WM QRS West Midlands Quality Review Service

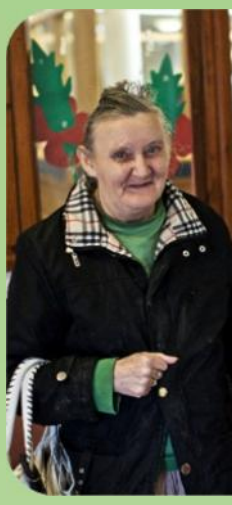
NHS

Transfer from Acute Hospital Care and Intermediate Care

Shropshire, Telford & Wrekin Health and Social Care Economy

Visit Date: 12th, 13th, 14th May 2015 Report Date: September 2015





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INTRODUCTION

This report presents the findings of the review of services for the transfer from acute hospital care and intermediate care services that took place on 12th, 13th and 14th 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 that reviewed the services in Shropshire, Telford and Wrekin 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 Shrewsbury & Telford Hospital NHS Trust
- The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
- Shropshire Community Health NHS Trust
- NHS Shropshire Clinical Commissioning Group
- NHS Telford & Wrekin 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 Shropshire and Telford & Wrekin 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 commissioners in relation to this report are NHS Shropshire Clinical Commissioning Group and NHS Telford & Wrekin 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 Shropshire, Telford and Wrekin 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

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 Shropshire, Telford and Wrekin health and social care economy.

Pathway	Provider	Quality Standards	Notes
Primary care	-	Primary care	Reviewers met with one GP.
Princess Royal Hospital	The Shrewsbury and Telford Hospital NHS Trust	Acute Trust: All wards	Reviewers reviewed documentary evidence and visited wards 9, 10 and 17, the Acute Medical Unit, Emergency Department and Ambulatory Care unit and met with a range of staff and patient representatives.
Royal Shrewsbury Hospital	The Shrewsbury and Telford Hospital NHS Trust	Acute Trust: All wards	Reviewers reviewed documentary evidence and visited wards 24 (Cardiology), 22 (Trauma and Orthopaedic}, 26 (Surgery), the Acute Medical Unit and Emergency Department. Reviewers attended 'Site Safety' and 'Fit to transfer' meetings. Reviewers met with a range of staff and patient representatives.
Robert Jones and Agnes Hunt (Orthopaedic) Hospital	The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	Acute Trust – Sheldon Ward	Reviewers visited Sheldon Ward (16 beds), reviewed documentary evidence and met staff and patients.
Community Hospitals providing intermediate care at Whitchurch, Bridgnorth, Ludlow and Bishops Castle	Shropshire Community Health NHS Trust	Intermediate care	Reviewers reviewed documentary evidence, visited intermediate care wards and met staff and patients.
Integrated Community Services Central, North and South Shropshire teams	Shropshire Community Health NHS Trust	Intermediate care	Reviewers met with staff from the service.
Telford & Wrekin Enablement Team	Shropshire Community Health NHS Trust and Telford and Wrekin Council	Intermediate care	Reviewers met with staff from the service.
Morris Care	Morris Care	Intermediate care	Reviewers met with staff and patients and viewed intermediate care facilities (10 intermediate care beds).
NHS Shropshire CCG		Commissioning	Reviewers met with staff from the CCGs.
NHS Telford & Wrekin CCG			
Other services:			
Rapid Response Team	Shropshire Community Health NHS Trust	-	Reviewers did not meet staff of this team but were told about their contribution to the pathway.

Pathway	Provider	Quality Standards	Notes
START (Short Term Assessment and Re-ablement Team)	Shropshire County Council	-	Reviewers did not meet staff of the START team but were told about its contribution to the pathway.
Access Team: Referral point for re-ablement and community care assessments	Telford and Wrekin Council	-	Reviewers did not meet staff of the Access Team but were told about its contribution to the pathway.
Cartlidge House Registered Care Home – Enablement Unit	Accord Group	-	Reviewers did not meet staff but saw evidence relating to its contribution to the pathway.
Farcroft, Lightmoor View, Cottage Christian Registered Care Homes	Coverage Care Services Ltd.		Reviewers were told of their involvement in the pathway.

General Comments and Achievements

Work was taking place within Shropshire and Telford & Wrekin to try and improve pathways for transfer from acute hospital care and intermediate care. Three pathways had been defined for each CCG:

Pathway 1 Supported discharge home

Pathway 2 Bed-based rehabilitation or enablement

Pathway 3 Bed-based nursing care for patients requiring complex assessments

Integrated (purple) working was being prioritised and a 'Breaking the Cycle' week was planned for June 2015. The 'Breaking the Cycle' initiative had been widely publicised and staff were clearly engaged and actively identifying ideas they wanted to try out. Several initiatives had already been tried as part of the health and social care economy's response to 'winter'.

Pathway 1 support was provided by Integrated Community Services (ICS) in North, Central and South Shropshire. These integrated health and social care teams provided early supported discharge for Shropshire patients. In Telford & Wrekin the Re-ablement Service provided home-based rehabilitation and re-ablement. This service had been evaluated and had been shown to lead to a reduction in admissions to care homes.

Pathway 2 was provided by 88 community hospital beds in North and South Shropshire and 15 step-down care home beds in Central Shropshire. In Telford & Wrekin, Morris Care provided ten beds for enablement support and Cartlidge House provided nine beds.

Pathway 3 was also provided in community hospitals (18 beds) in North and South Shropshire and by 10 'Discharge to Assess' beds in Central Shropshire. Morris Care provided eight 'Discharge to Assess' beds and two in Cottage Christian in Telford & Wrekin. Three further 'Discharge to Assess' beds were provided by Lightmoor View for patients with dementia. Additional beds were 'spot-purchased' if required.

Throughout the review visit the visiting team was impressed by the loyalty and commitment of staff who they met. Reviewers also noted a range of improvements in care pathways for people with dementia. Dementia friendly environments were being introduced, good information about dementia was available and nurses on several wards had specific training in the care of people with dementia. Staff awareness about the needs of patients with dementia was also good.

Immediate Risks: See The Shrewsbury and Telford Hospital NHS Trust section of this report.

Concerns

1 **System-wide Planning and Coordination**

Three aspects of system-wide planning and coordination were of concern to reviewers because of the lack of evidence of a coordinated approach to agreeing actions and driving these through to implementation:

a. A System Resilience Group had been meeting since September 2014 and had working groups on Urgent Care and Demand and Capacity. This group had agreed the three pathways but did not appear to have mechanisms to drive systematic implementation.

b. Some senior staff in health provider and commissioner organisations appeared to focus on barriers and obstacles to change, including criticising staff in other organisations, rather than on finding solutions and working together to drive implementation.

c. Clinical leaders in individual services had variable knowledge and awareness of, and commitment to, the changes being made and to achieving further change. Reviewers met inspirational clinical leaders but also with others who were less committed.

Robust mechanisms for planning and implementing changes to the pathway of transfer from acute hospital care and intermediate care across the health and social care economy were not evident. Lots of plans and pilot schemes were discussed with reviewers but it was not clear how and when these would be evaluated, decisions made and, if appropriate, wider implementation achieved. Executive-level staff were clear about the process for any particular plan or pilot but these arrangements were not generally well understood, including by operational staff involved in the delivery of some of the pilot schemes.

2 **Pathways of Care**

Pathways for transfer from acute hospital care and intermediate care varied depending on whether the patient was from Shropshire or Telford & Wrekin CCG, depending on whether they had been admitted to Royal Shrewsbury Hospital or Princess Royal Hospital and depending on which clinical team was managing their care. The three pathways of care were variably understood by staff who met reviewers and were not yet being systematically implemented. Reviewers were particularly concerned about:

a. **Admission Avoidance**

The planned pathways of care provided little support for admission avoidance, with some exceptions. Exceptions included the Diagnostic Assessment and Access to Referral and Treatment (DAART) service at Royal Shrewsbury Hospital, the primary care service in the Emergency Department at Princess Royal Hospital and the Telford & Wrekin and Re-Ablement Service and Rapid Response Team. Reviewers did not consider that these comprised a comprehensive 'admission avoidance' response. Reviewers also observed several in-patients, including patients with retention of urine and cellulitis, who they considered could have been cared for in non-acute settings. Reviewers were told that 'admission avoidance' was going to be addressed in future system resilience plans.

Pathway 1

Pathway 1 in Telford & Wrekin provided domiciliary care support 'with support from clinicians'. The presentation given to reviewers about ICS teams was that: 'multi-disciplinary and multi-agency support is available until the patient has reached their potential, which could take from several days to six weeks'. In practice, the emphasis in Telford & Wrekin appeared to be on domiciliary care and the emphasis in Shropshire on health and social care assessment. The arrangements for active healthcare input to Pathway 1 patients were not clear in either locality. Reviewers were given several examples of patients being admitted to short-stay beds in Shrewsbury and Telford Hospital NHS Trust or to nursing homes for interventions which could have been provided at home.

One particular example related to provision of intravenous antibiotics at home. An Interdisciplinary Team (IDT) provided some intravenous antibiotics at home but this team did not appear in the Pathway 1 description and the links between the IDT and Discharge to Assess pathways were not clear.

Reviewers were told that a limited range of antibiotics were supported at home and in community hospitals across Shropshire, and access to this service depended on capacity across the providers (Shropshire Community Health Trust and Shropdoc) to take responsibility for patients on intravenous antibiotics.

In general, the types of patient suitable for Pathway 1 and the arrangements for health care input to the supported discharge home were not clear to reviewers or to many of the staff who they met during the review visit.

b. **Implementation**

The three discharge to assess (D2A) pathways were not yet fully implemented. D2A was only in place on two wards on each site. Further implementation was part of a formal review taking place before further roll-out of the process. Reviewers were told of inappropriate transfers of care to each of the services reviewed. Some patients were waiting two to three days for a care package and up to 12 days for a 'discharge to assess' or Enablement bed.

Reviewers also saw examples of patients being transferred between Royal Shrewsbury Hospital and Princess Royal Hospital rather than going to a 'discharge to assess' bed. Ward staff at Shrewsbury and Telford Hospital NHS Trust had variable understanding of the agreed pathways of care and implementation appeared inconsistent.

c. **Capacity Overview**

The health and social care economy did not have an effective central overview of the capacity available at any one time. A 10.30am telephone call, involving social services, discussed delayed transfers of care. Some bed-based services were phoned at 12 noon to ask about their beds. The Single Point of Access Capacity Hub based at Halesfield co-ordinated the community hospital bed capacity which was declared 3 times a day. The systems for allocating beds did not appear robust and reviewers were given examples of patients whose discharge to a community hospital was planned, only to find that the bed had been taken by a GP admission. Capacity in ICS did not appear to be centrally monitored. Electronic 'Patient Status at a Glance' Boards were implemented in Shrewsbury and Telford Hospital NHS Trust and at Robert Jones and Agnes Hunt NHS Trust. 'Patient Status at a Glance' was not yet electronic in the community hospitals but this was planned as part of the introduction of the electronic patient record system in Autumn 2015. These systems were not used to provide a central overview of capacity. A capacity tool was available to Executive Directors in Shrewsbury and Telford Hospital NHS Trust and CCGs but this was not used for day to day management of capacity.

d. **Multiple Assessments**

Plans for the introduction of 'trusted assessors' were being developed and, at the time of the review, two discharge liaison practitioners had been appointed for the D2A pilot wards at Royal Shrewsbury Hospital and two at Princess Royal Hospital. These practitioners were working towards being 'trusted assessors', including for nursing home placements. As these systems were not yet fully developed and implemented across other wards, assessments were being undertaken by each service separately with resulting delays in the patient pathway. In particular, reviewers were told of delays in assessments by nursing home staff.

3 **Availability of Social Care Assessments in The Shrewsbury and Telford Hospital NHS Trust**

Social workers were not embedded in 'transfer of care' processes at The Shrewsbury and Telford Hospital NHS Trust. Reviewers were told that social workers would 'pop in' rather than being part of Board Rounds or multi-disciplinary discharge planning meetings. Reviewers considered that this must be contributing to longer lengths of stay and delayed transfers of care.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust, Whitchurch and Bridgnorth Community Hospitals had better access to social care assessments with social workers being based on site. Social care was available part-time at Bishops' Castle and Ludlow Community Hospitals. Integrated Community teams also had social workers as part of the team for Shropshire CCG patients**.**

4 **Pharmacy Services**

Several concerns about pharmacy services were raised:

a. **The Shrewsbury and Telford Hospital NHS Trust – 'TTOs'**

The Trust discharge policy required medication 'to take out' to be available within four hours, which reviewers considered too long. The actual times for medication 'to take out' to be available was not known, however, as only ad-hoc audits were undertaken. A pharmacist attended the daily site meeting and took a list of names of people due for discharge that day. These patients were then prioritised. Although a useful short-term measure, this arrangement was necessary only because the underlying arrangements for supplying medication 'to take out' were not working satisfactorily.

b. **The Shrewsbury and Telford Hospital NHS Trust – Incident recording**

Incidents identified by pharmacy were recorded separately from ward incidents and were not linked back to the ward or department where they originated. The level of medication errors known to ward staff (mainly nursing errors) therefore appeared very low, for example, the short stay unit had had only two medication errors in the previous month. Ward staff did not receive feedback on the errors recorded by pharmacy and learning from these events therefore did not occur.

c. **Shropshire Community Health NHS Trust - Community Hospitals**

Patients in community hospitals were waiting up to four days for medication 'to take out' dispensed from The Shrewsbury and Telford Hospital NHS Trust to be ready, with waits of four to seven days for dosset boxes.

There was some facility for using FP10 prescription forms to obtain medication 'to take out' but this was not the usual system. Arrangements for blister packs varied with most supplied by The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Trust although not to Community hospitals, and some supplied by community pharmacists in Telford and Wrekin.

In general, with the exception of The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Trust, the health and social care economy did not appear to be monitoring and actively managing the pharmacy contribution to the 'transfer from acute hospital care and intermediate care' pathway.

5 **Transport**

Delays for patient transport were being experienced in most of the wards visited by reviewers, with the exception of Robert Jones and Agnes Hunt Orthopaedic Hospital. Reviewers were told that the transport service did not arrive when they said they were going to and, as a result, patients were transferred very late in the day. Some patients were being transferred from acute care to community hospitals after 10pm which caused problems for community hospitals because they had no on-site medical cover after 10pm.

Some discharges were cancelled if the transfer became too late and was considered detrimental to the patient. Contributory factors to the late transfers were the access to community beds late in the

afternoon, lack of availability of medication 'to take out' and incorrect use of the booking transport process.

During the course of the review it emerged, however, that a new provider of patient transport had been commissioned (MSL Transport Ltd).Patient transport was therefore available within one hour of request. An on-line 'Make Ready' system for booking transport was available to ward staff and MSL Transport Ltd had good data on requests and response times and whether the one hour target was being met. Of the wards visited, only staff on Ward 17 at Princess Royal Hospital seemed to be aware of the new provider and how to effectively use the 'Make Ready' system.

At the time of the review, MSL Transport Ltd was consulting its staff about changes of working hours to provide more cover in the evenings, because of the number of late transfers. Although useful in the short-term, this was another example of the system adapting to accommodate problems rather than the underlying issues being resolved.

6 **Patients from Powys**

Several examples of delays in transfer of care of patients from Powys were given to reviewers during the course of the visit, including problems with equipment supply and difficulty discharging patients with tracheostomies. The impact appeared to be that patients stayed in acute beds longer than necessary, impacting on the capacity available for other patients. Reviewers saw little evidence of an active approach to this issue with staff either accepting it as 'too difficult' or 'not my problem'. In this case, short-term sub-optimal solutions did not appear to be being pursued, even when they might be of benefit to Shropshire and Telford & Wrekin residents, especially by freeing up acute capacity.

Further Consideration

1 Running at 'Level 3' capacity appeared to reviewers to have become accepted as the norm. Some helpful interventions were only brought in at Level 3, rather than being used at Levels 1 and 2 in order to prevent problems escalating. For example, the Rapid Response Team in Telford & Wrekin undertook in-reach into the acute hospitals only in the mornings. The ICS (see below) went in to Princess Royal Hospital only when the Trust was 'on Level 3'. Reviewers suggested that treating Levels 1 and 2 capacity with the same urgency and interventions as Level 3 may help the Trust to have a more proactive approach to transfers from acute hospital care.

2 Access to mental health advice and assessment was variable. At Princess Royal Hospital the acute mental health liaison service 'RAID' was available only from 9am to 5pm Mondays to Fridays, with the Crisis Team providing support at other times. At Royal Shrewsbury Hospital the RAID service was available 24hrs, seven days a week. Some community hospitals had good links with their local Community Psychiatric Nurses whereas others did not. Reviewers suggested that further investigation of this issue may be helpful to assess the extent to which delays in mental health assessments are contributing to length of stay in acute and community hospitals.

3 Arrangements for review and learning across the health and social care economy were not yet in place. Reviewers suggested that a mechanism for operational services to share and learn from issues arising at the interface between services would be helpful, especially given the complexity of some of the pathways.

4 A 'This is me' passport was in use by community services but did not appear to be routinely brought into hospital with patients or used by acute hospital staff.

5 Ward level staff, including in community hospitals, were generally not aware of data on their achievement of targets and key performance indicators. Most of the wards visited were not aware of the proportion of patients achieving their expected date of discharge or average length of stay. It was not clear whether total length of stay in hospital (acute and community) was being monitored at all. Senior staff in the Trusts and CCGs had access to relevant data but this did not appear to be communicated to ward staff or to be used as part of the improvement programme.

6 Reviewers commented that many of the acute and community hospital wards they visited were cluttered with equipment in corridors, a bathroom used as a store room for equipment and doors propped open on some wards.

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PRIMARY CARE

No specific issues relating to primary care were identified. Reviewers noted, however, that a self-assessment of compliance with the Primary Care Quality Standards had not been submitted, but they did meet with a GP who was also Medical Director of Shropshire Community Health NHS Trust and some GPs who were providing medical support to the Community Hospitals.

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ACUTE TRUST: THE SHREWSBURY & TELFORD HOSPITAL NHS TRUST

General Comments and Achievements

A range of developments had been introduced by The Shrewsbury and Telford Hospital NHS Trust. 'Patient Status at a Glance' (PSAG) Boards had been implemented throughout the Trust. The Trust's ambulatory care model was being re-launched as part of the 'Breaking the Circle' week (see above). Short-stay wards had been implemented providing care for either 24 or 48 hours. The Trust had worked with other services to implement the Diagnostic Assessment and Access to Referral and Treatment (DAART) service at Royal Shrewsbury Hospital and a primary care service within the Emergency Department at Princess Royal Hospital. The Datix system was being used for incident recording and feedback throughout the Trust with good feedback to staff, including ward staff, about action taken.

Good Practice

See health and social care economy section of this report. Additional points specifically related to The Shrewsbury and Telford Hospital NHS Trust were:

1 **Capacity management**

Capacity managers at Royal Shrewsbury Hospital and Princess Royal Hospital were actively using data and technology to plan and manage available capacity within the Trust. They were proactive and prepared to try out different approaches. They had an excellent knowledge of patients within the Trust who were 'fit for transfer' and a good vision for the future development of capacity management.

2 **Princess Royal Hospital, Ward 17, Frail Older People**

Ward 17 at Princess Royal Hospital provided 28 beds for the care of frail older people (14 beds) and for people with endocrine disorders (14 beds). Ward staff made very good use of the 'Patient at a Glance' Board, including use of electronic post-it notes to give information about delays and 'red, amber, green' rating of whether patients were ready to go home. 'Board rounds' were well-organised with good medical and nursing leadership and good multi-disciplinary involvement.

The nurse in charge for the day had responsibility for coordinating and ensuring progress with transfers of care. The environment had been made as suitable as possible for people with dementia including the use of clocks to allow patients to know what time it was and weather notices. Dementia workers were available on some wards.

Immediate Risks[1]

1 **Process from arrival to triage: Emergency Department, Princess Royal Hospital, Telford**

Patients arriving at the Emergency Department took either a numbered ticket or a card (when the ticket machine was not working) and waiting in the waiting area until called for triage. Patients were not 'booked in' until after triage. No receptionist or other member of staff had an overview of the waiting area. The condition of both children and adults could therefore deteriorate between arrival and triage without this being noticed by a member of staff.

2 **Information on patients discharged: Both sites**[2]

Patients discharged from The Shrewsbury and Telford Hospital NHS Trust were given a list of medication but not a discharge summary. The discharge summary was sent electronically to Shropshire and Telford and Wrekin GPs but was not accessible to other services. A yellow 'transfer of care' form was sent with patients transferred to community hospitals or some other services. This was a nursing handover document, although it contained space to include 'other relevant medical information'. The patient's condition could deteriorate after they were discharged and information about their previous condition and treatment in hospital would not be available.

Concerns

See health and social care economy section of this report. Additional points specifically related to The Shrewsbury and Telford Hospital NHS Trust were:

1 **Transfer of Care Process**

Several aspects of the process of discharge from Shrewsbury and Telford Hospital NHS Trust care were of concern to reviewers:

a. The order of the Trust-wide junior doctor's 'task list' meant that ordering medication 'to take out' did not happen until after the discharge letter had been completed. This resulted in medication 'to take out' being ordered later than it could have been with a resulting impact on lateness of transfers of care.

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[1] **Immediate risk response:** Following the review, the triage process at the Princess Royal Hospital has now been changed so that it mirrors that of the Emergency Department at the Royal Shrewsbury Hospital. This change had already been planned for the summer months, once building work in the department to improve the flow for patients had been completed.
WMQRS response: These actions, if fully implemented, address the immediate risk identified.

[2] **Immediate Risk Response:** A duplicate paper version of the full discharge summary will be printed at the time of the patient's discharge in addition to the electronic transmission of the discharge summary to the GP. This will require changes to be made to the software preparing discharge summaries but it is envisaged this will be fully implemented by July 2015. The Medical Director has written to all doctors impressing on them the importance of providing a timely discharge letter that must be sent to the patient's GP and printed to be given to the patient. This letter will be followed by more detailed guidance on continuing responsibilities post discharge and changes that will be made to the Trust's IT systems that will support the preparation of discharge letters. A similar letter will be sent to nursing staff and discussed at the Ward Manager meeting and Nursing and Midwifery Forum. The current discharge summary process is under long term review and is due to be replaced with a system that will support the national strategy of providing secure and paper free systems within the NHS. Part of the Trust's plan of providing a solution will be to ensure appropriate access to information contained within the discharge summary for providers of care who are unable to access information available to the patients GP.
WMQRS Response: Your response mitigates the risk identified and will address it fully when changes to the IT system have been made (by July 2015).

b. The PSAG Boards did not routinely show what was happening with medication 'to take out' and so this could not be easily monitored.

c. 'Board rounds' were variably organised and multi-disciplinary input was inconsistent. Some Board rounds had no medical input whereas others appeared medically dominated with little or no multi-disciplinary input.

2 **Admission Pathway: Royal Shrewsbury Hospital**

Pathways of care for patients admitted through the Emergency Department or Acute Medical Admission Unit (AMU) were complex and a clear flow of patients was not apparent. Admission pathways were not clearly defined. Patients could be admitted to the AMU from the Emergency Department, to the Clinical Decisions Unit or to specialty wards. Patients usually moved from the AMU to specialty wards or to short-stay ward. Patients were also transferred from short stay ward to specialty wards and vice versa. Patients could therefore be cared for in multiple locations, each involving disruption for the patient and family, and a clinical handover. The extent of the clinical handover at each stage was not clear to reviewers. Cardiology and gastroenterology were actively 'pulling' patients from the AMU, partly because these specialties did not take part in the general medical on-call rota and so beds were less likely to be filled with acute admissions.

3 **Weekend working**

a. Other than respiratory physiotherapy, therapists were not available at weekends. This resulted in delayed transfers of care while patients were waiting for therapy assessment and a lack of active mobilisation and rehabilitation for patients. A pilot of weekend therapy cover on one ward had been tried. Staff on the ward thought this had significantly improved care and reduced length of stay but were unclear whether the pilot would be continued.

b. Discharge liaison nurses were seen as an important change and key to the transfer from acute hospital care. These nurses were available Monday to Friday only and had no cover for absences.

Further Consideration

See health and social care economy section of this report. Additional points specifically related to The Shrewsbury and Telford Hospital NHS Trust were:

1 Completion of transfer of care information was variable. Some of the examples seen at community hospitals and at Robert Jones and Agnes Hunt Orthopaedic Hospital were incomplete.

2 Completion of electronic discharge summaries was reported by some staff to be variable. Electronic discharge summaries were sent to GPs but reviewers were told that some GPs did not have log-in details in order to be able to access them.

3 Updated nursing documentation was in the process of being implemented but both the old and new versions were in use in clinical areas and assessments were not always updated using the latest version.

4 The order of prioritising jobs on the junior doctor 'task list' started with responding to incidents and patients who were sick or who had deteriorating early warning scores. Reviewers supported the priority being given to sick patients but queried whether a response by middle grade doctors to these issues may be more appropriate. It may be helpful to consider linking junior and middle grade doctors' responsibilities.

5 Recording of the performance indicator of waiting times in the Princess Royal Hospital Emergency Department did not appear to be robust. When the ticket machine was not working patients being triaged were asked what time they had arrived. This appeared open to error, especially as patients did not know that they were going to be asked for this information.

6 The amount of rehabilitation provided to patients waiting for a community hospital or discharge bed was not clear to reviewers. Reviewers considered that active rehabilitation while waiting may mean that some patients would be fit enough to go home before a bed became available.

The Ambulatory Care Ward at Princess Royal Hospital had consultant presence only between 2pm and 5pm. Reviewers suggested that consultant availability earlier in the day may help to speed up the patient pathway.

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ACUTE TRUST: THE ROBERT JONES & AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST

General Comments and Achievements

Sheldon Ward provided a positive environment for the care of patients. The Ward Manager provided strong leadership of the service and patients who met the visiting team were positive about the care they received. There was good evidence of ward staff acting on feedback from patients. Most patients were admitted from Royal Shrewsbury Hospital and were discharged to home. An efficient and effective multi-disciplinary team meeting was in place for the discussion of patient care. A 'Patient Safety at a Glance' Board was in use and plans for this to become electronic were in place. 'Safety huddles' took place four times a day. The discharge checklist had good evidence of multi-disciplinary involvement in discharge planning. Access to equipment on the ward and to take home was good.

Good Practice

See health and social care economy section of this report. Additional points specifically related to The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Trust were:

1 Care of patients with dementia was being given a high priority with a 'Poppy Room' and a 'butterfly scheme' in operation. Patients with dementia also had a 'This is Me' document and a REACH (Resources for Enhancing Alzheimer's Caregiver Health) document.

2 Patients had access to Wifi.

3 A good 'self-administration of medication' assessment was in use.

Immediate Risks: No immediate risks were identified.

Concerns

See health and social care economy section of this report. Additional points specifically related to The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Trust were:

1 **Maintaining competences**

Evidence that staff were maintaining clinical skills, including skills in intravenous therapy, was not available. The ward manager did not have access to some staff training records and therefore did not have an overview of the training needs of the ward team.

2 **Palliative care support**

Support for patients needing palliative care was not available. There was a link nurse on the ward but no arrangements for access to a specialist palliative care team.

3 **Supply of wheelchairs**

Reviewers were told of long waits for non-standard wheelchairs, for example, specialist or electric wheelchairs. No specific dates for delivery were given and the reviewers were advised that this caused delays in the discharges of these patients.

Further Consideration

See health and social care economy section of this report. Additional points specifically related to The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Trust were:

1 Only two registered nurses were on duty at night. One nurse was also the bleep holder for the hospital and so may have to leave the ward.

2 The Trust self-assessed as an acute Trust. The care provided on Sheldon Ward was similar to that in community hospitals elsewhere in Shropshire except that medical staffing was significantly better. It may be helpful to consider whether the ward would be more appropriately categorised as providing intermediate care and, if so, whether the level of medical staffing is necessary for Sheldon Ward patients. (Medical staff may, of course, be needed to cover other parts of the hospital.)

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INTERMEDIATE CARE: SHROPSHIRE

General Comments and Achievements

Integrated Community Service: Shropshire Community Health NHS Trust

The Integrated Community Service comprised three teams covering Central, North and South Shropshire and had been commissioned to provide Pathway 1. The team included START (Short Term Assessment & Re-ablement Team) the provider of domiciliary care for Shropshire and also had good links with local communities and voluntary organisations. The team provided integrated health care and social care assessments and was flexible in responding to patients' needs with a strong focus on re-ablement.

Good Practice

1 Domiciliary carers provided by START undertook risk assessments which had reduced delays in starting domiciliary care.

Immediate Risks: No immediate risks were identified.

Concerns

See health and social care economy section of this report. Additional points specifically related to the Intermediate Care Service were:

1 **Weekend availability**

The service was available from 8am to 6pm on Mondays to Fridays and was not fully staffed at weekends. One nurse was available from 8.30am to 4.30pm at weekends and social workers could be accessed by phone between 9am and 1pm. Therapy staff were not available at weekends.

2 **Criteria for acceptance of patients**

Criteria for referral to the service were not clearly defined and staff who met the reviewers were unclear about the criteria for Pathway 1. Reviewers were told that the pathway was interpreted differently by teams in different parts of Shropshire.

Further Consideration

See health and social care economy section of this report. Additional points specifically related to the Intermediate Care Service were:

1 The service was commissioned to respond within 24 hours of referral. Reviewers suggested that a more rapid response time could improve the contribution which the service made to the transfer from acute care pathway.

2 Data on activity and outcomes of the service were not yet available. This issue is categorised as for 'further consideration' as the service had only recently been established but would be a 'concern' at any future review if not addressed.

3 It was not clear to reviewers how links between the Integrated Community Service and community nursing teams were maintained, especially so that handover took place at the earliest possible opportunity.

4 The Integrated Community Service visited Princess Royal Hospital only when The Shrewsbury and Telford Hospital NHS Trust was on 'level 3' capacity alert. Reviewers suggested that regular links with Princess Royal Hospital may be useful as part of preventing capacity reaching level 3.

5 The Integrated Community Service did not yet have effective links with care of older people consultants. Developing this relationship may improve the care available and the ability of the service to manage patients at home.

6 Reviewers also suggested that further links with mental health staff, or additional training for Integrated Community Service staff in the care of people with dementia, may be helpful. Only one mental health nurse was part of the service. Some staff were not aware of the 'This is Me' documentation in use in Shropshire and appeared to have limited knowledge of the Mental Capacity Act and its implications for patient care.

7 Multiple IT systems were in use. Social care staff were using different systems that not all health staff could access. Reviewers were told that staff had to use several mobile phones due to the prohibitive cost of making calls via their 'smart phones'.

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Community Hospitals: Shropshire Community Health NHS Trust

General Comments and Achievements

Staff working in community hospitals visited by the reviewers were generally enthusiastic and keen to provide good care. Average length of stay had been reduced to between 16 and 19 days (varying in the different hospitals). Service managers were keen to make further improvements. Facilities were generally good; Whitchurch Hospital had an impressive new bathroom and wet room and Bishop's Castle Hospital had an outdoor gym for respiratory rehabilitation. At Ludlow Hospital all patients had a discharge care plan and active use was being made of the Expected Date of Discharge (EDD). Daily 'board rounds' were in place at all the hospitals visited, although the extent to which these were being used actively to plan discharges was variable (see below).

Good Practice

1 As part of a 'sit and see' initiative, over 50 volunteers were being used to monitor quality in community hospitals and make suggestions for improvements which could be made.

2 A pharmacist regularly observed medication rounds in order to spot poor practice and potential problems, with the aim of reducing medication errors.

3 The environment at Ludlow Hospital was particularly good with shower rooms as part of the bed bays, a facility for caring for people near the end of life including an adjoining room for relatives to stay and dementia-friendly signage on all facilities. Ludlow Hospital also used a good end of life care pathway.

4 Patients who were discharged before lunch were provided with a packed lunch.

Immediate Risks: No immediate risks were identified.

Concerns

See health and social care economy section of this report. Additional points specifically related to community hospitals were:

1 **Criteria for admission**

Criteria for admission to community hospitals were not clearly defined and reviewers observed and heard about several patients who they considered could have gone straight home. Community hospitals were not providing a full range of sub-acute care which reviewers considered would have been a more appropriate use of staff and facilities.

2 **Active discharge planning**

Although progress was being made, a culture of active discharge planning was not evident to reviewers, except in Ludlow Hospital. The pace of rehabilitation and progress towards discharge appeared slow. For example, multi-disciplinary team meetings were generally held weekly. In Whitchurch Hospital the GP did a ward round only weekly. At Bridgnorth, Ludlow and Bishop's Castle the GP input was less clearly defined but did not appear to be actively supporting transfer of care to home as soon as possible. Feedback from some patients who met the visiting team was that they did not know when a medical review or multi-disciplinary team meeting would take place and when they would be updated on plans for their transfer home.

3 **Competences**

A framework of staff competences expected was not yet available. Mandatory training was monitored but training records for other competences were held on paper and managers did not have a good overview of whether their staff were maintaining appropriate competences. Staff competences in use of information technology (IT) were variable with some staff reported as having difficulty with use of IT. The Trust was, however, aware of this issue and had plans to address it.

4 **Case notes**

Reviewers observed multiple notes for the same patient in both Whitchurch and Bishop's Castle community hospitals, with nursing, physiotherapy and the GP's notes all stored separately. Reviewers also saw several examples of assessments not being fully completed.

Further Consideration

See health and social care economy section of this report. Additional points specifically related to community hospitals were:

1 At Whitchurch community hospital a bathroom was being used as an equipment store. Reviewers suggested it may be helpful to rename the room to avoid confusion for patients.

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INTERMEDIATE CARE: TELFORD AND WREKIN

See health and social care economy section of this report. Additional points specifically related to intermediate care services in Telford and Wrekin were:

Telford and Wrekin Rapid Response Team: Shropshire Community Health NHS Trust

The Telford and Wrekin Rapid Response Team provided care at home and also went into Princess Royal Hospital each morning in order to identify patients who were suitable for transfer home. An admission avoidance pathway was also in place.

Therapy teams at The Shrewsbury and Telford Hospital NHS Trust were actively involved with the Rapid Response Team. The Rapid Response Team could refer patients to the Enablement Team and to intermediate care beds provided by Morris Care. They also had the ability to broker domiciliary care and short term beds for admission avoidance.

Telford and Wrekin Enablement Team: Shropshire Community Health NHS Trust and Telford & Wrekin Council

The Enablement Team provided short-term rehabilitation, re-ablement and enablement in order to avoid admission or support transfer of care home following an acute admission. Domiciliary care, if required, was provided by Morris Care or Cartlidge House. The team also supported the care of people who were admitted to intermediate care beds provided by Morris Care. Good links with the community tissue viability and continence services were evident.

Most equipment could be accessed the same day as requested and the team was able to fit simple equipment. The service made good use of assistive technology. Access to transport, including wheelchair taxis, was also good.

Intermediate Care Beds: Morris Care

Admission to the 10 intermediate care beds provided by Morris Care was arranged by the Enablement Team following discussion with hospital staff or staff from the Rapid Response Team. At the time of the review visit, all residents had transferred from acute hospital care at The Shrewsbury and Telford Hospital NHS Trust. The beds were staffed by nurses, carers, physiotherapists, occupational therapists, a speech and language therapist and a social worker. Staff rotation between the bedded unit and the Enablement Team were in place. Average length of stay at the time of the review was 19 days. Most (68%) people admitted to the unit then went home. About 22% of admissions were discharged to long term care. Medical input to the care of residents was by a GP who visited twice weekly and attended other meetings as required. A full multi-disciplinary team meeting was held weekly. Case notes were well kept and comprehensive.

Good Practice

1 Kitchen and washing facilities were available for use in assessments.

2 Telford and Wrekin Enablement Team: The team had a strong focus on re-ablement and had achieved a demonstrable reduction in the number of people admitted to care homes or hospital.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Incident feedback**

Incidents were recorded by Morris Care but arrangements for feedback to other providers, including to The Shrewsbury and Telford Hospital NHS Trust were not yet in place. Reviewers were given several examples of problems which emerged following admission to Morris Care beds which could have led to improved patient care if they had been reported to Shrewsbury and Telford Hospital NHS Trust.

Further Consideration

1 Reviewers were told that 60% of residents go home with no support. Reviewers considered this a high proportion and wondered whether some could have gone straight home with support. Reviewers were also told of some inappropriate referrals to the service.

2 Some floor areas had tape on the floor and reviewers suggested that this should be removed and, if necessary, floor covering replaced.

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COMMISSIONING

NHS Shropshire and NHS Telford & Wrekin Clinical Commissioning Groups

Many commissioning-related issues are described in the health and social care economy section of this report. Additional points specifically related to commissioning were:

Further Consideration

1 Commissioning staff did not appear to appreciate the difficulty for clinical staff in Shrewsbury and Telford Hospital of having different pathways for Telford and Wrekin and for Shropshire. Reviewers suggested that commissioning staff may wish to spend some time with clinical staff in the Trust in order more fully to appreciate the operational difficulty and time implications of their commissioning decisions.

2 Reviewers considered there may be potential to use the Care Coordination Centre for managing intermediate care capacity (bedded and home-based) and for signposting professionals to most appropriate services.

Other sections of this report identify issues which require commissioner attention:

1 System-wide Planning and Coordination: See Health and Social Care Economy, Concern 1

2 Pathways of Care: See Health and Social Care Economy, Concern 2

3 Availability of Social Care Assessments in The Shrewsbury and Telford Hospital NHS Trust: See Health and Social Care Economy, Concern 3

4 Pharmacy Services: See Health and Social Care Economy, Concern 4

5 Transport: See Health and Social Care Economy, Concern 5

6 Patients from Powys: See Health and Social Care Economy, Concern 6

7 Process from arrival to triage: Emergency Department, Princess Royal Hospital, Telford: See Acute Trust – The Shrewsbury & Telford Hospital NHS Trust, Immediate Risk 1

8 Information on patients discharged: Both sites: See Acute Trust – The Shrewsbury & Telford Hospital NHS Trust, Immediate Risk 2

9 Transfer of Care Process: See Acute Trust – The Shrewsbury & Telford Hospital NHS Trust, Concern 1

10 Admission Pathway: Royal Shrewsbury Hospital: See Acute Trust – The Shrewsbury & Telford Hospital NHS Trust, Concern 2

11 Weekend working: See Acute Trust – The Shrewsbury & Telford Hospital NHS Trust, Concern 3

12 Maintaining competences: See Acute Trust – The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Trust, Concern 1

13 Palliative care support: See Acute Trust – The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Trust, Concern 2

14 Supply of wheelchairs: See Acute Trust – The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Trust, Concern 2

15 Weekend availability: See Intermediate Care, Shropshire ICS, Concern 1

16 Criteria for acceptance of patients: See Intermediate Care, Shropshire ICS, Concern 2

17 Criteria for admission: See Intermediate Care, Shropshire, Community Hospitals, Concern 1

18 Active discharge: planning See Intermediate Care, Shropshire, Community Hospitals, Concern 2

19 Competences: See Intermediate Care, Shropshire, Community Hospitals, Concern 3

20 Case notes: See Intermediate Care, Shropshire, Community Hospitals, Concern 4

21 Incident feedback: See Intermediate Care, Telford and Wrekin, Intermediate Care Beds, Concern 1

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APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Visiting Team

Joan Buck	User Representative	Staffordshire Link
Ann Carey	Divisional Director of Nursing - Medicine	Worcestershire Acute Hospitals NHS Trust
Liz Colley	Community Matron	Coventry & Warwickshire Partnership NHS Trust
Lisa Duncan	Lead for Social Care	Staffordshire & Stoke on Trent Partnership NHS Trust
Nick Flint	User Representative	
Amanda Futers	Clinical Nurse Specialist Older Adults	University Hospital of North Midlands NHS Trust
Tina Gallagher	Strategic Commissioning Analytics Lead	Central Midlands CSU
Cheryl Gilbert	Head of Nursing	Walsall Healthcare NHS Trust
Carol Herbert	Clinical Quality Assurance Programme Manager	Birmingham Community Healthcare NHS Trust
Janette Knight	Pharmacy Governance Manager	University Hospitals Coventry & Warwickshire NHS Trust
Sue Nicholls	Chief Nurse	NHS Solihull CCG
Carole Roberson	Professional Practice Facilitator for District Nursing/District Nurse Team Leader	Worcestershire Health & Care NHS Trust
Dr Narinder Sahota	Assistant Medical Director	NHS England Birmingham, Solihull and the Black Country
Sophie Snape	Occupational Therapist	Staffordshire & Stoke on Trent Partnership NHS Trust
Tom Taylor	Capacity Operations Manager, Operations	Worcestershire Acute Hospitals NHS Trust
Judith Whalley	Patient Representative	

WMQRS Team

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

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APPENDIX 2 COMPLIANCE WITH THE QUALITY STANDARDS

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

Table 1 - Percentage of Quality Standards met

Service	Number of Applicable QS	Number of QS Met	% met
Transfer from Acute Hospital Care and Intermediate Care			
Primary Care	**4**	**0**	**0**
Shropshire	(2)	(0)	(0)
Telford and Wrekin	(2)	(0)	(0)
Acute Trust	**46**	**19**	**41**
The Shrewsbury & Telford Hospital NHS Trust	(23)	(9)	39
The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	(23)	(10)	(43)
Intermediate Care Service – Shropshire Community Health Care NHS Trust	**99**	**48**	**48**
Shropshire Community Health Care NHS Trust - Integrated Community Services	(33)	(16)	(48)
Shropshire Community Health Care NHS Trust - Community Hospitals	(33)	(16)	(48)
Telford & Wrekin - Morris Care & Enablement Team	(33)	(16)	(48)
Commissioning	**8**	**4**	**50**
NHS Shropshire CCG & Local Authority	(4)	(2)	(50)
Telford & Wrekin CCG and Local Authority	(4)	(2)	(50)
Health and Social Care Economy	**157**	**71**	**45**

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

		Shropshire		Telford and Wrekin	
Ref	**Standard**	**Met? Y/N**	**Reviewer Comments**	**Met? Y/N**	**Reviewer Comments**
SA-101	**Patients at High Risk of Admission** Patients at high risk of admission to an acute hospital should have a 'Patient Passport' or equivalent patient-held record that covers: a. Diagnoses b. Allergies c. Medication d. Care package (or equivalent) e. Name and contact details of GP f. Name and contact details of main carer/s g. Advice for the patient and their carers on likely problems and what to do in an emergency h. Advice to emergency services on likely problems and recommendations for their management i. Advice for acute hospital services on the most appropriate ward (if admission is required)	N	Patient Passports as outlined in the Quality Standards were not in place for patients at high risk of admission in Shropshire	N	Patient Passports as outlined in the Quality Standards were not in place for patients at high risk of admission in Telford and Wrekin
SA-601	**Summary Medical Record** A summary of the patient's medical record including diagnoses, allergies, medication and agencies involved in their care should be sent with each patient referred to intermediate care or to an acute hospital for assessment or admission.	N	Summary records were not available for all patients referred to intermediate care.	N	Summary records were not available for all patients referred to intermediate care.

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ACUTE TRUST – ALL WARDS

		The Shrewsbury & Telford Hospital NHS Trust		The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	
Ref	**Standard**	**Met? Y/N**	**Reviewer Comments**	**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		Y	Information was included in the 'welcome pack'. A booklet specifically covering information about discharge was in the process of being developed.
SM-102	**Information about Leaving Hospital** Each ward should clearly display information for patients, carers and staff about arrangements for transfer of care on leaving the hospital, covering at least: a. The process of transfer of care b. Additional support available in the patient's usual place of residence c. Intermediate care options, criteria for accessing these and time limits on their provision (if applicable) d. How to access a discussion with medical and/or nursing staff about the patient's condition and plans for care on leaving hospital	Y	The 'Planning for discharge from Hospital' leaflet was comprehensive.	N	Information covering the Intermediate care service for patient sand carers was not in place. Information on other community services was available. The other aspects of the Quality Standard were covered in either the welcome pack or patient leaflets.
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	Ward booklets included how to arrange a discussion and the Discharge Liaison team also had contact cards.	Y	

		The Shrewsbury & Telford Hospital NHS Trust		The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	
Ref	**Standard**	**Met? Y/N**	**Reviewer Comments**	**Met? Y/N**	**Reviewer Comments**
SM-104	**Patients at High Risk of Re-Admission** Patients at high risk of re-admission should have their 'Patient Passport' or equivalent patient-held record (QS SA-101) updated during the course of their admission.	N	Passports were in use in the acute Trust for those with Dementia and Learning Difficulties but these did not always follow the patient to other care providers. Patient Passports were not in place across the health economy for other patients at high risk of admission.	N	'This is me' patient records were in use but not patient passports.

		The Shrewsbury & Telford Hospital NHS Trust		The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	
Ref	**Standard**	**Met? Y/N**	**Reviewer Comments**	**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 and carers were involved in discussion but not routinely given a written summary of their Transfer of Care Plan. A nursing discharge checklist and transfer of care forms were completed for hand over to other care settings. The documentation did not identify the arrangements for review.	Y	

		The Shrewsbury & Telford Hospital NHS Trust		The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	
Ref	**Standard**	**Met? Y/N**	**Reviewer Comments**	**Met? Y/N**	**Reviewer Comments**
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		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		Y	

		The Shrewsbury & Telford Hospital NHS Trust		The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	
Ref	**Standard**	**Met? Y/N**	**Reviewer Comments**	**Met? Y/N**	**Reviewer Comments**
SM-201	**Multi-Disciplinary Teams** A multi-disciplinary team to coordinate discharge planning should be available on each ward including: a. Staff with occupational therapy and physiotherapy competences with time allocated daily (7/7) for discharge planning, essential pre-discharge assessments and active pre-discharge rehabilitation b. Senior decision-maker review of patients' fitness for discharge at least daily (7/7) c. Nurse with competences in 'event-led' discharge from 9am to 8pm daily (7/7) d. Someone identified to coordinate discharge planning and preparation for discharge from 9am to 8pm daily (7/7) e. Access to social services staff available to undertake social care assessment within 24 hours of request f. Access to pharmacy services and medication 'To Take Out' available within four hours of request	N	Multi-disciplinary team coordination of discharge was not yet in place in all areas. Some wards had implemented 'Board Rounds'. Access to social services staff available to undertake social care assessment within 24 hours of request was not always possible. Nurse 'event led' discharge was not yet in place. Access to TTO's (medication 'To Take Out') within four hours of request was not audited.	N	Therapy services and access to social workers were only available five days a week. Nurse 'event led' discharge was not yet in place. Medical Staff were only available to review patients' fitness for discharge Monday to Fridays. Medical Staff were available on call at other times.
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 in place, therefore multiple assessments were undertaken. The discharge to assess team were 'Trusted Assessors' but were not available at weekends	N	The use of 'Trusted Assessors' across the whole health economy was not in place, therefore multiple assessments were undertaken.

		The Shrewsbury & Telford Hospital NHS Trust		The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	
Ref	**Standard**	**Met? Y/N**	**Reviewer Comments**	**Met? Y/N**	**Reviewer Comments**
SM-203	**Training in Transfer of Care from the Acute Hospital** All staff, including junior medical staff, should have training in the hospital transfer of care pathway (QS SM-597), local intermediate care services (QS SM-602) and local enabling agreements (QS SZ-602).	N	Not all staff had training in the hospital transfer of care pathway. Some training had been provided to ED medical staff, locums and student nurses.	N	Not all staff had training in the hospital transfer of care pathway. Some training had been provided to junior medical staff, registered nurses, social worker and therapy staff.

		The Shrewsbury & Telford Hospital NHS Trust		The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	
Ref	**Standard**	**Met? Y/N**	**Reviewer Comments**	**Met? Y/N**	**Reviewer Comments**
SM-301	**Support Services** Access to the following support services should be available daily (7/7): a. Appropriate staff to undertake a home assessment within 24 hours of request b. Patient transport able to respond within four hours of request c. 'Simple' equipment available within four hours of request d. Supply of sufficient dressings and continence aids for 72 hours available within four hours of request e. All equipment, including beds and hoists, available within 24 hours of request f. 'Simple' adaptations available within 24 hours of request g. Voluntary sector 'settling home' support able to respond by the end of the next working day and continue for up to five days h. 'Simple' assistive technology available within 24 hours of request i. Medicines reconciliation (7/7)	N	Home assessments were not always available within 24hrs of request and there was no 7/7 service. Reviewers were told that there were delays in the provision of patient transport within four hours of request - see also main report. Access to simple equipment within four hours of request was not possible for those living in Powys. 'f' , 'h' and were not available 7/7. A pilot project whereby Occupational Therapists and Physiotherapists volunteered to work over the weekend to support discharges for any patient across Royal Shrewsbury Hospital and Princess Royal Hospital had shown positive results. A business case for substantive funding for weekend working was in the process of being developed.	N	Home assessments were only available 5/7. Patient transport was not always possible within four hours of request. Simple adaptations and assistive technology were not always possible within 24 hours of request.

		The Shrewsbury & Telford Hospital NHS Trust		The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	
Ref	Standard	Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
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	A protocol covering access to local intermediate care services was not in place. Referral documentation was available about some services that were available.	N	Short term domiciliary care was not always available for more than two visits per day. Short term care was available from ICS with night visits for the first three days following discharge if required.
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 operation.	N	Multiple systems were in use across the different providers.
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	Ward and Consultant handovers were via the transfer of care form and recorded in the patients' notes. Problems with handing over the care and social components meant that nursing staff were in-reaching to other areas to assess appropriateness of patients before transfer.	Y	

		The Shrewsbury & Telford Hospital NHS Trust		The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	
Ref	**Standard**	**Met? Y/N**	**Reviewer Comments**	**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	Guidelines were in the process of being updated. The 2011 version did not cover the requirements of the Quality Standard. The draft guidelines did not cover g) v or g) v. The draft policy also mentioned discharge information though at the time of the visit patients were not given a full discharge summary only a medication list. The 'A3 form' transfer letter was attached to the notes for patients being transferred to community hospitals but not given to patients or for those going home.	N	Guidelines were not in place covering all the aspects of the Quality Standard. In practice expected dates of discharge were usually agreed within 48 hours, Transfers of care plans were not in use for those providing after hospital care, though GPs did get a copy of the discharge summary. Information on discharge did not include how to access funding decisions on specialist care not normally available in the local area (h). Contingency plan when capacity in intermediate care services was not available (l).

		The Shrewsbury & Telford Hospital NHS Trust		The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	
Ref	**Standard**	**Met? Y/N**	**Reviewer Comments**	**Met? Y/N**	**Reviewer Comments**
SM-597	**More Complex Transfers of Care** Guidelines should be in use covering: a. Transfer of care to other local authority or Clinical Commissioning Group areas covering at least social care assessments, intermediate care services available, patient transport and equipment supply or loan b. Transfer to a care home for long-term care c. NHS continuing care assessments and place-finding d. Liaison with palliative and end of life care services e. Patients and/or carers who do not agree a Transfer of Care Plan or who unreasonably delay their transfer of care	Y	Guidelines covering more complex transfers of care were in place.	Y	
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	Arrangements on the wards did not include identifying agencies and notifying them of admission. Wards were not aware of local enabling agreements.	N	Arrangements on the wards did not include rapid access to investigations and consultant clinics for patients following discharge 7/7. Staff were aware of some local enabling agreements. Patient passports were not in place across the health economy.

		The Shrewsbury & Telford Hospital NHS Trust		The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	
Ref	**Standard**	**Met? Y/N**	**Reviewer Comments**	**Met? Y/N**	**Reviewer Comments**
SM-602	**Intermediate Care** A protocol on access to local intermediate care services should be in use on each ward covering at least: a. Criteria for acceptance by each local intermediate care service and time limit for provision of the service (if applicable) b. Type of care, rehabilitation and re-ablement provided and, in particular, whether the service is able to support: i. 24/7 on-site care (community hospital or care home) ii. Overnight care (night-visiting or night sitting) iii. Intravenous therapy iv. PEG feeds v. Care for dementia or significant cognitive impairment vi. VAC therapy and other complex wound care c. 'Trusted Assessor' (QS SM-202) or other arrangements for agreement of patient suitability d. Arrangements for handover of the patient's Transfer of Care Plan	N	A protocol covering access to local intermediate care services was not in place. Referral documentation was available about some services that were available	N	A protocol covering access to local intermediate care services was not seen on the ward covering all the aspects of the Quality Standard.
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.	N	Data were collected on key quality and performance indicators, but not for 'b'.

		The Shrewsbury & Telford Hospital NHS Trust		The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	
Ref	**Standard**	**Met? Y/N**	**Reviewer Comments**	**Met? Y/N**	**Reviewer Comments**
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	Wards did not have a rolling programme of audit covering all aspects of the Quality Standard. Some data were collected on length of stay.	N	Monthly audits were undertaken on length of stay but not for other aspects of the Quality Standard.
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).	Y	A system-wide health and social care resilience group was in operation.	Y	A system-wide health and social care resilience group was in operation.
SM-798	**Multi-disciplinary Review and Learning** Each ward should have multi-disciplinary arrangements for the reviewing of, and implementation of learning from, positive feedback, complaints, outcomes, incidents and 'near misses' relating to transfer of care from the acute hospital.	N	Multi-disciplinary review and learning on each ward as defined by the Quality Standard was not yet in place. Uni-disciplinary and ward team meetings were held.	Y	Wards undertook 'safety huddles'.
SM-799	**Document Control** All policies, procedures and guidelines should comply with Trust (or equivalent) document control procedures.	N	Not all the information seen complies with Trust document control.	Y	

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INTERMEDIATE CARE SERVICE - SHROPSHIRE COMMUNITY HEALTH NHS TRUST

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

Ref	Standard	Integrated Community Services (ICS)		Community Hospitals	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
SN-101	**Service Information** Each service should offer patients and their carers written information covering: a. Organisation of the service b. Care and therapeutic interventions offered by the service c. If beds: routines, visiting times and how to get refreshments d. Staff and facilities available e. How to contact the service for help and advice, including out of hours f. Who to contact with concerns about the service g. 'After intermediate care', including information about the length of time for which the service will be provided and the options for, and process of transfer to, longer-term care (if required) h. Sources of further advice and information	Y	Information in the service leaflet was complicated and may benefit from review to ensure that the messages are clearly documented, particularly about the responsibilities of the assessors for those requiring long term care. Reviewers considered that involvement of users and carers in the development of future revisions may help develop information that is more user friendly.	Y	The rehabilitation service information was comprehensive. It also included directions to the hospitals but it was not clear if this information was accessible to patients and carers prior to admission. Reviewers were also told of the work of the Dementia Working Group. It may be helpful to include carer representatives in the work of this group.

Ref	Standard	Integrated Community Services (ICS)		Community Hospitals	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
SN-103	**Care Plan** Each patient and, where appropriate, their carer and appropriate members of the multi-disciplinary team should discuss and agree their Care Plan and should have easy access to a written record covering at least: a. Agreed goals, including life-style goals b. Self-management c. Medication d. Planned care and therapeutic interventions e. Early warning signs of problems, including acute exacerbations, and what to do if these occur f. Expected date of discharge from the service g. Name of care coordinator h. Name of doctor taking medical responsibility for their care i. Who to contact with queries or for advice j. Planned review date and how to access a review more quickly, if necessary	N	The care plan available to reviewers was from 2012 and did not include therapeutic goals. The Multi-disciplinary Team sheet did not have a regulated continuation sheet and the documentation seen included first names so it was not clear who the named coordinator was. ICS teams appeared to have different care planning documentation in use.	N	Care plans did not include ‘e’. Goals were not easily accessible for patient and carers. At Whitchurch and Bishops Castle the nursing, physiotherapy and the GP’s notes were stored separately. Nursing notes included skin bundle and observations. Item ‘j’ was not documented but in practice all patients were reviewed at the weekly Multi-disciplinary Team meeting. Reviewers were told that the 'about me' patient documentation was not transferred between services.

Ref	Standard	Integrated Community Services (ICS)		Community Hospitals	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
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	Outcomes were not recorded in the weekly meeting sheets. Documentation of the Multi-disciplinary Team review and goal planning was included. It was not clear form the documentation how the outcome was recorded in the care plan and shared with the patient.	N	Whitchurch: From the records seen the process did not appear to be robust. Multiple records were held; the nursing file with observation and assessment documentation, GP and therapy records that were kept at the nurses' station and clinical notes. A Multi-disciplinary Team file was updated on a weekly basis, so was not up to date as some patients had been discharged and other in-patients were not logged since the last meeting. This Quality Standard was met for the other community hospitals.
SN-105	**Contact for Queries and Advice** Each patient and, where appropriate, their carer should have a contact point within the service for queries and advice. If advice and support is not immediately available then the timescales for a response should be clear, and advice on what to do in an emergency should be given. Response times should be no longer than the end of the next day.	Y		Y	
SN-106	**Care Coordinator** Each patient should have a nominated individual responsible for planning and coordinating their care, including planning their longer-term care.	Y		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	

Ref	Standard	Integrated Community Services (ICS)		Community Hospitals	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
SN-108	**Patients at High Risk of Re-Admission** Patients at high risk of re-admission should have their 'Patient Passport' or equivalent patient-held record (QS SA-101) updated during the course of their intermediate care.	N	Patient passports were not in place across the health economy. The ICS team did liaise with the community matrons for those who had several admissions.	N	Patient passports were not in place across the health economy.

Ref	Standard	Integrated Community Services (ICS)		Community Hospitals	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
SN-196	**'After Intermediate Care' Plan** Patients and, when appropriate, their carers should be involved in discussing and agreeing the plan for their care after leaving the intermediate care service, and should be given a written summary of their 'After Intermediate Care' Plan, which should include: a. Expected date of discharge from the intermediate care service b. Care after leaving intermediate care, including self-care c. Medication d. Who is taking medical responsibility for care after leaving intermediate care e. Further investigations, treatment, rehabilitation and re-ablement to be carried out after leaving intermediate care, and who will arrange these, including separately identifying any of these which the GP is expected to arrange f. Possible complications and what to do if these occur, including in an emergency g. Transport (if required) h. Equipment supply or loan i. Dressings and continence aids j. Who to contact with queries or for advice k. Date by which their care should be reviewed, who is expected to undertake this review and how to access a review more quickly if required This 'After Intermediate Care' Plan should be copied to the patient's GP and to all services involved in providing ongoing care.	N	'After intermediate care plans' were not yet in use.	Y	A single referral form was in use which was sent with the patient when discharged.

Ref	Standard	Integrated Community Services (ICS)		Community Hospitals	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
SN-197	**General Support for Patients and Carers** Patients and carers should have easy access to the following services, and information about these services should be easily available: a. Interpreter services, including British Sign Language b. Independent advocacy services c. Complaints procedures d. Social workers e. Benefits advice f. Spiritual support g. *HealthWatch* or equivalent organisation h. Relevant voluntary organisations providing support and advice	N	The team who met the reviewing team were not clear about who provided independent advocacy.	Y	How to access benefits advice could be clearer.
SN-198	**Carers' Needs** Carers should be offered information on: a. How to access an assessment of their own needs b. Benefits available, including carers' allowance (if applicable), and how to access advice on these c. Services available to provide support	Y		Y	
SN-199	**Involving Patients and Carers** The service should have: a. Mechanisms for receiving regular feedback from patients and carers about the treatment and care they receive b. Examples of changes made as a result of the feedback and involvement of patients and carers	Y		Y	

Ref	Standard	Integrated Community Services (ICS)		Community Hospitals	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
SN-201	**Lead Clinician and Lead Manager** A nominated lead clinician and a lead manager should be responsible for the effective delivery of the service, including staffing, training, guidelines and protocols, service organisation, governance and liaison with other services. The lead clinician should be a registered healthcare professional with appropriate specialist competences in this role and should undertake regular clinical work within the service.	Y		Y	
SN-202	**Staffing Levels and Skill Mix** Sufficient health and care staff with appropriate competences should be available for: a. The number of patients usually cared for by the service and the usual case mix of patients b. The service's role in the patient pathway and expected timescales c. The assessments, care and therapeutic interventions offered by the service Staffing should include: i. At least two registered healthcare professionals at all times the service is operational ii. A registered nurse available 24/7 in bedded units and daily (7/7) in other services iii. Appropriate therapists for the needs of the patients daily (7/7) iv. Access to social services staff available to undertake social care assessments within 24 hours of request v. Medical staff (QS SN-205) Cover for absences should be available so that the patient pathway is not unreasonably delayed, and patient outcomes and experience are not adversely affected, when individual members of staff are away.	N	The service was staffed to 60% at the time of the visit with a plan increase staffing establishment to 94% by the end of June. This affected the team being able to run to full capacity. Care managers were on call till 10pm Monday to Friday. Social care were not always able to undertake social care assessments within 24hrs of request as they were only available 9am - 6pm Monday to Friday. START (Short Term Assessment & Re-ablement Team) were able to provide some cover on a Saturday.	N	Therapist were not available 7/7 and social care assessments were not possible within 24hrs of request. There were only two staff on nights at Bishops Castle which meant that there was no cover if one member of staff needed to leave. The trained nurse staff levels followed the Royal College of Nursing guidelines on acute hospitals.

Ref	Standard	Integrated Community Services (ICS)		Community Hospitals	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
SN-203	**Service Competences and Training Plan** The competences expected for each role in the service should be identified. A training and development plan for achieving and maintaining competences should be in place. If provided by the service, the competence framework should cover: a. Intravenous therapy b. PEG feeds c. Care for patients with dementia or significant cognitive impairment d. VAC therapy and other complex wound care	N	A training and competence plan was not yet in place. Identification of competencies by band was in the process of being developed and would inform training including a, b, c, d. Training programmes and Clinical Practice Tutors for a,b,c,d, are available and were utilised in line with staff appraisals or identified development need. The VAC (vacuum assisted closure) policy was out of date and relied on nurse gaining training from other link nurses and competences managed through appraisals.	N	A training and competence plan was not yet in place. Identification of competencies by band was in the process of being developed and would inform training including a, b, c, d. Training programmes and Clinical Practice Tutors for a, b, c, d, are available and were utilised in line with staff appraisals or identified development need. The rehabilitation and Occupational Therapy technician competences were in place as well as work on the skill mix of therapists. Reviewers considered that during the workforce review, consideration of a higher band who could work more autonomously may be helpful.

Ref	Standard	Integrated Community Services (ICS)		Community Hospitals	
		Met? Y/N	Reviewer Comments	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		Y	.
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	ICS worked alongside the patient's GP who provided the required medical interventions, but the GP was not always available within two hours where hospital admission could be avoided. Out of Hours cover was provided by ShropDoc.	N	Medical review did not occur seven days a week.
SN-299	**Administrative, Clerical and Data Collection Support** Administrative, clerical and data collection support should be available.	Y		Y	

Ref	Standard	Integrated Community Services (ICS)		Community Hospitals	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
SN-301	**Clinical Support Services** Timely access to an appropriate range of clinical support services should be available, including: a. Imaging b. Pathology, including microbiology c. Pharmacy, including medication supply and medicines management advice d. Appropriate staff to undertake a home assessment within 24 hours of request e. Infection control (7/7 and on call 24/7) f. Tissue viability (7/7) g. Falls prevention (next working day) h. Continence service (7/7) i. Mental health team (crisis response within four hours) j. Counselling	N	Access to imaging was via the GP. The Tissue Viability Continence service were not available 7/7.	N	X-ray imaging was only available on weekday mornings at Whitchurch and not available at Bishops Castle. Patients would need to be transported for imaging at other times. TTOs (medication to 'take out') were not always easily available. Falls prevention and continence leads were based at the hospital. Access to the mental health team within four hours for those in crisis was not always achieved. Counselling was not easily accessible.

Ref	Standard	Integrated Community Services (ICS)		Community Hospitals	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
SN-302	**Support Services for Patients Returning Home** Access to the following support services for patients returning home should be available daily (7/7): a. Appropriate staff to undertake a home assessment within 24 hours of request b. Medication 'To Take Out' available within four hours of request c. Patient transport able to respond within four hours of request d. 'Simple' equipment available within four hours of request e. Supply of sufficient dressings and continence aids for 72 hours available within four hours of request f. All equipment, including beds and hoists, available within 24 hours of request g. 'Simple' adaptations available within 24 hours of request h. Additional health and social care support within four hours of request, comprising up to four visits per day for up to 72 hours after return home i. Voluntary sector 'settling home' support able to respond by the end of the next working day and continue for up to five days j. 'Simple' assistive technology available within 24 hours of request	Y	At weekends carers undertook environmental risk assessments. ICS would see referrals in the Emergency Department within one hour and then assess fully at 24hrs.	N	'c' was not always possible . Reviewers were told that discharges were often delayed due to transport not being available.

Ref	Standard	Integrated Community Services (ICS)		Community Hospitals	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
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	ICS also held simple equipment e.g. key safes.	N	Some equipment such as low beds were not accessible. At Whitchurch, patients were not keen to use the dining room because it was not patient friendly or attractive. The two-bedded and four-bedded bays were cramped. The facilities a Ludlow were very good. See also good practice section of the main report.
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, social care staff used different systems that not all health staff could not access. Staff had to use several mobile phones due to the prohibitive cost of making calls via their 'smart phones'.	N	Multiple systems were in use. Not all GPs could access patient summaries.
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	Patients were assessed in the Acute Hospitals prior to being discharged and then fully assessed within 24hrs at home.	Y	

Ref	Standard	Integrated Community Services (ICS)		Community Hospitals	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
SN-502	**Clinical Guidelines** Guidelines on management of the usual case mix of patients referred to the service should be in use covering at least: a. Pain b. Depression c. Skin integrity d. Falls and mobility e. Continence f. Delirium and dementia g. Nutrition and hydration h. Sensory loss i. Medicines management j. Catheter care k. Spasticity management l. Care of patients with diabetes, COPD, heart failure and other long-term conditions m. Activities of daily living n. Health promotion, including smoking cessation, healthy eating, weight management, exercise, alcohol use, sexual and reproductive health, and mental and emotional health and well-being	N	Guidelines were not in place for spasticity, Chronic Obstructive Pulmonary Disease or Depression and sensory loss.	N	Guidelines were not yet in place covering 'b' 'k' or 'n'. Guidelines were in place for Heart Failure and Chronic Obstructive Pulmonary Disease, but not for other long -term conditions.

Ref	Standard	Integrated Community Services (ICS)		Community Hospitals	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
SN-597	**Transfer of Care Guidelines** Transfer of care guidelines for both simple and complex discharge pathways should be in use covering at least: a. Ensuring each patient has an expected date of discharge from the service b. Planning transfers of care from intermediate care including: i. Discussion with patients and carers about the 'After Intermediate Care' Plan ii. Availability for patient and carer queries iii. Multi-disciplinary review for complex or uncertain discharges iv. Single assessment process v. Transport options including patient transport service, relatives, taxis or care home transport vi. 'After Intermediate Care' Plan (QS SN-196) c. Agreement of 'After Intermediate Care' Plan and handover to services providing long-term care (if required) d. Informing the GP, the person taking medical responsibility for the patient and any other relevant services that the patient has left intermediate care, ideally within four hours of transfer of care	N	Guidelines and documentation covered all but 'vi, c' and 'd'.	N	Guidelines and documentation covered all but 'vi, c' and 'd'. Reviewers were told that in practice information from the acute hospitals was often incomplete.

Ref	Standard	Integrated Community Services (ICS)		Community Hospitals	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
SN-598	**More Complex Transfers of Care** Guidelines should be in use covering: a. Transfer of care to other local authority or Clinical Commissioning Group areas covering at least social care assessments, intermediate care services available, patient transport and equipment supply or loan b. Transfer to a care home for long-term care c. NHS continuing care assessments and place-finding d. Liaison with palliative and end of life care services e. Patients and/or carers who do not agree an 'After Intermediate Care' Plan or who unreasonably delay their transfer of care	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		Y	

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

Ref	Standard	Integrated Community Services (ICS)		Community Hospitals	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
SN-701	**Data Collection** Regular collection and monitoring of data should be in place, including: a. Referrals to the service, including source and appropriateness of referrals b. Number of assessments and therapeutic interventions undertaken by the service c. Outcome of assessments and therapeutic interventions d. Length of care by the service e. Proportion of patients achieving their expected date of discharge from the service f. Number and destination of transfer of care from the service g. Key quality and performance indicators	N	Data were not yet collected for 'c' or 'e'. Data were collected on whether ongoing support was required following discharge from ICS and all other aspects of the Quality Standard.	N	Data were not yet collected for 'c' or 'e'.
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	Evidence on audit as defined by the Quality Standard was not available.	N	Evidence on audit as defined by the Quality Standard was not available.
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	Integrated Community Services (ICS)		Community Hospitals	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
SN-797	**Health and Social Care Review and Learning** The service should have a mechanism for influencing and receiving feedback from the local Health and Social Care Review and Learning Group on transfer of care from acute hospitals and intermediate care (QS SZ-798).	N	There was no formal group that met to discuss, review and share learning from discharge planning regularly that frontline staff were able to attend. There were some shared learning events and information via newsletters. Reviewers were told that a system-wide health and social care resilience group was in operation.	N	There was no formal group that met to discuss, review and share learning from discharge planning regularly that frontline staff were able to attend. There were some shared learning events and information via newsletters. Reviewers were told that a system-wide health and social care resilience group was in operation.
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 within the ICS as defined by the Quality Standard was not yet in place.	N	Multi-disciplinary review and learning on each ward as defined by the Quality Standard was not yet in place. Ward team meetings were held.
SN-799	**Document Control** All policies, procedures and guidelines should comply with Trust (or equivalent) document control procedures.	Y		Y	

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INTERMEDIATE CARE SERVICE – TELFORD & WREKIN

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

Ref	Standard	Morris Care and Enablement Team	
		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	A range of information was available about the enablement services.
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	A range of documentation was seen covering 'a, b, c, f, g'. It was not clear if patients did have easy access to a written record covering all the aspects of the Quality Standard. The Enablement Team contact and enablement assessment forms did not appear to cover 'h' or 'j'. The 'About Me' documentation was used by the Accord Group (Cartlidge House).

Ref	Standard	Morris Care and Enablement Team	
		Met? Y/N	Reviewer Comments
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	Care plans were reviewed by the whole Multi-disciplinary Team on a weekly basis and a local GP undertook weekly 'bed rounds'.
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	
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	
SN-107	**Communication Aids** Communication aids should be available to enable patients with communication difficulties to participate in decisions about their care.	Y	
SN-108	**Patients at High Risk of Re-Admission** Patients at high risk of re-admission should have their 'Patient Passport' or equivalent patient-held record (QS SA-101) updated during the course of their intermediate care.	N	Patient passports were not in place across the health economy.

Ref	Standard	Morris Care and Enablement Team	
		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	Some assessments were completed prior to discharge and an ongoing support plan was in place. The information did not cover 'd' or 'e'.

Ref	Standard	Morris Care and Enablement Team	
		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	N	Some feedback was collated via the national patient survey but not specifically relating to the intermediate care service.
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	Morris Care and Enablement Team	
		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.	Y	
SN-203	**Service Competences and Training Plan** The competences expected for each role in the service should be identified. A training and development plan for achieving and maintaining competences should be in place. If provided by the service, the competence framework should cover: a. Intravenous therapy b. PEG feeds c. Care for patients with dementia or significant cognitive impairment d. VAC therapy and other complex wound care	N	A national capabilities framework was in place for social workers and other staff accessed the Shropshire Community mandatory training. It was not clear from the evidence provided if training for 'c' was in place. 'a', 'b' and 'd' were not applicable to the service.

Ref	Standard	Morris Care and Enablement Team	
		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	Evidence was seen for Telford and Wrekin Council and Shropshire Community employees.
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	The enablement service worked alongside the patient's GP who provided the required medical interventions but the GP was not always available within two hours (c). Medical cover for the Intermediate Care facility was via a local GP practice who could provide some emergency visits but not always available within 2hrs to avoid medical admission. Out of Hours cover was provided by ShropDoc.
SN-299	**Administrative, Clerical and Data Collection Support** Administrative, clerical and data collection support should be available.	Y	

Ref	Standard	Morris Care and Enablement Team	
		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	Tissue viability, falls prevention and continence services were not available 7/7. Counselling was not easily accessible. Access to the mental health team within four hours for those in crisis was not always possible. Imaging and pathology was accessible via the GP X-ray unit or Acute Trust.
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	

Ref	Standard	Morris Care and Enablement Team	
		Met? Y/N	Reviewer Comments
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	Kitchen and washing facilities were available for use in assessments.
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 systems were in use across the different providers. Morris Care used Carefirst.
SN-501	**Initial Assessment Guidelines** Guidelines on initial assessment should be in use that ensure that an initial assessment is undertaken within 30 minutes of transfer to the intermediate care service, or within four hours if intermediate care is provided in the home, covering at least: a. Assessment of pressure ulcers, nutrition, hydration and cognition b. Initial review of the Transfer of Care Plan to ensure its appropriateness for the intermediate care service	Y	Initial assessments were undertaken for those admitted to the care homes and at home.

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

Ref	Standard	Morris Care and Enablement Team	
		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	The Transfer of Care policy incorporated the use of the SBAR (Situation, Background Assessment, Recommendation) tool to aid communication and handover. The document covered the process for handover but did not include the specifics as required the by the Quality Standard.
SN-598	**More Complex Transfers of Care** Guidelines should be in use covering: a. Transfer of care to other local authority or Clinical Commissioning Group areas covering at least social care assessments, intermediate care services available, patient transport and equipment supply or loan b. Transfer to a care home for long-term care c. NHS continuing care assessments and place-finding d. Liaison with palliative and end of life care services e. Patients and/or carers who do not agree an 'After Intermediate Care' Plan or who unreasonably delay their transfer of care	N	Guidelines covering more complex transfers of care were not yet in place. A choice letter was in the process of being developed. Reviewers were told that transfer of care to long-term care provision followed the Adult Social Care policies.

Ref	Standard	Morris Care and Enablement Team	
		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	Shropshire Community guidelines were in place.

Ref	Standard	Morris Care and Enablement Team	
		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	No operational policies were place. The service level agreement was not specific about the arrangements in the Quality Standard. Initial assessments were undertaken in 30 minutes of the transfer but not always within four hours of returning home. The service was not able to start therapeutic interventions 7/7.

Ref	Standard	Morris Care and Enablement Team	
		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 seen for 'a', 'd' and 'f' but not for the other aspects.
SN-702	**Audit** The services should have a rolling programme of audit of: a. Achievement of expected timescales for the patient pathway b. Compliance with evidence-based clinical guidelines (QS SN-500s) c. Compliance with standards of record keeping	N	A rolling programme of audit covering compliance with evidence-based clinical guidelines was not in place. Record keeping audits were 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	Evidence was not available for compliance to be determined. Reviewers were told that meetings with commissioners did take place. Some information was included in the service specification.
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 that frontline staff were able to attend. Reviewers were told that a system-wide health and social care resilience group was in operation.

Ref	Standard	Morris Care and Enablement Team	
		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 within the Intermediate Care Teams as defined by the Quality Standard was not yet in place.
SN-799	**Document Control** All policies, procedures and guidelines should comply with Trust (or equivalent) document control procedures.	Y	

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COMMISSIONING

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

		NHS Shropshire CCG & Local Authority		Telford & Wrekin CCG and Local Authority	
Ref	Standard	Met? Y/N	Reviewer Comments	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	c' and 'e' were in place but not other agreements.	N	Local enabling agreements covering the requirements of the Quality Standard were not seen. Reviewers were told that 'c' was in place.
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	Compliance is based on self-assessment as data were not available at the time of the visit.	Y	Data collected on transfer of care from Acute hospitals was reported via the Urgent Care working group and Better Care fund management board. Performance monitoring meetings with Morris Care took place against the agreed service specification.
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.	Y	A system-wide health and social care resilience group was in operation.	Y	A system-wide health and social care resilience group was in operation.

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