WM QRS West Midlands Quality Review Service

NHS

Transfer from Acute Hospital Care and Intermediate Care

Wolverhampton Health and Social Care Economy

Visit Date: 21st and 22nd April 2015 Report Date: July 2015

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INDEX

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 21st and 22nd 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 that reviewed the services in Wolverhampton health and social care economy. Appendix 2 contains the details of compliance with each of the standards, and the percentage of standards met.

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

- The Royal Wolverhampton NHS Trust
- NHS Wolverhampton 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 Wolverhampton or jointly provided or commissioned services. Actions by commissioners and providers of social care may be required in order to address the issues identified in this report.

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

ABOUT WEST MIDLANDS QUALITY REVIEW SERVICE

WMQRS is a collaborative venture between 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 Wolverhampton 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.

Return to *Index*

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 Wolverhampton health and social care economy.

Pathway	Provider	Quality Standards	Notes
Primary care	-	Primary care	Reviewers did not meet any GPs or other primary care staff.
New Cross Hospital	The Royal Wolverhampton NHS Trust	Acute Trust: All wards	Reviewers reviewed documentary evidence and visited wards C16 and C18, the Acute Medical Unit, Appleby ward, the cardiothoracic ward, the discharge lounge and the Emergency Department, and met with a range of staff, patients and patient representatives. Reviewers also met staff from the Integrated Health and Social Care Team, managed by The Royal Wolverhampton NHS Trust but with social work staff employed by Wolverhampton City Council.
West Park Rehabilitation Hospital	The Royal Wolverhampton NHS Trust	Intermediate care	Reviewers reviewed documentary evidence, visited elderly care wards and met staff and patients.
Community Intermediate Care Team (CICT)	The Royal Wolverhampton NHS Trust	Intermediate care	Reviewers reviewed documentary evidence and met staff from this service.
Home Intervention Team (HIT)	The Royal Wolverhampton NHS Trust	Intermediate care	Reviewers reviewed documentary evidence and met staff from this service.
Probert Court	Heantun Care Housing Association Limited	Nursing home template	Reviewers reviewed documentary evidence, visited Probert Court and met staff, residents and families.
Other services:			
Wolverhampton Urgent Care Triage and Access Service (WUCTAS)	The Royal Wolverhampton NHS Trust	-	Reviewers did not meet staff of these teams but were told about their contribution to the pathway.
Rapid Response Team (REACT)			
Hospital at Home Team			
Outpatient Parenteral Antimicrobial Therapy (OPAT) Team			Reviewers met staff of the OPAT team.
Pharmacy			Reviewers met with staff from pharmacy and were told about their contribution to the pathway.
Home Assisted Reablement Programme (HARP)	Wolverhampton City Council	-	Reviewers did not meet staff of the HARP team but were told about its contribution to the pathway.
NHS Wolverhampton Clinical Commissioning Group	-	Commissioning	Reviewers met CCG staff. Documentary evidence of compliance with Quality Standards was not provided.

Support for this pathway was also provided by Wolverhampton City Council Resource Centres and by The Royal Wolverhampton NHS Trust's community matrons and district nursing teams. Additional intermediate care beds were sometimes 'spot-purchased' from nursing homes in and around Wolverhampton.

General Comments and Achievements

Throughout this review, reviewers met staff who were enthusiastic, committed to providing high quality care, aware of the problems their services faced and trying to find a compassionate and caring solution to these problems. Senior staff from commissioning and provider organisations were aware of changes that needed to be made, and several reviews had taken place. Plans were being made, using the Better Care Fund, to improve and streamline pathways of care.

Summary Care Records from general practices were available to The Royal Wolverhampton NHS Trust via 'Graphnet' from all except nine local practices.

Good Practice

1 'Core care plans' covering emergency care planning were available to staff via the 'Clinical Web Portal'. The 'core care plans' defined care for patients attending the Emergency Department and were in addition to personalised management plans. The plans were also used to facilitate timely discharge if admission was required. Reviewers were impressed at the governance process for agreeing and managing the 'core care plans'.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Social Care Assessment and Provision**

Reviewers were seriously concerned about several aspects of assessments for and provision of social care:

a. **Delays in assessments for social care**

Patients on wards at New Cross Hospital were waiting up to seven days for a Wolverhampton social worker to be allocated, and to be assessed for social care needs. Patients from outside Wolverhampton (for example, from Staffordshire or Walsall) were waiting longer, and reviewers were told that these patients could wait up to two weeks for a social worker to be allocated. At the time of the review approximately 100 Wolverhampton patients were waiting to be allocated a social worker for a social care assessment.

Reviewers were told that the high levels of outstanding social work allocations were due to:

- 20% of social work posts being filled by agency staff at the time of the review
- Agency staff having to give only one week's notice of leaving.
- Approximately 12% long-term sickness absence
- Some delays in recruitment due to a re-structuring programme

Some measures were in place to reduce the pressure on social workers, including reducing their caseloads to a maximum of 20 cases. An education programme for ward staff was also in place with the aim of avoiding unnecessary referrals in the acute setting and providing contact details for arranging social work assessments in the community.

This finding did not apply to the Emergency Department and Clinical Decisions Unit, which reported social work as providing a responsive, proactive and positive service. This service was provided by the Integrated Health and Social Care Team duty social care staff during normal working hours and by a volunteer rota at weekends, bank holidays and from 5pm to midnight on weekdays. The Acute Medical Unit was able to access the same service but some staff were not aware of this, and were concerned that the assessment process would be started again if a patient was admitted.

If intermediate care in a nursing home was 'spot-purchased', social workers from the Integrated Health and Social Care Team went out to the nursing home to undertake assessments. The timeliness of these assessments had also been affected by the staffing issues described above.

b. **Social care provision**

Reviewers were told that City Council-funded domiciliary care packages were assessed so they would meet the needs of the patient but usually involved only one visit per day. More complex care packages, such as those involving four calls per day or calls requiring two carers, were not easily available and patients were usually offered alternatives, such as an interim placement. Domiciliary care availability was also reported as being difficult to access during holiday periods, with some difficulties in provision immediately prior to a holiday period. Patients were usually offered an interim placement in an intermediate care facility in order to avoid a longer stay in an acute bed. At the time of the review the availability of interim placements was reduced, partly because 40 beds were closed to admissions.

Once a care package start date was agreed, the Community Intermediate Care Team provided a 'bridging service' of support for up to two weeks.

c. **Integrated Health and Social Care Team**

The Integrated Health and Social Care Team based at New Cross Hospital was made up of a capacity (health) team and social work staff. The capacity team comprised a patient flow manager, coordinators and assistants. Social work staff were employed by the City Council. These teams shared an office. Managers said that the teams were working closely together due to the staffing challenges, but this collaborative working was not evident to reviewers.

Effective working arrangements between the social care team and ward staff were also not evident. Social workers had previously attended ward multi-disciplinary meetings and board rounds, but this arrangement had ceased because of the staffing issues described above. Social workers from the Integrated Health and Social Care Team did not attend all multi-disciplinary meetings at West Park Rehabilitation Hospital. Social workers from the locality teams did not in-reach into New Cross or West Park Hospitals.

d. **Impact**

The health and social care economy had a clear, documented understanding of this issue but did not have a plan to resolve the current difficulties. Solutions were taking time to formulate because priority was being given to resolving staffing issues. Reviewers considered that the issue must be having a significant impact at every stage of the acute and intermediate care pathway. The risks to patients from their extended stays in hospital, as well as the impact on overall capacity and delays in care for other patients, did not appear to have been fully assessed. Reviewers were unclear if there was an action plan with clear targets for reducing delays, although the Integrated Health and Social Care Team Manager was in daily contact with the Deputy Chief Operating Officer and/or the Chief Operating Officer of The Royal Wolverhampton NHS Trust. Reviewers were told that a re-structure of the City Council's social work services was taking place, and that the Integrated Health and Social Care Team was employing agency staff until this was completed (expected to be in the summer of 2015).

2 Strategy for Transfer from Acute Hospital Care and Intermediate Care

Wolverhampton did not have an overall strategy for transfer from acute hospital care and intermediate care. Plans were being developed, using the Better Care Fund, but clinical staff did not appear to be aware of or involved in developing these plans. Reviewers had concerns about several aspects of the arrangements in place at the time of the review:

a. **Fragmentation of services**

Several community-based services, for example, CICT, REACT, Hospital at Home, OPAT and HARP, were available to support the transfer from acute hospital care and intermediate care pathway, including admission avoidance. These services were additional to the care provided by community matrons and district nurses. (Community matrons were proactively 'in-reaching' into hospital to facilitate discharge of patients already under their care, and care of older people consultants were working well with community matrons, including visiting patients at home with the aim of preventing admission.) The hospital respiratory specialist nursing team liaised with the community Hospital at Home team, but this effective 'out-reaching' in order to expedite discharge was not so evident in other areas visited by the reviewing team.

The role of each of the services and the criteria for acceptance were sometimes documented but were not clearly understood by ward-based and other clinical staff met by reviewers. Reviewers were told that the Community Intermediate Care Team was the most responsive and so referrals were often made to this service rather than others, which may explain the pressures on the capacity of this team (see below).

Duplication in the roles of these services was apparent, with clear potential for multiple assessments and multiple providers of care. The arrangements also appeared to be an inefficient use of the resources available for community-based services.

b. **Unclear pathways**

The pathways for transfer from acute hospital care and intermediate care were unclear. WUCTAS had a role in managing demand and capacity but was having difficulty coping with the number of referrals received (see below). Ward-based staff referred patients directly to other services as well as to WUCTAS. Plans for a Single Point of Access service were being considered.

c. **'Step up' and 'discharge to assess' arrangements**

Wolverhampton did not have any beds to which patients could be admitted in order to avoid an acute hospital admission. Reviewers were told that 'step up' beds had been available at Warstones Resource Centre but that these had not been used effectively, possibly because the criteria for admission were tight and significant paperwork was involved in arranging admission. Patients were occasionally admitted to West Park Rehabilitation Hospital for 'step up' care but this was on an ad hoc basis rather than an established and recognised pathway.

'Discharge to assess' arrangements were not yet in place in Wolverhampton. Patients therefore waited in hospital until their assessments were completed, increasing hospital lengths of stay. Occasionally patients were moved to West Park Rehabilitation Hospital while awaiting assessment for nursing home care. This reduced their acute hospital length of stay but was still not an ideal setting for their care.

South Staffordshire residents awaiting assessment for NHS Continuing Care were waiting in hospital until the Decision Support Tool had been completed.

d. **Multiple assessments**

'Trusted assessor' arrangements had not yet been implemented in any part of the transfer from acute hospital care and intermediate care pathway. Health and social care assessments were conducted separately, and each service undertook its own assessments. Health staff could refer to health services and social care staff to social care services, but effective integration between health and social care was not apparent. Some patients could have a WUCTAS assessment as well as an assessment by each service.

3 **Health and Social Care Economy Planning and Coordination Group**

A group was meeting to develop plans for use of the Better Care Fund, but the health and social care economy did not have any group, involving all relevant stakeholders, for the planning and coordination of this pathway. Arrangements for review and learning across the health and social care economy were not yet in place. Given the enthusiasm and expertise of staff who had developed the range of services in place at the time of the review, reviewers also suggested that actively involving clinical staff in the development of plans for the future would be helpful.

Further Consideration

1 Bedded intermediate care services were commissioned for a maximum period of six weeks but lengths of stay appeared often to exceed the expected level. Incentives to get people home in less than the maximum period were not apparent and reviewers saw some evidence of a culture of acceptance of longer lengths of stay. It may be helpful to consider the need for cultural change as well as incentives to get people to the most appropriate setting with appropriate care as soon as possible.

2 The education programme for ward staff intended to avoid unnecessary referrals in the acute setting and provide details of how to arrange community-based social care assessments. Some ward staff perceived the programme as avoiding referrals to social care, however, which may have unhelpful longer-term consequences for patients for whom early provision of social care could prevent later problems.

Return to *Index*

PRIMARY CARE

General Comments and Achievements

Reviewers did not meet any general practitioners or other providers of primary care.

Further Consideration

1 Throughout the review of this pathway there was little evidence of the proactive involvement of GPs or of service development with the clinical involvement of GPs. Further consideration of potential opportunities for enhancing the clinical contribution that GPs make to this pathway may be helpful.

Return to *Index*

ACUTE CARE

NEW CROSS HOSPITAL: THE ROYAL WOLVERHAMPTON NHS TRUST

General Comments and Achievements

Reviewers were impressed by many of the achievements at The Royal Wolverhampton NHS Trust. Staff who met reviewers were clearly motivated and enthusiastic about their work. Wards were using 'planned or predicted' dates of discharge rather than 'estimated' dates in order to support active discharge planning. Pharmacy provided good support and medicines reconciliation was in place in the Acute Medical Unit and wards. Access to training and development opportunities was good. Strong ward leadership was evident and reviewers also saw good examples of feedback and learning from incidents being shared with ward staff. The Safer Hands Dashboard was being developed beyond its initial infection control function. A good integrated safeguarding training package was being introduced covering safeguarding of children and adults, Mental Capacity Act and Deprivation of Liberty Safeguards.

The Patient Advice and Liaison Service was actively supporting patient and carer engagement in the Trust's work, including effective use of patient stories for training, input to induction programmes and good displays of information on all wards visited by reviewers. Volunteers were also working in the Trust seven days a week.

Reviewers also commented on the range of initiatives and developments that had been led by clinical staff within the Trust.

Good Practice

1 Senior nurses were working at both West Park and New Cross Hospitals in order to ensure consistency of standards of care and sharing of best practice.

2 The Trust had adapted the 'SBAR' tool to 'SBART' as a structured method to enhance communication and the process of transferring patients between services.

3 Wards visited by reviewers had extremely good displays of patient experience data including positive and negative feedback, infection rates, staff training, roles and responsibilities and staff on duty.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Preparation for transfer from acute hospital care**

Several issues were identified relating to the process of preparation for transfer from acute hospital care:

a. **Discharge without medication and discharge information**

Some patients were being discharged before their medication and discharge information was ready. Medication and discharge letters were then sent in a taxi later. Reviewers were told that this often happened, and examples were seen when reviewers visited Probert Court. This arrangement was only made if the patient or their carers agreed, but it was not clear that the full implications were explained to them, including the impact of a lack of medication and clinical information if the patient's condition deteriorated before the taxi arrived.

b. **Turnaround times for drugs 'to take out'**

Board meetings took place on all wards at 9am and then later in the afternoon. Consultants attended these meetings. Only an average of 34% of each day's requests for drugs 'to take out' were received in pharmacy before 12 noon, however, and an average of 23% were received after 4pm. Dispensing of drugs 'to take out' took a maximum of two hours. Reviewers were told that there were then delays of up to three hours in these drugs reaching the ward. Ways to speed up these processes were being considered.

c. **Transport requests**

Patient transport was available within 90 minutes of request (and sooner for patients nearing the end of life who wanted to go home) but reviewers were told of delays in requesting transport and 'bottlenecks' because of many requests being received in the late afternoon or early evening.

d. **Patient information**

It was not clear that patients were always given appropriate information about their care after discharge and the future provision of services.

Taken together, these issues suggested delays at ward level in preparing for and acting on decisions of the morning board or ward rounds. Reviewers also saw examples of patients who had been assessed as ready for discharge the day before but whose medication was still not available the following day.

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

Further Consideration

1 Plans for a range of 'hot clinics' were being developed, which may help to support earlier discharge from acute hospital care (respiratory and neurology hot clinics were already in place).

2 The draft 'Rapid Home to Die' guidelines did not cover discussions with patients, carers and those who may have power of attorney. Reviewers suggested that this should be specifically included.

Return to *Index*

WOLVERHAMPTON URGENT CARE TRIAGE AND ACCESS SERVICE (WUCTAS): THE ROYAL WOLVERHAMPTON NHS TRUST

General Comments and Achievements

This service provided nurse-led triage of urgent care referrals and was available from 10am to 7pm seven days a week. The service could be accessed by healthcare professionals who phoned initially and then provided further information by email. WUCTAS provided direct access to adult community services and triage of adult urgent medical referrals. Reviewers were told that the service had been reviewed annually since it was established three years ago and a further review was planned.

Immediate Risks: No immediate risks were identified.

Concerns

1 See also the health and social care economy section of this report; in particular, the criteria for referral to WUCTAS were not clearly defined, and referrals sometimes appeared to be sent directly to services as well as via WUCTAS.

Return to *Index*

RAPID RESPONSE TEAM (REACT): THE ROYAL WOLVERHAMPTON NHS TRUST

The Rapid Response Team of occupational therapists plus some physiotherapists actively supported the discharge of patients from New Cross Hospital and West Park Rehabilitation Hospital. Priority was given to patients in the Emergency Department. The service was available from 8am to 8pm, Mondays to Fridays, and from 8am to 6pm at weekends. The team usually had a caseload of 20 patients per day. Staff rotation between New Cross and West Park Hospitals was in place. The team also supported the care of people in 'step down' beds. The service accessed community services through WUCTAS and was considering the development of extended roles for therapy practitioners.

Return to *Index*

INTERMEDIATE CARE

WEST PARK REHABILITATION HOSPITAL: THE ROYAL WOLVERHAMPTON NHS TRUST

General Comments and Achievements

West Park Rehabilitation Hospital had 80 intermediate care / rehabilitation beds for older people as well as stroke and neurological rehabilitation beds. The environment was pleasant and clean. In ward 3 the isolation areas had glass screens so that they were light and patients could be observed. Cupboard areas had been re-used to provide a toilet and shower room for the isolation areas. Dementia bays had been introduced as part of the implementation of a five year strategy for the care of people with dementia.

A goal-oriented approach towards pathways of care was in place. An 'About me' document was also in use on all wards. At the time of the review, average length of stay was 32 days with a target of 28 days. Medical cover for the elderly care beds was from care of older people consultants until 7pm and then by the GP out of hours service overnight.

An intermediate care allocation tool had been implemented shortly before the review and provided a daily overview of acuity of patients, capacity and staffing. This tool was also used by the Community Intermediate Care

Team. Projections were also available. At the time of the review information had to be entered manually, but there were plans to introduce automatic updating of the system.

Reviewers were told that multi-disciplinary discussions involving patients and their carers had been in place for some time and that visiting times had been altered in order to facilitate this. A good range of information for patients and carers was available.

Good Practice

1 Patients were classified as 'red', 'amber' or 'green' depending on their readiness for discharge. Red-rated patients were not medically fit for discharge. The ratings were linked to the patients' goals. This system allowed staff quickly and clearly to see the stage of patients' care.

2 Patients were supplied with bottled water, marked with their name and the date. This enabled fluid intake to be monitored. The arrangement had been evaluated and had shown that patients valued being able to monitor their own fluid intake and that it had become easier to identify those patients who were at risk of dehydration.

Immediate Risks: No immediate risks were identified.

Concerns: See health and social care economy section of this report.

Further Consideration

1 Average length of stay appeared long, based on the acuity of patients on the wards at the time of the review visit. Reviewers suggested that there may be potential further to reduce length of stay by an even more active approach to rehabilitation, and suggested consideration of the following:

   a. Physiotherapists and occupational therapists did not cover the hospital at weekends. A rehabilitation assistant was available at weekends and would actively support ongoing rehabilitation plans but could not assess and initiate therapy plans for patients admitted to West Park Rehabilitation Hospital on Friday afternoons or over the weekend.

   b. An on-site advanced nurse practitioner or senior nurse at weekends could support more active management of patient 'journeys', especially as medical cover was dependent on the 'Out of Hours' GP service. A senior sister bleep holder was available to provide advice and support out of hours.

2 GPs could not admit patients directly to the elderly care beds at West Park Rehabilitation Hospital. Reviewers considered that provision of 'step up' beds would be a useful addition to local services and would avoid the need for some patients to be admitted to New Cross Hospital.

3 Reviewers also considered that there was the potential to provide more sub-acute care at West Park Rehabilitation Hospital so long as staff undertook training in nursing patients with a higher level of acuity. It may be possible for the co-located Community Intermediate Care Team to support this change. Rotation of senior nurses from New Cross Hospital also provided a helpful basis for the provision of more sub-acute care.

4 The Lead Consultant for the service at West Park Rehabilitation Hospital had a clear vision for the future development of the services, although it was not clear to what extent this vision was shared by other staff, The Royal Wolverhampton NHS Trust Board and commissioners.

Return to *Index*

COMMUNITY INTERMEDIATE CARE TEAM (CICT): THE ROYAL WOLVERHAMPTON NHS TRUST

General Comments and Achievements

The Community Intermediate Care Team consisted of nurses and therapists, and provided intermediate care in order to avoid admission, or following an acute hospital stay. The team responded within 24 hours of referral and was commissioned to provide care for up to six weeks as indicated by the assessment of needs. Some patients had been with the team for longer than six weeks, however, because of delays in social care assessments or provision of domiciliary care packages (see the health and social care section of this report). The CICT was available from 8am to 10pm Mondays to Fridays, with limited staffing available in the evenings and at weekends. Referrals were taken up to 4pm, following which time messages were left on an answerphone. The caseload at the time of the review was between 110 and 120 patients. The service was appreciated and seen as responsive by staff at New Cross Hospital, which may explain the increasing rate of referrals.

Good Practice

1 A strong focus on patient-defined goals was evident, with achievement of these goals being reviewed regularly and the information collected. The Trust was considering using this information to formulate a patient's planned discharge date (PDD) as well as including the monitoring as part of its internal key performance indicator dashboard to drive quality.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Capacity**

The CICT received between 16 and 20 referrals per day but only had capacity to see 12 patients per day. Care of some patients was therefore being delayed. Also, only one registered nurse was on duty in the evenings and at weekends and so, in practice, additional capacity for caring for emergency referrals was limited.

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

Further Consideration

1 The team had no IT support and relied on paper records that did not link with other systems.

2 The team had competences to provide sub-acute care but, in practice, were spending most of their time providing goal-based rehabilitation programmes and were relying on the Hospital at Home team, the OPAT team or district nurses to support patients with syringe drivers, PEG feeds and intravenous antibiotics. The role of the CICT in relation to district nursing services and the HARP team was not clear.

3 Access to 'step up' beds could be arranged, but reviewers were told that this was often difficult and so, in practice, patients needing more intensive care were usually admitted to New Cross Hospital.

4 Arrangements for the allocation of a care coordinator were not clear and the name of the care coordinator was not in the patients' notes seen by reviewers.

5 Medical cover for the team was from the patients' GPs. It may be helpful to consider some sessional support and advice for the team from a care of older people consultant.

6 Clinical records seen by reviewers did not record whether inhaler technique had been observed. It may be helpful to ensure this is recorded (when applicable).

Return to *Index*

HOME INTERVENTION TEAM (HIT): THE ROYAL WOLVERHAMPTON NHS TRUST

General Comments and Achievements

The Home Intervention Team provided support for 10 of the 20 nursing homes in Wolverhampton in order to avoid admissions to New Cross Hospital or to support residents following discharge from hospital. There were plans to roll the service out to all nursing homes later in 2015/16. The service had developed following an analysis of the number of patients being admitted to hospital from nursing homes. The team received between five and 10 referrals per day. The team had good IT support including access to the 'portal' and information about patient assessments.

Further Consideration

1 It was unclear whether GPs could refer patients to the Home Intervention Team. Reviewers suggested that this should be considered if it is not already available.

2 The team had a dashboard of metrics, which included achievement of personalised management plans. It may be helpful to include metrics on admission avoidance.

3 Reviewers were told that residential homes were visited by the CCG Quality Nurse Adviser. It may be helpful to consider extending the remit of the HIT service to residential homes as well as nursing homes.

Return to *Index*

HOSPITAL AT HOME TEAM: THE ROYAL WOLVERHAMPTON NHS TRUST

The Hospital at Home Team provided more intensive community-based nursing support, for example for patients needing intravenous therapy, PEG feeds or other interventions. The team supported patients after discharge from acute care but not for admission avoidance. Some work had been undertaken in fostering relationships with the acute services (respiratory) in order to expedite the discharge of patients back into the community.

Return to *Index*

OUTPATIENT PARENTERAL ANTIMICROBIAL THERAPY (OPAT) TEAM: THE ROYAL WOLVERHAMPTON NHS TRUST

The OPAT team provided post-admission community-based antimicrobial therapy for patients meeting specific criteria. An acute consultant retained clinical responsibility for the patients, who could be re-admitted if their progress was not satisfactory. Antibiotic medication was supplied fortnightly and collected from the hospital by relatives. The service usually cared for between 13 and 15 patients at any one time, with an average stay with the service of 21 days. Over three years the service had saved over 6,000 in-patient bed-days. The service worked closely with district nursing teams. The OPAT team did not provide care for patients in order to avoid an acute admission.

Return to *Index*

PROBERT COURT: HEANTUN CARE HOUSING ASSOCIATION LIMITED

General Comments and Achievements

Probert Court provided 20 intermediate care beds with an expected length of stay of six weeks. Actual length of stay was usually between six and twelve weeks. The environment at the home was pleasant, with a good range of activities taking place. A new manager had taken up post shortly before the review visit and was keen to improve standards of care further. The service did not admit people with challenging mental health problems or learning disabilities, or people who were permanently resident in another nursing home.

Medical cover was provided by a GP who visited each morning, Mondays to Fridays. The GP actively managed the care of patients and tried to prevent deterioration in their condition and re-admission. A good training matrix was in place.

Concerns: See health and social care economy section of this report.

Further Consideration

1 Physiotherapy services for patients at Probert Court were provided by the Rapid Response Team. Reviewers were told that it could take up to 72 hours for a patient to receive physiotherapy following transfer to Probert Court.

2 Residents who met reviewers did not have information about why they were in Probert Court or about plans for their care after being at Probert Court. The care plans seen by the reviewers were not all up to date.

3 Reviewers suggested that 'asepsis' should be added to the training matrix.

4 Probert Court accepted and used 'Do not attempt resuscitation' documentation completed at The Royal Wolverhampton NHS Trust. Reviewers suggested that the service should review whether this arrangement meets relevant national guidance.

5 Initial 'step down' social care assessment documentation was not always complete.

6 Beds were held for residents who were admitted to hospital. These people were sometimes then transferred to permanent nursing home care without Probert Court being informed. Reviewers queried the appropriateness of keeping intermediate care beds for residents admitted to hospital.

7 Mechanisms for review and leaning within the organisation were in place, but lessons learnt were not routinely cascaded to the Acute Trust. Involving 'frontline staff' in feedback would help to raise awareness of issues experienced around the transfer of patients, such as late transfers and lack of medication.

Return to *Index*

HOME ASSISTED REABLEMENT PROGRAMME (HARP): WOLVERHAMPTON CITY COUNCIL

Wolverhampton City Council's HARP service provided personal care and re-enablement support to enable people to remain in their own homes. Reviewers commented on possible duplication between the work of this team and that of others described in this report.

Return to *Index*

COMMISSIONING

NHS Wolverhampton Clinical Commissioning Group did not provide any documentary evidence of compliance with the expected Quality Standards. Details of compliance with Quality Standards (Appendix 2) may therefore underestimate the actual achievement of these Standards.

Concerns

1 The issues identified in this report, especially those highlighted in the 'Health and Social Care Economy' section of the report, will require the engagement of commissioners to ensure they are addressed:

   a. Social Care Assessment and Provision: see Health and Social Care Economy, Concern 1

   b. Strategy for Transfer from Acute Hospital Care and Intermediate Care: see Health and Social Care Economy, Concern 2

   c. Health and Social Care Economy Planning and Coordination Group: see Health and Social Care Economy, Concern 3

   d. Preparation for transfer from acute hospital care: see Acute Care, New Cross Hospital, Concern 1

   e. Capacity: see Intermediate Care – Community Intermediate Care Team: The Royal Wolverhampton NHS Trust, Concern 1

2 **Quality monitoring**

Delayed discharges were monitored, but other key performance indicators about transfer from acute care and intermediate care did not appear to be being monitored. Reviewers did not see evidence of the use of CQUINS to support improvements to the process of transfer from acute care and intermediate care.

Further consideration

1 Further work with Probert Court on releasing intermediate care beds when residents are admitted to hospital may be helpful.

Return to *Index*

APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Visiting Team

Karen Anderson	Acute Matron, Haematology, Oncology, Respiratory & MHDU	The Dudley Group NHS Foundation Trust
Christine Choudhary	Service User	Telford Round Table, Telford HealthWatch
Adele Dean	Clinical Quality Manager	West Midlands Ambulance Service NHS Foundation Trust
Dr Simon Harlin	GP Lead, Frail Elderly Pathway	Walsall Healthcare NHS Trust
Gina Jones	Community Matron	Coventry & Warwickshire Partnership NHS Trust
Janette Knight	Pharmacy Governance Manager	University Hospitals Coventry & Warwickshire NHS Trust
Emma Osborne	Advanced Nurse Practitioner – Urgent Response	Staffordshire & Stoke on Trent Partnership NHS Trust
Marie Tideswell	Head of Patient Experience	West Midlands Ambulance Service NHS Foundation Trust
Sarah Wallace	Quality Improvement Coordinator	NHS Staffordshire & Lancashire CSU/NHS Herefordshire CCG
Liza Walsh	Associate Director of Nursing/Interim Clinical Director Adults & Communities	Birmingham Community Healthcare NHS Trust
Pauline Ward	Complex Discharge Nurse Specialist	Sandwell & West Birmingham Hospitals NHS Trust
Katie Welborn	Community Matron	Walsall Healthcare NHS Trust

Observers

Babatunde Adewopo	Divisional Manager, Women's and Children	Nobles Hospital, Isle of Man
David Sewell	Senior Nurse	Nobles Hospital, Isle of Man

WMQRS Team

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

Return to *Index*

APPENDIX 2 COMPLIANCE WITH THE QUALITY STANDARDS

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

Table 1 - Percentage of Quality Standards met

Service	Number of Applicable QS	Number of QS Met	% met
Transfer from Acute Hospital Care and Intermediate Care			
Primary Care	2	0	0
Acute Trust – All Wards	23	13	57
Intermediate Care: Community Intermediate Care Team (CICT) and Home Intervention Team (HIT)	33	19	58
Intermediate Care: West Park Hospital Ward 3	33	24	73
Commissioning	4	0	0
Health and Social Care Economy	**95**	**56**	**59**

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

Return to *Index*

PRIMARY CARE

Ref	Standard	Met?	Comment
SA-101	**Patients at High Risk of Admission** Patients at high risk of admission to an acute hospital should have a 'Patient Passport' or equivalent patient-held record that covers: a. Diagnoses b. Allergies c. Medication d. Care package (or equivalent) e. Name and contact details of GP f. Name and contact details of main carer/s g. Advice for the patient and their carers on likely problems and what to do in an emergency h. Advice to emergency services on likely problems and recommendations for their management i. Advice for acute hospital services on the most appropriate ward (if admission is required)	N	Access to patients' demographics was available via the Clinical Web Portal. Patient Passports as outlined in the Quality Standard were not in place for patients at high risk of admission.
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 available via 'Graphnet for all but nine GP practices.

Return to *Index*

ACUTE TRUST – ALL WARDS

Ref	Standard	Met?	Comment
SM-101	**Planned Admissions** All patients awaiting a planned admission to hospital should be offered written information about arrangements for leaving the hospital and returning to their usual place of residence.	Y	Staff on Appleby ward also phoned patients a week before admission, which had reduced the level of cancellations on the day of admission.

Ref	Standard	Met?	Comment
SM-102	**Information about Leaving Hospital** Each ward should clearly display information for patients, carers and staff about arrangements for transfer of care on leaving the hospital, covering at least: a. The process of transfer of care b. Additional support available in the patient's usual place of residence c. Intermediate care options, criteria for accessing these and time limits on their provision (if applicable) d. How to access a discussion with medical and/or nursing staff about the patient's condition and plans for care on leaving hospital	Y	Information leaflets were clear about arrangements for leaving hospital.
SM-103	**Discussion with Families** Members of the multi-disciplinary team should be easily available to families for discussions about the patient's condition and plans for care on leaving hospital. Information on how to arrange a discussion should be clearly displayed in all ward areas.	Y	Information about how to access advice was visible in ward areas. Not all areas had information clearly displayed about how to arrange discussions with 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.	Y	Access to patients' demographics was available via the Clinical Web Portal. Patients with Chronic Obstructive Pulmonary Disease and diabetes had patient-held care plans. An 'End of Life' Care Pathway had recently been launched. A range of information was available for those being discharged following surgery.

Ref	Standard	Met?	Comment
SM-196	**Transfer of Care Plan** Patients and, when appropriate, their carers should be involved in discussing and agreeing the plan for their care after leaving the hospital and should be given a written summary of their Transfer of Care Plan, which should include: a. Expected date of discharge b. Essential pre-discharge assessments c. Care after leaving the acute hospital, including self-care d. Medication required on leaving the acute hospital e. Who is taking medical responsibility for care after leaving the acute hospital f. Further investigations, treatment, rehabilitation and re-ablement to be carried out after leaving hospital, and who will arrange these, including separately identifying any of these which the GP is expected to arrange g. Possible complications and what to do if these occur, including in an emergency h. Transport i. Equipment supply or loan j. Dressings and continence aids k. Who to contact with queries or for advice l. Date by which their care should be reviewed, who is expected to undertake this review and how to access a review more quickly if required This Transfer of Care Plan should be copied to the patient's GP and to all services involved in providing after-hospital care.	N	Patients were sometimes discharged without medicines and accompanying summary ('d'), although a process was in place whereby patients should have received a copy of their discharge summary. See also main report.
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 some wards.

Ref	Standard	Met?	Comment
SM-201	**Multi-Disciplinary Teams** A multi-disciplinary team to coordinate discharge planning should be available on each ward including: a. Staff with occupational therapy and physiotherapy competences with time allocated daily (7/7) for discharge planning, essential pre-discharge assessments and active pre-discharge rehabilitation b. Senior decision-maker review of patients' fitness for discharge at least daily (7/7) c. Nurse with competences in 'event-led' discharge from 9am to 8pm daily (7/7) d. Someone identified to coordinate discharge planning and preparation for discharge from 9am to 8pm daily (7/7) e. Access to social services staff available to undertake social care assessment within 24 hours of request f. Access to pharmacy services and medication 'To Take Out' available within four hours of request	N	Access to social services staff available to undertake social care assessment within 24 hours of request was not possible apart from in the Emergency Department, Clinical Decision and Acute Medical Units. Access to 'take out' medication was not always available when the patient was being discharged - see main report for details about these issues. Other aspects of the Quality Standard were met. Daily multi-disciplinary team 'discharge huddles 'were held as part of the '*Safehands'* best practice programme and seven day working was in place across all in-patient areas. Nurse and therapy event-led discharges were in place as part of Integrated Care Pathway in Cardiology, Orthopaedics, Surgery and unscheduled care.
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	Some staff had not yet had training in the hospital transfer of care pathway. Continuing Health Care (CHC) checklist training had been delivered and posters about the hospital discharge process were displayed.

Ref	Standard	Met?	Comment
SM-301	**Support Services** Access to the following support services should be available daily (7/7): a. Appropriate staff to undertake a home assessment within 24 hours of request b. Patient transport able to respond within four hours of request c. 'Simple' equipment available within four hours of request d. Supply of sufficient dressings and continence aids for 72 hours available within four hours of request e. All equipment, including beds and hoists, available within 24 hours of request f. 'Simple' adaptations available within 24 hours of request g. Voluntary sector 'settling home' support able to respond by the end of the next working day and continue for up to five days h. 'Simple' assistive technology available within 24 hours of request i. Medicines reconciliation (7/7)	Y	Therapists were available 7/7. The Rapid Response therapists also worked extended hours including weekends. A new transport provision (NSL) had been commissioned. Age Concern, the Red Cross and Wolverhampton Neighbourhood Support Scheme provided some 'settling home' support.
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 usually only available for two visits per day. More complex care packages were not easily available.
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)	Y	The Clinical Web Portal was available to all Trust employees.
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	The Discharge checklist and Intra- & Inter-Hospital transfer checklist was used.

Ref	Standard	Met?	Comment
SM-596	**Transfer of Care Guidelines** Transfer of care guidelines for both simple and complex discharge pathways should be in use covering at least: a. Ensuring each patient has an expected date of discharge, ideally within 12 hours of admission b. 'Event-led' discharge c. Discussion with patients and carers about the Transfer of Care Plan d. Multi-disciplinary review for complex discharges or where discharge destination is unclear, ideally within 24 hours of admission e. Single assessment process f. Transport options including patient transport service, relatives, taxis or care home transport g. Development, agreement and giving the patient, GP and, where appropriate, carers a copy of the of the Transfer of Care Plan: i. Expected date of discharge ii. Essential pre-discharge assessments iii. Care after leaving the acute hospital, including self-care iv. Medication required on leaving the acute hospital v. Who is taking medical responsibility for care after leaving the acute hospital vi. Further investigations, treatment, rehabilitation and re-ablement to be carried out after leaving hospital, and who will arrange these, including separately identifying any of these which the GP is expected to arrange vii. Possible complications and what to do if these occur, including in an emergency viii. Transport ix. Equipment supply or loan x. Dressings and continence aids xi. Who to contact with queries or for advice xii. Date by which their care should be reviewed, who is expected to undertake this review and how to access a review more quickly if required h. How to access funding decisions on specialist care not normally available in the local area i. Latest time when patients can normally be discharged home or to care homes j. Handover of the Transfer of Care Plan to services providing after-hospital care, including intermediate care services k. Informing the GP, the person taking medical responsibility for the patient and any other relevant services that the patient has left hospital, ideally within four hours of transfer of care l. Contingency plan when capacity in intermediate care services is not available	N	Guidelines covering transfer of care were in place but did not cover who was taking medical responsibility for care after leaving the acute hospital, any further investigations, treatment, rehabilitation and re-ablement to be carried out after leaving hospital, and who was responsible for arranging these. A single assessment process was in place for some conditions, for example stroke and orthopaedics.

Ref	Standard	Met?	Comment
SM-597	**More Complex Transfers of Care** Guidelines should be in use covering: a. Transfer of care to other local authority or Clinical Commissioning Group areas covering at least social care assessments, intermediate care services available, patient transport and equipment supply or loan b. Transfer to a care home for long-term care c. NHS continuing care assessments and place-finding d. Liaison with palliative and end of life care services e. Patients and/or carers who do not agree a Transfer of Care Plan or who unreasonably delay their transfer of care	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)	N	Summary records were available from the GP practices using Graphnet but not from the nine practices who used a different system. The Trust was in the process of implementing '*Safehands'* boards on the wards which would replace the 'Patient at a Glance' system.

Ref	Standard	Met?	Comment
SM-602	**Intermediate Care** A protocol on access to local intermediate care services should be in use on each ward covering at least: a. Criteria for acceptance by each local intermediate care service and time limit for provision of the service (if applicable) b. Type of care, rehabilitation and re-ablement provided and, in particular, whether the service is able to support: i. 24/7 on-site care (community hospital or care home) ii. Overnight care (night-visiting or night sitting) iii. Intravenous therapy iv. PEG feeds v. Care for dementia or significant cognitive impairment vi. VAC therapy and other complex wound care c. 'Trusted Assessor' (QS SM-202) or other arrangements for agreement of patient suitability d. Arrangements for handover of the patient's Transfer of Care Plan	N	A protocol did include some information about all the local intermediate care services, but it did not include specific details as required by the Quality Standard, in particular the criteria for acceptance and a description of each of the services provided. Individual service leaflets included criteria and contact numbers.
SM-701	**Data Collection and Monitoring** Each ward should have access to data on its own performance and comparative information for other wards covering: a. Proportion of patients achieving their expected date of discharge b. Proportion of patients 'home for lunch' c. Key quality and performance indicators agreed with commissioners	Y	Data were collected and monitored via a number of mechanisms. The Trust was in the process of introducing the *'Safehands'* programme which would allow real-time monitoring and reporting.
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	Y	A range of audit mechanism was in place including Matron case note reviews, and length of stay, access and waiting times, and re-admission rate audits. The proportion of investigations and follow-up within five days was audited for some pathways but was not routine.
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	There was no formal group that met to discuss, review and share learning from discharge planning regularly. There was some shared learning across other areas including implementing a 'Discharge with Risk' alert, whereby any concerns regarding discharge or transfer of care were relayed by the Senior Matron for Community Services back to the Matron for the discharging ward.

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

Return to *Index*

INTERMEDIATE CARE SERVICE

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

Ref	Standard	Community Intermediate Care Team (CICT) Home Intervention Team (HIT)		West Park Hospital Ward 3	
		Met?	Comment	Met?	Comment
SN-101	**Service Information** Each service should offer patients and their carers written information covering: a. Organisation of the service b. Care and therapeutic interventions offered by the service c. If beds: routines, visiting times and how to get refreshments d. Staff and facilities available e. How to contact the service for help and advice, including out of hours f. Who to contact with concerns about the service g. 'After intermediate care', including information about the length of time for which the service will be provided and the options for, and process of transfer to, longer-term care (if required) h. Sources of further advice and information	Y	Information was available for patients and carers with details of the Community Intermediate Care Team and Home Intervention Team services.	Y	Patient information booklets were available in the bays and information was on noticeboards in the ward and surrounding corridors. The booklet included expected length of stay of three weeks.

Ref	Standard	Community Intermediate Care Team (CICT) Home Intervention Team (HIT)		West Park Hospital Ward 3	
		Met?	Comment	Met?	Comment
SN-103	**Care Plan** Each patient and, where appropriate, their carer and appropriate members of the multi-disciplinary team should discuss and agree their Care Plan and should have easy access to a written record covering at least: a. Agreed goals, including life-style goals b. Self-management c. Medication d. Planned care and therapeutic interventions e. Early warning signs of problems, including acute exacerbations, and what to do if these occur f. Expected date of discharge from the service g. Name of care coordinator h. Name of doctor taking medical responsibility for their care i. Who to contact with queries or for advice j. Planned review date and how to access a review more quickly, if necessary	N	All but 'g' was recorded on the documentation seen by reviewers. The Community Intermediate Care Team was in the process of piloting documentation and changing to a more specific goal-directed plan of care process. The information for patients and carers detailed the process of agreeing rehabilitation goals to be completed within the first few days and referral to a social worker if more support was required.	Y	Documentation also included specific information about the patient - 'about me', which meant that a personalised approach to care planning and goal-setting was achieved.
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	In the Community Intermediate Care Team twice weekly reviews took place between the team, but it was not clear if the patient's GP was involved. Social care representation at the multi-disciplinary team meeting was not possible.	Y	A weekly multi-disciplinary team meeting took place. There were plans to include the patients and carers at these meetings.

Ref	Standard	Community Intermediate Care Team (CICT) Home Intervention Team (HIT)		West Park Hospital Ward 3	
		Met?	Comment	Met?	Comment
SN-105	**Contact for Queries and Advice** Each patient and, where appropriate, their carer should have a contact point within the service for queries and advice. If advice and support is not immediately available then the timescales for a response should be clear, and advice on what to do in an emergency should be given. Response times should be no longer than the end of the next day.	Y	The introductory leaflet included details of who to contact.	Y	The ward had open visiting for carers and families. The staff reported that this change had improved the communication between all parties and allowed carers and families to support the patients in achieving their goals.
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	The care coordinator was not documented in the records seen by the reviewers. In practice it was a team responsibility.	Y	
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.	Y	Information about those at high risk of admission was available via the Clinical Web Portal. Patient-held records that could be updated during intermediate care were not in use across the health economy.	Y	Information about those at high risk of admission was available via the Clinical Web Portal. Patient-held records that could be updated during intermediate care were not in use across the health economy.

Ref	Standard	Community Intermediate Care Team (CICT) Home Intervention Team (HIT)		West Park Hospital Ward 3	
		Met?	Comment	Met?	Comment
SN-196	**'After Intermediate Care' Plan** Patients and, when appropriate, their carers should be involved in discussing and agreeing the plan for their care after leaving the intermediate care service, and should be given a written summary of their 'After Intermediate Care' Plan, which should include: a. Expected date of discharge from the intermediate care service b. Care after leaving intermediate care, including self-care c. Medication d. Who is taking medical responsibility for care after leaving intermediate care e. Further investigations, treatment, rehabilitation and re-ablement to be carried out after leaving intermediate care, and who will arrange these, including separately identifying any of these which the GP is expected to arrange f. Possible complications and what to do if these occur, including in an emergency g. Transport (if required) h. Equipment supply or loan i. Dressings and continence aids j. Who to contact with queries or for advice k. Date by which their care should be reviewed, who is expected to undertake this review and how to access a review more quickly if required This 'After Intermediate Care' Plan should be copied to the patient's GP and to all services involved in providing ongoing care.	N	Some information was covered in the long-term condition management plans and the End of Life pathway. Guidance forms were available but did not seem to be completed and patients who met with the visiting team were not clear about plans for their care after leaving the intermediate care service. .	N	Some information was covered in the long-term condition management plans and the End of Life pathway. Guidance forms were available but did not seem to be completed and patients who met with the visiting team were not clear about plans for their care after leaving the intermediate care service. Discharge planning did take place and meetings with patients and carers about care after discharge also took place. There was no evidence of written plans being shared with patients and carers.

Ref	Standard	Community Intermediate Care Team (CICT) Home Intervention Team (HIT)		West Park Hospital Ward 3	
		Met?	Comment	Met?	Comment
SN-197	**General Support for Patients and Carers** Patients and carers should have easy access to the following services, and information about these services should be easily available: a. Interpreter services, including British Sign Language b. Independent advocacy services c. Complaints procedures d. Social workers e. Benefits advice f. Spiritual support g. *HealthWatch* or equivalent organisation h. Relevant voluntary organisations providing support and advice	N	Patients and carers did not have easy access to social workers. Reviewers were told of delays in accessing support. All other aspects of the Quality Standard were met.	N	Patients and carers did not have easy access to social workers. Reviewers were told of delays in accessing support. All other aspects of the Quality Standard were met.
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	See also main report	Y	See also main report
SN-199	**Involving Patients and Carers** The service should have: a. Mechanisms for receiving regular feedback from patients and carers about the treatment and care they receive b. Examples of changes made as a result of the feedback and involvement of patients and carers	Y	A range of mechanisms for receiving feedback was in place.	Y	A range of mechanism for receiving feedback was in place and Ward 3 had changed the choice of meals available at lunchtime and in the evening as a response to feedback. Annual environmental audits were undertaken.

Ref	Standard	Community Intermediate Care Team (CICT) Home Intervention Team (HIT)		West Park Hospital Ward 3	
		Met?	Comment	Met?	Comment
SN-201	**Lead Clinician and Lead Manager** A nominated lead clinician and a lead manager should be responsible for the effective delivery of the service, including staffing, training, guidelines and protocols, service organisation, governance and liaison with other services. The lead clinician should be a registered healthcare professional with appropriate specialist competences in this role and should undertake regular clinical work within the service.	Y	Leads were in place for the Community Intermediate Care Team and Home Intervention Team.	Y	There was a lead for the elderly care service at West Park. Additional leads were in place for the other services provided at the hospital.
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	**Community Intermediate Care Team:** This team worked mainly Monday to Friday 8am -10pm. The team comprised physiotherapy, occupational therapy, speech and language therapy, nurses, senior support workers, rehabilitation assistants and therapy technicians. The team offered short term care for periods of up to six weeks. Limited cover was available out of hours and at weekends for emergency referrals (one Registered Nurse). Delays in accessing social workers and other domiciliary care meant that patients remained under the care of the team for longer than appropriate. **Home In-reach Team:** Interventions were delivered under the direction of a Consultant Physician. Patients were followed up by this team having attended the 'Hot Clinics'.	N	A social worker was available Monday to Friday and on alternate Saturdays. However, there was no cover for the social worker, and reviewers were told that patient discharges were delayed due to lack of social worker input. Therapists were not available on the ward at weekends and over bank holidays. For other staff the Quality Standard was met. .

Ref	Standard	Community Intermediate Care Team (CICT) Home Intervention Team (HIT)		West Park Hospital Ward 3	
		Met?	Comment	Met?	Comment
SN-203	**Service Competences and Training Plan** The competences expected for each role in the service should be identified. A training and development plan for achieving and maintaining competences should be in place. If provided by the service, the competence framework should cover: a. Intravenous therapy b. PEG feeds c. Care for patients with dementia or significant cognitive impairment d. VAC therapy and other complex wound care	Y		Y	
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	A robust process was in place and a new training package covering safeguarding had been introduced.	Y	A robust process was in place and a new training packaged covering safeguarding had been introduced.

Ref	Standard	Community Intermediate Care Team (CICT) Home Intervention Team (HIT)		West Park Hospital Ward 3	
		Met?	Comment	Met?	Comment
SN-205	**Medical Staff** The service should have the following medical staffing: a. A nominated lead doctor with responsibility for coordinating medical input to the service b. A doctor available for emergencies 24/7 c. A doctor or other registered health professional with authorisation to prescribe who can attend within two hours of request, for conditions where hospital admission may be avoided d. Medical review of patients: i. Community hospitals: Daily (7/7) ii. Other intermediate care services: As appropriate for the usual case mix of patients and at least weekly.	N	**CICT:** Medical cover was via the patient's own GP. A doctor was not always available to respond within two hours of request for patients where hospital admission may be avoided. **HIT:** A lead consultant geriatrician was available during operational hours. Out of hours cover was provided by the GP out of hours service. Monday to Friday, a prescribing nurse was available to respond to calls within two hours of referral.	Y	
SN-299	**Administrative, Clerical and Data Collection Support** Administrative, clerical and data collection support should be available.	Y		Y	

Ref	Standard	Community Intermediate Care Team (CICT) Home Intervention Team (HIT)		West Park Hospital Ward 3	
		Met?	Comment	Met?	Comment
SN-301	**Clinical Support Services** Timely access to an appropriate range of clinical support services should be available, including: a. Imaging b. Pathology, including microbiology c. Pharmacy, including medication supply and medicines management advice d. Appropriate staff to undertake a home assessment within 24 hours of request e. Infection control (7/7 and on call 24/7) f. Tissue viability (7/7) g. Falls prevention (next working day) h. Continence service (7/7) i. Mental health team (crisis response within four hours) j. Counselling	N	The Integrated Tissue Viability service was not available at weekends. The Falls Prevention Service was not always able to respond by the next working day. All other aspects of the Quality Standard were met.	N	The Integrated Tissue Viability service was not available at weekends. Staff were not always available to undertake a home assessment within 24 hours of request. The Falls Prevention Service was community-based and did not provide care for in-patients. All other aspects of the Quality Standard were met.

Ref	Standard	Community Intermediate Care Team (CICT) Home Intervention Team (HIT)		West Park Hospital Ward 3	
		Met?	Comment	Met?	Comment
SN-302	**Support Services for Patients Returning Home** Access to the following support services for patients returning home should be available daily (7/7): a. Appropriate staff to undertake a home assessment within 24 hours of request b. Medication 'To Take Out' available within four hours of request c. Patient transport able to respond within four hours of request d. 'Simple' equipment available within four hours of request e. Supply of sufficient dressings and continence aids for 72 hours available within four hours of request f. All equipment, including beds and hoists, available within 24 hours of request g. 'Simple' adaptations available within 24 hours of request h. Additional health and social care support within four hours of request, comprising up to four visits per day for up to 72 hours after return home i. Voluntary sector 'settling home' support able to respond by the end of the next working day and continue for up to five days j. 'Simple' assistive technology available within 24 hours of request	Y		Y	
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	

Ref	Standard	Community Intermediate Care Team (CICT) Home Intervention Team (HIT)		West Park Hospital Ward 3	
		Met?	Comment	Met?	Comment
SN-499	**IT System** IT systems for storage, retrieval and transmission of patient information should be in use for patient administration, clinical records, outcome information and other data to support service improvement, audit and revalidation.	Y	The Clinical Web Portal was available to all Trust employees.	Y	The Clinical Web Portal was available to all Trust employees.
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	The document may benefit from including the time from first referral to assessment, to enable auditing of the pathway.	Y	The document may benefit from including the time from first referral to assessment, to enable auditing of the pathway.

Ref	Standard	Community Intermediate Care Team (CICT) Home Intervention Team (HIT)		West Park Hospital Ward 3	
		Met?	Comment	Met?	Comment
SN-502	**Clinical Guidelines** Guidelines on management of the usual case mix of patients referred to the service should be in use covering at least: a. Pain b. Depression c. Skin integrity d. Falls and mobility e. Continence f. Delirium and dementia g. Nutrition and hydration h. Sensory loss i. Medicines management j. Catheter care k. Spasticity management l. Care of patients with diabetes, COPD, heart failure and other long-term conditions m. Activities of daily living n. Health promotion, including smoking cessation, healthy eating, weight management, exercise, alcohol use, sexual and reproductive health, and mental and emotional health and well-being	N	Guidelines for 'b', ' h' and 'k' were not yet in place. All other aspects of the Quality Standard were met.	N	Guidelines for ‘b’, ‘h’ and ‘k’ were not yet in place. All other aspects of the Quality Standard were met.

Ref	Standard	Community Intermediate Care Team (CICT) Home Intervention Team (HIT)		West Park Hospital Ward 3	
		Met?	Comment	Met?	Comment
SN-597	**Transfer of Care Guidelines** Transfer of care guidelines for both simple and complex discharge pathways should be in use covering at least: a. Ensuring each patient has an expected date of discharge from the service b. Planning transfers of care from intermediate care including: i. Discussion with patients and carers about the 'After Intermediate Care' Plan ii. Availability for patient and carer queries iii. Multi-disciplinary review for complex or uncertain discharges iv. Single assessment process v. Transport options including patient transport service, relatives, taxis or care home transport vi. 'After Intermediate Care' Plan (QS SN-196) c. Agreement of 'After Intermediate Care' Plan and handover to services providing long-term care (if required) d. Informing the GP, the person taking medical responsibility for the patient and any other relevant services that the patient has left intermediate care, ideally within four hours of transfer of care	N	Intermediate care was not included in transfer of care guidelines. All other aspect were met. 'iv': A Single assessment process was not in place across the health economy.	N	Intermediate care was not included in transfer of care guidelines. All patients were discharged following the Trust's discharge policy.

Ref	Standard	Community Intermediate Care Team (CICT) Home Intervention Team (HIT)		West Park Hospital Ward 3	
		Met?	Comment	Met?	Comment
SN-598	**More Complex Transfers of Care** Guidelines should be in use covering: a. Transfer of care to other local authority or Clinical Commissioning Group areas covering at least social care assessments, intermediate care services available, patient transport and equipment supply or loan b. Transfer to a care home for long-term care c. NHS continuing care assessments and place-finding d. Liaison with palliative and end of life care services e. Patients and/or carers who do not agree an 'After Intermediate Care' Plan or who unreasonably delay their transfer of care	Y		Y	
SN-599	**Care of Vulnerable People** Guidelines for the care of vulnerable adults should be in use covering, in particular: a. Identification and care of vulnerable people b. Individualised care plans for people identified as being particularly vulnerable c. Restraint and sedation d. Missing patients e. Mental Capacity Act and Deprivation of Liberty Safeguards f. Safeguarding g. Information sharing h. Palliative care i. End of life care j. 'Do not resuscitate'	Y	Guidelines for the care of vulnerable adults were comprehensive.	Y	Guidelines for the care of vulnerable adults were comprehensive.

Ref	Standard	Community Intermediate Care Team (CICT) Home Intervention Team (HIT)		West Park Hospital Ward 3	
		Met?	Comment	Met?	Comment
SN-601	**Operational Policy** The service should have an operational policy describing the organisation of the service including, at least, arrangements for: a. Admission of patients to the service who meet the agreed criteria b. Initial assessment within 30 minutes of transfer, or within four hours if the patient has returned home c. On admission: i. Requesting a Summary Medical Record from the patient's GP if this is not sent with the patient (QS SA-601) ii. Identifying agencies involved in the patient's care and, if necessary, informing them of the admission d. Agreement of Care Plan within 24 hours of transfer to intermediate care e. Start of therapeutic interventions within 24 hours of transfer to intermediate care f. Setting and reviewing expected date of discharge from the service g. Daily review of all patients h. Review of Care Plans at least weekly, including medical review i. Allocation of a care coordinator for each patient (QS SN-106) j. Giving the patient and, where appropriate, their carer information at each stage of the patient journey k. Responding to patients' and carers' queries or requests for advice l. Multi-disciplinary discussion of appropriate patients m. Developing and agreeing an 'After Intermediate Care' Plan for each patient (QS SN-196) within seven days of admission n. Ensuring that an 'After Intermediate Care' checklist (or equivalent) is included in each patient's notes showing their stage on the transfer of care pathway and actions required o. Updating the 'Patient Passport' (QS SA-101) for people at high risk of re-admission or issuing one if not available p. Communication with the patient's GP q. Maintenance of equipment (QS SN-401) r. Responsibilities for IT systems (QS SN-499)	N	An operational policy was not in place for either service. In practice the services undertook the requirements of the Quality Standard, though for 'b', 'd', 'g', and 'h', it was not always achieved within the timescales defined or with all the required personnel. **HIT**: A business case was in the process of being prepared. The draft business case did not include some requirements as defined in the Quality Standard and was based on the pilot for the Home Intervention Team from 2012.	N	An operational policy was not in place for the service.

Ref	Standard	Community Intermediate Care Team (CICT) Home Intervention Team (HIT)		West Park Hospital Ward 3	
		Met?	Comment	Met?	Comment
SN-701	**Data Collection** Regular collection and monitoring of data should be in place, including: a. Referrals to the service, including source and appropriateness of referrals b. Number of assessments and therapeutic interventions undertaken by the service c. Outcome of assessments and therapeutic interventions d. Length of care by the service e. Proportion of patients achieving their expected date of discharge from the service f. Number and destination of transfer of care from the service g. Key quality and performance indicators	Y		Y	
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	An audit programme including evidence-based clinical guidelines was not yet in place. **CICT:** A range of audits were undertaken covering key performance indicators and other relevant topics. **HIT:** Audits covering 'a' were undertaken but not for the other areas defined in the Quality Standard. There were plans to include other generic Trust audits.	Y	The ward had an active audit programme that included internal key performance Indicators and other relevant topics.
SN-703	**Key Performance Indicators** Key performance indicators (QS SN-701) should be reviewed regularly with Trust (or equivalent) management and with commissioners.	Y		Y	

Ref	Standard	Community Intermediate Care Team (CICT) Home Intervention Team (HIT)		West Park Hospital Ward 3	
		Met?	Comment	Met?	Comment
SN-797	**Health and Social Care Review and Learning** The service should have a mechanism for influencing and receiving feedback from the local Health and Social Care Review and Learning Group on transfer of care from acute hospitals and intermediate care (QS SZ-798).	N	There was no formal group that met regularly to discuss, review and share learning from discharge planning. There was some shared learning across other areas including implementing a 'Discharge with Risk' alert, whereby any concerns regarding discharge or transfer of care were relayed by the Senior Matron for Community Services back to the Matron for the discharging ward. Incidents were discussed as part of governance meetings.	N	There was no formal group that met regularly to discuss, review and share learning from discharge planning. There was some shared learning across other areas including implementing a 'Discharge with Risk' alert, whereby any concerns regarding discharge or transfer of care were relayed by the Senior Matron for Community Services back to the Matron for the discharging ward. Incidents were discussed as part of governance meetings.
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	Y		Y	
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. Corporate documentation was document controlled.	N	Not all documentation was up to date or had review dates included. Corporate documentation was document controlled.

Return to *Index*

NURSING HOME - PROBERT COURT

This proforma (based on the Quality Standards) was used for review of Nursing and Residential Care Homes providing intermediate care where a full review of WMQRS Quality Standards for Intermediate Care Services was not considered appropriate.

	Standard	Met?	Comment
Number of commissioned Intermediate care beds		-	The home had 23 beds of which two were occupied by permanent residents, leaving 21 beds available for intermediate care
Operational arrangements			
1	a. Admission of patients to the service who meet the agreed criteria	Y	Staff from the home visited and assessed all patients against the agreed criteria for intermediate care.
	b. Initial assessment within 30 minutes of transfer	Y	The initial care plan assessment started on admission and was completed within six hours in accordance with Heantun protocol. Completion of other more detailed assessments was completed within 24 hours of the patient's admission.
	c. On admission: i. Requesting a Summary Medical Record from the patient's GP if this is not sent with the patient ii. Identifying agencies involved in the patient's care and, if necessary, informing them of the admission	N	See main report. Reviewers saw one example and were told of other occasions when discharge information and medication did not accompany the patient to the Home. Referrals to social workers were re-commenced following assessment at Probert Court.
	d. Agreement of Care Plan within 24 hours of transfer to intermediate care	N	Care plans were agreed within 72 hours of admission.
	e. Start of therapeutic interventions within 24 hours of transfer to intermediate care	N	Therapeutic interventions commenced within 72 hours. Therapeutic interventions were provided by the Community Intermediate Care Team.
	f. Setting and reviewing expected date of discharge from the service	N	Estimated dates for discharge were set about seven days after admission, following discussions with the social care team.
	g. Medical review of patients: ii. As appropriate for the usual case mix of patients and at least weekly.	Y	Patients were reviewed five days a week by a GP who was commissioned to provide sessional support by the Clinical Commissioning Group.
	h. Review of Care Plans at least weekly, including medical review	N	Care plans were reviewed monthly. Reviewers considered that for some patients, this was not frequent enough to plan their discharge from the service.
	i. Allocation of a care coordinator for each patient	Y	

	Standard	Met?	Comment
	j. Giving the patient and, where appropriate, their carer information at each stage of the patient journey	Y	Carers and families commented that they were able to liaise with members of the multi-disciplinary team more easily since visiting hours had been extended. For those with more complex needs, planning meetings with families and carers were held.
	l. Multi-disciplinary discussion of appropriate patients	Y	Multi-disciplinary discussions took place during GP review meetings.
	k. Responding to patients' and carers' queries or requests for advice	Y	The service operated an 'open door' policy so that residents and family concerns were addressed as soon as possible. No complaints had been received by the service in the six months prior to the visit.
	m. Developing and agreeing an 'After Intermediate Care' Plan for each patient within seven days of admission	N	'After intermediate care' plans were not yet in place.
	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	N	'After intermediate care' plans were not yet in place.
	o. Updating the 'Patient Passport' for people at high risk of re-admission or issuing one if not available	N	'Patient Passports' were not yet in use.
	p. Communication with the patient's GP	Y	
	q. Maintenance of equipment	Y	
	r. Responsibilities for IT systems	Y	
Staffing and maintenance of competences			
2	a. Medical Cover	Y	Medical cover was available five days per week and was provided by the Out of Hours emergency service at other times.
	b. Staffing Levels and Skill Mix for the number of patients usually cared for by the service and the usual case mix of patients	N	The service provided 20 IC beds. The ratio of registered to non-registered staff was as follows:- Early 2:6, Late 1:4, Night 1:2 . The Home had one registered staff member on duty over-night and therefore this part of the intermediate care Quality Standards was not met.
	c. Arrangements and monitoring of ongoing staff training and assurance of competence	Y	Staff training was monitored and the staff training matrix updated monthly. The majority of staff records were up to date at the time of the visit.
Facilities and Equipment			
3	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	
Guidelines			

	Standard	Met?	Comment
4	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	_	Reviewers did not assess whether all guidelines were available during the visit so compliance could not be determined.
5	Care of Vulnerable People Guidelines for the care of vulnerable adults should be in use covering, in particular: a. Identification and care of vulnerable people b. Individualised care plans for people identified as being particularly vulnerable c. Restraint and sedation d. Missing patients e. Mental Capacity Act and Deprivation of Liberty Safeguards f. Safeguarding g. Information sharing h. Palliative care i. End of life care j. 'Do not resuscitate'	Y	The training matrix covered training needs, processes and procedures for the care of vulnerable adults. Arrangements had been made that 'Do not attempt resuscitation ' agreements were accepted as valid when patients were transferred to the home - see main report.
Governance			
6	Health and Social Care Review and Learning The 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	Y	Local mechanisms were in place for reporting to the Clinical Commissioning Group and Heantun Group.
7	Arrangements for collection and monitoring of data and key performance indicators	Y	
8	Involvement in any Quality Review meetings	Y	

Return to *Index*

COMMISSIONING

Ref	Standard	Met?	Comment
SZ-601	**Commissioning of Services** Commissioners should commission intermediate care services for people at home and intermediate care services with beds sufficient for the needs of their population and should specify: a. Criteria and arrangements for acceptance by each intermediate care service, including the use of 'Trusted Assessors' (QS SM-202) b. Time limit for provision of intermediate care service c. Type of care, rehabilitation and re-ablement provided, in particular, whether care is available for patients needing: i. 24/7 on-site care (community hospital or care home) ii. Overnight care (night-visiting or night sitting) iii. Intravenous therapy iv. PEG feeds v. Care for dementia or significant cognitive impairment vi. VAC therapy and other complex wound care d. Arrangements for supply of medication, dressings and continence aids, equipment, adaptations and assistive technology within expected timescales (QS SM-301 and SN-302) e. Short-term health and social care support comprising up to four visits per day for at least 72 hours after returning home (QS SM-302 and SN-302) f. Key performance indicators for each service g. Any specialist care not normally available in the local area for which specific funding decisions are required	N	Several aspects of this QS were not met. See 'health and social care economy' section of the main report for details.
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 meeting the requirements of the Quality Standard were not yet in place.

Ref	Standard	Met?	Comment
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	See main report
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	There was no formal group that met regularly to discuss, review and share learning from discharge planning. Quality review meetings with individual providers were in place.

Return to *Index*