WM QRS West Midlands Quality Review Service

NHS

Transfer from Acute Hospital Care and Intermediate Care

Worcestershire Health and Social Care Economy

Visit Date: 16th, 17th & 18th March 2015 Report Date: July 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 16th, 17th and 18th March 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 in which 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 the Worcestershire Health and Social Care Economy. 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:

- Worcestershire Acute Hospitals NHS Trust
- Worcestershire Health and Care NHS Trust
- NHS Redditch and Bromsgrove Clinical Commissioning Group
- NHS Wyre Forest Clinical Commissioning Group
- NHS South Worcestershire 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 Worcestershire, or jointly provided or commissioned services. Actions by providers and commissioners of social care may be 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 commissioner input. 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.

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 Worcestershire Health and Social Care Economy for their hard work in preparing for the review and for their kindness and helpfulness during the course of the visit. Thanks are also due to the visiting team and their employing organisations for the time and expertise they contributed to this review.

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TRANSFER FROM ACUTE HOSPITAL CARE AND INTERMEDIATE CARE

This review looked at the following aspects of the pathway of transfer from acute hospital care and intermediate care in the Worcestershire Health and Social Care Economy:

Pathway	Provider	Quality Standards	Notes
Primary care	-	Primary care	
Acute Trust: All wards	Worcestershire Acute Hospitals NHS Trust	Acute Trust: All wards	Reviewers visited both the Alexandra Hospital, Redditch and Worcestershire Royal Hospital, Worcester. Reviewers went to the Emergency Departments, acute admissions wards and several other wards and met patients and staff.
Community Enhanced Care Teams	Worcestershire Health and Care NHS Trust		Reviewers met representatives from teams in Evesham, Malvern and Wyre Forest (Admission Prevention Team). Reviewers did not meet representatives from the Worcester or Redditch and Bromsgrove teams.
Community Hospitals	Worcestershire Health and Care NHS Trust	Intermediate care	Community hospitals in Evesham, Malvern and Bromsgrove were visited by reviewers, who met patients and staff. Reviewers did not go to community hospitals in Pershore and Tenbury.
Timberdine Nursing and Rehabilitation Unit	Worcestershire County Council	Intermediate care	Reviewers visited this facility and met residents and staff.
Worcester Intermediate Care Unit	Worcestershire County Council	Intermediate care	Reviewers visited this facility and met residents and staff.
Kidderminster Treatment Centre	Worcestershire Acute Hospitals NHS Trust	Intermediate care	Reviewers visited Cookley Ward and met patients and staff.
Commissioning	NHS South Worcestershire CCG, NHS Wyre Forest CCG, NHS Redditch and Bromsgrove CCG	Commissioning	Reviewers also visited the Patient Flow Centre at Wildwood.

Reviewers did not visit The Grange or Howbury House Resource Centre, both of which also provided NHS and social care resources in support of this pathway of care. Howbury House (16 beds) primarily took admissions from the south of Worcestershire and The Grange (28 beds) from the north. Intermediate care beds were also 'spot purchased' from nursing homes.

The review also did not look in detail at the work of the Urgent Promoting Independence Service, which provided care and support for service users for up to 74 hours. This was a county-wide service that completed assessments at home for people who were medically stable. The contribution of this service to the overall pathway of care was, however, considered by reviewers.

Some of the findings of this review were common across the health and social care economy and are summarised at the start of this report.

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Health and Social Care Economy

General Comments and Achievements

Organisations within Worcestershire had made significant progress in improving the pathway for transfer from acute hospital care and intermediate care. All staff who met reviewers were keen to improve the services provided and were open to doing this. Links with voluntary sector organisations, including the British Red Cross and Age UK, were good.

Good Practice

1 Three pathways for transfer from acute hospital care had been defined and implemented across Worcestershire. These pathways were clear about the process and expected timescales for transfer. Staff were aware of some improvements and refinements needed, and the health and social care economy had good mechanisms in place to achieve these changes. For example, the Redditch 'Discharge to Assess' Pathway Team had clear processes and were actively promoting the use of the pathway. The three main pathways were:

Pathway 1: The 'recover at home' model of care provided by Enhanced Care Teams.

Pathway 2: Short-term rehabilitation in a community hospital or other intermediate care facility (such as Timberdine, Howbury House, The Grange or the Worcester Intermediate Care Unit).

Pathway 3: Transfer of medically fit patients to a care home for assessment for long-term care or continuing health care.

Six Enhanced Care Teams provided integrated health and social care across Worcestershire. These teams provided 24/7 care for people at home and included nurses, therapists, social workers and mental health staff.

2 GP support for community hospitals and other intermediate care beds, including those in nursing homes, had been re-commissioned, with a clear specification that required daily attendance (Monday to Friday) and review of patients. Commissioners were considering the need for GP attendance at weekends. Emergency and out of hours cover for community hospitals was also provided by GPs, with a very prompt response reported.

3 Pharmacy staff in the Worcestershire Acute Hospitals NHS Trust, Worcestershire Health and Care NHS Trust and the three Clinical Commissioning Groups (CCGs) were working well together, ensuring good pharmacy support across the pathway of transfer from acute hospital care and intermediate care. In the Emergency Department at Worcester Royal Hospital the Emergency Department pharmacist undertook medicine reconciliation and, if required, would liaise with a patient's nursing or residential home or with the community pharmacist to assess the patient's concordance and compliance.

4 Very clear 'Green Sleeve / Red Sleeve' documentation had been introduced across Worcestershire; this contained advanced care plans in the green sleeve and 'do not attempt resuscitation' documentation in the red sleeve. This documentation had been shown to reduce inappropriate admissions to hospital.

5 The Discharge Liaison Team in Worcestershire undertook 'Trusted Assessments' to provide appropriate health-related information to the other NHS providers of services. The team also jointly case managed patients on 'pathway 3' with social care colleagues, and case managed those patients on the 'fast track' pathway and those patients with complex discharge needs.

6 The Patient Flow Centre had been running since October 2014, coordinating the transfer of patients from acute hospitals to home with additional support or to community hospitals and other intermediate care beds. The Centre built on the previous work of the Worcestershire 'Hub'. Reviewers considered that the vision for the Patient Flow Centre was excellent, and that significant progress had been made in implementing this vision. Electronic white boards gave an up to date view of capacity in all acute and

community hospital and intermediate care beds across Worcestershire. These white boards were in place in each facility and in the Patient Flow Centre. Reviewers were particularly impressed by the leadership of the service and the commitment to ongoing service improvement, including active use of 'Plan, Do, Study, Act' (PDSA) cycles. Reviewers were also impressed that staff they met throughout Worcestershire were aware of the Patient Flow Centre and its role, although 'front-line' staff had less understanding.

7 Reviewers were told that there were no problems with supply of equipment for patients transferring from acute hospital care, even at short notice.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Availability of domiciliary carers**

Significant difficulties in the supply of domiciliary carers were reported to reviewers, with delays of several days in the availability of domiciliary care, especially for those in the more rural parts of the county. This was leading to delays in transfer of care home. Reviewers were told that recruitment and retention of staff was the main cause of this problem, because expenses for travel between clients were not paid and pay was therefore, in effect, below that which could be earned from local supermarkets and 'minimum wage' employers. The impact of this was that people who were fit to return home were staying in acute, community and intermediate care beds and this capacity was not available for the admission of other patients. For example, the Redditch 'Discharge to Assess' Pathway Team had had to develop a pathway 1.5 involving discharge to a care home for situations where there was a delay in the availability of domiciliary care packages.

2 **Patient Flow Centre**

Reviewers were impressed with many aspects of the Patient Flow Centre (see 'good practice' above). Some aspects of its work were not yet working as planned, which was not surprising given the speed with which the service had been set up in the autumn of 2014. Reviewers strongly recommended continuation of the service, but considered that action involving all organisations should be taken to address the following issues:

a. The speed of response from the Patient Flow Centre was not yet meeting the needs of staff in Worcestershire Acute Hospitals NHS Trust. Acute Trust staff were therefore sometimes by-passing the Patient Flow Centre, or ringing the Patient Flow Centre and then finding a bed for the patient themselves, especially when acute bed capacity was under significant pressure.

b. The Patient Flow Centre was routinely available only Monday to Friday and Saturdays until 2pm (although staff sometimes came in on Sundays). There were therefore no Pathway 3 discharges from acute beds at weekends, and the availability of pathway 2 discharges was variable.

c. It was not clear who was responsible for the assessment of patients and whether this assessor was 'trusted' by the health and social care system. Ward staff gathered together relevant information about patients who were ready for discharge from acute beds, and there was then a telephone conversation with the Patient Flow Centre. This system had a number of disadvantages:

    i. The telephone call could take quite a long time, especially if the ward staff did not have all the relevant information ready. Examples quoted were 20 minutes if the information was prepared in advance and 45 minutes if not. This was partly because the systems used by the Patient Flow Centre were rigid, requiring the completion of all information including, for example, information for Pathway 1 even if this was not the ideal pathway or a section 2 form had been sent previously. The Patient Flow Centre relied on telephone communication, with no option for the pre-completion and electronic communication of relevant documentation. Reviewers were given examples of incomplete information as well as delays. Ward staff commented that this was adding

to their workload because, previously, the Discharge Liaison Team had undertaken this work.

ii. Ward staff had to relay information to the Patient Flow Centre even though they already knew the patient and which pathway of care would best meet the patient's needs. The decision about the pathway of care was then made by the Patient Flow Centre who did not know and had not seen the patient.

iii. The introduction of the Patient Flow Centre meant that the clinician to clinician discussion about the transfer of patients no longer took place. This may have contributed to some of the inappropriate transfers of care that were reported by staff. Handover documentation was completed, but clinical discussion before the transfer took place had been lost.

iv. Information was faxed by the Patient Flow Centre to the service to which the patient was being transferred, rather than being communicated electronically.

v. The Patient Flow Centre did not yet have systems for routinely capturing feedback information about inappropriate transfers or difficulties and delays in the transfer process. Some services felt that they could challenge the appropriateness of Patient Flow Centre decisions whereas others, for example staff in the Worcester Intermediate Care Unit, thought that this was not allowed.

vi. Some clinical staff in the acute Trust appeared unwilling to add information to the electronic white boards.

Further Consideration

1 Reviewers made the following suggestions for improving the functioning of the Patient Flow Centre:

a. Ensuring the Centre is staffed regularly on Saturdays (possibly until slightly later in the day) and Sundays, with local agreements about action to be taken for patients who are ready for discharge from acute hospital care outside the times when the Centre is functioning. Activity analysis could be used to show the times for which the service is most needed.

b. Introduction of electronic 'transfer of care' forms for communicating information to the Patient Flow Centre and then onward to the service to which the patient is transferred. These forms would need to be aligned with acute Trust discharge documentation to avoid duplication.

c. Introduction of a 'trusted assessor' system whereby staff in the acute Trust who know the patient make the decision about the appropriate pathway of care. The Patient Flow Centre would still have the important role of finding appropriate care and carrying out capacity management of the intermediate care resources (including intermediate care at home).

d. Introduction of the option for clinician to clinician discussion if considered necessary by either the transferring or the receiving clinical staff.

e. Introduction of audits and feedback about the appropriateness of transfers. This should include learning about transfers to intermediate care beds of patients who could have gone home with additional support. It may be possible to use the white boards to capture this information.

f. Arrangements for staff from the Patient Flow Centre to spend some time in the Emergency Departments, medical admissions and other wards in order to understand the pressures on staff working in those areas.

g. Ongoing work to explain to staff in acute, intermediate care and community services the benefits of the Patient Flow Centre and the arrangements for using the Centre and white boards, and ways of providing feedback about any problems that they experience.

h. Extending the role of the Patient Flow Centre to cover patients in acute hospital beds in Worcestershire who are resident outside Worcestershire.

2 Reviewers were given different views about whether capacity in Enhanced Care Teams was available. Some teams said that they had spare capacity and would welcome more referrals. Some acute Trust staff reported that capacity was a problem and there were delays in transfer from acute hospital care for patients on Pathway 1 because of capacity issues. Developing a clear, shared understanding of capacity in Enhanced Care Teams by locality, which could be updated on the Patient Flow Centre white board may be helpful.

3 Although criteria for admission to community hospitals and other intermediate care beds were available, it was not clear that all staff were aware of and fully understood these. Some of the criteria also appeared to be exclusion criteria rather than admission criteria. Reviewers were told that the level of care which could be provided was different in different facilities and may also vary depending on which staff were on duty and the level of dependency of other patients. Further work on summarising and widely communicating information about the level of care which can be provided at home and criteria for admission and level of care provided in each community hospital and intermediate care facility may be helpful. This communication should specifically target staff working in Worcestershire Acute Hospitals NHS Trust as well as others in the health and social care economy.

4 Reviewers commented on a view expressed by many staff that patients expected to go to a community hospital after an acute stay. Reviewers suggested that, in their experience, most patients would actually prefer to go home with appropriate support. Active patient engagement and a programme of cultural change, specifically targeting staff attitudes, may be helpful.

5 'Transfer of care' guidelines were not yet in place across the health and social care economy. Various tools and checklists were in use but there was no overall summary of the expected process in a format which could be easily understood by staff, patients and relatives.

6 Reviewers were given different views about whether relatives could accompany patients in ambulances. Re-stating the local policy may be helpful, especially to relatives of people with dementia.

7 The specification for intermediate care in bedded facilities stated that this care was for a maximum of six weeks. There appeared little incentive to discharge patients before the end of this period. Reviewers were given several examples of patients who could have gone home more quickly but stayed for the full six weeks. Commissioning incentives to encourage transfer home from intermediate care beds may be worthy of further consideration.

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PRIMARY CARE

General Comments and Achievements

Reviewers met only one GP during the course of the review and so were able to draw limited conclusions about this aspect of the pathway.

General practitioners were clearly very actively involved in driving improvements in the transfer from acute hospital care pathway. GPs were engaged with the admission avoidance team and alternatives to Emergency Department attendance, as well as actively supporting care of patients in community hospitals and other intermediate care beds.

Further Consideration

1 Reviewers were given some feedback about inefficiencies in the new arrangements for GP cover for patients in nursing homes. Further discussion with the GPs providing this service may be helpful.

ACUTE TRUST

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

General Comments and Achievements

Reviewers commented on the friendliness, helpfulness and commitment of all staff they met at the Alexandra Hospital and Worcestershire Royal Hospital. 'Board rounds' took place three times a day on all wards. An active urgent care improvement programme was in place with clear timescales and responsibility for action. Discharge 'champions' on each ward were being introduced. Pathology and radiology services provided very good support for the pathway of transfer from acute hospital care with rapid responses to requests for investigations.

Good Practice

1 Guidance for staff on 'useful information to consider when caring for patients from prison' was in use across the acute Trust. This provided simple but practical advice on how to communicate with prisons, medications, discharge arrangements, support for families and who to contact with queries.

2 Pharmacy staff were based in the Emergency Department at Worcestershire Royal Hospital were contributing to 'post-take' ward rounds (Mondays to Fridays) and were completing medicines reviews within 24 hours of admission for 84% of in-patients across the Trust. The Medical Assessment Unit was supported by the Emergency Department pharmacist until 4pm at weekends. Reviewers were also impressed by clarity and detail included on the medication charts in use at Worcestershire Royal Hospital. This recorded medicines reconciliation, counselling given and concordance issues. None of these support services were available to the Emergency Department at the Alexandra Hospital.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Engagement of medical staff**

Reviewers saw several examples of medical staff not being engaged as expected in the pathway of transfer from acute hospital care. Medical staff did not attend some of the 'board rounds' observed by reviewers, and other staff said that this was common practice on some wards. Also, information required on the electronic discharge summary was not always fully completed by medical staff, leading to delays in transfers of care (although see 'further consideration' 4 below in relation to the information expected).

2 **Worcestershire Royal Hospital Acute Medical Unit –assessment facilities**

Facilities for assessing patients on the acute medical unit at Worcestershire Royal Hospital were inadequate. Patients could be taken to three different areas, or moved around between these areas. The assessment room was used, but patients often had to wait in the corridor outside. Patients were redirected to the Emergency Department at busy times because of the shortage of assessment facilities. With the exception of assessment facilities, the move of the unit closer to the Emergency Department was generally seen in a positive light, with a reduction in incidents and complaints.

3 **Therapists at weekends**

The only therapists available at weekends were a respiratory physiotherapist and physiotherapists in trauma and orthopaedic services. Patient pathways were therefore being delayed because of the lack of active rehabilitation at weekends and because appropriate staff were not available to undertake assessments. Business cases had been prepared but not yet approved.

Further Consideration

1 Given the range of services available, reviewers were surprised that the capacity at the Trust was consistently on level 3 or 4 for long periods of time. Reviewers commented that the response to capacity pressures appeared to be reactive, and suggested that greater emphasis on 'thinking ahead' and 'getting ahead', at the same time as responding to immediate problems, may be helpful. Reviewers also commented on an apparent culture of accepting level 3 or 4 capacity as 'normal', noting that this was combined with a view that there was 'nothing the Trust could do about it' and 'everyone else' needed to take action. Reviewers suggested that challenging this culture may be helpful.

2 The discharge lounges at both the Alexandra Hospital and Worcestershire Royal Hospital appeared to add little to the pathway of transfer from acute hospital care. The environment in both lounges was poor, especially at Worcester where the 'lounge' was small and only consisted of two rows of chairs. The discharge lounge at the Alexandra Hospital was fully staffed and reviewers considered there may be potential for more effective use of these resources.

3 Reviewers saw little evidence of work to increase active rehabilitation of patients waiting for community hospital or other intermediate care beds. There may be potential for more active rehabilitation during the time spent waiting, which could either result in a shorter length of stay in intermediate care or avoid the need for intermediate care. The lack of availability of therapists at weekends (see concern 3 above) contributed to this issue.

4 The electronic discharge summary was a complex document. Reviewers considered that the quantity of information expected could be reduced, which may improve accuracy and speed of completion.

5 Reviewers saw some potential for improvements to the capacity management system. Bed managers were regularly visited or rang wards to ask about their beds, rather than looking at the information available on the white boards. Use of a standard format for information needed at capacity meetings may be helpful. It may also be useful to summarise actions agreed at the end of each meeting, which was not done in the meetings observed by reviewers.

6 Some delays in availability of drugs 'to take out' were reported, but a clear action plan for addressing these was in place and staff were confident that this issue would be resolved by the summer of 2015.

7 Some staff said that it was Trust policy that patients should not be discharged until the afternoon. This clearly was not Trust policy but further work to inform staff may be helpful.

8 Reviewers highlighted some issues of incomplete equipment checks by ward staff during their visits, including for fridges and resuscitation trolleys.

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Intermediate Care

WORCESTERSHIRE HEALTH AND CARE NHS TRUST: Enhanced Care Teams

Caseloads at the time of the review visit:

Evesham: 29 patients. The team received approximately 90 referrals per month and provided care for approximately six weeks.

Malvern: 56 patients.

Wyre Forest: The Admission Prevention Team philosophy was to accept all referrals and then signpost to other services as appropriate. The team received approximately 99 referrals per month and a quarter of these referrals (25) were then redirected or referred to other services. Length of stay within the service was over twelve weeks.

Redditch: Caseload not known.

Bromsgrove: Caseload not known.

Worcester: Caseload not known.

General Comments and Achievements

The six Enhanced Care Teams appeared to be working very well (see 'good practice' in the health and social care economy section of this report). These teams prioritised admission avoidance and getting patients home from acute hospital care as quickly as possible. A newsletter for GPs about the services provided had been introduced, initially in Evesham but then throughout Worcestershire.

Evesham: Standardised multi-disciplinary team records had been introduced. The multi-disciplinary approach to intermediate care at home meant that each specialism knew where and how to access the appropriate services, and the team were active in signposting patients, carers and community hospital staff to the right services required. Reviewers were told that this had reduced delays in discharging patients from the service and enabled timely referrals to alternative pathways.

Good Practice

1 Malvern: The team was highly focussed on providing personalised patient care. There were very good links between the Enhanced Care Team and community hospital staff, and clear evidence of effective integration between health and social care.

See also the health and social care economy section of this report.

Immediate Risks: No immediate risks were identified.

Concerns

1 Malvern: The service was having difficulty recruiting to physiotherapy and occupational therapy vacancies. The Trust was aware of this issue and had a plan for addressing the problem.

2 Wyre Forest (Admission Prevention Team): Recruitment and retention of matrons to work in the service was proving difficult because of broadly similar posts elsewhere in the county being banded at a higher level.

Further Consideration

1 All: The option for 'step up' to community hospital care (rather than 'step down' from acute hospital care) did not appear to be actively used or prioritised. It may be helpful to develop this aspect of the work of community hospitals further, especially if this could avoid admission to acute hospital care.

2 Evesham: The team said that they had the capacity to provide more care for people at home and would like to provide more of this care. The team had the competences to care for patients needing intravenous antibiotics but said that they received few referrals for this service.

3 Malvern: Reviewers did not see evidence of 'after intermediate care' plans.

4 Redditch: The team appeared overwhelmed by the number of patients for whom they were providing care.

5 Wyre Forest (Admission Prevention Team): This team had evolved over time and did not appear to have a clear view of its role. Links with local GPs were good. The team was collecting relatively little data about its work and so was not able to analyse and improve the service provided. Reviewers were interested that the service specification said that all patients could be cared for by the team but that, in practice, approximately 25% of patients were transferred from acute hospital care to other teams. The reasons for this were not clear.

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WORCESTERSHIRE HEALTH AND CARE NHS TRUST: Community Hospitals

Community Hospital	Wards visited	Beds
Evesham	Izod (ITC and 4 Palliative Care beds) Abbott (16 beds + one bed for extra capacity)	16 16+1
Malvern	Intermediate Care GP Unit	24
Bromsgrove	Lickey Ward (mixed Rehab/ITC and GP beds)	24
Pershore	(Not visited)	-
Tenbury	(Not visited)	-

General Comments and Achievements

All of the teams providing care in community hospitals were enthusiastic and clearly committed to providing high quality care and improving the service for patients. Reviewers commented positively on all the Worcestershire Health and Care NHS Trust community hospitals, saying, for example, 'they are doing exactly what they should be doing'.

Evesham: Good use was being made of an old building. The team had worked hard to reduce length of stay, which was down to an average of 21 days at the time of the review visit. Nurse prescribers were available on site. Some problems with GP cover for the community hospital had been successfully overcome.

Malvern: The service was providing an increasing amount of sub-acute care as staff competences for this were achieved.

Good Practice

1 All: Excellent information for patients and their families was easily accessible in all the community hospitals visited. This information exceeded the requirements of the Quality Standards, was of a very high standard and was displayed clearly at the entrance of all the hospitals visited.

2 Evesham: The National Hydration Bundle had been fully implemented. A pictorial chart was in use for those who did not require detailed fluid management. This clearly identified the number of drinks consumed and the time urine was voided. Patients had a clear understanding of their 'after intermediate care' plan. Packed lunches were provided for patients discharged home before lunch.

3 Evesham: A white board on Abbott Ward provided visual information about staff competences. This gave an easily accessible overview of which staff had completed or were due training, and training plans.

4 Malvern: The environment was of a very high standard. The team was highly focussed on providing personalised patient care. Leadership of the team was strong and leaders were working well to motivate all staff. There were very good links between community hospital staff and the Enhanced Care Team, and clear evidence of effective integration between health and social care. Metrics were prominently displayed, including metrics relating to infection control, pressure ulcers, the hydration bundle, dementia care and the 'friends and family' test.

5 Bromsgrove: Leadership of the service was strong and staff had achieved particularly high levels of mandatory training. The wards were calm and well-organised.

Immediate Risks: No immediate risks were identified.

Concerns

1 Evesham: Space in the end bays of Abbott and Izod Wards was cramped, with what appeared to be an extra bed in the bays. There was a curtain track around these bed-spaces but it was difficult to see how patients' privacy and dignity could be maintained. The limited space must also have been difficult for staff providing care.

2 Malvern: The service was having difficulty in recruiting to physiotherapy and occupational therapy vacancies. The Trust was aware of this issue and had a plan for addressing the problem.

3 Bromsgrove: Faxes from the Patient Flow Centre arrived in an open area rather than a 'safe haven'.

Further Consideration

1 All: Visiting hours had been reduced to provide more time for rehabilitation activities. Some families who met reviewers commented that this was causing them problems – for example, in helping with feeding relatives with dementia. It may be helpful to consider a more flexible approach, especially if this can be used to support the involvement and empowerment of carers.

2 Evesham: Boards were used to identify risks to patients but did not include the risk of falls.

3 Malvern: Available patient information did not cover the local Enhanced Care Team.

4 Malvern: Drugs 'to take out' were supplied from Redditch. This arrangement appeared to introduce unnecessary delays in transfers home.

5 Bromsgrove: The list of patients who were 'ready to go' appeared inaccurate. Reviewers were told that, at times, over 50% of these patients were not 'ready to go'.

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TIMBERDINE NURSING AND REHABILITATION UNIT

Good Practice

1 This was an excellent unit in all respects. It provided 36 beds for rehabilitation, including for people who had suffered a stroke. The integrated team of nurses, social workers, physiotherapists, occupational therapists, GPs and mental health nurses was clearly highly committed and took a very proactive approach to rehabilitation. Leadership of the service was strong, and all staff, including catering staff, appeared empowered and engaged in providing care of the highest quality. Patient feedback about the care provided was excellent.

Immediate Risks: No immediate risks were identified.

Concerns: No concerns were identified.

Further Consideration

1 Health and social care staff were employed on different terms and conditions. It may be helpful to address this issue as the service develops.

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WORCESTERSHIRE COUNTY COUNCIL: SHAW RED HILL (Worcester Intermediate Care Unit)

General Comments and Achievements

The service was provided from pleasant facilities that were being improved at the time of the review visit; in particular, improvements were being made to the day room. There were 20 beds providing intermediate care. The unit's social worker was very actively engaged in the service provided. The unit had a pharmacy support

team during normal working hours. Standardised documentation was in use. The unit made use of e-learning mandatory training materials from Worcestershire Acute Hospitals NHS Trust.

Good Practice

1 A good sized, well-equipped therapies room was available with good physiotherapy and occupational therapy cover, linked with the local Enhanced Care Team.

2 A 'ready to go' ticket was used to inform relatives of the expected date of discharge from the unit.

3 An excellent 'service user guide' to the service was easily available to residents and families.

Immediate Risks: No immediate risks were identified.

Concerns: No concerns were identified.

Further Consideration

1 Staff had First Aid training but not Basic Life Support training. Reviewers suggested that Basic Life Support training would be appropriate given the dependency of residents on the unit.

2 Staff who met reviewers were aware of some residents being inappropriately placed on the unit, but did not realise that they could challenge the decisions of the Patient Flow Centre. Reviewers suggested that staff should be encouraged to provide feedback to the Patient Flow Centre and, if necessary, challenge their decisions.

3 Reviewers were not able to access information on staff vacancies and the level of use of agency staff. Reviewers suggested that further local assurance on this issue may be helpful.

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WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST: Kidderminster Treatment Centre (Cookley Ward)

General Comments and Achievements

Cookley Ward comprised 17 beds for sub-acute care and up to nine beds for stroke rehabilitation. Care was provided by a team of nurse practitioners, nurses, physiotherapists, occupational therapists and speech and language therapists. The team had plans for improving the use of the day room and gymnasium which were not fully utilised at the time of the review. The ward had a good range of useful, up to date leaflets and a 'who's who?' board for patients and carers. Care plans were clear and comprehensive, and were agreed through a multi-disciplinary meeting with patients and their carers.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Medical input**

A doctor attended the ward only once a week in order to join the multi-disciplinary team meeting. Medical staff could be called at other times if required, but pro-active medical input to the care of patients and to supporting their transfer home was not in place.

2 **Nursing staff vacancies and competences**

Recruitment and retention of nursing staff was problematic; based on the rotas seen by reviewers, at least 13 shifts per week were covered by bank and agency staff. It was not clear that all nursing staff had appropriate competences for their work on the ward, particularly PEG feeding and care of patients on intravenous therapies.

3 **Active rehabilitation**

Ward staff did not appear clear about the purpose of the ward and, although care plans were in place, a multi-disciplinary approach to discharge planning from day one with clear rehabilitation goals for patients needing intermediate care was not demonstrated.

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COMMISSIONING

General Comments and Achievements

Reviewers met representatives from South Worcestershire Clinical Commissioning Group but none from Wyre Forest or Redditch and Bromsgrove CCGs.

The three CCGs were working well together to improve the pathway for transfer from acute hospital care and intermediate care. They had appointed a joint lead for urgent care, had introduced a CQUIN to improve patient flow and had cooperated to achieve much of the progress described in this report.

Reviewers were impressed by the pro-active approach taken by the CCGs, by their engagement with operational issues when there were difficulties and by their willingness to give freedom to providers when key performance indicators were achieved. Commissioners had identified and were monitoring key metrics. Occupancy of intermediate care beds and the number of patients 'home for lunch' had increased. Readmission rates were being investigated further.

Good Practice

1 A review of medical care in community hospitals had resulted in this service being re-commissioned. This change had been associated with reduced length of stay in community hospitals and improved management of care, including ensuring medical input to ward rounds daily.

2 GP engagement with improvements to pathways of care was extensive. An 'Alliance Board' comprising the three CCGs and the South Worcestershire GP Federation was actively driving improvements in care.

3 Links with the County Council were working well. Worcestershire was a 'Pioneers Site' for the 'Well Connected' programme covering creation of care plans and roll-out of Emergency Care Plans. Work was being undertaken to introduce electronic comprehensive care plans (COMPASS).

Immediate Risks: No immediate risks were identified.

Concerns

Several of the issues identified in the health and social care economy and provider sections of this report will require action, support and monitoring by commissioners to ensure progress is made:

1 Availability of domiciliary carers: see Health and Social Care Economy, Concern 1

2 Patient Flow Centre: see Health and Social Care Economy, Concern 2

3 Engagement of medical staff: see Acute Trust, Concern 1

4 Worcestershire Royal Hospital Acute Medical Unit –assessment facilities: see Acute Trust, Concern 1

5 Therapists at weekends: see Acute Trust, Concern 1

6 Intermediate Care: Worcestershire Health and Care NHS Trust – Enhanced Care Teams, Concerns 1 & 2

7 Intermediate Care: Worcestershire Health and Care NHS Trust – Community Hospitals, Concerns 1, 2 & 3

8 Medical input: see Intermediate Care - Worcestershire Acute Hospitals NHS Trust, Kidderminster Treatment Centre (Cookley Ward), Concern 1

9 Nursing staff vacancies and competences: see Intermediate Care - Worcestershire Acute Hospitals NHS Trust, Kidderminster Treatment Centre (Cookley Ward), Concern 2

10 Active rehabilitation: see Intermediate Care - Worcestershire Acute Hospitals NHS Trust, Kidderminster Treatment Centre (Cookley Ward), Concern 3

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APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Visiting Team

Karen Anderson	Acute Matron, Haematology, Oncology, Respiratory & MHDU	The Dudley Group NHS Foundation Trust
Kerry Anelli	Matron for General Surgery , Urology & Head & Neck Services	The Royal Wolverhampton NHS Trust
Jonathan Beasley	Compliance Manager	Heart of England NHS Foundation Trust
Julie Booth	Clinical Quality Manager	NHS Solihull CCG
Sandra Coates	Deputy Director of Operations	Burton Hospitals NHS Foundation Trust
Jill Crockett	Matron for Respiratory and Sexual Health	The Royal Wolverhampton NHS Trust
Adele Dean	Clinical Quality Manager	West Midlands Ambulance Service NHS Foundation Trust
Sara Hilditch	Advanced Nurse Practitioner	Staffordshire & Stoke on Trent Partnership NHS Trust
Marian Long	Group Head of Nursing Community & Therapies Clinical Group	Sandwell & West Birmingham Hospitals NHS Trust
Diana Polowyj	User Representative	
Dr Narinder Sahota	PEC Chair/Medical Director	NHS Walsall CCG
Dr Ravinder Sandhu	GP Partner/Trainer	NHS Walsall CCG
Steve Snart	Patient Representative	
Hilary Sullivan	Head of Discharge	Burton Hospitals NHS Foundation Trust
Judith Whalley	Patient Representative	

WMQRS Team

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

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 Trust	23	9	39
Intermediate Care:	132	81	61
Worcestershire Health and Care Trust	(33)	(20)	(61)
Worcestershire Acute Hospitals Trust	(33)	(16)	(48)
Worcestershire County Council: Timberdine	(33)	(25)	(76)
Shaw Red Hill : Worcester Intermediate Care Unit	(33)	(20)	(61)
Commissioning	4	1	25
Health and Social Care Economy	**161**	**91**	**57**

Pathway and Service Letters:
Standards for Transfer from Acute Hospital Care use the pathway letter S. The Standards are in the following sections:

	Pathway	Service
SA -	Transfer from Acute Hospital Care	Primary Care
SM-	Transfer from Acute Hospital Care	Acute Trust: All wards
SN -	Transfer from Acute Hospital Care	Intermediate Care Service
SZ -	Transfer from Acute Hospital Care	Commissioning

Topic Sections: Each section covers the following topics:

-100	Information and Support for Patients and Carers
-200	Staffing
-300	Support Services
-400	Facilities and Equipment
-500	Guidelines and Protocols
-600	Service Organisation and Liaison with Other Services
-700	Governance

PRIMARY CARE

Ref No	Quality Standards	Met? Y/N	Reviewer 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	Patient Passports as outlined in the QS were not in place for all patients at high risk of admission in Worcestershire Emergency care plans and the Amber Care Bundle had been implemented. Advanced care planning 'Greensleeves' was in the process of being implemented.
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 records were not available for all patients referred to intermediate care. Work was being undertaken as part of the 'well-connected' programme to develop a comprehensive care plan across health and social care. Emergency care action plans were in place with WMAS and OOH services.

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ACUTE TRUST

Ref No	Quality Standards	Met? Y/N	Reviewer 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 'Planned Elective Surgery' leaflet was comprehensive. The pre-operative questionnaire incorporated discharge planning Pathway leaflets for orthopaedic procedures were in place.
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	The assessment document was very good and the 'Timely Transfer' information leaflet was given to patients on admission. An information letter for patients and carers explaining expected discharge arrangements had been published in collaboration across Health and Social Care and, showed agreement by each of the Chief Executive Officers
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	Good assessment tools were being used by all disciplines and discussions with patients and families were clearly recorded in the health records seen by reviewers.
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	Patient Passports were not in use across Worcestershire, however the use of the Amber bundle was exemplary. Those at high risk of admission had been identified for specific bundles for example Chronic Obstructive Pulmonary Disease (COPD), Enhanced Recovery and Uro-gynaecology

Ref No	Quality Standards	Met? Y/N	Reviewer 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.	Y	An Electronic Discharge Summary was in the process of being implemented, although information about transport or equipment was not included. Equipment loans were managed via the Enhanced Care Team or central equipment store. A medicines helpline leaflet was very useful and good practice. Timely Transfer assessments were completed with all patients and their family/carers, which ensured that pre discharge assessments were completed. A useful outside contact leaflet had been developed with health providers and the County Council. The stroke pathway and stroke information pack was very good. Clear medical responsibility for the Community Hospitals and Timberdine Nursing and Rehab Unit for transfers of care was in place. Medical responsibility for patients under the care of the Enhanced Care Team was the patient's own GP.
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	Y	Information leaflets and a support action group were in place for carers. All admission assessments in the Community Hospitals and Rehabilitation Units include carers' assessments.
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	Y	Friends and Family surveys were in use across all the areas and staff encouraged patients and their families to complete the feedback forms on discharge. Clear processes were in place for complaints to be made and patient forums/groups could raise concerns with Trust staff if required.

Ref No	Quality Standards	Met? Y/N	Reviewer 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	Therapy provision was not available over the weekends to facilitate discharge planning. Competences in 'event-led' discharge 7/7 were not yet in place. Access to social services staff available to undertake social care assessment within 24 hours of request and access to pharmacy services for medication 'To Take Out' was not always available within four hours of request.
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	The health economy was in the process of implementing the 'Trusted Assessor' model which had included information for staff and training workshops.
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	Some training had been provided, but it had not been consistent and across all areas of clinical staff. The Trust had trialled a 'Perfect week' pilot.

Ref No	Quality Standards	Met? Y/N	Reviewer 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	Transport was not always available within four hours of request. All other aspects of the QS were met.
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.	Y	Short-term domiciliary care at home was possible depending on the capacity within the community teams. Age UK and the Red Cross provided some of these services.
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	The IT systems used in the Acute Trust could not be accessed by any outside organisations apart from ICE and PACs which are both accessible by GP's. Patient Health records were not accessible.
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.	N	Board rounds were predominantly nurse led, Consultants and their medical teams were not always present.

Ref No	Quality Standards	Met? Y/N	Reviewer 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	Transfer of Care guidelines covering all aspects of the QS were not yet in place. Event led discharge was not yet in place. Multi-disciplinary review could not always take place within 24 hours of admission. The Single Assessment Process was not in use across all the acute areas. For most discharges an electronic discharge summary was available rather than a transfer of care plan.

Ref No	Quality Standards	Met? Y/N	Reviewer 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	Y	Clear processes were in place for assessing and planning for complex discharges. The 'Discharge to Assess' model was in place, enabling patients to be transferred to a more appropriate environment for further assessment. The Amber Care Bundle for end of life care was embedded into clinical practice.
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	The Electronic Discharge summary process worked well though some medical colleagues and GP's commented that the quality of the information was variable. Information was not always relevant, which GP's reported as being misleading and difficult to decipher at times. Some 'hot clinics' were available for those from the Medical Assessment Unit (MAU) but not via the general wards. Most clinics did not run seven days a week. It was not clear what local enabling agreements were in place.

Ref No	Quality Standards	Met? Y/N	Reviewer 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	N	Access from the Acute Trust to services able to deliver sub-acute care across the health economy was variable. Across the community hospitals different levels of sub-acute care were provided. Capacity within the Worcester Enhanced Care Team was also limited.
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 and the Nursing Metrics and discharge data displayed on the ward notice boards.
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	Some data was collected by the Trust, however 'b' was not audited.
SM-797	**Health and Social Care Review and Learning Group** 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	A formal group that met to discuss, review and share learning from discharge planning regularly was not yet in place. There were some shared learning events but these were predominantly available to NHS Managers and not to frontline staff.

Ref No	Quality Standards	Met? Y/N	Reviewer 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 The Trust had a Health Economy Patient Experience Group, though this group did not review discharge planning or transfers of care.
SM-799	**Document Control** All policies, procedures and guidelines should comply with Trust (or equivalent) document control procedures.	N	Many of the documents reviewed did not have a version number, were out of date or had passed their review date.

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Intermediate Care

Worcestershire Health and Care NHS Trust – Evesham, Princess of Wales and Malvern Community Hospitals and Enhanced Care Teams

Worcestershire Acute Hospitals NHS Trust – Kidderminster Treatment Centre – Cookley ward

Ref No	Quality Standards	Met? Y/N	Worcestershire Health and Care NHS Trust Reviewer Comment	Met? Y/N	Worcestershire Acute Hospitals NHS Trust Reviewer 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	Information was clearly visible on the wards and a pack was available to relatives and patients in all areas. Friends and Family outcomes and visiting times were displayed on notice boards outside the wards. An advice sheet with contact details was also given to families.	N	Cookley Ward staff were planning to develop a ward leaflet to cover specific information for patients and carers. Information about staff and who to contact was visible.

Ref No	Quality Standards	Met? Y/N	Worcestershire Health and Care NHS Trust Reviewer Comment	Met? Y/N	Worcestershire Acute Hospitals NHS Trust Reviewer 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	In all the community hospitals visited, patients had an assessment on arrival, based on the Activities of Daily Life (ADL). Care plan goals and aims were based on realistic achievement of gaps in the ADL's. Care plans were also discussed with patients and families (if appropriate) Multi-disciplinary team meetings were held weekly and care plans reviewed. An advice sheet with contact details was given to families A nominated GP had been identified for the Community Hospitals.	Y	A Consultant was allocated for all the patients admitted to Cookley ward.
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.	N	At the time of the visit a doctor was not available to attend the weekly multi-disciplinary team meeting on Abbot ward at Evesham. Weekly reviews took place with the multi-disciplinary team in the other community wards and enhanced teams. Best practice ward rounds were also in place as part of a 'Patient Flow' CQUIN.	Y	Weekly reviews took place with the named Consultant for the patients admitted to Cookley ward.

Ref No	Quality Standards	Met? Y/N	Worcestershire Health and Care NHS Trust Reviewer Comment	Met? Y/N	Worcestershire Acute Hospitals NHS Trust Reviewer 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	An advice sheet with contact details was given to families.	Y	
SN-106	**Care Coordinator** Each patient should have a nominated individual responsible for planning and coordinating their care, including planning their longer-term care.	Y	A named nurse/key coordinator was allocated to each patient staying in the Community Hospitals.	Y	A named nurse/key coordinator was allocated to each patient.
SN-107	**Communication Aids** Communication aids should be available to enable patients with communication difficulties to participate in decisions about their care.	Y		Y	
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 Passports were not in use in Worcestershire. Some work was being undertaken as part of the EMIS community pilot in Worcester City which would allow GP summaries to be viewed by the Enhanced Care Team staff, care home practitioners and the proactive care team in South Worcestershire.	N	Patient Passports were not in use in Worcestershire.

Ref No	Quality Standards	Met? Y/N	Worcestershire Health and Care NHS Trust Reviewer Comment	Met? Y/N	Worcestershire Acute Hospitals NHS Trust Reviewer 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	A transfer of care or discharge plan was being developed to facilitate transfer of care between services. The Electronic Discharge Summary (EDS) was used to share some information.	N	An 'after Intermediate care plan' was not in place, some information was shared via the Electronic Discharge Summary (EDS).

Ref No	Quality Standards	Met? Y/N	Worcestershire Health and Care NHS Trust Reviewer Comment	Met? Y/N	Worcestershire Acute Hospitals NHS Trust Reviewer 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	See also good practice section of the main report	Y	All aspects of the Quality Standard were available.
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	Carers support leaflets were accessible. A Carers Action group leaflet was also available and 'How to access Social care'.	Y	There were leaflets available for carers and access to a support action group for further advice and support.
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	Friends and Family results were evident on the notice boards on wards at Evesham, Princess of Wales Community Hospital and Malvern. An external group had undertaken a snap shot of services provided by the enhanced care team. The Trust communication dept. undertook surveys at each of the community hospitals.	N	Trust-wide mechanisms were in place but there was no evidence of changes made as a result of feedback. The friends and family test had been commenced but results were not displayed.

Ref No	Quality Standards	Met? Y/N	Worcestershire Health and Care NHS Trust Reviewer Comment	Met? Y/N	Worcestershire Acute Hospitals NHS Trust Reviewer 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	Strong clinical leadership was in place for the Community Hospitals. A nominated GP had been identified for each Community hospital and locum consultant medical support was available from Worcestershire Health and Care NHS Trust.	Y	The Advanced Practitioner and the Ward Sister provided leadership for the service.
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.	Y	The Shelford Group safer nursing toolkit was used to determine staffing levels and this was reviewed on a 6 monthly basis. Malvern Community Hospital wards: 24 beds staffing was 2: 4 trained/untrained at all times (24/7). Evesham Community wards: Staffing was 2:2 trained/ untrained on late and night shifts Princess of Wales Community Hospital: staffing was 1:8 trained/ untrained. Some work was in progress to review therapy input to Community Hospital intermediate care services due to difficulties in recruiting to the vacant Band 5 posts. Social workers were based on the Community wards and about to be incorporated into the enhanced teams.	N	At the time of the visit there were a number of vacancies and staff sickness absence on the ward. Evidence of rotas seen for the week beginning 8th March, 13 shifts were covered by staff working their annual leave or by bank staff.

Ref No	Quality Standards	Met? Y/N	Worcestershire Health and Care NHS Trust Reviewer Comment	Met? Y/N	Worcestershire Acute Hospitals NHS Trust Reviewer Comment
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	Y	Competences were in place for 'a', 'b', and 'c.' VAC therapy was not provided by community hospitals by the enhanced care team.	Y	Competences were in place for ' a', 'b', and 'c.' VAC therapy was not provided on Cookley Ward.
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)	Y	Competencies were in place for 'a' – 'h'.	Y	

Ref No	Quality Standards	Met? Y/N	Worcestershire Health and Care NHS Trust Reviewer Comment	Met? Y/N	Worcestershire Acute Hospitals NHS Trust Reviewer Comment
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 doctor or other registered health professional with authorisation to prescribe was not always available within two hours (c). A consultant Clinical Director for both the North and South of the county was in place. In-house medical cover was available in the community hospitals.	Y	An Advanced Nurse Practitioner was available on the ward on a Monday to Friday. A named consultant visited weekly. A Resident Medical Officer (RMO) provided cover at other times.
SN-299	**Administrative, Clerical and Data Collection Support** Administrative, clerical and data collection support should be available.	Y	Admin staff were part of the establishment for Enhanced Care Team and the Community Hospital wards	Y	Admin staff were part of the Ward establishment.
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	Y	Community hospitals could access all support services. Tissue viability, continence, and infection control advice was available seven days a week. The Enhanced teams included mental health staff.	N	Home assessments were not always possible within 24hrs of request. Mental health team (crisis response) was not always possible within four hours. Other support was available via the acute services 7/7.

Ref No	Quality Standards	Met? Y/N	Worcestershire Health and Care NHS Trust Reviewer Comment	Met? Y/N	Worcestershire Acute Hospitals NHS Trust Reviewer 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	Y	Malvern and Evesham: Medication was not always available within four hours as it was accessed from the Princess Alexandra Hospital in Redditch. Staff were able to arrange medication for discharge by using an FP10 which could be dispensed via the local pharmacy so that discharges were not delayed. Age UK and Red Cross provided services for 'i.'	N	Transport was not always available within four hours of request. All other aspects of the Quality Standard were met.
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	Staff had access to a robust buffer stock of equipment in all the Community Hospitals, this equipment was also available to the Enhanced Care Teams. An excellent service was provided by Wychbold Community Equipment Service	Y	Equipment and facilities were appropriate to the clinical area.

Ref No	Quality Standards	Met? Y/N	Worcestershire Health and Care NHS Trust Reviewer Comment	Met? Y/N	Worcestershire Acute Hospitals NHS Trust Reviewer Comment
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	IT systems were fragmented through the Trust. The IT strategy included working towards a single integrated patient care record that would have intra-operability with other IT systems. A Trust-wide phased roll out for the 'Care Notes' system was planned for 2015/16.	N	IT systems were not linked to the patient flow centre who required separate records.
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	A range of assessment tools and checklists were in place across all the hospitals and teams.	Y	A range of assessment tools and checklists were in place.

Ref No	Quality Standards	Met? Y/N	Worcestershire Health and Care NHS Trust Reviewer Comment	Met? Y/N	Worcestershire Acute Hospitals NHS Trust Reviewer 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	Y	Worcestershire Health and Care NHS Trust Guidelines covered all aspects of the Quality Standard.	N	All but guidelines for Spasticity management were in place. The Trust Stroke positioning guidance did not cover spasticity management.

Ref No	Quality Standards	Met? Y/N	Worcestershire Health and Care NHS Trust Reviewer Comment	Met? Y/N	Worcestershire Acute Hospitals NHS Trust Reviewer 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	Transfer of care guidelines had not been finalised.	N	Transfer of care guidelines had not been finalised.
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	Guidelines covering more complex transfers of care were not yet in place.	Y	Trust guidelines were in place.

Ref No	Quality Standards	Met? Y/N	Worcestershire Health and Care NHS Trust Reviewer Comment	Met? Y/N	Worcestershire Acute Hospitals NHS Trust Reviewer Comment
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	Guidance was in place for caring for vulnerable adults and there were good links with the relevant agencies. Staff who spoke to the reviewing teams had a good understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards.	Y	Guidance was in place for caring for vulnerable adults and there were good links with the relevant agencies. Ward staff were aware of the Mental Capacity Act and Deprivation of Liberty Safeguards.

Ref No	Quality Standards	Met? Y/N	Worcestershire Health and Care NHS Trust Reviewer Comment	Met? Y/N	Worcestershire Acute Hospitals NHS Trust Reviewer 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	An operational policy was not in place. Admission criteria were defined but not always followed, depending on other health economy pressures. Initial assessments within 30 minutes of transfer were undertaken. Agreement of care plans did take place and therapeutic interventions were commenced within 24 hrs except for those who were transferred over the weekend. Medical staff were available for daily reviews. Multi-disciplinary team meetings took place weekly. The Enhanced Care team (South) standard operational policy was in the process of being finalised. There were also plans being developed to introduce 7 day therapy services to all in-patient areas.	N	An operational policy was not in place. The Advanced Nurse Practitioner undertook daily reviews. Initial assessments within 30 minutes of transfer were undertaken.

Ref No	Quality Standards	Met? Y/N	Worcestershire Health and Care NHS Trust Reviewer Comment	Met? Y/N	Worcestershire Acute Hospitals NHS Trust Reviewer 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	Y	Data were collected via NCRS (NHS Care Records Service) and the Trust productivity management control system data (Meridian).	N	Data covering 'b' was not seen. Data on referrals to the service, length of stay and expected date of discharge were collected.
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 in place but not covering compliance with evidence based clinical guidelines (QS SN – 500s).	N	A rolling programme of audit was in place but not covering compliance with evidence based clinical guidelines (QS-SN – 500s).
SN-703	**Key Performance Indicators** Key performance indicators (QS SN-701) should be reviewed regularly with Trust (or equivalent) management and with commissioners.	N	The service specification for the Enhanced Care Team was still in draft. Monthly monitoring meetings were held with the CCGs. Nursing metrics were collected on all wards. An 'improving patient flow' CQUIN was in place.	N	It was not clear what Key Performance Indicators were being collected. Friends and Family survey results were not displayed. Nursing metrics were collected on all wards. An' improving patient flow' CQUIN was in place.
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	A formal group that met to discuss, review and share learning from discharge planning regularly was not yet in place. There were some shared learning events but these were predominantly available to NHS Managers and not to frontline staff	N	A formal group that met to discuss, review and share learning from discharge planning regularly was not yet in place. There were some shared learning events but these were predominantly available to NHS Managers and not to frontline staff.

Ref No	Quality Standards	Met? Y/N	Worcestershire Health and Care NHS Trust Reviewer Comment	Met? Y/N	Worcestershire Acute Hospitals NHS Trust Reviewer 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 review and learning on each ward and Enhanced Care Team as defined by the Quality Standard was not yet in place. Quality and performance meetings were held monthly and information disseminated to operational staff.	N	Multi-disciplinary review and learning on each ward as defined by the Quality Standard was not yet in place.
SN-799	**Document Control** All policies, procedures and guidelines should comply with Trust (or equivalent) document control procedures.	N	Many leaflets and documents were out of date or did not include version control information.	N	There were many documents reviewed that did not have a version number, were out of date or had passed their review date.

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Ref No	Quality Standards	Met? Y/N	Timberdine Intermediate Care Unit (Worcestershire County Council) Reviewer Comment	Met? Y/N	Worcester Intermediate Care Unit (Shaw Red Hill) Reviewer Comment
SN-101	**Service Information** Each service should offer patients and their carers writteninformation 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	A service user guide was in place with all the relevant information incorporated.	Y	The 'welcome' letter/contract was very detailed and informed the patients of the period of rehabilitation, and what to expect in terms of rehabilitation goals, care plans and discharge planning. The information also covered staff, contact details and visiting times. Patients signed to say that they had understood the reasons for admission. The Worcester Intermediate Care Unit service guide covered all other information.

Ref No	Quality Standards	Met? Y/N	Timberdine Intermediate Care Unit (Worcestershire County Council) Reviewer Comment	Met? Y/N	Worcester Intermediate Care Unit (Shaw Red Hill) Reviewer 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	Timberdine used the Single Assessment Process (SAP), their patients had red folders which transferred with the service users. Service users who did not have a red folder were assessed and an individualised care plan was devised.	Y	Initial assessments were done on the day of arrival to Worcester Intermediate Care Unit. Nursing and Therapy plans were discussed with patients and carers (where appropriate). Some therapy plans included specific night time goals. A good process for communicating the discharge arrangements to all involved was the 'ticket home' this was visible at the bedside.
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	Weekly multi-disciplinary team meetings took place to review care plans, and individual goals were reassessed weekly.	Y	Multi-disciplinary team meetings were held on a Tuesday and 'catch up' meetings took place on a Friday to check the progress of actions.
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	All rooms at Timberdine had staff allocated to them 24/7 so that the service user knew who was looking after them.	Y	Each service user and carer/relative was given contact details for the unit.

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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	A named care co-ordinator for each service user was not in place, however, the Unit allocated a team of nurses to each area of the Unit for the day which ensured continuity of care.	Y	
SN-107	**Communication Aids** Communication aids should be available to enable patients with communication difficulties to participate in decisions about their care.	Y	Aa variety of communication aids were available and in use. Loop systems were in operation in some lounges. Communication charts, paper and pens, whiteboards and Interpreters were also available.	Y	A hospital communication booklet was available. Staff did not raise any issues with accessing any other aids to communication.
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 Passports were not in use across the health economy.	N	Patient Passports were not in use across the health economy.

Ref No	Quality Standards	Met? Y/N	Timberdine Intermediate Care Unit (Worcestershire County Council) Reviewer Comment	Met? Y/N	Worcester Intermediate Care Unit (Shaw Red Hill) Reviewer 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	Y	Service users were discharged with a discharge letter which was also copied to their GP and any other professionals involved in their care e.g. Community Stroke Service or District Nursing services. The discharge letter included all the criteria outlined in the Quality Standard.	Y	Patients and carers were involved in decisions about care after discharge.
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	Timberdine had information leaflets and systems in place to enable access to services and to offer advice on all aspects of this Quality Standard.	Y	Information leaflets and systems were in place to enable access to services and to offer advice on all aspects of this Quality Standard.

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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	Timberdine offered carer support and assessed the needs of carers as part of their daily work, they also had access to an onsite social worker who assisted families with financial advice.	Y	Information for carers was displayed in the unit.
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	Feedback from Service users and carers was actively sought by Timberdine. A 'Having your Say' questionnaire was given out to all service users at the time of their discharge and the results were collated into a report which was displayed.	Y	Feedback forms were given to patients and carers prior to discharge. A previous registration visit had identified the need for a social area which was in the process of being developed.
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	Good leadership was provided at Timberdine with a Registered Manager and Lead Clinician/Advanced Nurse Practitioner.	Y	

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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.	Y	Timberdine had 36 beds of which 20 beds were step-down/Intermediate care beds. The skill mix during the day was: One registered nurse: 9 service users and One care staff member (untrained): 3.6 service users Two hours of physiotherapy and 2.8 hours of occupational therapy was available for each patient per week. At night: One registered nurse: 12 service users One care staff member:7.2 service users	N	Only one registered health care professional was on duty overnight for the intermediate care service. A competency framework was in place and audited, along with mandatory training compliance. From the evidence seen it was not clear that the competency audit had been completed for all WICU staff. Staffing levels were: 07.30-21.30: two Registered Nurses and 4 care staff 21.30-07.30: 1 Registered Nurse and 2 care staff. Additional support was available from the in-house therapy team which consisted of a part time Physiotherapist, Occupational Therapist and part time assistant, Social Worker and a designated GP.

Ref No	Quality Standards	Met? Y/N	Timberdine Intermediate Care Unit (Worcestershire County Council) Reviewer Comment	Met? Y/N	Worcester Intermediate Care Unit (Shaw Red Hill) Reviewer Comment
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	Y	Timberdine had a training plan in place which covered mandatory training and other specialist training. The services was able to demonstrate a strong professional development ethos using in-house training and buying in specialist training from outside organisations when required. Competencies were available for: • Wound care • Vac therapy • Catheterisation • Male catheterisation • Venepuncture • IV therapy and drugs • Syringe drivers • ECG (electrocardiogram) • PEG (percutaneous endoscopic gastrostomy) feeds	Y	Mandatory training was in place. A competency audit was completed for staff during appraisals. See SN-202 comments about competency compliance. 'a and 'd' were not undertaken by Worcester Intermediate Care Unit staff.

Ref No	Quality Standards	Met? Y/N	Timberdine Intermediate Care Unit (Worcestershire County Council) Reviewer Comment	Met? Y/N	Worcester Intermediate Care Unit (Shaw Red Hill) Reviewer 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)	Y	All the staff at Timberdine had undertaken the 'Common Induction Standards' (CIS) which will transfer to the Fundamentals of Care for new staff from April 15. CIS and the mandatory training plan covered all elements of the Quality Standard.	N	Not all staff were trained in basic life support. Staff were trained in first aid.
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.	Y	A GP contract was in place from a nominated practice, providing four hours per day of GP hands-on cover in the Unit, 365 days a year. The practice staff covered 8.30 – 18.00 every day with out of hours cover at other times.	N	A doctor was not always able to attend within 2 hours of request, for conditions where hospital admission may be avoided. The GP Out of Hours services provided evening, weekend and emergency cover. A nominated GP visited daily during weekdays and medical reviews were completed.
SN-299	**Administrative, Clerical and Data Collection Support** Administrative, clerical and data collection support should be available.	Y	Adequate admin cover was seen to be in place.	Y	Adequate admin cover was seen to be in place.

Ref No	Quality Standards	Met? Y/N	Timberdine Intermediate Care Unit (Worcestershire County Council) Reviewer Comment	Met? Y/N	Worcester Intermediate Care Unit (Shaw Red Hill) Reviewer 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	Y	All elements of this Quality Standard were met, Timberdine were able to access services from the Acute Hospital through the GP and Consultants and also from Mental Health team if required. The Therapies team based in Timberdine were able to offer assessments as required.	Y	Tissue viability, falls prevention were provided in- house. For specialist advice Worcester Intermediate Care Unit were able to access services from the Acute Hospital.

Ref No	Quality Standards	Met? Y/N	Timberdine Intermediate Care Unit (Worcestershire County Council) Reviewer Comment	Met? Y/N	Worcester Intermediate Care Unit (Shaw Red Hill) Reviewer 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	Timberdine were able to meet all elements of the Quality Standard except for 'c'. Transport was rarely able to respond to non-urgent transport requests within 4 hours.	N	The Worcester Intermediate Care Unit was able to meet all elements of the Quality Standard except for 'c'. Transport was rarely able to respond to non-urgent transport requests within 4 hours.
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	All the facilities and equipment at Timberdine were appropriate and suitable for the services provided.	N	Patients had en -suite rooms, but at the time of the visit there was no social area for patients. This had been identified previously and a new area was in the process being constructed.
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	Patient health records were mainly paper based. The IT systems in place were the Worcestershire County Council information system and 'Framework I'. None of the systems in place interfaced with each other.	N	Records were paper based. There were plans to develop and implement electronic records for handovers.

Ref No	Quality Standards	Met? Y/N	Timberdine Intermediate Care Unit (Worcestershire County Council) Reviewer Comment	Met? Y/N	Worcester Intermediate Care Unit (Shaw Red Hill) Reviewer Comment
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	Initial assessments as per the Quality Standard were undertaken using an agreed format.	Y	Initial assessments as per the Quality Standard were undertaken using an agreed format.
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	Y	Comprehensive guidelines were devised to support the Unit when it was set up (two years before the visit). These guidelines covered all the elements of the Quality Standard including spasticity management.	N	Guidelines for spasticity and depression were not seen. Staff said that they would access a mixture of Worcestershire Acute Hospital and Worcestershire Health and Care NHS Trust guidelines. Some NICE (National Institute for Health and Care Excellence) guidance was referred to but this had not been localised for use.

Ref No	Quality Standards	Met? Y/N	Timberdine Intermediate Care Unit (Worcestershire County Council) Reviewer Comment	Met? Y/N	Worcester Intermediate Care Unit (Shaw Red Hill) Reviewer 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: vii. Discussion with patients and carers about the 'After Intermediate Care' Plan viii. Availability for patient and carer queries ix. Multi-disciplinary review for complex or uncertain discharges x. Single assessment process xi. Transport options including patient transport service, relatives, taxis or care home transport xii. '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	A formal guideline was not yet in place however, in practice Timberdine staff were able to demonstrate all aspects of the Quality Standard. All relevant planning and information was recorded in service user's care plans, and discharge arrangements were well planned with the families and carers.	N	Guidelines covering the transfer of care were not yet in place. In practice processes were in place and there was a good laminated sheet discharge checklist sheet in patient's rooms.

Ref No	Quality Standards	Met? Y/N	Timberdine Intermediate Care Unit (Worcestershire County Council) Reviewer Comment	Met? Y/N	Worcester Intermediate Care Unit (Shaw Red Hill) Reviewer 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	Y	Timberdine provided a discharge summary for each service user that was faxed immediately after discharge to the GP and any other professionals involved. Timberdine staff would also phone the GP if the discharge was particularly complex. The SAP (single assessment process) folder was also transferred with the service user. Continuing Healthcare funding was initiated at Timberdine and future care home placements were agreed.	N	Guidelines covering more complex transfers of care were not yet in place.
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	'c' was not yet in place. The service did not feel that they cared for people who required any sedation.	Y	'c' was not yet in place. The service did not feel that they cared for people who required any sedation.

Ref No	Quality Standards	Met? Y/N	Timberdine Intermediate Care Unit (Worcestershire County Council) Reviewer Comment	Met? Y/N	Worcester Intermediate Care Unit (Shaw Red Hill) Reviewer 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	All but 'c) i' was included in the service specification for Intermediate care beds at Timberdine.	Y	

Ref No	Quality Standards	Met? Y/N	Timberdine Intermediate Care Unit (Worcestershire County Council) Reviewer Comment	Met? Y/N	Worcester Intermediate Care Unit (Shaw Red Hill) Reviewer 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	Y	Data were collected on activity and performance and reviewed by the CCG. Inappropriate referrals were reported. The Therapy team collected data on rehabilitation outcomes.	Y	Data were collected on activity and performance and reviewed by the CCG. Inappropriate referrals were reported. The Therapy team collected data on rehabilitation outcomes.
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	Y	A rolling audit programme was in place. The audit plan had recently been reviewed for all services due to the changes made to the Care Quality Commission standards.	N	Audit of compliance with guidelines was not yet undertaken. Contract audits were undertaken and discussed with the CCG.
SN-703	**Key Performance Indicators** Key performance indicators (QS SN-701) should be reviewed regularly with Trust (or equivalent) management and with commissioners.	Y	Timberdine and Worcestershire County Council collated data monthly and had produced a data dashboard. Highlight reports from the dashboard were sent as requested and monitored by the Adult Performance Quality Group. Adult Social Care Outcome Framework 2b data was reported nationally.	Y	Key performance indicators were reported to the South Worcestershire CCG quality team.

Ref No	Quality Standards	Met? Y/N	Timberdine Intermediate Care Unit (Worcestershire County Council) Reviewer Comment	Met? Y/N	Worcester Intermediate Care Unit (Shaw Red Hill) Reviewer Comment
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	A health and social care review and learning group was not in operation across the health economy. Mechanisms were in place for discussing issues as part of the 'improving patient flow' work.	N	A health and social care review and learning group was not in operation across the health economy. Mechanisms were in place for discussing issues as part of the 'improving patient flow' work.
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	Multidisciplinary review and learning was not yet in place. Staff did have regular team meetings but these did not cover 'b' or 'c'. Staff also commented that they did not get feedback after submitting inappropriate admission reports.	N	Multidisciplinary review and learning was not yet in place. Staff did have regular team meetings but these did not cover 'b' or 'c'. Staff also commented that they did not get feedback after submitting inappropriate admission reports.
SN-799	**Document Control** All policies, procedures and guidelines should comply with Trust (or equivalent) document control procedures.	Y	Documents and policies provided were in date and had version control in place	Y	Documentation available was controlled.

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COMMISSIONING

Ref No	Quality Standards	Met? Y/N	Reviewer Comment
SZ-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 records were not available for all patients referred to intermediate care. Work was being undertaken to develop a comprehensive care plan across health and social care called 'well connected'. Emergency care action plans were in place with West Midlands Ambulance Service NHS Trust and the Out of Hours service.
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 in place covering the requirements of the Quality Standard. In practice:- Care packages could be restarted within 14 days if care needs had not changed. Discharge to assess pathways had been agreed. Cross boundary complex discharges were dealt with on a case by case basis. Full implementation of the single assessment process was in progress as part of the delivery plan for the health economy.
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)	Y	Data were collected for all services.
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	A Health and Social Care Review and Learning Group was not yet in place. Some discussions with commissioners and providers was undertaken as part of the 'Outcome1' work

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