed, with twice daily observations completed.	Y	However, from discussions with staff it was unclear if the GP was always aware that he/she was taking full medical responsibility. This may be due to the Single Point of Access being the main point of contact.
SN-104	**Review of Care Plan** A formal review of the patient's Care Plan should take place as planned and, at least, weekly. This review should involve the patient, their carer, where appropriate, and appropriate members of the multi-disciplinary team. The outcome of the review should be recorded in the Care Plan.	Y	SJ: The care plans seen by the reviewers were, in the main, problem focused, but because there was use of multiple documents it was difficult to see the overall objectives of the care plan.	Y	

Ref	Standard	Sir Robert Peel (RP) & Samuel Johnson (SJ) Community Hospitals		Community Intervention Service (CIS)	
		Met?	Comment	Met?	Comment
SN-105	**Contact for Queries and Advice** Each patient and, where appropriate, their carer should have a contact point within the service for queries and advice. If advice and support is not immediately available then the timescales for a response should be clear, and advice on what to do in an emergency should be given. Response times should be no longer than the end of the next day.	Y	Sir Robert Peel had an information leaflet on how to contact the ward, Ward Sister and medical staff.	Y	A helpline was in place as well as written information. The helpline was checked every 30 minutes.
SN-106	**Care Coordinator** Each patient should have a nominated individual responsible for planning and coordinating their care, including planning their longer-term care.	N	Nurses were allocated per shift. Others may be allocated for those requiring longer-term care. SJ: At the time of the visit the wards were reliant on temporary staff and it was not clear how care would be coordinated.	Y	There was a team co-ordinator and a named nurse for patients and relatives to discuss patient care.
SN-107	**Communication Aids** Communication aids should be available to enable patients with communication difficulties to participate in decisions about their care.	N	Both community hospitals reported delays in accessing communication aids.	N	Reviewers were told of delays in accessing communication equipment and aids for patients as they had to be ordered.
SN-108	**Patients at High Risk of Re-Admission** Patients at high risk of re-admission should have their 'Patient Passport' or equivalent patient-held record (QS SA-101) updated during the course of their intermediate care.	N	Patient passport was only in use for some patients. Sharing of patient-held records between services did not always take place.	N	Patient passport was only in use for some patients. For other patients there were two sets of records that would require updating.

Ref	Standard	Sir Robert Peel (RP) & Samuel Johnson (SJ) Community Hospitals		Community Intervention Service (CIS)	
		Met?	Comment	Met?	Comment
SN-196	**'After Intermediate Care' Plan** Patients and, when appropriate, their carers should be involved in discussing and agreeing the plan for their care after leaving the intermediate care service, and should be given a written summary of their 'After Intermediate Care' Plan, which should include: a. Expected date of discharge from the intermediate care service b. Care after leaving intermediate care, including self-care c. Medication d. Who is taking medical responsibility for care after leaving intermediate care e. Further investigations, treatment, rehabilitation and re-ablement to be carried out after leaving intermediate care, and who will arrange these, including separately identifying any of these which the GP is expected to arrange f. Possible complications and what to do if these occur, including in an emergency g. Transport (if required) h. Equipment supply or loan i. Dressings and continence aids j. Who to contact with queries or for advice k. Date by which their care should be reviewed, who is expected to undertake this review and how to access a review more quickly if required This 'After Intermediate Care' Plan should be copied to the patient's GP and to all services involved in providing ongoing care.	N	SJ: The discharge folder included information but did not include an 'after intermediate care' plan. RP: Care plans included a discharge plan that was sent to GPs and other relevant services. For both community hospitals the discharge nurse completed documentation for those with very complex discharge needs. 'f': in the records seen by the reviewers, information about possible complications including emergencies, and how this was managed when preparing for discharge, was not always clear.	Y	All information was detailed on the IT system and a hard copy summary could be made available.

Ref	Standard	Sir Robert Peel (RP) & Samuel Johnson (SJ) Community Hospitals		Community Intervention Service (CIS)	
		Met?	Comment	Met?	Comment
SN-197	**General Support for Patients and Carers** Patients and carers should have easy access to the following services, and information about these services should be easily available: a. Interpreter services, including British Sign Language b. Independent advocacy services c. Complaints procedures d. Social workers e. Benefits advice f. Spiritual support g. *HealthWatch* or equivalent organisation h. Relevant voluntary organisations providing support and advice	Y		Y	
SN-198	**Carers' Needs** Carers should be offered information on: a. How to access an assessment of their own needs b. Benefits available, including carers' allowance (if applicable), and how to access advice on these c. Services available to provide support	Y	Involvement of carers and relatives was actively encouraged. Open visiting had been implemented and there was also an option to meet with staff at a coffee morning on a Monday.	Y	The Community team included an assessment of care needs as part of the patient assessment.
SN-199	**Involving Patients and Carers** The service should have: a. Mechanisms for receiving regular feedback from patients and carers about the treatment and care they receive b. Examples of changes made as a result of the feedback and involvement of patients and carers	Y		Y	

Ref	Standard	Sir Robert Peel (RP) & Samuel Johnson (SJ) Community Hospitals		Community Intervention Service (CIS)	
		Met?	Comment	Met?	Comment
SN-201	**Lead Clinician and Lead Manager** A nominated lead clinician and a lead manager should be responsible for the effective delivery of the service, including staffing, training, guidelines and protocols, service organisation, governance and liaison with other services. The lead clinician should be a registered healthcare professional with appropriate specialist competences in this role and should undertake regular clinical work within the service.	Y	SJ: There was a lead clinician and a lead manager. RP: There was a lead GP and a lead manager, though there were no set roles and responsibilities for the clinical lead.	N	There was no overall lead clinician for the service. A lead manager was in place.

Ref	Standard	Sir Robert Peel (RP) & Samuel Johnson (SJ) Community Hospitals		Community Intervention Service (CIS)	
		Met?	Comment	Met?	Comment
SN-202	**Staffing Levels and Skill Mix** Sufficient health and care staff with appropriate competences should be available for: a. The number of patients usually cared for by the service and the usual case mix of patients b. The service's role in the patient pathway and expected timescales c. The assessments, care and therapeutic interventions offered by the service Staffing should include: i. At least two registered healthcare professionals at all times the service is operational ii. A registered nurse available 24/7 in bedded units and daily (7/7) in other services iii. Appropriate therapists for the needs of the patients daily (7/7) iv. Access to social services staff available to undertake social care assessments within 24 hours of request v. Medical staff (QS SN-205) Cover for absences should be available so that the patient pathway is not unreasonably delayed, and patient outcomes and experience are not adversely affected, when individual members of staff are away.	N	SJ: Nurse staffing had been increased to cover the extra 3 open beds. For the 26 beds the cover was 4/3, 3/3, 2/2. On Darwin Ward the majority of staff were temporary and it was not clear if all the temporary staff would have the relevant competences. Physiotherapy and occupational therapy support was available 8.30am - 5pm and on Saturday mornings. Nurses and pharmacists were prescribers, and nurses had recently undertaken training to deliver intravenous therapy. Speech and language therapy was available on Tuesdays. A dietician was available on Wednesdays and Fridays. Reviewers were told that there were delays in allocating social workers.	Y	The service had also been creative about the assistant practitioner role, using this role as part of succession planning, and considering how this role would best work within the service.

Ref	Standard	Sir Robert Peel (RP) & Samuel Johnson (SJ) Community Hospitals		Community Intervention Service (CIS)	
		Met?	Comment	Met?	Comment
			RP: Nurse staffing for the 24 beds was 4/3, 3/3, 2/2. Physiotherapy and Occupational Therapy was available 8.30am - 5pm and Saturday mornings. Access to a dietician and speech and language therapy was via referral only, and reviewers were told that this was causing delays in care provision. Training to develop nursing staff to be prescribers and deliver intravenous therapy had commenced.		
SN-203	**Service Competences and Training Plan** The competences expected for each role in the service should be identified. A training and development plan for achieving and maintaining competences should be in place. If provided by the service, the competence framework should cover: a. Intravenous therapy b. PEG feeds c. Care for patients with dementia or significant cognitive impairment d. VAC therapy and other complex wound care	N	Competences were available for 'a' and 'c'. SJ was delivering intravenous therapy, but this was not yet in place at RP. 'b' was not in place. 'd': VAC therapy was not undertaken.	N	A service training and development plan was not yet in place. Service competences were available for all grades but did not cover 'c'. Established PEG patients could be managed within the service if required but those who needed new PEG insertions could not. VAC therapy was not provided by the team.

Ref	Standard	Sir Robert Peel (RP) & Samuel Johnson (SJ) Community Hospitals		Community Intervention Service (CIS)	
		Met?	Comment	Met?	Comment
SN-204	**Competences – All Health and Social Care Professionals** All health and social care professionals working in the service should have competences appropriate to their role in: a. Resuscitation b. Safeguarding vulnerable adults c. Recognising and meeting the needs of vulnerable adults d. Dealing with challenging behaviour, violence and aggression e. Mental Capacity Act and Deprivation of Liberty Safeguards f. Privacy and dignity g. Infection control h. Information governance, information sharing and awareness of any local information sharing agreements i. Local enabling agreements (QS SZ-602)	N	All but 'i' were in place, and records were completed.	N	Point 'i' was not yet met, and compliance for 'h' was very low.
SN-205	**Medical Staff** The service should have the following medical staffing: a. A nominated lead doctor with responsibility for coordinating medical input to the service b. A doctor available for emergencies 24/7 c. A doctor or other registered health professional with authorisation to prescribe who can attend within two hours of request, for conditions where hospital admission may be avoided d. Medical review of patients: i. Community hospitals: Daily (7/7) ii. Other intermediate care services: As appropriate for the usual case mix of patients and at least weekly.	N	A medical review was not available 7 days a week. Patients were reviewed Monday - Friday. RP: 'c' was not always possible as nurse prescribers were not yet in place so there was reliance on the GP Out of Hours service.	Y	Medical staffing requirements were met by the patient's GP or via the Out of Hours services.
SN-299	**Administrative, Clerical and Data Collection Support** Administrative, clerical and data collection support should be available.	N	Ward clerks were not available at weekends and worked limited hours during the week.	N	Ward clerks were not available at weekends.

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		Met?	Comment	Met?	Comment
SN-301	**Clinical Support Services** Timely access to an appropriate range of clinical support services should be available, including: a. Imaging b. Pathology, including microbiology c. Pharmacy, including medication supply and medicines management advice d. Appropriate staff to undertake a home assessment within 24 hours of request e. Infection control (7/7 and on call 24/7) f. Tissue viability (7/7) g. Falls prevention (next working day) h. Continence service (7/7) i. Mental health team (crisis response within four hours) j. Counselling	N	Clinical support services were available for advice from the Acute Trust. Neither access to mental health teams within four hours nor timely access to counselling services were always possible.	N	For the community Team: 'a' and 'b' required referrals from a GP and there was no direct access; 'c' and 'd' were met; 'e': infection control was available during core hours, but also out of hours via an on-call microbiologist; 'f': there was limited provision, and the team was reliant on the Acute Trust service; 'g' was available weekdays only; 'h' was available weekdays only via the district nurses; 'i' was available weekdays only; 'j' was referral based.

Ref	Standard	Sir Robert Peel (RP) & Samuel Johnson (SJ) Community Hospitals		Community Intervention Service (CIS)	
		Met?	Comment	Met?	Comment
SN-302	**Support Services for Patients Returning Home** Access to the following support services for patients returning home should be available daily (7/7): a. Appropriate staff to undertake a home assessment within 24 hours of request b. Medication 'To Take Out' available within four hours of request c. Patient transport able to respond within four hours of request d. 'Simple' equipment available within four hours of request e. Supply of sufficient dressings and continence aids for 72 hours available within four hours of request f. All equipment, including beds and hoists, available within 24 hours of request g. 'Simple' adaptations available within 24 hours of request h. Additional health and social care support within four hours of request, comprising up to four visits per day for up to 72 hours after return home i. Voluntary sector 'settling home' support able to respond by the end of the next working day and continue for up to five days j. 'Simple' assistive technology available within 24 hours of request	N	All but 'c', 'd' and 'h' were met. Access to transport within four hours was limited. At the time of the visit simple equipment was not available within four hours but could be obtained within a day. Domiciliary care provision was not always available at short notice to support discharge home.	N	For the Community Team: 'a', 'b', 'e' and 'f' were met; 'c': patient transport had to be booked the afternoon prior to patient discharge the following morning. Reviewers were told that this was due to ambulance capacity issues. Access to transport within four hours was limited; 'f': hoists were not always available within 24 hours because of the numbers available from MediQuip. Alterations such as 'grab handles' were not always available within 24 hours of request. 'h': provision was available to bridge care packages within the CIS and LIS teams. This would normally be available within four hours, but depended on the capacity of the team at the time of request. This support was available for up to four calls a day (double and single) and also for at least 72 hours. Domiciliary care provision was not always available at short notice. 'i': Work with the Red Cross to provide a 'settling home' service was being considered, as funding for this provision had recently been withdrawn.

Ref	Standard	Sir Robert Peel (RP) & Samuel Johnson (SJ) Community Hospitals		Community Intervention Service (CIS)	
		Met?	Comment	Met?	Comment
SN-401	**Facilities and Equipment** Facilities and equipment available should be appropriate for the assessments, care and therapeutic interventions offered by the service for the usual number and case mix of patients.	Y	RP: the environment was particularly welcoming, with bright and natural light, wide corridors and spacious bays.	Y	
SN-499	**IT System** IT systems for storage, retrieval and transmission of patient information should be in use for patient administration, clinical records, outcome information and other data to support service improvement, audit and revalidation.	N	Meditech was not available in the community hospitals. Some authorised staff had access to patient records on a read-only basis. Reviewers were told that the IT system would be upgraded within the next two years.	Y	The Care Director IT system had just been implemented.
SN-501	**Initial Assessment Guidelines** Guidelines on initial assessment should be in use that ensure that an initial assessment is undertaken within 30 minutes of transfer to the intermediate care service, or within four hours if intermediate care is provided in the home, covering at least: a. Assessment of pressure ulcers, nutrition, hydration and cognition b. Initial review of the Transfer of Care Plan to ensure its appropriateness for the intermediate care service	Y	RP: The care plans were very comprehensive.	Y	

Ref	Standard	Sir Robert Peel (RP) & Samuel Johnson (SJ) Community Hospitals		Community Intervention Service (CIS)	
		Met?	Comment	Met?	Comment
SN-502	**Clinical Guidelines** Guidelines on management of the usual case mix of patients referred to the service should be in use covering at least: a. Pain b. Depression c. Skin integrity d. Falls and mobility e. Continence f. Delirium and dementia g. Nutrition and hydration h. Sensory loss i. Medicines management j. Catheter care k. Spasticity management l. Care of patients with diabetes, COPD, heart failure and other long-term conditions m. Activities of daily living n. Health promotion, including smoking cessation, healthy eating, weight management, exercise, alcohol use, sexual and reproductive health, and mental and emotional health and well-being	N	All were available except 'k' and 'n'.	N	Guidelines were not available for 'h', 'k' or heart failure.

Ref	Standard	Sir Robert Peel (RP) & Samuel Johnson (SJ) Community Hospitals		Community Intervention Service (CIS)	
		Met?	Comment	Met?	Comment
SN-597	**Transfer of Care Guidelines** Transfer of care guidelines for both simple and complex discharge pathways should be in use covering at least: a. Ensuring each patient has an expected date of discharge from the service b. Planning transfers of care from intermediate care including: i. Discussion with patients and carers about the 'After Intermediate Care' Plan ii. Availability for patient and carer queries iii. Multi-disciplinary review for complex or uncertain discharges iv. Single assessment process v. Transport options including patient transport service, relatives, taxis or care home transport vi. 'After Intermediate Care' Plan (QS SN-196) c. Agreement of 'After Intermediate Care' Plan and handover to services providing long-term care (if required) d. Informing the GP, the person taking medical responsibility for the patient and any other relevant services that the patient has left intermediate care, ideally within four hours of transfer of care	N	The Trust transfer guidelines covered all but 'b' and 'c'. In practice this was implemented at both community hospitals. RP: The criteria for transfer from Acute Trust into Intermediate Care beds were not always followed, and patients with more complex needs were transferred.	N	Guidelines covering the transfer of care for both simple and complex discharge pathways were not yet in place. In practice, the expected date of discharge was agreed and indicated on the ward board. Planning of care following Intermediate Care was documented in patients' notes. Patients and relatives also had open access to staff to discuss any issues concerning discharge plans or care. Multi-disciplinary meetings were held for those patients with complex needs and for patients where there were delays in discharge.

Ref	Standard	Sir Robert Peel (RP) & Samuel Johnson (SJ) Community Hospitals		Community Intervention Service (CIS)	
		Met?	Comment	Met?	Comment
SN-598	**More Complex Transfers of Care** Guidelines should be in use covering: a. Transfer of care to other local authority or Clinical Commissioning Group areas covering at least social care assessments, intermediate care services available, patient transport and equipment supply or loan b. Transfer to a care home for long-term care c. NHS continuing care assessments and place-finding d. Liaison with palliative and end of life care services e. Patients and/or carers who do not agree an 'After Intermediate Care' Plan or who unreasonably delay their transfer of care	N	Transfer guidelines did not cover more complex transfer of care. There were plans to revise the policy and incorporate the requirements of the QS.	N	Guidelines covering more complex transfers of care were not yet in place. Guidance for the transfer of care to and from other areas, and a 'refusal of care' policy were in place. See also main report about delays in discharge and access to care packages.
SN-599	**Care of Vulnerable People** Guidelines for the care of vulnerable adults should be in use covering, in particular: a. Identification and care of vulnerable people b. Individualised care plans for people identified as being particularly vulnerable c. Restraint and sedation d. Missing patients e. Mental Capacity Act and Deprivation of Liberty Safeguards f. Safeguarding g. Information sharing h. Palliative care i. End of life care j. 'Do not resuscitate'	Y		Y	

Ref	Standard	Sir Robert Peel (RP) & Samuel Johnson (SJ) Community Hospitals		Community Intervention Service (CIS)	
		Met?	Comment	Met?	Comment
SN-601	**Operational Policy** The service should have an operational policy describing the organisation of the service including, at least, arrangements for: a. Admission of patients to the service who meet the agreed criteria b. Initial assessment within 30 minutes of transfer, or within four hours if the patient has returned home c. On admission: i. Requesting a Summary Medical Record from the patient's GP if this is not sent with the patient (QS SA-601) ii. Identifying agencies involved in the patient's care and, if necessary, informing them of the admission d. Agreement of Care Plan within 24 hours of transfer to intermediate care e. Start of therapeutic interventions within 24 hours of transfer to intermediate care f. Setting and reviewing expected date of discharge from the service g. Daily review of all patients h. Review of Care Plans at least weekly, including medical review i. Allocation of a care coordinator for each patient (QS SN-106) j. Giving the patient and, where appropriate, their carer information at each stage of the patient journey k. Responding to patients' and carers' queries or requests for advice l. Multi-disciplinary discussion of appropriate patients m. Developing and agreeing an 'After Intermediate Care' Plan for each patient (QS SN-196) within seven days of admission n. Ensuring that an 'After Intermediate Care' checklist (or equivalent) is included in each patient's notes showing their stage on the transfer of care pathway and actions required o. Updating the 'Patient Passport' (QS SA-101) for people at high risk of re-admission or issuing one if not available p. Communication with the patient's GP q. Maintenance of equipment (QS SN-401) r. Responsibilities for IT systems (QS SN-499)	N	Polices were not in place for 'ci', 'cii', 'm', 'n' and 'o'. Many aspects of the Quality Standard were met in practice.	N	Polices were not yet in place. In practice 'ci' and 'd' to 'l' were undertaken. Initial assessments within four hours of the patient returning home were not always possible.

Ref	Standard	Sir Robert Peel (RP) & Samuel Johnson (SJ) Community Hospitals		Community Intervention Service (CIS)	
		Met?	Comment	Met?	Comment
SN-701	**Data Collection** Regular collection and monitoring of data should be in place, including: a. Referrals to the service, including source and appropriateness of referrals b. Number of assessments and therapeutic interventions undertaken by the service c. Outcome of assessments and therapeutic interventions d. Length of care by the service e. Proportion of patients achieving their expected date of discharge from the service f. Number and destination of transfer of care from the service g. Key quality and performance indicators	N	Some data were collected at the community hospitals although 'c' was not yet collected. All referrals were received by a coordinator at the Robert Peel hospital.	Y	Data were collected on assessment, timeliness of interventions and whether outcomes had been achieved.
SN-702	**Audit** The services should have a rolling programme of audit of: a. Achievement of expected timescales for the patient pathway b. Compliance with evidence-based clinical guidelines (QS SN-500s) c. Compliance with standards of record keeping	N	A rolling programme of audit was not in place in either community hospital. There were some evidence-based audits for therapies.	N	Some audits were undertaken, but not as required by the Quality Standard.
SN-703	**Key Performance Indicators** Key performance indicators (QS SN-701) should be reviewed regularly with Trust (or equivalent) management and with commissioners.	N	Some data were reviewed as part of a monthly quality review.	Y	A Social Care Scorecard and Performance indicator was in use.
SN-797	**Health and Social Care Review and Learning** The service should have a mechanism for influencing and receiving feedback from the local Health and Social Care Review and Learning Group on transfer of care from acute hospitals and intermediate care (QS SZ-798).	N	Health and Social Care review and learning was not yet in place.	N	Health and Social Care review and learning was not yet in place.

Ref	Standard	Sir Robert Peel (RP) & Samuel Johnson (SJ) Community Hospitals		Community Intervention Service (CIS)	
		Met?	Comment	Met?	Comment
SN-798	**Multi-disciplinary Review and Learning** The service should have multi-disciplinary arrangements for a. Review of, and implementation of learning from, positive feedback, complaints, outcomes, incidents and 'near misses' b. Review of, and implementation of learning from, published scientific research and guidance c. Ongoing review and improvement of service quality, safety and efficiency	N	Multi-disciplinary arrangements were not yet in place.	N	Multi-disciplinary arrangements were not yet in place.
SN-799	**Document Control** All policies, procedures and guidelines should comply with Trust (or equivalent) document control procedures.	N	See main report.	N	Not all documentation seen by the reviewers was correctly version controlled.

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COMMISSIONING

Ref	Standard	Met?	Comment
SZ-601	**Commissioning of Services** Commissioners should commission intermediate care services for people at home and intermediate care services with beds sufficient for the needs of their population and should specify: a. Criteria and arrangements for acceptance by each intermediate care service, including the use of 'Trusted Assessors' (QS SM-202) b. Time limit for provision of intermediate care service c. Type of care, rehabilitation and re-ablement provided, in particular, whether care is available for patients needing: i. 24/7 on-site care (community hospital or care home) ii. Overnight care (night-visiting or night sitting) iii. Intravenous therapy iv. PEG feeds v. Care for dementia or significant cognitive impairment vi. VAC therapy and other complex wound care d. Arrangements for supply of medication, dressings and continence aids, equipment, adaptations and assistive technology within expected timescales (QS SM-301 and SN-302) e. Short-term health and social care support comprising up to four visits per day for at least 72 hours after returning home (QS SM-302 and SN-302) f. Key performance indicators for each service g. Any specialist care not normally available in the local area for which specific funding decisions are required	N	This standard was not yet met: 'a': criteria were in place but not the use of a 'trusted assessor'. Multiple assessments were undertaken; 'b': time limits were in place from Living Independently Staffordshire who were able to offer two-, four- or six-week packages. Spot purchases of six weeks could be commissioned from other providers, Barton under Needwood Health and Community Care Centre was able to offer six-week packages of care, Community Intervention Service offered a range of packages and short-term health and social care support; 'c': support was available from the Local Authority Dementia Centre of Excellence service; 'd': evidence was not available about what was commissioned in East Staffordshire, and there was no 'buffer stock' of equipment available for patients from Leicestershire; 'e' was met by the provision of the Community Intervention Service; Arrangements for 'f and 'g' were not clear following discussions with commissioners.

Ref	Standard	Met?	Comment
SZ-602	**Local Enabling Agreements** Health and social care commissioners should have local enabling agreements covering: a. Care package continuity during hospital admission b. Flexibility of re-start following hospital admission c. 'Discharge to assess' d. Cross-boundary agreements e. Single assessment process f. Arrangements for assessment and transfer of care for patients not resident in the local area, and reciprocal arrangements for local patients admitted to hospitals outside the local area	N	Local enabling agreements were not seen although discussions with staff and commissioner representatives identified that: 'a': care packages could be re-instated by the discharge team up to 14 days following admission, 'b': there was only flexibility in restarting packages up to 14 days following admission 'd' was met, and good cross-boundary agreements were in place with Good Hope Hospital (Heart of England NHS Foundation Trust) and The Royal Wolverhampton NHS Trust. 'e': a single assessment process was not yet in place, though there were discussions as to how the 'trusted assessor' process could be implemented across the health economy. 'f': arrangements were in place in practice but it was not clear if these were formally documented.
SZ-701	**Quality Monitoring** Commissioners should monitor key quality and performance indicators for: a. Transfer of care from acute hospitals (QS SM-701) b. Intermediate care services (QS SN-701)	N	Monitoring of the areas defined in the Quality Standard was not yet in place. Clinical quality review meetings did take place and there was a 'Systems Resilience Group' in operation.
SZ-798	**Health and Social Care Review and Learning Group** Arrangements for transfer of care from acute hospitals and intermediate care should be discussed with all relevant local services at least annually in order to review positive feedback, complaints, outcomes, incidents and 'near misses', identify and address problems, and identify improvements that could be made.	N	The 'Systems Resilience Group' had members from health and social care but was not linked to these services. Representatives from Living Independently Staffordshire told reviewers that although incidents were completed on the 'DATIX' system they did not receive feedback.

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