WM QRS West Midlands Quality Review Service

NHS

Transfer from Acute Hospital Care and Intermediate Care

Walsall Health and Social Care Economy

Visit Date: 5th and 6th May 2015 Report Date: July 2015

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INTRODUCTION

This report presents the findings of the review of services for the transfer of care from acute hospital and intermediate care services that took place on 5th and 6th May 2015. The purpose of the visit was to review compliance with the following West Midlands Quality Review Service (WMQRS) Quality Standards:

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

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

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

- Walsall Healthcare NHS Trust
- NHS Walsall 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 Walsall or jointly provided or commissioned services. Actions by commissioners and providers of social care maybe required in order to address the issues identified in this report.

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

ABOUT WEST MIDLANDS QUALITY REVIEW SERVICE

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

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

ACKNOWLEDGMENTS

West Midlands Quality Review Service would like to thank the staff and service users and carers of Walsall 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.

TRANSFER FROM ACUTE HOSPITAL CARE AND INTERMEDIATE CARE

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

Pathway	Provider	Quality Standards	Notes
Primary care	-	Primary care	Reviewers met with GPs during the visit
Walsall Manor Hospital	Walsall Healthcare NHS Trust	Acute Trust: All wards	
Intermediate Care Team (ICT)	Walsall Healthcare NHS Trust	Intermediate care	Reviewers reviewed documentary evidence and met staff from this service.
Richmond Hall	Stonnall Care Ltd		Reviewers visited the nursing home, met with the intermediate care team, talked to patients and carers. Reviewers did not meet any Richmond Hall staff. Eight intermediate care beds plus five 'spot purchased' to June 2015 (of 63 beds in total).
Hollybank House	Walsall Metropolitan Borough Council		Reviewers visited the integrated reablement unit, met with staff, and talked to patients and carers. 21 beds for reablement care.
NHS Walsall CCG		Commissioning	Reviewers met CCG staff and reviewed evidence.
Other services:			
Aldridge Court	*www.aldridgecourt.co.uk*		Reviewers met with staff from this service and were told about the contribution they made to the pathway. 15 intermediate care beds. 40 'Discharge to Assess' beds.
Other Intermediate care provision in care homes.			Reviewers were told about this provision and the contribution they made to the pathway. Six 'spot-purchased' beds.

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HEALTH AND SOCIAL CARE ECONOMY

General Comments and Achievements

Walsall health and social care economy had made significant progress on improving the process of transfer from acute hospital care and intermediate care, in particular, with establishing admission avoidance schemes (see below). Good examples of integrated working between health and social care were evident in several areas. Senior staff within the health and social care economy had a good understanding of the problems still facing local services. Operational staff who met reviewers were positive, motivated and passionate about providing high quality care.

Good Practice

1 **Admission avoidance**

Several schemes aimed at avoiding admission to hospital were fully operational, based around a Locality Model of integrated care:

a. Integrated Locality Teams had been set up covering a population of approximately 55,000. A seven day a week Single Point of Access provided clinical triage and supported admission avoidance. This was accessed by GPs, community nurses, social workers and staff from the Manor Hospital. The Integrated Locality Teams used a case management approach, including for residents in care homes who were at high risk of admission to hospital.

b. The Rapid Response Team assessed patients within two hours seven days a week. The Team then accessed other services to support patients at home. The Rapid Response Team had direct access to imaging services, through the frail older people pathway. The Team had achieved a high rate (84%) of admission avoidance for the 1014 patients referred in Quarters 3 and 4 of 2014/15.

Redesigned community nursing services were an integral part of the Locality Teams. Community Intervention nursing teams were providing end of life care and a range of other interventions in patients' homes, for example, intravenous antibiotics, treatment for deep vein thrombosis, trials of catheter removal and bladder scans. The Intravenous Therapy (IV) team also provided IV antibiotics, IV prednisolone for MS patients. IV frusemide for HF patients and treatment for DVT.

c. Community nurses were also allocated to nursing homes in order to support improvements to the quality of care and try to prevent admissions. This had been run initially as a pilot with 11 homes but was being extended. This had been shown to lead to a reduction in calls to the West Midlands Ambulance Service.

d. Social workers were allocated to 11 GP practices which improved access to social care packages. Feed-back from GPs about this arrangement was very positive.

e. Community nurses were based in the Emergency Department and Acute Medical Unit seven days a week, in order to identify and support patients who could go home without hospital admission. Staff in the Emergency Department could also admit patients directly to intermediate care beds during the daytime seven days a week. Up to 10pm, mental health assessments were available for patients in the Emergency Department and Acute Medical Unit within four hours of request.

f. Community matrons were alerted when their patients were admitted to the emergency department or hospital. They then liaised with the emergency department or ward in order to try and get the patient home as quickly as possible.

2 The Frail Older People pathway was working well with early identification and lots of support for patients brought to hospital in order to get them home as quickly as possible. Staff covered Monday to Sunday - 8am to 6pm (sometimes to 8pm).

3 The Re-ablement Team supported patients discharged from hospital, with 100% patients referred to the team discharged home within 24 hours of referral. This team comprised domiciliary care providers and occupational therapists. The team had good links with other services. The team was available 7/7 but were only able to take referrals up to 16.30pm.

4 Telehealth and telecare were being actively used to promote independence with good links between ward and community staff. Ward staff were setting up some equipment and supporting patients until they were ready to go home. Patients and families were therefore more confident about using the equipment.

5 A good range of domiciliary care packages was available with people being supported at home with up to four 'double up' visits per day and up to three nights of night sitting.

6 Support available for carers was good across the health and social care economy. There was good advice for carers on a variety of subjects, including information available via an internet site.

7 Pharmacists from Walsall CCG had worked with nursing homes on medication audits and training for nursing home staff. This had been shown to produce a reduction in antipsychotic medication use in the homes with which the pharmacist had worked.

8 Several integrated roles across acute and community services had been implemented, including tissue viability and infection control teams. This was particularly helpful in supporting the pathway of transfer from acute hospital care and intermediate care.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Delays in social care assessments**

Reviewers were told of significant vacancies and difficulty recruiting social workers which were resulting in high use of agency staff and high turnover. For example, Aldridge Court had had four different social workers in the six months before the review. This was resulting in delays in assessments for social care and longer lengths of stay in the Manor Hospital and in intermediate care facilities.

In the Manor Hospital, social workers were not allocated until patients were medically fit for discharge and patients were then often waiting over seven days from allocation to assessment.

2 **Pathway of transfer from acute hospital care: Delays and multiple assessments:**

Actions along the discharge pathway took place mainly sequentially, rather than happening in parallel, leading to delays and multiple assessments:

a. In addition to the delays for social care assessments (see above), patients were sometimes waiting over seven days for assessment by nursing home staff who then might say that the patient was not suitable. Similar delays were experienced by patients waiting for 'Discharge to Assess' beds. Some patients referred through the Single Point of Access did have telephone triage and could access a nursing home place more quickly.

b. A 'Choice' policy had been agreed but was not being implemented. The policy required the first letter to be issued by ward staff but this was not happening routinely and the rest of the policy therefore could not be implemented.

c. With the exception of the Frail Older People pathway and some occupational therapy and physiotherapy assessments, 'trusted assessors' were not yet in place. Assessments were therefore repeated by social care staff, nursing home staff and intermediate care providers.

d. The lack of 'trusted assessors' also resulted in some patients being admitted to intermediate care facilities who could have gone home. In particular, reviewers were told that approximately a third of patients in Richmond House and Hollybank House could have gone straight home.

e. Length of stay in intermediate care facilities generally seemed long, with the potential for patients to go home more quickly. This is described in more detail in the sections of this report relating to each service reviewed. This was impacting on the ability to discharge patients from the Manor Hospital to intermediate care beds, especially at weekends. Intermediate care beds could be 'spot-purchased' but staff reported that the manager who could authorise these was not always available, especially at weekends.

3 **Information for patients and families**

Throughout the review visit, reviewers saw little written information for patients and families about the pathway of transfer from acute hospital care and intermediate care. Conversations took place but patients and families may not all have received the same information. It was not clear that patients and families had the information they needed, including information about access to support services, and opportunities to inform and influence patients' and families' expectations of the pathway were being missed.

4 **Stroke rehabilitation beds**

Community-based stroke rehabilitation beds were not available in Walsall and patients were therefore being discharged to intermediate care beds, sometimes inappropriately. The stroke 'in-reach' team went into the Manor Hospital and supported rehabilitation of patients at home but was not staffed to provide stroke rehabilitation in intermediate care facilities, including 'spot purchased' beds. Some patients were therefore not receiving appropriate rehabilitation after a stroke and length of stay in the Manor Hospital was probably longer than necessary.

5 **Transfer from Acute Hospital Care Pathway for Staffordshire residents**

Reviewers were told by several staff that transfers from the Manor Hospital of Staffordshire residents were often delayed.

Further Consideration

1 Reviewers were told of some problems with patient transport services for patients being transferred from the Manor Hospital. It was not clear to what extent these difficulties arose from the patient transport specification (including the requirement for four hours' notice), delays in requesting transport due to a lack of proactive discharge planning (see acute hospital section of this report), or an unwillingness to accept patients at intermediate care facilities in the evening. Reviewers suggested that further work on patient transport could be helpful in order to understand the extent of the problems and whether they are resulting in patients staying longer than necessary on acute hospital wards.

2 Multiple care records were in use and there was no 'patient passport' for those at high risk of admission and re-admission. A yellow 'Standard Assessment Procedure' (SAP) was used by the Integrated Locality Teams and the electronic discharge summary was added to this following a hospital admission. Staff in the Emergency Department were using this documentation but this approach was not yet taken by other services in the Manor Hospital. Some community teams advised patients not to take the yellow documentation with them to hospital. Some patients therefore had several SAP documents and several sets of notes.

3 The number of reported delayed transfers of care appeared low, possibly because Section 5 forms had not previously been issued. Reviewers commented that many of the 'Board rounds' observed included a high proportion of 'medically fit for discharge' patients and could not understand how this linked with the reportedly low number of delayed transfers of care. For example, on the day of the review, Ward 9 had 12 patients who were medically fit for discharge. Reviewers suggested that delayed transfers of care may not be being counted appropriately. This issue links with the use of the Expected Date of Discharge (see acute hospital section of this report). Also, the number of patients on the 'clinically well boards' held by the Integrated Locality Teams did not appear to match with the reported number of delayed transfers of care.

4 Several good initiatives were 'in development', including direct access to imaging services to avoid admissions where possible, revisions to nursing documentation, consideration of 'trusted assessors' and work by pharmacists to reduce waiting times for medication 'to take out'. Reviewers encouraged continuation of these schemes.

5 Reviewers were told that admission avoidance schemes were available seven days a week but some staff on acute wards of the Manor Hospital reported difficulties in accessing these services at weekends. It may be helpful to look at whether this is historical, whether staff are not aware of the services available or whether there really are difficulties accessing some services at weekends.

6 Further work with ward staff at the Manor Hospital and with GPs to explain and publicise the services available may be helpful. Ward staff were not all aware of the range of local services available and reviewers were given examples of GPs referring patients to the Emergency Department who could have been cared for at home if the Single Point of Access had been contacted. This issue links with the concern (above) about written information for patients and carers; good information for patients and carers may also be helpful for ward staff and GPs if supported by appropriate training.

7 Reviewers found an acceptance that transfers from the Manor Hospital of Staffordshire residents were a problem without specific data or a clear plan to address this issue. Cooperation across the health and social care economy in tackling this issue might help in finding innovative solutions.

8 Reviewers were told of problems accessing community mental health services for people aged under 65 with some being admitted to the Manor Hospital inappropriately as a result. Reviewers did not have the time to look into this issue in detail.

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Primary Care

General Comments and Achievements

Reviewers saw several examples of good involvement of primary care in the pathway of transfer from acute hospital care and intermediate care. Reviewers commented particularly on the GP involvement in the frail older people pathway, GP leadership at the intermediate care service at Hollybank House, the work of the Integrated Locality Teams and pharmacy audits in nursing homes. These examples are described in more detail in other sections of this report.

Good Practice

1 Summaries of GP records were available within 20 minutes of request from all practices for patients being admitted to 'step up' intermediate care (Mondays to Fridays).

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Acute Hospital Care: Manor Hospital

General Comments and Achievements

Wards visited by reviewers were calm and well organised. A good electronic discharge summary was in use which was pre-populated by pharmacy. Good use was being made of ward-based pharmacy technicians and pharmacists were bleeped when medication 'to take out' was needed. Key Performance Indicators were clearly identified with pharmacy aiming for 50% of medication 'to take out' being ready within 30 minutes of request and 80% within 60 minutes (but see concern 2 below).

Good Practice

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

1 A good 'bed management' board was in use in the Emergency Department and in-patient wards. This linked to Hollybush House and provided a good overview of capacity available. At the time of the review Richmond House and Aldridge Court were not included in this capacity system, reviewers would suggest including them as well to enable a broader and more accurate status of beds available in real time.

2 Considerable effort had gone into improving the care of people with dementia on acute hospital wards, including use of colour-coded curtains, beakers, music and support by Age UK volunteers.

3 The Trust had a comprehensive 'Weekend Plan' which summarised exactly which services were available over the weekend and how to contact them. This Plan was very useful for the on-call manager but also helped ward staff to manage patient pathways.

4 'Board rounds' on wards 1 and 17 were very well organised. Community staff and the palliative care consultant were actively involved in planning discharges from acute hospital care.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Discharge Lounge**

Reviewers were seriously concerned about care of patients in the Discharge Lounge. Arrangements were put in place during the course of the visit to reduce the risk to patients and the Trust should ensure that full implementation of these arrangements has been achieved. At the time of the visit, patients were being transferred to the Discharge Lounge from some wards without notes, medication or discharge letters. (Some patients did have their own medication which they had brought in with them.). As a result, staff in the Discharge Lounge did not have appropriate clinical information about the patients under their care and were not in a position to provide appropriate care if a patient's condition deteriorated. Patients were waiting in the Discharge Lounge for several hours. There were particular problems on Thursdays when patients were moved to the Discharge Lounge before 9am but transport did not collect any patients before 1.30pm. Staff reported that they regularly stayed after 6pm when the Discharge Lounge was supposed to close.[1]

The Discharge Lounge cared for patients in bed and on seats and did not provide a single sex environment for patients still in their bed-clothes. There was no toilet in the Discharge Lounge and patients had to walk across a corridor and past other waiting patients to get to the toilet.

Incident forms had been completed by staff in the Discharge Lounge but it was not clear that effective action had been taken.

2 **Patients discharged without medication**

Reviewers were given several examples of patients being discharged to intermediate care beds and nursing homes without prescribed medication and some examples of medication being incorrect when it arrived later. Medication was sent in taxis if it was not ready when the patient was collected by patient transport.

[1] Action taken by the Trust during the course of the visit included:
1. A Standard Operating Procedure for the Discharge Lounge was introduced.
2. A drug trolley and stock of medication was provided in the Discharge Lounge
3. Health records and medication charts were to accompany patients going to the Discharge Lounge.
4. Medication rounds were to be undertaken in the Discharge Lounge.

3 **Proactive Discharge Planning**

a. **Lack of Multi-Disciplinary Discharge Planning**

'Board rounds' to plan discharges were not yet working effectively on most wards. Several of the 'Board rounds' were medically dominated and appeared to be 'ward rounds' discussing clinical care rather than multi-disciplinary meetings proactively planning discharges. It appeared that therapists were actively involved only after patients were considered to be 'medically fit for discharge'. Some actions from the 'board rounds' did not take place quickly. In particular, delays in requesting medication 'to take out' were reported.

b. **Use of Discharge Checklist**

A discharge checklist was available but was not in any of the patients' notes seen by reviewers. It appeared that the checklist was used at the time of discharge to confirm that actions had taken place rather than being used proactively to drive the discharge process.

c. **Use of 'Expected Date of Discharge'**

Reviewers saw several examples of the Expected Date of Discharge being elongated because patients were waiting for an assessment or a review. Some wards and consultants appeared to move the Expected Date of Discharge to after the assessment / review rather than allowing patients to exceed their Expected Date of Discharge. This issue links with the counting of delayed transfers of care (see health and social care economy section of this report).

4 **Junior doctors' safeguarding training**

Safeguarding training for junior doctors was supposed to be part of their ward-based induction. Reviewers were told that this did not always take place and there was no central record of whether junior doctors had had safeguarding training. Reviewers also observed some examples of junior doctors with limited understanding of safeguarding processes.

Further Consideration

1 There may be potential for improving patient pathways by more active rehabilitation by therapists on acute wards. On several wards this was considered only when the patient was 'medically fit for discharge' rather than starting at the time of admission. Also, patients who were medically fit for discharge did not appear to have an active rehabilitation programme. Some patients may be able to go straight home, rather than to intermediate care, if they have more therapy input while on the acute wards.

2 Discharge coordinators were band 3 posts and it was not clear what contribution they made to the discharge process other than data gathering. Discharge coordinators were not able to discuss clinical issues or actively to drive the discharge process. The role expected of the discharge coordinators and the skills and competences needed for this role may benefit from review.

3 Some voluntary sector organisations were actively involved with the Manor Hospital. Others said that they would like to become more involved but were unsure how to achieve this. The point was made by the voluntary sector people who met with reviewers. They articulated that they get passed on from one person to another and that there was a lack coordination and understanding of the role of the voluntary sector services in Walsall which they would like the local authority to address. The Trust may wish to review the way in which it links with voluntary sector organisations. The Frail Elderly team mentioned a befriending service called the Silver scheme, which was very good and entailed volunteers calling patients on a weekly basis as a buddy. They felt this could be more widely used to good effect.

4 Friends and Family Survey display boards were available but the information was not broken down to 'ward level' and the only 'you said – we did' information was more than six months old. It may be helpful to consider displays of ward-based data and more regular updates on the action taken.

INTERMEDIATE CARE

INTERMEDIATE CARE TEAM / INTEGRATED HEALTH AND SOCIAL CARE TEAMS

General Comments and Achievements

The Integrated Health and Social Care Locality Teams provided intermediate care with a rehabilitation-focused pathway. The teams provided rehabilitation to residents in Hollybank House, Richmond Hall, Aldridge Court and six other 'spot-purchased' intermediate care beds were in use at the time of the review.

The Locality Teams had a good understanding of the patients under their care and linked closely with GPs and other agencies within their locality. Links with Age UK were also good with Age UK representatives attending the weekly multi-disciplinary team meeting. Age UK also provided some patient information. The Rapid Response Team was embedded within the Integrated Locality Teams and all team members were based at Hollybank House. The Clinical Interventions Team were also based in the same office and staff appeared to understand their roles and work together well.

Good Practice

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

2 The Integrated Health and Social Care Teams had a 'clinically well board' which included information about patients in the Manor Hospital who were medically fit for discharge. The Teams were then able to target their work to getting these patients out of hospital.

3 A robust training course for carers of people on PEG feeds was in place.

Immediate Risks: No immediate risks were identified.

Concerns: No concerns were identified.

Further Consideration

1 The Intermediate Care Team was having to check equipment which they had issued, even when the patient was no longer under their care. This appeared an inefficient use of staff time and reviewers suggested that improved arrangements could be introduced.

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RICHMOND HALL

General Comments and Achievements

Richmond Hall was a 64 bedded care home, of which eight beds were used for intermediate care. Five additional intermediate care beds had been 'spot-purchased' until the end on June 2015. The beds were used for both 'step up' and 'step down' care. The social worker who was linked to Richmond House had left two weeks before the review visit.

Concerns

1 **Staff competences in intermediate care**

Reviewers did not see evidence that staff at Richmond Hall had the competences needed to provide intermediate care. Links with the Locality Team did not seem well developed. Reviewers were told that staff retention was poor, although reviewers did not see data on this. Reviewers were also told that staff at the Manor Hospital tried to send less sick patients to Richmond Hall because of uncertainties about staff competences. Some concerns about basic nursing care, including care relating to pressure ulcers, were also

raised with reviewers; reviewers did not have the opportunity to discuss these issues with staff from Richmond Hall.

2 **Availability of medical cover**

The GP who worked with Richmond House routinely attended only once a week, on Wednesdays, and was not able to attend multi-disciplinary team meetings. Discharge letters and medication to take out could be delayed by up to a week.

Further Consideration

1 Richmond Hall did not have facilities for active rehabilitation of residents who were going to go home. For example, there was no kitchen and only a small gym.

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HOLLYBANK HOUSE

General Comments and Achievements

Hollybank House was a care home where 21 beds were for intermediate care. Care at Hollybank House was supported by a full multi-disciplinary team including mental health services, a social worker and Age UK. Good facilities were available including a gym and a kitchen for preparing residents to return home. Hollybank House was an impressive facility with good integration with social care, a strong rehabilitation focus and good teamwork among staff. The environment was pleasant.

Good Practice

1 Medical cover at Hollybank House was very good. The home was supported by a GP who was accessible to patients and relatives and attended the home on a flexible basis. The GP was fully integrated with the work of the home and committed to ensuring good standards of care and helping residents to return home as soon as possible. This often included ringing the patient's own GP prior to discharge to explain what had happened and ensure the GP was fully briefed.

2 Staff training was good. A third of registered healthcare staff were non-medical prescribers and patients admitted to the home required a range of sub-acute interventions, including intravenous antibiotics.

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ALDRIDGE COURT

General Comments and Achievements

Most of the 40 Walsall 'discharge to assess' beds were located in Aldridge Court which also had 15 beds for 'step up' or 'step down' care.

Concerns

1 **Staffing levels at night**

Reviewers were seriously concern that, at night, one registered nurse and seven health care assistants provided care for 40 patients in the 'discharge to assess' beds. Many of these patients had high levels of nursing need, for example, patients on syringe drivers or needing intravenous antibiotics.

2 **Lack of active rehabilitation**

Up to six weeks of intermediate care was provided at Aldridge Court and reviewers did not find an active approach to trying to get residents home in less than six weeks. (This situation was not helped by the many

changes in social worker – see 'health and social care economy' section of this report.) The expectation among staff and residents appeared to be that intermediate care would be for six weeks.

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COMMISSIONING

General Comments and Achievements

Good working relationships across the health and social care economy were evident and commissioners had a good understanding of the issues facing local services. Commissioners were actively trying to use contractual levels, including CQUINS, to improve the pathway of transfer from acute hospital care and intermediate care.

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

Immediate Risks: No immediate risks were identified

Concerns

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

1 Delays in social care assessments: see health and social care economy section, Concern 1

2 Pathway of transfer from acute hospital care - Delays and multiple assessments: see health and social care economy section, Concern 2

3 Information for patients and families: see health and social care economy section, Concern 3

4 Stroke rehabilitation beds: see health and social care economy section, Concern 4

5 Transfer from Acute Hospital Care Pathway for Staffordshire residents: see health and social care economy section, Concern 5

6 Discharge Lounge: see Acute Hospital Care – Manor Hospital, Concern 1

7 Patients discharged without medication: see Acute Hospital Care – Manor Hospital, Concern 2

8 Proactive Discharge Planning: see Acute Hospital Care – Manor Hospital, Concern 3

9 Junior doctors' safeguarding training: see Acute Hospital Care – Manor Hospital, Concern 4

10 Staff competences in intermediate care: see Intermediate Care – Richmond Hall, Concern 1

11 Availability of medical cover: see Intermediate Care – Richmond Hall, Concern 2

12 Staffing levels at night: see Intermediate Care – Aldridge Court, Concern 1

13 Lack of active rehabilitation see Intermediate Care – Aldridge Court, Concern 2

Further Consideration

1 Further discussion with senior managers at Walsall Healthcare about contractual levers which could support cultural change within the Manor Hospital may be helpful.

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APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Visiting Team

Dr Mona Arora	General Practitioner	NHS North Staffordshire CCG
Kerry Anelli	Matron for General Surgery , Urology & Head & Neck Services	The Royal Wolverhampton NHS Trust
Jonathan Beasley	Compliance Manager	Heart of England NHS Foundation Trust
Louise Crathorne	Specialist Pharmacist - Elderly Care	The Dudley Group NHS Foundation Trust
Adele Dean	Clinical Quality Manager	West Midlands Ambulance Service NHS Foundation Trust
Emma Jewiss	MAU Ward Manager	Sandwell & West Birmingham Hospitals NHS Trust
Michelle Linnane	Associate Director of Nursing	University Hospitals Coventry and Warwickshire NHS Trust
Beverley Marriott	Clinical Case Manager/Community Matron	Birmingham Community Healthcare NHS Trust
Diana Polowyj	Patient Representative	
Joanne Tolley	Senior Redesign Manager Frailty & EOLC	NHS Solihull CCG
Pauline Ward	Complex Discharge Nurse Specialist	Sandwell & West Birmingham Hospitals NHS Trust
Jane Williams	Patient representative	

WMQRS Team

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

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APPENDIX 2 COMPLIANCE WITH THE QUALITY STANDARDS

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

Table 1 - Percentage of Quality Standards met

Service	Number of Applicable QS	Number of QS Met	% met
Review of Transfer from Acute Hospital and Intermediate Care			
Primary Care	2	1	50
Acute Trust – all wards	23	8	35
Intermediate Care Service	33	14	42
Commissioning	4	1	25
Health and Social Care Economy	**62**	**24**	**39**

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

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

Topic Sections: Each section covers the following topics:

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

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PRIMARY CARE

Ref	Standard	Met? Y/N	Reviewer Comments
SA-101	**Patients at High Risk of Admission** Patients at high risk of admission to an acute hospital should have a 'Patient Passport' or equivalent patient-held record that covers: a. Diagnoses b. Allergies c. Medication d. Care package (or equivalent) e. Name and contact details of GP f. Name and contact details of main carer/s g. Advice for the patient and their carers on likely problems and what to do in an emergency h. Advice to emergency services on likely problems and recommendations for their management i. Advice for acute hospital services on the most appropriate ward (if admission is required)	N	Most patients did not have a passport, some areas have used single assessment procedure (SAP) with some success but it was not across the health economy. Communication from Out of Hours Badger service was considered good. Information from their visits was put on the GP system to enable follow up from the patient's own GP. IV antibiotics were prescribed and available in the community.
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.	Y	Summary medical records were not routinely sent with the patients being referred to either 'step-up' or for acute admission. Staff who met the visiting team said that requests for a copy of the medical summary would be responded to and acted on within 20 minutes.

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ACUTE TRUST – ALL WARDS

Ref	Standard	Met? Y/N	Reviewer Comments
SM-101	**Planned Admissions** All patients awaiting a planned admission to hospital should be offered written information about arrangements for leaving the hospital and returning to their usual place of residence.	Y	Information was available for those attending pre-assessment. Patients who met with the reviewing team in the community intermediate care services felt that information would be helpful if given earlier in their acute hospital stay.
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	N	The Trust did not display discharge information. New nursing documentation was being finalised which would include a written summary for patients.
SM-103	**Discussion with Families** Members of the multi-disciplinary team should be easily available to families for discussions about the patient's condition and plans for care on leaving hospital. Information on how to arrange a discussion should be clearly displayed in all ward areas.	N	There was very little written information visible on the wards visited. Staff seemed to rely on verbal communication with patients and families. Discharge coordinators were not available on every ward.
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	A pilot project was looking at identification of those patients of high risk of admission, who were then linked to the community matron services. These patients were then assessed using the Standard Assessment Procedure (SAP) document. Nurses in the Frail Older People team were trained in assessing for equipment.

Ref	Standard	Met? Y/N	Reviewer Comments
SM-196	**Transfer of Care Plan** Patients and, when appropriate, their carers should be involved in discussing and agreeing the plan for their care after leaving the hospital and should be given a written summary of their Transfer of Care Plan, which should include: a. Expected date of discharge b. Essential pre-discharge assessments c. Care after leaving the acute hospital, including self-care d. Medication required on leaving the acute hospital e. Who is taking medical responsibility for care after leaving the acute hospital f. Further investigations, treatment, rehabilitation and re-ablement to be carried out after leaving hospital, and who will arrange these, including separately identifying any of these which the GP is expected to arrange g. Possible complications and what to do if these occur, including in an emergency h. Transport i. Equipment supply or loan j. Dressings and continence aids k. Who to contact with queries or for advice l. Date by which their care should be reviewed, who is expected to undertake this review and how to access a review more quickly if required This Transfer of Care Plan should be copied to the patient's GP and to all services involved in providing after-hospital care.	N	Patients were given a copy of their electronic discharge summary. The summary did not include contacts for advice. Reviewers were told that this information was included in patients' letters but these did not appear to be in use in all areas visited.
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	A range of support was available. Reviewers were told that information was given by social workers. Little information for carers was visible in the areas visited.

Ref	Standard	Met? Y/N	Reviewer Comments
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	A range of mechanisms were in place, including surveys, focus groups and 'in your shoes' campaigns. The results of the Friends and Family survey were seen but did not highlight specific areas, for example, comments on discharge to help drive improvements. Feedback and actions taken as a result were not displayed.
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	Board rounds had just been implemented but were not yet action focused on discharge. Liaison between ward staff and social care staff was variable. There were no ward based social workers and social workers could only accept formal referrals and were not available to discuss potential cases. Senior decision makers were not available 7/7, and not all wards had access to a discharge liaison nurse. Therapy staff reported that they were asked to assess patients when they were fit for discharge rather than at the beginning of the treatment.
SM-202	**'Trusted Assessors'** A member of staff 'trusted' and with competences to assess for local intermediate care services, including intermediate care in community hospitals, in care homes or at home, should be available to each ward daily (7/7) and able to respond on the same day to requests received by 12 noon.	N	Trusted assessors were not in place within the Acute Trust and therefore multiple assessments were undertaken. Care homes were unable to assess potential patients on the same day.
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	Formal training on the transfer of care was not yet in place. Training was available covering use of the Electronic Discharge Summary.

Ref	Standard	Met? Y/N	Reviewer Comments
SM-301	**Support Services** Access to the following support services should be available daily (7/7): a. Appropriate staff to undertake a home assessment within 24 hours of request b. Patient transport able to respond within four hours of request c. 'Simple' equipment available within four hours of request d. Supply of sufficient dressings and continence aids for 72 hours available within four hours of request e. All equipment, including beds and hoists, available within 24 hours of request f. 'Simple' adaptations available within 24 hours of request g. Voluntary sector 'settling home' support able to respond by the end of the next working day and continue for up to five days h. 'Simple' assistive technology available within 24 hours of request i. Medicines reconciliation (7/7)	N	Reviewers were told that transport was not always available within 4 hours of request. Medicines to take out were not always available to accompany the patient on discharge.
SM-302	**Short-Term Care at Home** Additional health and social care support should be available within four hours of request, comprising up to four visits per day for at least 72 hours after return home.	Y	Short- term care was available for up to four visits a day, with two carers. Night sitters were also available for three nights
SM-499	**IT System** 'Trusted assessors' and ward-based staff responsible for coordinating discharge planning (QS SM-201) should have electronic access to: a. Health and social care records of patients from the main areas served by the hospital b. 'Patient Passports' (if electronic)	N	Multiple IT systems were in use across the organisation. Some work was being undertaken to share systems. 'Fusion' did link to 'Lorenzo' and the production of the Electronic Discharge Summary was very good.
SM-595	**Ward and Consultant Handover** The latest version of their Transfer of Care Plan should be handed over to the new ward or consultant whenever patients are transferred to another ward within the acute hospital or to the care of another consultant and the Transfer of Care Checklist (QS SM-601) updated.	N	Patients who were transferred to the Discharge Lounge did not always have transfer of care plan information - see main report. A transfer of care policy with a checklist for inter-hospital and to other community settings was available but was not always used.

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

Ref	Standard	Met? Y/N	Reviewer Comments
SM-597	**More Complex Transfers of Care** Guidelines should be in use covering: a. Transfer of care to other local authority or Clinical Commissioning Group areas covering at least social care assessments, intermediate care services available, patient transport and equipment supply or loan b. Transfer to a care home for long-term care c. NHS continuing care assessments and place-finding d. Liaison with palliative and end of life care services e. Patients and/or carers who do not agree a Transfer of Care Plan or who unreasonably delay their transfer of care	N	Guidelines covering more complex transfers of care were not in place. There was guidance covering 'c' continuing health care and 'd' liaison with palliative and end of life services.
SM-601	**Ward-Level Arrangements** The following arrangements should be implemented on each ward: a. On admission: i. Requesting a Summary Medical Record from the patient's GP if this is not sent with the patient (QS SA-601) ii. Identifying agencies involved in the patient's care and, if necessary, informing them of the admission b. Availability for discussion with families (QS SM-103) c. A 'Patient at a Glance' or equivalent system so that all staff can see the patient's stage on the transfer of care pathway and actions required d. A Transfer of Care checklist (or equivalent) in each patient's notes showing their stage on the transfer of care pathway and actions required e. Updating the 'Patient Passport' (QS SA-101) for people at high risk of re-admission or issuing one if not available f. Rapid access to investigations and consultant clinics for patients following discharge (7/7) g. Local enabling agreements (QS SZ-602)	Y	Though wards did not issue the Standard Assessment Procedure (SAP) document.

Ref	Standard	Met? Y/N	Reviewer Comments
SM-602	**Intermediate Care** A protocol on access to local intermediate care services should be in use on each ward covering at least: a. Criteria for acceptance by each local intermediate care service and time limit for provision of the service (if applicable) b. Type of care, rehabilitation and re-ablement provided and, in particular, whether the service is able to support: i. 24/7 on-site care (community hospital or care home) ii. Overnight care (night-visiting or night sitting) iii. Intravenous therapy iv. PEG feeds v. Care for dementia or significant cognitive impairment vi. VAC therapy and other complex wound care c. 'Trusted Assessor' (QS SM-202) or other arrangements for agreement of patient suitability d. Arrangements for handover of the patient's Transfer of Care Plan	Y	Ward staff undertook all assessments for ITC. Trusted assessors were not yet in place.
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	
SM-702	**Audit** Each ward should have a rolling programme of audit of: a. Achievement of expected timescales for the patient pathway b. Patients re-admitted within 28 days who did not have a 'Patient Passport' or equivalent patient-held record *c.* Proportion of further investigations or follow up appointments arranged within five days of transfer from acute hospital	N	Auditing of 'a' and 'c' was not yet undertaken. A pilot project covering those of high risk of admission was in process in the community. Other Trust agreed audits were taking place.
SM-797	**Health and Social Care Review and Learning** Each ward should have a mechanism for influencing, and receiving feedback from, the local Health and Social Care Review and Learning Group on transfer of care from acute hospitals and intermediate care (QS SZ-798).	N	There was no formal group that met to discuss, review and share learning from discharge planning regularly. There were some individual operational groups.

Ref	Standard	Met? Y/N	Reviewer Comments
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 as defined by the Quality Standard was not yet in place on the wards. Uni-disciplinary and ward meetings did take place as well as some multi-disciplinary care group meetings.
SM-799	**Document Control** All policies, procedures and guidelines should comply with Trust (or equivalent) document control procedures.	N	Not all documents provided were document controlled and included other organisation headers. Corporate documentation was document controlled.

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INTERMEDIATE CARE SERVICE

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

Ref	Standard	Intermediate Care Team (ICT) Hollybank House Richmond Hall ICT (Excludes Richmond Hall Care Staff)	
		Met? Y/N	Reviewer Comments
SN-101	**Service Information** Each service should offer patients and their carers written information covering: a. Organisation of the service b. Care and therapeutic interventions offered by the service c. If beds: routines, visiting times and how to get refreshments d. Staff and facilities available e. How to contact the service for help and advice, including out of hours f. Who to contact with concerns about the service g. 'After intermediate care', including information about the length of time for which the service will be provided and the options for, and process of transfer to, longer-term care (if required) h. Sources of further advice and information	Y	The Patient Advisory Liaison Service leaflet directed users and carers to the Trust or an internet address. Reviewers considered that including who residents could contact locally might be helpful. **Hollybank:** The welcome pack for residents was concise and clear.

Ref	Standard	Intermediate Care Team (ICT) Hollybank House Richmond Hall ICT (Excludes Richmond Hall Care Staff)	
		Met? Y/N	Reviewer Comments
SN-103	**Care Plan** Each patient and, where appropriate, their carer and appropriate members of the multi-disciplinary team should discuss and agree their Care Plan and should have easy access to a written record covering at least: a. Agreed goals, including life-style goals b. Self-management c. Medication d. Planned care and therapeutic interventions e. Early warning signs of problems, including acute exacerbations, and what to do if these occur f. Expected date of discharge from the service g. Name of care coordinator h. Name of doctor taking medical responsibility for their care i. Who to contact with queries or for advice j. Planned review date and how to access a review more quickly, if necessary	N	**Richmond Hall:** Care plans were kept in an office and did not always document the expected date of discharge. Separate information was kept by the ICT. **Hollybank House and ICT:** Care plans were easily accessible to patients and their carers **Rapid Response Team:** A daily multi-disciplinary team was in place.
SN-104	**Review of Care Plan** A formal review of the patient's Care Plan should take place as planned and, at least, weekly. This review should involve the patient, their carer, where appropriate, and appropriate members of the multi-disciplinary team. The outcome of the review should be recorded in the Care Plan.	Y	Weekly multi-disciplinary teams were held. Patients did not routinely attend but did receive feedback and care plans were updated.
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	Local information and contact numbers were available. The single point of access referral number was also available for advice. Patients and carers could also contact the GP lead at Hollybank House for advice and queries.
SN-106	**Care Coordinator** Each patient should have a nominated individual responsible for planning and coordinating their care, including planning their longer-term care.	Y	In practice care was coordinated by the multi-disciplinary team professional most involved with the individual patient. Clarity on who is actually taking the lead could be made clearer for patients.

Ref	Standard	Intermediate Care Team (ICT) Hollybank House Richmond Hall ICT (Excludes Richmond Hall Care Staff)	
		Met? Y/N	Reviewer Comments
SN-107	**Communication Aids** Communication aids should be available to enable patients with communication difficulties to participate in decisions about their care.	N	Information was not easily available in other languages or for those with learning difficulties. Access to those able to communicate in sign language and an interpreter services were in place. Picture cards were also available.
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 and cases were managed by the community nursing teams. The single assessment documentation was used and updated during any course of intermediate care.

Ref	Standard	Intermediate Care Team (ICT) Hollybank House Richmond Hall ICT (Excludes Richmond Hall Care Staff)	
		Met? Y/N	Reviewer Comments
SN-196	**'After Intermediate Care' Plan** Patients and, when appropriate, their carers should be involved in discussing and agreeing the plan for their care after leaving the intermediate care service, and should be given a written summary of their 'After Intermediate Care' Plan, which should include: a. Expected date of discharge from the intermediate care service b. Care after leaving intermediate care, including self-care c. Medication d. Who is taking medical responsibility for care after leaving intermediate care e. Further investigations, treatment, rehabilitation and re-ablement to be carried out after leaving intermediate care, and who will arrange these, including separately identifying any of these which the GP is expected to arrange f. Possible complications and what to do if these occur, including in an emergency g. Transport (if required) h. Equipment supply or loan i. Dressings and continence aids j. Who to contact with queries or for advice k. Date by which their care should be reviewed, who is expected to undertake this review and how to access a review more quickly if required This 'After Intermediate Care' Plan should be copied to the patient's GP and to all services involved in providing ongoing care.	N	'After intermediate care' plans were not in use across all services. Some information across the various professions was covered in the Standard Assessment Procedure (SAP) folders, and some contact details, but the not all patients were clear about their' after intermediate care' plan and where to access advice.

Ref	Standard	Intermediate Care Team (ICT) Hollybank House Richmond Hall ICT (Excludes Richmond Hall Care Staff)	
		Met? Y/N	Reviewer Comments
SN-197	**General Support for Patients and Carers** Patients and carers should have easy access to the following services, and information about these services should be easily available: a. Interpreter services, including British Sign Language b. Independent advocacy services c. Complaints procedures d. Social workers e. Benefits advice f. Spiritual support g. *HealthWatch* or equivalent organisation h. Relevant voluntary organisations providing support and advice	Y	
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	
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	Mechanisms were in place including Graffiti Board with comments. A 'you said, we did' detailed changes made as a result, though this information was not clearly displayed in the areas visited.
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	

Ref	Standard	Intermediate Care Team (ICT) Hollybank House Richmond Hall ICT (Excludes Richmond Hall Care Staff)	
		Met? Y/N	Reviewer Comments
SN-202	**Staffing Levels and Skill Mix** Sufficient health and care staff with appropriate competences should be available for: a. The number of patients usually cared for by the service and the usual case mix of patients b. The service's role in the patient pathway and expected timescales c. The assessments, care and therapeutic interventions offered by the service Staffing should include: i. At least two registered healthcare professionals at all times the service is operational ii. A registered nurse available 24/7 in bedded units and daily (7/7) in other services iii. Appropriate therapists for the needs of the patients daily (7/7) iv. Access to social services staff available to undertake social care assessments within 24 hours of request v. Medical staff (QS SN-205) Cover for absences should be available so that the patient pathway is not unreasonably delayed, and patient outcomes and experience are not adversely affected, when individual members of staff are away.	N	Therapists were not available on the ICT units at weekends and over bank holidays. Therapy input to additional 'spot purchased' IC beds in other care homes was only weekly. **Richmond Hall:** there was a high staff turnover for the ICT beds. In the ICT team the social worker post was vacant and there was no mental health input to the team. A GP provided cover for the nursing home and visited weekly with Out of Hours cover at other times. **Hollybank House:** The multi-disciplinary team included mental health and social care input.
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	A plan and training was in place for all Walsall Healthcare areas. Social carers were also trained to deliver PEG feeds (medication was delivered by registered nurses).

Ref	Standard	Intermediate Care Team (ICT) Hollybank House Richmond Hall ICT (Excludes Richmond Hall Care Staff)	
		Met? Y/N	Reviewer Comments
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	Mandatory training was in place.
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	Medical review took place weekly. Out of hours cover was provided by the Badger Group. **Richmond Hall**: See main report about availability.
SN-299	**Administrative, Clerical and Data Collection Support** Administrative, clerical and data collection support should be available.	Y	

Ref	Standard	Intermediate Care Team (ICT) Hollybank House Richmond Hall ICT (Excludes Richmond Hall Care Staff)	
		Met? Y/N	Reviewer Comments
SN-301	**Clinical Support Services** Timely access to an appropriate range of clinical support services should be available, including: a. Imaging b. Pathology, including microbiology c. Pharmacy, including medication supply and medicines management advice d. Appropriate staff to undertake a home assessment within 24 hours of request e. Infection control (7/7 and on call 24/7) f. Tissue viability (7/7) g. Falls prevention (next working day) h. Continence service (7/7) i. Mental health team (crisis response within four hours) j. Counselling	N	Staff were not always available to undertake a home assessment within 24 hours of request. All other aspects of the Quality Standard were met.

Ref	Standard	Intermediate Care Team (ICT) Hollybank House Richmond Hall ICT (Excludes Richmond Hall Care Staff)	
		Met? Y/N	Reviewer Comments
SN-302	**Support Services for Patients Returning Home** Access to the following support services for patients returning home should be available daily (7/7): a. Appropriate staff to undertake a home assessment within 24 hours of request b. Medication 'To Take Out' available within four hours of request c. Patient transport able to respond within four hours of request d. 'Simple' equipment available within four hours of request e. Supply of sufficient dressings and continence aids for 72 hours available within four hours of request f. All equipment, including beds and hoists, available within 24 hours of request g. 'Simple' adaptations available within 24 hours of request h. Additional health and social care support within four hours of request, comprising up to four visits per day for up to 72 hours after return home i. Voluntary sector 'settling home' support able to respond by the end of the next working day and continue for up to five days j. 'Simple' assistive technology available within 24 hours of request	N	Medication to take out was not always available within 24 hours at Richmond Hall. Reviewers were told that it could be up to 4 days. Patient transport was not always possible within four hours of request as transfers were not undertaken after 7pm and there were often delays in assessments for transfer. All other aspects of the Quality Standard were met (a and d-j).
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	
SN-499	**IT System** IT systems for storage, retrieval and transmission of patient information should be in use for patient administration, clinical records, outcome information and other data to support service improvement, audit and revalidation.	N	Multiple IT systems were in use across the organisations. Some work was being undertaken to share systems.

Ref	Standard	Intermediate Care Team (ICT) Hollybank House Richmond Hall ICT (Excludes Richmond Hall Care Staff)	
		Met? Y/N	Reviewer Comments
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	N	Initial assessment documentation was in place but did not appear to cover 'cognition assessment'. Reviewers were told that cognitive assessments were undertaken in the Acute Trust but the process for those being admitted via other routes was not clear.
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 covering health promotion, spasticity, mental health and depression were not yet in place. All other aspects of the Quality Standard were met.

Ref	Standard	Intermediate Care Team (ICT) Hollybank House Richmond Hall ICT (Excludes Richmond Hall Care Staff)	
		Met? Y/N	Reviewer Comments
SN-597	**Transfer of Care Guidelines** Transfer of care guidelines for both simple and complex discharge pathways should be in use covering at least: a. Ensuring each patient has an expected date of discharge from the service b. Planning transfers of care from intermediate care including: i. Discussion with patients and carers about the 'After Intermediate Care' Plan ii. Availability for patient and carer queries iii. Multi-disciplinary review for complex or uncertain discharges iv. Single assessment process v. Transport options including patient transport service, relatives, taxis or care home transport vi. 'After Intermediate Care' Plan (QS SN-196) c. Agreement of 'After Intermediate Care' Plan and handover to services providing long-term care (if required) d. Informing the GP, the person taking medical responsibility for the patient and any other relevant services that the patient has left intermediate care, ideally within four hours of transfer of care	N	Transfer of Care Guidelines as defined in the Quality Standard were not yet in place. A discharge checklist and nursing transfer care summary proforma was in use.
SN-598	**More Complex Transfers of Care** Guidelines should be in use covering: a. Transfer of care to other local authority or Clinical Commissioning Group areas covering at least social care assessments, intermediate care services available, patient transport and equipment supply or loan b. Transfer to a care home for long-term care c. NHS continuing care assessments and place-finding d. Liaison with palliative and end of life care services e. Patients and/or carers who do not agree an 'After Intermediate Care' Plan or who unreasonably delay their transfer of care	N	Guidelines covering more complex transfers of care were not in place. Guidance covering 'c' continuing health care and 'd' liaison with palliative and end of life services was in place.

Ref	Standard	Intermediate Care Team (ICT) Hollybank House Richmond Hall ICT (Excludes Richmond Hall Care Staff)	
		Met? Y/N	Reviewer Comments
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	

Ref	Standard	Intermediate Care Team (ICT) Hollybank House Richmond Hall ICT (Excludes Richmond Hall Care Staff)	
		Met? Y/N	Reviewer Comments
SN-601	**Operational Policy** The service should have an operational policy describing the organisation of the service including, at least, arrangements for: a. Admission of patients to the service who meet the agreed criteria b. Initial assessment within 30 minutes of transfer, or within four hours if the patient has returned home c. On admission: i. Requesting a Summary Medical Record from the patient's GP if this is not sent with the patient (QS SA-601) ii. Identifying agencies involved in the patient's care and, if necessary, informing them of the admission d. Agreement of Care Plan within 24 hours of transfer to intermediate care e. Start of therapeutic interventions within 24 hours of transfer to intermediate care f. Setting and reviewing expected date of discharge from the service g. Daily review of all patients h. Review of Care Plans at least weekly, including medical review i. Allocation of a care coordinator for each patient (QS SN-106) j. Giving the patient and, where appropriate, their carer information at each stage of the patient journey k. Responding to patients' and carers' queries or requests for advice l. Multi-disciplinary discussion of appropriate patients m. Developing and agreeing an 'After Intermediate Care' Plan for each patient (QS SN-196) within seven days of admission n. Ensuring that an 'After Intermediate Care' checklist (or equivalent) is included in each patient's notes showing their stage on the transfer of care pathway and actions required o. Updating the 'Patient Passport' (QS SA-101) for people at high risk of re-admission or issuing one if not available p. Communication with the patient's GP q. Maintenance of equipment (QS SN-401) r. Responsibilities for IT systems (QS SN-499)	N	The ICT policy did not include any timescales as defined in the Quality Standard. The Frail Elderly Pathway document was in the process of being ratified but was more comprehensive. Hours of working and response times by services were included but not ci, cii, d, e, f,or g. The documents were not clear about the operational arrangements of the care homes.

Ref	Standard	Intermediate Care Team (ICT) Hollybank House Richmond Hall ICT (Excludes Richmond Hall Care Staff)	
		Met? Y/N	Reviewer Comments
SN-701	**Data Collection** Regular collection and monitoring of data should be in place, including: a. Referrals to the service, including source and appropriateness of referrals b. Number of assessments and therapeutic interventions undertaken by the service c. Outcome of assessments and therapeutic interventions d. Length of care by the service e. Proportion of patients achieving their expected date of discharge from the service f. Number and destination of transfer of care from the service g. Key quality and performance indicators	N	Data were not collected on the proportion of patients achieving their expected date of discharge. The ICT was planning to collect data on the outcome of assessments and therapeutic interventions.
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 covering compliance with evidence-based clinical guidelines (QS 500) was not yet in place. Audits covering achievement of timescales and record-keeping had been undertaken.
SN-703	**Key Performance Indicators** Key performance indicators (QS SN-701) should be reviewed regularly with Trust (or equivalent) management and with commissioners.	N	The Key Performance Indicator dashboard included response times and readmission rates but appeared to be incomplete, due to technical issues, for the ICT teams (apart from Rapid Response Team).
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 to discuss, review and share learning from discharge planning regularly. There were some individual operational groups. From the information seen, there did not appear to be a regular agenda for the meetings.

Ref	Standard	Intermediate Care Team (ICT) Hollybank House Richmond Hall ICT (Excludes Richmond Hall Care Staff)	
		Met? Y/N	Reviewer Comments
SN-798	**Multi-disciplinary Review and Learning** The service should have multi-disciplinary arrangements for a. Review of, and implementation of learning from, positive feedback, complaints, outcomes, incidents and 'near misses' b. Review of, and implementation of learning from, published scientific research and guidance c. Ongoing review and improvement of service quality, safety and efficiency	N	Multi-disciplinary review and learning as defined by the Quality Standard was not yet in place at Richmond Hall. The ICT team did meet, but staff from the home did not always attend. This Quality Standard was met at Hollybank House. Reviewers were told that feedback from the safeguarding board was not always available to the team.
SN-799	**Document Control** All policies, procedures and guidelines should comply with Trust (or equivalent) document control procedures.	N	Not all documentation seen for the community services was up to date or had review dates included. Corporate documentation was document controlled.

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COMMISSIONING

Ref	Standard	Met? Y/N	Reviewer Comments
SZ-601	**Commissioning of Services** Commissioners should commission intermediate care services for people at home and intermediate care services with beds sufficient for the needs of their population and should specify: a. Criteria and arrangements for acceptance by each intermediate care service, including the use of 'Trusted Assessors' (QS SM-202) b. Time limit for provision of intermediate care service c. Type of care, rehabilitation and re-ablement provided, in particular, whether care is available for patients needing: i. 24/7 on-site care (community hospital or care home) ii. Overnight care (night-visiting or night sitting) iii. Intravenous therapy iv. PEG feeds v. Care for dementia or significant cognitive impairment vi. VAC therapy and other complex wound care d. Arrangements for supply of medication, dressings and continence aids, equipment, adaptations and assistive technology within expected timescales (QS SM-301 and SN-302) e. Short-term health and social care support comprising up to four visits per day for at least 72 hours after returning home (QS SM-302 and SN-302) f. Key performance indicators for each service g. Any specialist care not normally available in the local area for which specific funding decisions are required	N	Criteria for those accessing 'step-down' services did not appear to cover i, ii, iii, or iv, and there was no mention of any dementia care pathways. There were some Key Performance Indicators in the overall scorecard, but these were not for the individual services to use as a basis of a report. The specification seen by reviewers was still in draft form, did not appear to be completed and had not been reviewed since 2012. The specification only referred to Hollybank House and did not include intermediate care provided by Richmond Hall. The criteria for acceptance of patients for 'step-up' services was clear.

Ref	Standard	Met? Y/N	Reviewer Comments
SZ-602	**Local Enabling Agreements** Health and social care commissioners should have local enabling agreements covering: a. Care package continuity during hospital admission b. Flexibility of re-start following hospital admission c. 'Discharge to assess' d. Cross-boundary agreements e. Single assessment process f. Arrangements for assessment and transfer of care for patients not resident in the local area, and reciprocal arrangements for local patients admitted to hospitals outside the local area	N	There was no specific specification for Richmond Hall. The original specification was still in draft form. Local enabling agreements were not seen for the Single Assessment process (SAP) or Discharge to Assess.
SZ-701	**Quality Monitoring** Commissioners should monitor key quality and performance indicators for: a. Transfer of care from acute hospitals (QS SM-701) b. Intermediate care services (QS SN-701)	Y	A Clinical Quality Review Scorecard was in place. Data were collated and monitored.
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 included all providers which met to discuss, review and share learning from discharge planning. A joint health and social care meeting was in place but minutes available showed that this group was not a forum for review and learning as expected by the Quality Standard.

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