WM QRS West Midlands Quality Review Service

NHS

Transfer from Acute Hospital Care and Intermediate Care

North Staffordshire Health and Social Care Economy

Visit Date: 14th and 15th April 2015 Report Date: October 2015 **Version 2**

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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 14th and 15th April 2015. The purpose of the visit was to review compliance with the following West Midlands Quality Review Service (WMQRS) Quality Standards:

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

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

The report reflects the situation at the time of the visit. The text of this report identifies the main issues raised during the course of the visit. Appendix 1 lists the visiting team which reviewed the services at North Staffordshire 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 NHS organisations:

- University Hospital of North Midlands NHS Trust
- Staffordshire & Stoke on Trent Partnership NHS Trust
- NHS North Staffordshire Clinical Commissioning Group
- NHS Stoke on Trent Clinical Commissioning Group

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

Most of the issues identified by quality reviews can be resolved by providers' and commissioners' own governance arrangements. Many can be tackled by the use of appropriate service improvement approaches; some require 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. The lead commissioners in relation to this report are NHS North Staffordshire and NHS Stoke on Trent Clinical Commissioning Groups.

ABOUT WEST MIDLANDS QUALITY REVIEW SERVICE

WMQRS is 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 North Staffordshire 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

Health and Social Care Economy

This review looked at the following aspects of the 'transfer from acute hospital care and intermediate care' pathway for the North Staffordshire health and social care economy.

Pathway	Provider	Quality Standards	Notes
Primary care	-	Primary care	Reviewers met the lead GP at the presentation but did not meet other GPs or primary care staff.
Royal Stoke Hospital	University Hospital of North Midlands NHS Trust	Acute-Trust: All wards	Reviewers reviewed documentary evidence and visited ward 123 (Diabetes and Endocrinology) and ward 230 (Gastroenterology and Hepatology), the Acute Medical Unit, discharge lounge and Emergency Department, and met with a range of staff and patients / patient representatives. Reviewers also met representatives from the Rapid Response and 'Pull' Team in the Clinical Decisions Unit, Ambulatory Care Pathway and Frail Elderly Unit.
Hayward Hospital - Grange Ward	Staffordshire and Stoke on Trent Partnership NHS Trust	Intermediate care	Reviewers visited the hospital and met with the team but were unable to visit the Intermediate care ward as visiting restrictions were in place on the day of the visit.
Leek Community Hospital	Staffordshire and Stoke on Trent Partnership NHS Trust	Intermediate care	Reviewers visited the hospital, met with staff and talked to patients and carers.
Community Intermediate Care	Staffordshire and Stoke on Trent Partnership NHS Trust	Intermediate care	Reviewers reviewed documentary evidence and met staff from this service.
NHS Stoke on Trent CCG NHS North Staffordshire CCG	University Hospital of North Midlands NHS Trust	Commissioning	Reviewers met CCG staff. Documentary evidence of compliance with Quality Standards was not provided.
Other services:			
Clinical Coordination Hub	Staffordshire and Stoke on Trent Partnership NHS Trust	-	Reviewers visited the facilities, met with staff and were told about the contribution to the pathway.
District Integrated Local Care Teams			Reviewers met with staff providing these services and were told about their contribution to the pathway.
Living Independently Staffordshire (LIS)			Reviewers met with representatives providing this service and were told about its contribution to the pathway.
Social prescribing and locality 'hubs'	Voluntary Action Stoke-on-Trent in partnership with Staffordshire and Stoke-on-Trent Partnership NHS Trust	-	Reviewers were told about these services and the contribution they made to the pathway.

General Comments and Achievements

The health and social care economy had a clear, agreed strategy for this pathway of care, based around localities of approximately 50,000 population. All organisations had a good understanding of the issues facing the local health and social care economy. A large number of reviews had been undertaken and a good matrix comparing the issues identified from these reviews had been produced. Joint working between health and social care professionals was generally good with mutual respect evident and a commitment to staff being co-located whenever possible. An awareness-raising 'Home First' campaign was being run with the aim of reducing inappropriate admissions to hospital and facilitating timely discharge to a patient's home where this was clinically safe and appropriate.

Staff across the health and social care economy were friendly, welcoming, enthusiastic and keen to share what they were doing with reviewers. Several new initiatives were being planned or piloted.

Integrated Locality Care Teams (ILCTs) were in place with each team made up of district nurses, community matrons and social care staff. These teams used shared documentation and provided long-term case management for people with more complex needs in their locality. A competency framework for the ILCTs was being developed at the time of this review. The teams were able to support the care of people needing intravenous antibiotics or PEG feeds, or who had tracheostomies. A workforce tool was in use which predicted the increased acuity and dependency of patients as the hospital bed base decreased.

Well-being teams were based in each locality. An active Patient Congress was in place with representatives sitting on each of the Locality Boards.

Arrangements for supply of equipment were good. The Mediquip service ensured that urgent referrals for equipment received before 4pm were supplied the next day at the latest. Handrails fitted within 24 hours of request.

Emergency Care Plans were in place in some patients' homes, with a copy held by the Clinical Coordination Hub, ambulance service, the patient's GP and their district nurse. These plans were used by GPs, the ambulance service, district nurses and other services to help manage emergencies, and to try and avoid admission to hospital whenever possible.

Good progress had been made on developing Advanced Nurse Practitioner (ANP) roles. Roles had been created in several services with a proactive approach to supporting local staff to undertake ANP training and providing mentorship when they were new in post.

Good Practice

1 Hospital social workers responded very quickly to requests for social care assessment with patients usually being seen on request without waiting for a section 2 or section 5 form to be completed and received.

2 A very good technology-based 'Befriending Service' was providing support for patients living at home who had been identified as vulnerable and who were receiving a package of care. This used the television (or skype) to link with the individual and so was available to anyone living in a house with broadband. The scheme had demonstrated a 50% reduction in visits to the GP and improved medicines management (plus a £3m saving).

3 An excellent scheme for developing therapy technicians was in place, run in coordination with the Princes Trust. Therapy apprentices worked towards dual roles (physiotherapy and occupational therapy) with a band 3 post as a therapy technician available on completion of their apprenticeship.

4 'Living Independently Staffordshire' provided excellent support for patients after their return home. This service responded within 24 hours of request with one of four pathways:

   a. Enablement, providing reablement support until assessment completed and for up to six weeks, delivered by a multidisciplinary Community Intervention Service team (in conjunction with therapists and social care teams).

b. ‘Staying Home’ Scheme, including three days of 24/7 assessments and a maximum ‘stay’ of 14 days. This pathway was led by the community psychiatric nurse and was provided for people with dementia who required additional support at home in order to avoid admission to a care home or hospital.

c. ‘Discharge to Assess’: A (specialist) designated social care assessor undertook assessments within two or three days, completing the assessment at home within seven days, following discharge home. At the end of this period service users were signposted to (other) appropriate services if required. Living Independently Staffordshire (LIS) would respond within 3 hours of receiving the referral.

d. Domiciliary care packages for patients with more complex needs where care agencies were having difficulty providing the package of care. This service was mainly provided by Band 2 staff and patients were charged for the service in the same way as for other packages of care.

5 Intermediate Care Home Project: Intermediate care nurses contacted the ‘top 18’ care homes with the highest number of hospital admissions on a daily basis. The team responded directly to care homes when a resident was identified as being at risk of an acute illness. This had been shown to lead to a reduction in hospital admissions from these homes.

6 Staff from care homes would go into hospitals to do assessments within 24 hours of request.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Cultural perception of ‘lack of capacity’**

Reviewers found a widely held view among operational staff across the health and social economy, especially those working in acute services, that available bed capacity was insufficient. Many staff appeared to assume that patients would transfer to a community hospital bed before going home. This was frequently expressed as ‘the public expect that they will go to a community hospital’. In practice, transfer to a community hospital appeared often to happen because of a perceived lack of domiciliary care capacity within the community Intermediate Care Teams or delays in availability of domiciliary packages of care (see below) rather than because it was clinically required. Reviewers observed patients in community hospitals who could have been cared for at home with appropriate support, and noted the short lengths of stay (two or three days) for some patients. Reviewers commented on the large bed base (275 beds for older people) and found no evidence of a shortage of bedded intermediate care capacity. The awareness-raising campaign ‘Home First’ was attempting to address staff and public expectations on this issue.

2 **Speed of response and availability of domiciliary care packages**

In many of the services visited, reviewers were told of delays in provision of domiciliary care packages. As a result some patients were in community hospitals or other intermediate care facilities who could have been cared for at home. Reviewers met patients who had been waiting four months for an appropriate package. Reviewers were told that there had been a significant increase in assessments for ‘double up’ packages of care although packages involving two, three or four staff were available. It appeared that these difficulties arose because domiciliary care providers were not paying for carers’ travel between clients and, as a result, effective pay rates were low and staff retention poor, especially in rural areas where significant travel between clients was required. Data on the number of people waiting for a domiciliary care package and average waits were available for patients in community hospitals but not on a health and social care economy basis. In the time available reviewers were not able to look at differences between Staffordshire and Stoke-on-Trent residents in speed of response and availability of domiciliary care packages.

3 Pathways of Care

Several related aspects of the pathways of transfer from acute hospital care and intermediate care were of concern to reviewers:

a. Unclear pathways

The available pathways were not clear or, when defined, were not being implemented as intended. Criteria for admission to community hospital or care by the Intermediate Care Teams were defined, but staff working within acute and community services did not appear to be aware of them, and they did not appear to be being followed. The specification for community hospitals was that they should be providing mainly 'step up' care but, in practice, most admissions appeared to be for 'step down' care especially when the Acute Trust was under pressure. Reviewers were told by staff of patients being admitted to community hospitals inappropriately.

Step up referrals to community hospitals were supposed to go via the Advanced Nurse Practitioner (ANP) in the Intermediate Care Teams. If the ANP was busy with a patient this referral route was not available. Community hospitals received referral requests from the Clinical Coordination Hub, Intermediate Care Team ANPs, ward staff, Patient Flow Coordinators and Care Navigators.

b. Hubs

Several 'hubs' were in place and the role of each was not clear. A Clinical Coordination Hub took referrals, between 8am and 10pm, of patients where admission might be avoided. This service was based in the community, triaged patients and could admit patients directly to community hospital (or via the ANP in the Intermediate Care Teams). Advanced Nurse Practitioner roles in the service were in development, plus Band 2 call handlers. Between 15 and 20 new patients were referred to the service each day. Reviewers were told that GPs were not all using this Hub and preferred to refer patients directly to the Acute Medical Unit, Emergency Department or Intermediate Care Team, because response times were variable and because the patient was often referred to the Emergency Department, especially if imaging was required.

A 'step-down' hub was based in Stoke Health Centre. A Band 6 nurse in this Hub took calls from ward staff and referred them on to 'Allocation Hubs' in each of four localities. The Allocation Hubs identified the intermediate care capacity available to respond to these needs and arranged for this care to be provided.

An Intermediate Care Team Hub was also available seven days a week, coordinating referrals to the Intermediate Care Teams and to the Social Prescribing Hubs. The Social Prescribing Hubs were available in each locality, providing access to social care, befriending schemes and other support services.

c. Clinical Handover

Clinician to clinician handover following acute admission did not always take place for referrals which went via the 'Hubs'. Reviewers were also told of problems of medication not being sent with the patient, transfer documentation not being completed and patients not being appropriately prepared for the transfer of care. Staff said that patients and carers were also sometimes given unrealistic expectations about what would happen in the community hospital. An exception to this was Ward 123 which used a 'transfer of care form' which was faxed to the relevant community ward or Intermediate Care Team and followed by phone handover.

d. Capacity Overview

An overview of intermediate care capacity did not appear to be held anywhere in the health and social care economy, except at the time of the morning bed state and 'capacity phone call'. Commissioners considered that the Clinical Coordination Hub did monitor overall capacity and

circulate reports but, if so, other staff were not aware of this function. It was also not clear how issues of patient (or family) choice were related to available capacity.

e. **Multiple assessments**

With the exception of the 'Pull Team' (see Acute Trust-wide section of this report) and some therapy assessments, 'trusted assessor' arrangements were not yet in place. Clinical and social care assessments were undertaken separately by each service. Discharge processes did not flow effectively from acute to community hospitals or other services, partly due to the lack of effective clinical handover (see above). Delays in nursing home assessment for patients from Stafford and Cheshire were also reported.

4 **Intermediate Care Team Capacity**

At the time of the review, reviewers were told that the Intermediate Care Teams had capacity for between 100 and 150 patients, depending on the need, although only 87 patients were being cared for at the time of the review. Information supplied subsequently was that there had been some debate as to whether Advanced Nurse Practitioner activity should be counted as part of the Team's activity and that, if this was included, the service met its commissioned activity level of delivering support to a minimum of 282 patients per month. Intermediate care bed capacity was 328 beds of which 275 were for older people. Reviewers considered that the actual capacity of the Intermediate Care Teams was unclear and appeared low, especially given the proportion of patients in community hospitals who could have been cared for at home with appropriate support.

5 **Document control**

Many of the documents seen by reviewers which related to the transfer from acute hospital care and intermediate care pathway did not have appropriate version control. Flow charts and policies were frequently undated and it was not clear whether they reflected the latest version. This may contribute to the lack of clarity about pathways (see above).

Further Consideration

1 Delays of up to four weeks for Decision Support Tool (DST) assessments for continuing health care in the acute hospital were reported. As a result, some patients needing continuing health care were waiting in hospital for at least six to eight weeks before they could be transferred to continuing health care. Reviewers were told that in community hospitals delays were usually post-DST assessment.

2 Several health and social care economy groups and forums were in place. These appeared to have a good understanding and analysis of the problems facing the health and social care economy but it was less clear which group or groups had responsibility for taking action. Several initiatives were happening, but the focus for strategy, decisions and implementation was less clear, especially to staff with responsibility for individual clinical services. Reviewers sympathised, however, with the complexity of working across multiple health and social care commissioners, multiple providers, multiple localities and significant inflow of patients from outside the local area.

3 A health and social care economy 'review and learning' group was starting with representation from acute and community-based medical staff and senior nurses. Reviewers encouraged continuation of this approach, for example, reviewers were told of some inappropriate admissions to community hospitals which had been raised as incidents but where community hospital staff were unaware of the action taken and the group may provide a useful forum for learning from these events.

4 Staff were permanently based with the Clinical Coordination Hub and it was not clear to reviewers whether the roles provided sufficient acute experience to ensure clinical skills needed for their assessment role would being kept up to date.

5 Clinical records in each service were separate, especially because community hospital records were paper-based at the time of the review. There were plans, however, for the introduction of electronic records which may help communication of clinical information between acute and community services.

6 Reviewers suggested that public engagement work, exploring the widely held view (among staff) that the public expected to transfer to a community hospital, may be helpful. Reviewers considered it possible that this was an assumption by staff rather than, necessarily, the public's preferred pathway of care.

Primary Care

General Comments and Achievements

Reviewers did not meet any GPs or other primary care staff. Reviewers were told that support by GPs for the work of the Community Intermediate Care Teams was variable.

Further Consideration:

1 Reviewers suggested there may be potential to further involve local GPs in admission avoidance and 'step down' intermediate care services (see section of this report relating to 'Community Intermediate Care Teams'). It may also be helpful to look at the ways in which other health and social care economies have made use of general practitioners in this pathway.

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Acute Trust-Wide

UNIVERSITY HOSPITAL OF NORTH MIDLANDS NHS TRUST

General Comments and Achievements

In addition to the comments in the 'health and social care economy' section of this report, reviewers found good pharmacy support on acute hospital wards, including extended pharmacy opening times at weekends. The number of non-medical prescribers in the Trust had increased significantly and two wards were trialling e-prescribing. Pharmacy provided a good, rapid response to requests for 'take out' medication once prescription sheets had been received.

Medical engagement with the transfer of care process was generally good, including good medical input to Board rounds observed by reviewers.

The Acute Medical Unit (AMU) was working well with 46 beds, two triage bays and 14 'high care' beds. Average length of stay was 23 hours. Average length of stay on the short-stay unit was 47 hours. Links between the AMU Discharge Facilitators and the Clinical Coordination Hub worked well. Staff did not have to fill in section 2 forms or make referrals to individual services; they just picked up the phone to the Hub who then organised all the necessary services. The AMU had a dedicated pharmacist and was due to start electronic prescribing in September 2015. An AMU 'hot clinic' was available one day a week with plans to increase to five days a week with implementation of new ambulatory care pathways.

The 'Pull Team' worked with patients on the Emergency Department, Clinical Decisions Unit, Acute Medical Unit, Frail Elderly Unit and Acute Surgical Unit. This team of nurses with additional assessment skills, therapists and social workers from each locality worked well together, identifying patients who could go home and ensuring that any necessary support was put in place quickly.

Good electronic referral systems to physiotherapy and occupation therapy were in use for non-urgent referrals, although these did not yet link to the 'patient at a glance' boards.

Good Practice

1 Board rounds were well organised with very good medical involvement. The Board rounds took place twice a day and were action-focussed. Pharmacists were usually part of these rounds. Reviewers were particularly impressed by the Board round on Ward 123 which started at 8.30am each day, included the consultant, ward manager, therapy staff, pharmacist and discharge facilitator. Clear objectives were set for each patient for the day which were reviewed at 4.30pm. Criteria-led discharge was in place with senior nurses trained for this role on each shift who were able to discharge patients if pathology or imaging results were within agreed parameters.

2 Consultants cover for medical wards was organised in two week blocks which provided very good continuity of care. Each Friday the consultant on ward 123 sent a handover email to the consultant who was on site over the weekend, copied to the discharge facilitator. This email provided information on all patients who were likely to be ready for discharge over the weekend.

3 The Frail Older People's Unit provided excellent, holistic care for frail older people with acute care needs. This unit accepted referrals from a wide range of sources and actively managed patients with the aim of getting them home as soon as possible. Medical input to this unit was particularly proactive and staff had good plans for expanding the range of services offered.

4 The Acute Medical Unit had a dashboard which showed in 'real time' how many patients were in the Emergency Department, how many had been referred to the Acute Medical Unit and how long they had been waiting. It also showed patients in the Acute Medical Unit waiting for input from another specialist service and how long they had been waiting. This system showed very clearly where there were delays in the flow of patients through the urgent care system.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Admission of patients to wards before a bed was available**

Reviewers were seriously concerned about the system of admitting patients to wards when the hospital was on capacity level 4. Patients were admitted to beds where the existing patients were likely to be discharged during the day. The new patients would wait in the day room or in a treatment room until the bed became available. Reviewers were told that all patients admitted this way had been MEWS-scored and were medically stable. It was not clear how closely these patients were monitored and whether easy access to oxygen and suction was available if required. Senior staff said that wards could say 'no' to this type of admission but that was not the view expressed by some ward staff. Some ward staff were also very concerned that this arrangement was becoming 'the norm'.

2 **Use of Expected Date of Discharge**

The expected date of discharge did not appear to be being actively used within the Trust. It was not obvious in any of the medical notes or care plans seen by reviewers and was not discussed all Board Rounds observed. There was some suggestion that patients were automatically given an expected date of discharge of seven days after their admission date. Patients and families who reviewers met were not aware of their Expected Date of Discharge and did not appear to have been given the information that was available about future care options. Reviewers suggested that more proactive use of the Expected Date of Discharge could help wards to 'get ahead' with arrangements for discharge of patients from acute care.

In addition, reviewers noted specific delays in getting prescriptions to pharmacy for 'take out' medication.

3 See also 'Health and Social Care Economy' section of this report.

Further Consideration

1 Many different groups of staff within the Royal Stoke University Hospital were involved in discharge planning. As well as ward staff, discharge coordinators on each ward were responsible for facilitating

discharge, non-clinical patient flow coordinators were in post and staff in the Control Room (where the social work team was based) were also involved. A new model was being tried of seven days a week Band 7 managers on site, to whom the patient flow coordinators were accountable.

2 The contribution of the Clinical Decisions Unit to the urgent care pathway was not clear, especially as both the Acute Medical Unit and Short-Stay Unit were available. The Clinical Decisions Unit did not have a dashboard and information on patients' length of stay was not clear.

3 A Hospital at Home service was available. Reviewers did not meet staff from this service and so were not able to clarity its contribution to this pathway. Other staff who reviewers did meet were not able, however, clearly to describe the role and contribution of the Hospital at Home service.

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INTERMEDIATE CARE

STAFFORDSHIRE & STOKE ON TRENT PARTNERSHIP NHS TRUST – Trust-wide

Reviewers did not have approval from the Trust to look at case notes in order to determine compliance with Quality Standards. The percentage of Standards met may therefore be lower than if case notes had been reviewed. Some of the issues raised by reviewers may also have been clarified by review of case notes.

STAFFORDSHIRE & STOKE ON TRENT PARTNERSHIP NHS TRUST – Community Intermediate Care Teams

General Comments and Achievements

Community-based intermediate care for North Staffordshire and Stoke on Trent was provided by four Community Intermediate Care Teams. These worked as two pairs of teams which provided cover for each other and were available seven days a week. Each team comprised at least one Band 6 nurse, one Band 5 nurse, a therapy technician and a nursing assistant. At least three therapy staff were also part of each team from 9am to 8pm Monday to Friday seven days per week. Therapy staff were also available earlier to complete washing and dressing assessments, if required. Advanced nurse practitioners were in place. One advanced nurse practitioner was available from 9am to midnight seven days a week, working across the teams. A paramedic had been recruited to the service shortly before the review visit. Patients were under the care of their GP although medical advice for the Teams was also available from care of older people consultants working in the community.

The Community Intermediate Care Teams were able to provide a range of sub-acute care, including care of patients needing intravenous antibiotic therapy and intravenous or subcutaneous fluids. Staffing of the teams was managed centrally to ensure staffing was appropriate for the workload in each team.

The Community Intermediate Care Teams had good links with care homes, community hospitals and Integrated Locality Care Teams. The teams attended the community hospitals weekly, often in order to identify patients who could transfer home with support from the Community Intermediate Care Service. Approximately 70% of the caseload was related to 'admission avoidance' or 'step up' care with approximately 30% of patients requiring 'step down' care. The teams had an average caseload of 20 to 30 patients with a total of 87 patients receiving care at the time of the review. (NB. Information supplied subsequently was that activity levels were higher if Advanced Nurse Practitioner activity was included.) The expected response time was two hours for 'step up' patients and 24 hours for 'step down' patients. Average length of care by the Community Intermediate Care Teams was between 17 and 21 days.

Reviewers also saw good evidence of staff learning and reflective practice through Learning Forums, which had patient involvement and were linked to a '7 day CQUIN'.

Good Practice

1 The Advanced Nurse Practitioner role, working across the four Community Intermediate Care Teams, provided a high level of skills and leadership to support the care of patients at home.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Clinical guidelines and care plans**

Reviewers did not see evidence of clinical pathways and guidelines used in the Community Intermediate Care Service. It was also not clear that all patients had clearly documented care plans with an identified lead nurse and doctor for the care of the patients.

Further Consideration

1 The model for medical support and governance of the work of the Community Intermediate Care Teams may benefit from review. Reviewers were told that the teams could access either the care of older people consultants working in the community or the patients' GP for advice, but that GP support for the work of the Teams was variable. It was not clear how often advice was sought from care of older people consultants. It may be possible for the teams to deliver more care at home with more consistent medical input and governance.

2 Arrangements for the Community Intermediate Care Teams (and the Integrated Locality Care Teams) to access support from mental health services may benefit from review. Reviewers were told of a variety of pathways and it was not clear that these provided 'streamlined' access to integrated care.

3 Response time-scales were much shorter for 'step-up' care (two hours) compared with 'step-down' care (24 hours). Reviewers suggested that both timescales may benefit from review with commissioners. Reviewers considered that the two hour response may not always be required and that some transfers from acute care with less than 24 hours' notice may be appropriate.

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STAFFORDSHIRE & STOKE ON TRENT PARTNERSHIP NHS TRUST

ALL COMMUNITY HOSPITALS

General Comments and Achievements

Each of the eight localities within North Staffordshire and Stoke on Trent had access to a community hospital. The five community hospitals had a total of 328 beds of which 275 were used for the care of older people. The remaining beds provided specialist neurology, stroke and rheumatology rehabilitation

In addition to the comments in the 'health and social care economy' section of this report, reviewers found that all of the community hospitals visited by reviewers were welcoming with positive and enthusiastic staff. A 'meet and greet' system for new patients was in place with newly admitted patients given written information as well as meeting the matron and one of the doctors. Community hospitals had undertaken a significant amount of development work, including implementing an acuity tool and working to reduce length of stay by pro-actively managing the discharge process. Staff were aiming for a standardised seven day a week discharge process. The target for average length of stay was 14 days, which had not yet been reached. A good range of sub-acute care was provided, including provision of intravenous therapy. Community hospital matrons had a daily conference call to discuss staffing issues and ensure appropriate cover was in place on all wards. There was good evidence of adult protection processes and use of incident reporting systems.

A senior nurse was available three days a week to support assessments for NHS continuing care using the Decision Support Tool.

Good Practice

1 Active discharge planning was in place in all the community hospitals visited. A discussion about discharge arrangements took place with all patients within 24 hours of admission. 'Board rounds' took place daily and display boards showed clearly the Expected Date of Discharge for patients (with confidential information covered by privacy boards).

2 Medical support to the community hospitals was very good, with a consultant and registrar present Monday to Friday (9am to 8pm) and a medical and Advanced Nurse Practitioner (ANP) cover at weekends. Staff, patients and families had good access to the medical staff and the ANP and so any queries about patient care were dealt with quickly. Many 'thank you' cards showed how much patients appreciated this. At Hayward Hospital, medical staff were supported by a physicians' assistant.

3 The format of the multi-disciplinary care planning documentation used in all community hospitals was clear and comprehensive (although reviewers were not able to see whether it was implemented in practice).

4 Community hospitals were supported by a 'RAID' service which provided rapid access to a mental health assessment when required.

5 Community hospitals use a 'traffic light' system for walking frames. Red, amber and green wristbands were attached to the front of the frame indicating whether the patient could walk with two people helping, one person helping or supervised. Walking frames without a wristband indicated that the patient did not need assistance. The system was simple and easy to use and had been shown to reduce the number of falls.

Immediate Risks: No immediate risks were identified

Concerns

1 **Consultant vacancies**

At the time of the review, the four consultant posts covering community hospitals were vacant and filled by locums. Substantive recruitment to these posts was proving difficult.

2 See also 'Health and Social Care Economy' section of this report.

Further Consideration

1 Community hospitals did not have therapists available at weekends. Therapy staff did, however, leave very good plans for the interventions needed over the weekend which nursing staff were able to able to follow.

2 Vacancy levels for nursing and therapy staff in community hospitals appeared high, although reviewers were not able fully to investigate this issue. At the time of the review there were vacancies for two Band 6 nurses and one therapist on Grange Ward (Hayward Hospital), although bank staff could be offered two to three month contracts. Leek Community Hospital had one Band 5 nurse vacancy at the time of the review. Reviewers were told that some agency nursing staff at Leek Community Hospital were working 12 hour shifts for up to six consecutive days. An acuity exercise had been carried out which indicated a need for more staff. Arrangements for daily staffing assurance and the daily conference call were, however, in place.

3 Some of the patients admitted to community hospitals had very short lengths of stay (two to three days). It may be helpful specifically to review these patients, looking at why they were admitted and whether admission to a community hospital could have been avoided. This may, of course, lead to an increase in the average length of stay for all patients in community hospitals.

4 Reviewers suggested that the Trust may wish to consider some shared consultant appointments with University Hospitals of North Midlands NHS Trust. It may be easier to recruit to the vacant posts if they include some element of acute care as well as community-based care. Other models of medical support for community-based services may also benefit from further consideration, including greater use of general practitioners with a special interest.

5 The care planning documentation used in the community hospitals was not transferred with the patient to other care settings. Integration of documentation with that used in other settings may be a helpful way forward.

HAYWARD HOSPITAL – GRANGE WARD

General Comments and Achievements

Grange Ward was a well-organised ward with good leadership and a clear commitment to providing high quality care. The facilities and environment were of high quality. A good admission process was evident with assessments completed within 48 hours of admission. Admissions were taken from home and from emergency services for 'step up' care. The number of dedicated 'step up' intermediate care beds provided had increased from 17 in September 2013 to 32 in January 2014, with a stronger emphasis on the provision of 'step-up' care. At the time of the review visit, average length of stay had reduced to 22.7 days and the ward was actively working to reduce this further. A pharmacist undertook medication reviews daily and linked well with community pharmacists. Workforce planning was taking place with a review of competences for the type of care provided, development of a training programme including links to University Hospitals of North Midlands NHS Trust for input on specialist competences, and introduction of a Band 5 development programme including preceptorship. The training programme included skills in sub-acute care. The ward was working on improving the care of people with Dementia by adopting the UK 'Butterfly Scheme' and the introduction of 'Dementia Champions'.

Further Consideration

1 Stronger links with the Local Integrated Care Teams may be helpful, possibly learning from the arrangements in place at Leek Community Hospital. A representative of the local team visited Grange Ward one day a week.

LEEK COMMUNITY HOSPITAL

General Comments and Achievements

Leek Community Hospital provided in-patient beds for assessment, rehabilitation and palliative care. Reviewers visited Saddler Ward (17 beds) and Cottage Ward (19 beds). Acuity of patients on these wards had been increasing and average length of stay was 18 days at the time of the review visit. The community hospital was working closely with other health and social care services. As well as daily telephone conferences about discharge from acute hospitals, the local Integrated Locality Care Team (ILCT) and Community Intervention Service (CIS) attended the wards daily with the aim of speeding discharges home (from intermediate care). Patients were also 'stepped up' from CIS/ ILCT care and then supported to return home as soon as possible. Pharmacy support to the ward was good. Leek Community Hospital was planning to pilot the implementation of computerised patient records. Monthly 'tea parties' for all patients and their relatives or carers were held. The hospital also ran a 'pets as therapy' programme, led by the Diversional Therapist who worked in the hospital three days a week.

Good Practice

1 A strong audit programme was in place with audits of antibiotic use, communication, use of 'do not attempt resuscitation' forms, transfers from acute hospital and mortality rates.

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COMMISSIONING

NHS NORTH STAFFORDSHIRE CLINICAL COMMISSIONING GROUP & NHS STOKE ON TRENT CLINICAL COMMISSIONING GROUP

General Comments and Achievements

NHS commissioners were working closely with commissioners of social care. Commissioners had a good vision and strategy for the development of services and provider organisations understood this strategy. Commissioners were prepared to utilise a good range of mechanisms to drive implementation of the strategy, including a significant commitment to development of a 'step up' approach to intermediate care and supporting development of district nursing services.

Good Practice

1 Commissioners had a good matrix of issues identified from a range of sources. This allowed them to identify common themes and target their interventions accordingly.

Immediate Risks: No immediate risks were identified.

Concerns

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

2 Concerns identified for the health and social care economy and provider services will require commissioner support and monitoring to ensure these issues are addressed, in particular:

a. Admission of patients to wards before a bed was available: see Acute Trust-wide, Concern 1

b. Use of Expected Date of Discharge: see Acute Trust-wide, Concern 2

c. Clinical guidelines and care plans: see Intermediate Care, Staffordshire & Stoke on Trent Partnership NHS Trust Community Intermediate Care Teams, Concern 1

d. Consultant vacancies: see Intermediate Care, Staffordshire & Stoke on Trent Partnership NHS Trust, All Community Hospitals, Concern 1

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APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Visiting Team

Dr Domnick D'Costa	Consultant, Frail Elderly	The Royal Wolverhampton NHS Trust
Lesley Galvin	Admissions/Discharge Pharmacist	University Hospitals Coventry & Warwickshire NHS Trust
Wendy Godwin	Lead Commissioner Planned Care	NHS Walsall Clinical Commissioning Group
Marsha Jones	Matron for Patient Flow	Worcestershire Acute Hospitals NHS Trust
Cath Molineux	Nurse Consultant Primary Care	Shropshire Community Health NHS Trust
Dee Radford	Lead Nurse for Quality	Shropshire Community Health NHS Trust
Sheree Randall	Matron for Trauma and Orthopaedics	The Dudley Group NHS Foundation Trust
Thomas Taylor	Capacity Operations Manager, Operations	Worcestershire Acute Hospitals NHS Trust
Samantha Townsend	Team Leader - Integrated Community Services (South)	Shropshire Community Health NHS 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
Jane Smith	Clinical Lead	West Midlands Quality Review Service

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APPENDIX 2 COMPLIANCE WITH THE QUALITY STANDARDS

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

Reviewers did not have approval from the Trust to look at case notes in order to determine compliance with Quality Standards. The percentage of Standards met may therefore be lower than if case notes had been reviewed.

Table 1 - Percentage of Quality Standards met

Service	Number of Applicable QS	Number of QS Met	% met
Review of Transfer from Acute Hospital and Intermediate Care			
Primary Care	2	0	0
Acute Trust: All wards	23	11	48
Intermediate Care Service	66	20	30
Community Hospitals	(33)	(10)	(30)
Community Intermediate Care Team	(33)	(10)	(30)
Commissioning	4	0	0
Health and Social Care Economy	**95**	**31**	**33**

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

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PRIMARY CARE

Ref	Standard	Met? Y/N	Reviewer Comments
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 Quality Standard were not in place for patients at high risk of admission in North Staffordshire.
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. For those being admitted via the Clinical Coordination Hub, a transfer of care form was in use which included some information, but reviewers were told that this did not always accompany the patient. Summary records were available to staff in the Emergency Department via the GP EMIS system.

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ACUTE TRUST – ALL WARDS

		University Hospital of North Midlands NHS Trust	
Ref	**Standard**	**Met? Y/N**	**Reviewer Comments**
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	Information was available for planned admissions in surgery, older adults, respiratory and gastroenterology.
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 discharge leaflet was clear and contained the relevant information
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.	N	Not all areas had information visible for relatives and carers which explained how to arrange discussions with the multidisciplinary team. Some wards visited did have display boards at the entrance with visiting times, the consultant on duty and who to contact for information. The speciality wards visited did have leaflets which included information about how to obtain advice and the process for meeting with members of the multidisciplinary team.
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 as outlined in the Quality Standard were not in place for patients at high risk of admission in North Staffordshire. Some work had been undertaken to develop a frailty register which would be held by the GPs and be accessible to the Intermediate Locality Care Teams.

		University Hospital of North Midlands NHS Trust	
Ref	**Standard**	**Met? Y/N**	**Reviewer Comments**
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	Documentation was seen and reviewers were told that a process was in place. Three of the five patients who met with the visiting team were not clear about their arrangements for discharge.
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	
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	Feedback was also visible on notice boards on the some wards.

		University Hospital of North Midlands NHS Trust	
Ref	**Standard**	**Met? Y/N**	**Reviewer Comments**
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	Y	
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 use of 'Trusted Assessors' across the whole health economy was not yet in place, therefore multiple assessments were undertaken.
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	Not all staff had training in the hospital transfer of care pathway. Some training had been delivered on criteria led discharge. There were discharge coordinators on each ward who were able to advise staff.

		University Hospital of North Midlands NHS Trust	
Ref	**Standard**	**Met? Y/N**	**Reviewer Comments**
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	Home assessments within 24hrs of request were not always possible and depended on the capacity within the team. Beds and hoists were not always supplied within 24 hours of request. 'Settling home' support was available from Hospital @Home and Age UK. The Red Cross were also able to provide some support in some areas of Staffordshire.
SM-302	**Short-Term Care at Home** Additional health and social care support should be available within four hours of request, comprising up to four visits per day for at least 72 hours after return home.	N	Short-term domiciliary care at home was only able to offer up to three visits per day.
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	Electronic health and social care records were not available to all staff who coordinated discharge. Access to blood results and hospital letters were accessible. 'Graphnet' was accessible to some users in the Emergency Department and Acute Medical Unit.
SM-595	**Ward and Consultant Handover** The latest version of their Transfer of Care Plan should be handed over to the new ward or consultant whenever patients are transferred to another ward within the acute hospital or to the care of another consultant and the Transfer of Care Checklist (QS SM-601) updated.	Y	Electronic consultant-to-consultant discharge letters and handovers were completed. Acute hospital notes did accompany patients who were transferred to the community hospitals.

		University Hospital of North Midlands NHS Trust	
Ref	**Standard**	**Met? Y/N**	**Reviewer Comments**
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 did not cover the transfer of care plans or multidisciplinary review of complex discharges within 24 hours of admission. A criteria-led discharge standard operating procedure was seen though 'event-led' discharge was not yet in operation.

		University Hospital of North Midlands NHS Trust	
Ref	**Standard**	**Met? Y/N**	**Reviewer Comments**
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	Guidelines covering more complex transfers of care were in place.
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)	Y	GP summary care records were available and filed in the clinical records seen. 'Patient at a Glance' systems were in place in all areas visited. Reviewers also saw evidence of completed transfer of care checklists.

		University Hospital of North Midlands NHS Trust	
Ref	**Standard**	**Met? Y/N**	**Reviewer Comments**
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	A protocol on access to local intermediate care services was not yet in place on the wards. Some information was accessible via the Clinical Coordination Hub.
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 collection and monitoring was reported though the Directorate Performance Reviews.
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 'a' and 'c' were not audited for all conditions. Readmission rates were audited.

		University Hospital of North Midlands NHS Trust	
Ref	**Standard**	**Met? Y/N**	**Reviewer Comments**
SM-797	**Health and Social Care Review and Learning** Each ward should have a mechanism for influencing, and receiving feedback from, the local Health and Social Care Review and Learning Group on transfer of care from acute hospitals and intermediate care (QS SZ-798).	N	A formal group that met to discuss, review and share learning from discharge planning regularly, was not yet in place. Some shared learning events took place but these were predominantly available to NHS Managers and not to frontline staff.
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. Uni-disciplinary and ward team meetings were held.
SM-799	**Document Control** All policies, procedures and guidelines should comply with Trust (or equivalent) document control procedures.	Y	

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INTERMEDIATE CARE SERVICE

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

Ref	Standard	Community Hospitals		Community Intermediate Care Team	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
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	N	**Hayward:** Information for 'b' and 'g' was not available. **Leek:** Information for 'g' was not yet in place. All other aspects of the Quality Standard were met. The health and social care information leaflet about *'Your Care and Planning for Transfer and Discharge*' would benefit from the contacts list being updated.	N	Information for 'b' and 'g' was not available.

Ref	Standard	Community Hospitals		Community Intermediate Care Team	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
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	N	The multi-disciplinary assessment / care plan booklet included all the information but reviewers were unable to see completed documentation at the time of the visit.	N	Documentation included most elements apart from 'h'. Reviewers were unable to see completed documentation at the time of the visit. In practice staff said that all areas of the Quality Standard were discussed with the patient.
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	**Hayward:** Reviewers were told that reviews took place but they were unable to see any completed documentation at the time of the visit. **Leek:** Reviewers were told that reviews took place but they were unable to see any completed documentation at the time of the visit.	N	Reviewers were told that reviews took place but they were unable to see any completed documentation at the time of the visit.

Ref	Standard	Community Hospitals		Community Intermediate Care Team	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
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		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.	N	Documentation and information leaflets included space to record the named nurse. Reviewers were unable to see any completed documentation at the time of the visit.	N	Compliance is based on the self-assessment as reviewers were unable to see any completed documentation at the time of the visit.
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' or equivalent were not in place across the health economy.	N	Patient passports' or equivalent were not in place across the health economy. Patients did have patient held care plans at home but these were not used by other providers.

Ref	Standard	Community Hospitals		Community Intermediate Care Team	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
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	An 'After Intermediate Care' plan was not in place. Some information was shared via the GP discharge summary and patients did have information about self-care.	N	An 'After Intermediate Care' plan was not in place. Some information was shared via the GP discharge summary and patients did have information about self-care.

Ref	Standard	Community Hospitals		Community Intermediate Care Team	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
SN-197	**General Support for Patients and Carers** Patients and carers should have easy access to the following services, and information about these services should be easily available: a. Interpreter services, including British Sign Language b. Independent advocacy services c. Complaints procedures d. Social workers e. Benefits advice f. Spiritual support g. *HealthWatch* or equivalent organisation h. Relevant voluntary organisations providing support and advice	Y		Y	
SN-198	**Carers' Needs** Carers should be offered information on: a. How to access an assessment of their own needs b. Benefits available, including carers' allowance (if applicable), and how to access advice on these c. Services available to provide support	Y		Y	Social workers within the Integrated Locality Teams undertook carers assessments.

Ref	Standard	Community Hospitals		Community Intermediate Care Team	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
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	N	**Hayward:** Mechanisms were in place (surveys and patients stories) but there was no evidence of changes made as a result of feedback. **Leek: This Quality Standard was met.** Monthly Tea parties were held for patients and carers and the feedback board was impressive. Patient stories had been collected from those attending and were being analysed.	N	Mechanisms were in place but there was no evidence of changes made as a result of feedback.
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		Y	

Ref	Standard	Community Hospitals		Community Intermediate Care Team	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
SN-202	**Staffing Levels and Skill Mix** Sufficient health and care staff with appropriate competences should be available for: a. The number of patients usually cared for by the service and the usual case mix of patients b. The service's role in the patient pathway and expected timescales c. The assessments, care and therapeutic interventions offered by the service Staffing should include: i. At least two registered healthcare professionals at all times the service is operational ii. A registered nurse available 24/7 in bedded units and daily (7/7) in other services iii. Appropriate therapists for the needs of the patients daily (7/7) iv. Access to social services staff available to undertake social care assessments within 24 hours of request v. Medical staff (QS SN-205) Cover for absences should be available so that the patient pathway is not unreasonably delayed, and patient outcomes and experience are not adversely affected, when individual members of staff are away.	N	The Trust had four Consultant vacancies at the time of the visit. Grange Ward had a locum Consultant, two locum specialist Doctors and a locum Advanced Nurse Practitioner. Out of hours medical cover was provided by the out of hours GP service. Therapists were not available on the ward at weekends and over bank holidays. Nurse staffing levels were appropriate for the number of patients usually cared for at Leek Hospital and Grange Ward at the Hayward Hospital.	Y	Staffing for the Community Intermediate Care Team (CICT) should this be was as follows:- 8.73 wte. Advanced Nurse Practitioners (ANP) covered all four areas. They were assigned to a location but worked on a rota to provide a rapid response during the hours of 9am -12 midnight. They could be accessed via the Clinical Coordination Hub. Within the CICT, two shifts patterns were in place:- A Physiotherapist or Occupational Therapist and a nurse on every shift in each location. A total of 60 wte, rehab support workers (Band 3) provided care and there was a 5 hour overlap of shifts during the day. The reviewers were told that the high level of care referrals meant that the team were not using their sub-acute skills effectively. Staffing was sufficient for the activity at the time of the review but the team was not in a position to increase capacity. Reviewers were told that staff cared for 87 patients daily with a monthly target of 282 new patients per month. The service was running to about 220 new referrals per month at the time of the visit.

Ref	Standard	Community Hospitals		Community Intermediate Care Team	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
SN-203	**Service Competences and Training Plan** The competences expected for each role in the service should be identified. A training and development plan for achieving and maintaining competences should be in place. If provided by the service, the competence framework should cover: a. Intravenous therapy b. PEG feeds c. Care for patients with dementia or significant cognitive impairment d. VAC therapy and other complex wound care	N	Work was being undertaken in the Trust to develop a competency framework for all staff using skill for health competences. The training team were in the process of developing the care certificate for Healthcare Support Workers. **Hayward:** A training programme was in place for some specialist skills The ward had band development preceptorship programmes in place.	N	Work was being undertaken in the Trust to develop a competency framework for all staff using skill for health competences. The training team were in the process of developing the care certificate for Healthcare Support Workers.
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		Y	

Ref	Standard	Community Hospitals		Community Intermediate Care Team	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
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	**Hayward:** A medical review of patients did not take place daily. The emergency GP service provided cover Out of Hours. **Leek:** This Quality Standard was met.	N	The Community Intermediate Care service worked alongside the patient's GP who provided the required medical interventions, but the GP was not always available within two hours (c).
SN-299	**Administrative, Clerical and Data Collection Support** Administrative, clerical and data collection support should be available.	Y		Y	

Ref	Standard	Community Hospitals		Community Intermediate Care Team	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
SN-301	**Clinical Support Services** Timely access to an appropriate range of clinical support services should be available, including: a. Imaging b. Pathology, including microbiology c. Pharmacy, including medication supply and medicines management advice d. Appropriate staff to undertake a home assessment within 24 hours of request e. Infection control (7/7 and on call 24/7) f. Tissue viability (7/7) g. Falls prevention (next working day) h. Continence service (7/7) i. Mental health team (crisis response within four hours) j. Counselling	N	Home assessments were not always possible within 24 hours of request. Community hospitals could access all other support services. The RAID service provided some cover but was not always able to respond within four hours (i).	N	Home assessments were not always possible within 24 hours of request. Mental health team crisis response was not always possible within four hours.

Ref	Standard	Community Hospitals		Community Intermediate Care Team	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
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	Social care support was not always available within four hours of request.	N	Social care support was not always available within four hours of request. Reviewers were told that some of the team had delayed discharges due to delays in availability of care packages (see main report).
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		Y	Compliance is based on the self-assessment as reviewers did not visit any facilities.

Ref	Standard	Community Hospitals		Community Intermediate Care Team	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
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	The Trust had plans to implement the "Evolve" programme (electronic record system) which will address the implementation of integrated care records.	N	The Trust had plans to implement the "Evolve" programme (electronic record system) which will address the implementation of integrated care 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		Y	

Ref	Standard	Community Hospitals		Community Intermediate Care Team	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
SN-502	**Clinical Guidelines** Guidelines on management of the usual case mix of patients referred to the service should be in use covering at least: a. Pain b. Depression c. Skin integrity d. Falls and mobility e. Continence f. Delirium and dementia g. Nutrition and hydration h. Sensory loss i. Medicines management j. Catheter care k. Spasticity management l. Care of patients with diabetes, COPD, heart failure and other long-term conditions m. Activities of daily living n. Health promotion, including smoking cessation, healthy eating, weight management, exercise, alcohol use, sexual and reproductive health, and mental and emotional health and well-being	N	Not all the guidelines defined in the Quality Standard were in place.	N	Not all the guidelines defined in the Quality Standard were in place.

Ref	Standard	Community Hospitals		Community Intermediate Care Team	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
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 were not yet in place. In practice there were a number of discharge documents in use.	N	Transfer of Care Guidelines were not yet in place. In practice there were a number of discharge documents in use.

Ref	Standard	Community Hospitals		Community Intermediate Care Team	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
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 were not yet in place. Transfer of care documentation and forms were in use.	N	Guidelines were not yet in place. Guidelines were not yet in place. Transfer of care documentation and forms were in use.
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'	N	Guidelines were not available for reviewers to access. Some information was available around DNAR (do not attempt resuscitation orders), multiagency safeguarding and MCA (Mental Capacity Act).	N	Guidelines were not available for reviewers to access. Some information was available around DNAR (do not attempt resuscitation orders, multiagency safeguarding and (Mental Capacity Act).

Ref	Standard	Community Hospitals		Community Intermediate Care Team	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
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	There was no operational policy in place covering all the requirements of the Quality Standard. In practice 'a', 'b', 'c', 'd', 'e', 'f', 'g' (Leek only) 'h', 'j', 'm' 'p' were undertaken.	N	There was no operational policy in place covering all the requirements of the Quality Standard. In practice 'a', 'b', 'd', 'e', 'f', 'h', 'm', and 'p', were undertaken.

Ref	Standard	Community Hospitals		Community Intermediate Care Team	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
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		N	Activity levels for the service were not clearly defined (see main report).
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	Audits against ward assurance dashboard and record keeping, and the safety thermometer were undertaken, but not compliance with evidence-based guidelines.	N	A rolling programme of audit covering compliance with evidence-based clinical guidelines was not in place. Audits related to a CQUIN had been conducted during 2014/15. Monthly record keeping audits were coordinated via the Trust Practice Audit Team.
SN-703	**Key Performance Indicators** Key performance indicators (QS SN-701) should be reviewed regularly with Trust (or equivalent) management and with commissioners.	N	Evidence was not available for compliance to be determined. Reviewers were told that meetings with commissioners did take place.	N	Evidence was not available for compliance to be determined. Reviewers were told that meetings with commissioners did take place.

Ref	Standard	Community Hospitals		Community Intermediate Care Team	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
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. Some shared learning events took place 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. Some shared learning events took place, but these were predominantly available to NHS Managers and not to frontline staff.
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	**Hayward:** Multi-disciplinary arrangements for review and learning were in place. **Leek:** Review and learning took place in various groups rather than within a multi-disciplinary forum.	N	Multi-disciplinary review and learning within the Intermediate Care Teams 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	Not all documentation was up to date or had review dates included.	N	Not all documentation was up to date or had review dates included.

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COMMISSIONING

Ref	Standard	Met? Y/N	Reviewer Comments
SZ-601	**Commissioning of Services** Commissioners should commission intermediate care services for people at home and intermediate care services with beds sufficient for the needs of their population and should specify: a. Criteria and arrangements for acceptance by each intermediate care service, including the use of 'Trusted Assessors' (QS SM-202) b. Time limit for provision of intermediate care service c. Type of care, rehabilitation and re-ablement provided, in particular, whether care is available for patients needing: i. 24/7 on-site care (community hospital or care home) ii. Overnight care (night-visiting or night sitting) iii. Intravenous therapy iv. PEG feeds v. Care for dementia or significant cognitive impairment vi. VAC therapy and other complex wound care d. Arrangements for supply of medication, dressings and continence aids, equipment, adaptations and assistive technology within expected timescales (QS SM-301 and SN-302) e. Short-term health and social care support comprising up to four visits per day for at least 72 hours after returning home (QS SM-302 and SN-302) f. Key performance indicators for each service g. Any specialist care not normally available in the local area for which specific funding decisions are required	N	Trusted assessors were not fully embedded in all areas across the health economy and reviewers were told that multiple assessment took place. Short term health and social care support was provided in some areas. Key Performance Indicators for community services were not available. A range of 'score cards/ dashboards' against some of the community services following commissioning reviews were now in place.

Ref	Standard	Met? Y/N	Reviewer Comments
SZ-602	**Local Enabling Agreements** Health and social care commissioners should have local enabling agreements covering: a. Care package continuity during hospital admission b. Flexibility of re-start following hospital admission c. 'Discharge to assess' d. Cross-boundary agreements e. Single assessment process f. Arrangements for assessment and transfer of care for patients not resident in the local area, and reciprocal arrangements for local patients admitted to hospitals outside the local area	N	Local enabling agreements were not seen. Reviewers were told that care packages continuity was dependent on length of stay in hospital. All restarts for care packages were managed by the specialist Social Care teams attached to acute and community hospitals 'Discharge to Assess' (c) was in development. Cross boundary agreements were not yet formalised (d). A single assessment process had been commissioned but had not been fully implemented (e). 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 was not in place (f).
SZ-701	**Quality Monitoring** Commissioners should monitor key quality and performance indicators for: a. Transfer of care from acute hospitals (QS SM-701) b. Intermediate care services (QS SN-701)	N	Transfer of care Key Performance Indicators were not measured or monitored by Commissioners (a). Some monitoring was in place for community intermediate care services but not for all the expected timescales.
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 were held following the evaluation of the new service specification of the community intermediate care services.

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