WM QRS West Midlands Quality Review Service

NHS

Transfer from Acute Hospital Care and Intermediate Care

Sandwell & West Birmingham Health and Social Care Economy

Visit Date: 16th and 17th June 2015 Report Date: October 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 that took place on 16th and 17th June 2015. The purpose of the visit was to review compliance with the following West Midlands Quality Review Service (WMQRS) Quality Standards:

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

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

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

- Sandwell and West Birmingham Hospitals NHS Trust, with some services provided in partnership with Midland Heart and Sevacare
- Birmingham Community Healthcare NHS Trust
- NHS Sandwell and West Birmingham Clinical Commissioning Group (CCG)

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 Sandwell and Birmingham or jointly provided or commissioned services. Actions by commissioners and providers of social care maybe required in order to address the issues identified in this report.

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

ACKNOWLEDGEMENTS

West Midlands Quality Review Service would like to thank the staff and service users and carers of Sandwell and West Birmingham health and social care economy for their hard work in preparing for the review and for their kindness and helpfulness during the course of the visit. Thanks are also due to the visiting team and their employing organisations for the time and expertise they contributed to this review.

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TRANSFER FROM ACUTE HOSPITAL CARE AND INTERMEDIATE CARE

HEALTH AND SOCIAL CARE ECONOMY

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

Pathway	Provider	Quality Standards	Notes
Primary care	-	Primary care	Reviewers met with GPs during the visit.
Sandwell Hospital	Sandwell and West Birmingham Hospitals NHS Trust	Acute Trust: All wards	Reviewers reviewed Trust policies and guidelines on the Trust intranet, visited wards and met staff and patients.
City Hospital	Sandwell and West Birmingham Hospitals NHS Trust		Reviewers reviewed Trust policies and guidelines on the Trust intranet, visited wards and met staff and patients
Leasowes (18 intermediate care beds)	Sandwell and West Birmingham Hospitals NHS Trust	Intermediate Care	Reviewers visited the unit and met with staff and patients.
Rowley Regis Hospital Henderson Ward (24 beds) Macarthy Unit (20 beds) Eliza Tinsley Unit (Medically Fit for Discharge) (24 beds)	Sandwell and West Birmingham Hospitals NHS Trust (Macarthy Ward provided in partnership with Sandwell Metropolitan Borough Council (MBC) and Sevacare)		Reviewers visited the wards / unit, met with staff and talked to patients and carers. NB. Macarthy Unit opened February 2015 as a 12 week pilot.
City Hospital, Wards D43 (27 beds) and D47 (27 'Flexi-beds')	Sandwell and West Birmingham Hospitals NHS Trust in partnership with Midland Heart (D47)		Reviewers visited D43 and D47 as providers of Intermediate care beds.
Integrated Care Services (ICARES) (Sandwell) comprising: • Primary Care Assessment and Treatment Service (PCAT) • 'Own Bed Instead' (10 virtual beds) • Integrated Locality Teams	Sandwell and West Birmingham Hospitals NHS Trust	Intermediate care	Reviewers reviewed documentary evidence and met staff from this service.
Rapid Response Service and 'Own Bed Instead' (OBI)	Birmingham Community Health Care NHS Trust	Intermediate care	Reviewers met with OBI team members and the Case Manager of OBI and the Rapid Response Service. Reviewers did not see case notes. A 10 patient audit of case notes had been undertaken but results were not available to reviewers.
NHS Sandwell and West Birmingham CCG		Commissioning	Reviewers met CCG staff and reviewed evidence.

Other services:			
Other Intermediate care provision in care homes (Waterside, Ryland View, Allerton Court, Hall Green)		-	Reviewers were told about these services and the contribution they made to the pathway. Waterside provided a self-assessment for reviewers.
STAR (Sandwell) Social care re-ablement		-	Reviewers were told about this service and the contribution it made to the pathway.

With the exception of the intermediate care team, documentary evidence of compliance with Quality Standards was not provided for Sandwell and West Birmingham Hospitals NHS Trust services. Reviewers looked at policies and guidelines available on the Trust intranet and saw some documentation when they visited facilities. The number of Quality Standards met may, however, be under-represented as a result of the lack of documentary evidence made available to reviewers.

General Comments and Achievements

Reviewers met many staff who were passionate about providing good care for patients and visited some excellent facilities, especially community-based facilities. Some inspirational leaders were working hard to develop their service. Patient facilities seen by reviewers were all clean and calm with good use being made of the space available. An 'Urgent Care Challenge' week had taken place shortly before the review and staff were enthusiastic about the improvements that had been achieved during this week.

Overall, reviewers considered that good progress had been made on improving the pathway of transfer from acute hospital care and intermediate care and identified opportunities which could further improve the care provided.

Good Practice

1 Community-based beds used the same electronic bed system as acute beds. As a result, staff working in community-based services could identify patients who may be appropriate for their care and actively encourage and support their transfer from acute hospital care. All community-based beds, including those in care homes, were visible on the community hub capacity tool.

2 The speech and language therapy service provided 'outreach' swallowing assessments, including for residents of nursing homes or people in their own homes, with a 'same day' response.

3 'Fast-track' continuing NHS care funding decisions were available for Sandwell and West Birmingham CCG residents. 'Fast-track' decisions were available within 24 hours of the assessment. This system had speeded up the patient pathway and reduced the number of decision panels that were needed.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Pathways of Care**

A wide range of intermediate care services was available, especially in Sandwell. The criteria for acceptance by these services and the type of care provided were not clear. Staff, especially those working on acute wards, were not generally aware of the function of each of the intermediate care services. This situation was not helped by some services having multiple names and acronyms. Hall Green care home was particularly concerned about the type of patients referred to the facility. Hall Green was a 'low impact' rehabilitation unit and was only able to take patients with rehabilitation potential. The home was unable to manage complex patients as nursing staff were not available. Residents assessed as requiring nursing care were usually transferred to Ryland View Nursing Home.

2 **Delays in Patient Pathways**

Reviewers saw some examples of delays in the pathways of transfer from acute hospital care and intermediate care, in particular:

a. Some patients were waiting up for up to seven days for continuing NHS healthcare assessments. Reviewers were also told about long waits for assessments for Deprivation of Liberty Safeguards.

b. The Sandwell Bed Hub was available from 8am to 4pm daily. Mechanisms for arranging transfers of patients after 4pm were not clearly defined. All CCG-funded intermediate care beds were commissioned to admit patients 24/7. Reviewers were told by some staff that, because admissions had to go through the bed hub, some patients who could have been admitted to an intermediate care bed after 4pm were having to stay in an acute bed.

c. The expected timescale for assessments by nursing homes was within 24 hours of request. Achievement of this standard did not appear to be being monitored and reviewers were told of delays of up to seven days in nursing home assessments.

d. With the exception of some therapy assessments, patients were being re-assessed within each different service. 'Trusted assessors' were not yet in place and patients were experiencing multiple assessments and re-assessments, often using different processes and approaches. This was adding to length of stay in acute and intermediate care beds.

3 **Overview of Patient Pathway**

Patients appeared to be being moved between services and facilities several times without the length of their whole stay away from home being calculated or visible. Reviewers were given examples of patients moved up to four times within City Hospital and three times within Rowley Regis. Representatives of transport services also commented on the frequency of multiple moves for the same patient. Reviewers also saw some evidence of the Expected Date of Discharge being re-set when patients moved to a new facility, although the Trust was trying to prevent this happening. CQUINS were in place for 'out of hours' moves and for moves of patients with dementia but not for other admissions.

4 **Health and social care review and learning**

The health and social care economy did not yet have a system for review and learning from incidents, complaints and compliments relating to issues across the patient pathway. Reviewers were given several examples of problems which became apparent when patients were transferred to intermediate care beds to nursing homes or to their own home. Staff had completed incident forms but had not had any feedback because the cause of the problem was in a different service.

Further Consideration

1 Arrangements for care of patients needing intravenous antibiotics following transfer home may benefit from review. Reviewers were told by some staff that district nurses would only visit at home once a day and that patients on intravenous antibiotics had to come to clinic twice a day. Staff said that some patients therefore stayed in hospital who could have gone home if more home visits were available. Other staff said that, in Birmingham, district nurses could visit patients on intravenous antibiotics twice a day although there were sometimes delays due to limited capacity. Reviewers were also surprised by the reported frequent use of Ceftriaxone, especially given the risk of this drug causing Clostridium Difficile in people aged over 65 years.

2 Capacity management involved several different IT systems, with approximately 10 computer screens (for different systems) located in the capacity management room. These systems were supplemented by staff visiting all wards prior to the morning bed management meeting, and by a significant amount of paper and fax-based communication and handover. Capacity management processes appeared very labour intensive

and reviewers suggested there may be the potential for stream-lining processes. Safeguarding alerts had to be entered onto three different systems. Reviewers also commented that the information from the computer screens did not appear to be actively discussed during the capacity meeting and actions agreed at the meeting were not clearly identified (other than an agreement to meet again two hours later).

3 Reviewers suggested that simplified, more standardised criteria for acceptance by intermediate care services would help staff and patients to understand the services available and their function. Visual summaries of the pathways of care may help to inform staff, patients and carers.

4 Several 'hubs' were in place. In Sandwell the 'i-Cares Hub' coordinated teams of therapists and community matrons. The Sandwell i-bed Hub coordinated admissions for 'step up' and 'step down'. Referrals from the Emergency Departments and Acute Medical Units were prioritised. Staff attended board rounds on the acute wards whenever possible to facilitate transfers to intermediate care beds. Whenever possible, the team also offered an initial nurse assessment. The 'hub' acted as a single point of access and took calls and directed patients to the Primary Care Assessment and Treatment Centre or to the Acute Medical Triage and Assessment Service, as appropriate. In Birmingham the Urgent Care Bureau triaged referrals. Staff working within Sandwell and West Birmingham service did not appear to understand the different hubs and their functions and greater publicity about their role may be helpful.

5 At the time of the review 157 intermediate care beds were available within Sandwell but only 44 within the West Birmingham area (excluding the 10 'own bed instead' virtual beds in each area). Some of the Sandwell intermediate care beds could only be accessed by Sandwell residents as they were funded by Sandwell MBC. Other of the Sandwell-located services could be used by West Birmingham residents but were not conveniently located for them or their families. Availability of 'Enhanced Assessment' beds for Birmingham residents was mentioned after the review visit but this was not included in the background information and staff did not describe this capacity on the day of the review visit. The reason for the difference in need for intermediate care was not apparent and the capacity available in Sandwell was not being fully utilised at the time of the review, for example, Rowley Regis Hospital had empty beds on the wards visited by reviewers.

Facility	Location	Funding	Intermediate Care Beds
Rowley Regis Hospital: Eliza Tinsley Unit	Sandwell	S&WB CCG	24
Rowley Regis Hospital: Henderson Ward	Sandwell	S&WB CCG	24
Rowley Regis Hospital: Macarthy Unit	Sandwell	Sandwell MBC	20
Leasowes	Sandwell	S&WB CCG	18
Waterside	Sandwell	S&WB CCG	12
Ryland View	Sandwell	S&WB CCG	10
Ryland View	Sandwell	Sandwell MBC	18
Hall Green	Sandwell	Sandwell MBC	19
Allerton Court	Sandwell	Sandwell MBC	12
Total located in Sandwell			**157**
D43 City Hospital	West Birmingham	S&WB CCG	27
D47 City Hospital	West Birmingham	S&WB CCG	20
Total located in West Birmingham			**44**
TOTAL			**201**

6 An evaluation of three intermediate care pilot projects, the 'Flexi-Beds' on Ward D47 at City Hospital and the two 'Own Bed Instead' services had been undertaken by Birmingham University during April and May 2015. Several of the findings of this evaluation are similar to those of this review visit, in particular, the need for more robust admission criteria and greater involvement of service users and carers, the potential to reduce length of stay and improve occupancy levels, and the need to look across the whole patient pathway – rather than at stays within individual services.

7 A system-wide discharge policy was in the process of being produced in order reflect the range of services available. Reviewers suggested that the launch of the new policy could usefully be combined with a programme of staff awareness about the pathways of care and with improved information for staff, patients and families. As part of this work it may be helpful to review the name and acronym used for each service.

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Primary Care

No specific issues relating to primary care were identified.

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Acute Trust: Sandwell & West Birmingham Hospitals NHS Trust

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

General Comments and Achievements

Reviewers observed good acute hospital care at both Sandwell and City Hospitals. Patients appeared well cared for and wards were calm and uncluttered. Ward leadership was strong on all the wards visited with senior nurses managing their wards well; this was especially noticeable on Lyndon 3, 4 and D7 wards. Good input from therapy staff was evident on all wards. Ward staff were clearly highly motivated and keen to provide good care for their patients. Good use was made of checklists, especially on the Acute Medical Unit at Sandwell Hospital. A 'delirium pathway' was in use on Lyndon 4 ward at Sandwell Hospital. Implementation of this pathway had been led by the consultant who had trained all ward staff, including domestics. Band 3 'Progress Chasers' were present on each ward, in addition to ward clerks, and worked to ensure patient pathways moved as quickly as possible, including following up investigations and care package availability. Introduction of these staff had been shown to reduce length of stay. A plan was in place for 1:1 safeguarding training by the Safeguarding Lead for consultants who had not completed their mandatory training.

Good Practice

1 Board rounds were undertaken well on all wards visited with consistent, good multi-disciplinary input.

2 Lyndon 4 ward had a very good, colourful information board for patients and carers.

3 An excellent visual display of the patient pathway in the form of a map was in place on the Ambulatory Care Unit at Sandwell Hospital.

4 Equipment was available within four hours for patients who were going home.

5 The Rapid Response Therapy Service was actively involved on all hospital wards. This service identified patients who were suitable for discharge from acute care, contacted the community bed hub if a bed was needed and negotiated suitable community alternatives for patients who could go straight home.

6 The Trust has a comprehensive Policy for Physical Intervention (Restraint) which was available on the Trust intranet.

Immediate Risks: No immediate risks were identified.

Concerns

1 The electronic screen on the Acute Medical Unit at City Hospital was sited so that patient information was easily visible to other patients and relatives. Staff had been told always to minimise the display but this clearly did not always happen.

Further Consideration

1 Nursing recruitment, especially band 5 nurses, was causing problems in several services. The Clinical Decisions Unit at Sandwell Hospital could not be opened because of a shortage of nursing staff. Reviewers were also told of nursing shortages at Rowley Regis Hospital and at City Hospital. Reviewers suggested that more active marketing of the quality of care provided, creating posts which provide a range of community, intermediate care and acute experience and, possibly, international recruitment, may be helpful.

2 The role of ward-based pharmacists may benefit from review. In general, pharmacists attended wards daily but were not involved in ward rounds or multi-disciplinary discussions. On Lyndon 3 ward a pharmacist was based on the ward and the additional input was highly appreciated by ward staff.

3 On the Acute Medical Unit at Sandwell Hospital only the pharmacist could access the GP summary care record. Doctors working on the unit said that they could not do this, although this may have been because they had not activated their access. Further work to ensure all medical staff can access GP summary care records may be helpful.

4 Reviewers were told of medication 'to take out' being sent in taxis to patients because it was not ready when the patient left the building. Reviewers were assured that discharge documentation was always ready to go with the patient, medication was always sent the same day and no serious incidents had been reported. Nursing home staff who met the visiting team also reported sometimes receiving medication for the wrong patient. In the time available reviewers were unable to undertake further investigation of this issue, in particular, looking at the length of time until medication was available and any clinical impact on the patient. Reviewers suggested that further work in this area should be undertaken.

5 Reviewers considered that the chute pod in the Emergency Department may benefit from being cleaned.

6 Across Sandwell and West Birmingham Hospitals NHS Trust services, reviewers saw relatively little evidence of patient and carer engagement in improving services or of use of feedback from patients and carers. Patient experience was recorded but some displays of the results and action taken were up to two years old. Audits of the 'top ten checklist' had been undertaken but reviewers saw no evidence of action taken following the audits. No Sandwell and West Birmingham Hospitals NHS Trust carers' strategy was available and carers did not appear to be systematically involved in feedback or improvement mechanisms.

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Intermediate Care Services: Sandwell & West Birmingham Hospitals NHS Trust

ALL INTERMEDIATE CARE SERVICES

Further Consideration

1 The Sandwell and West Birmingham Hospitals Trust policy was that initial assessment in intermediate care facilities took place within 24 hours rather than the expected Quality Standard of within four hours. Reducing the time to initial assessment may help to promote more active rehabilitation and to reduce length of stay in intermediate care.

2 The Trust specification for GP support to intermediate care facilities were not clear about the role that GPs were expected to provide and the timescales for response. GPs came into the units daily from Monday to Friday but not at weekends and support was also available from advanced nurse practitioners. Staff could contact care of older people consultants if they needed a more urgent response.

LEASOWES

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

General Comments and Achievements

At the time of the review Leasowes was a 20-bedded unit with 18 intermediate care beds and two beds for end of life care. The environment on the unit was pleasant, clean, tidy and well-decorated with clear signage. Patient care was clearly focussed on active rehabilitation.

Average length of stay at the time of the review was 24 days. Patients were admitted for a varying length of time with no set expectation on the number of weeks for which they would remain in the unit. There was no waiting list for admission to the unit; patients who could not be admitted immediately went to another intermediate care facility. Patients were mostly dressed and went to lunch in the day room rather than eating beside their beds. Leadership of the unit was strong.

Good Practice

1 Good use was made of assistive technology including mattress sensors to detect if patients go into or out of bed. These could be activated or de-activated for individual patients. The unit also had entry / exit sensors.

Immediate Risks: No immediate risks were identified.

Concerns: No concerns were identified.

Further Consideration

1 Beds upstairs in the unit were old and were not 'profiling beds'. Reviewers suggested that replacement of these beds should be considered.

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ROWLEY REGIS HOSPITAL – WARDS / UNITS

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

General Comments and Achievements

Three intermediate care bedded units were available at Rowley Regis Hospital:

- Henderson Ward: 24 beds
- Eliza Tinsley Unit: - beds for patients who were medically fit for discharge
- Macarthy Unit: social care unit for people who were medically fit for discharge. This unit opened in February 2015 as a 12 week pilot. Care was delivered through a partnership approach between Sandwell and West Birmingham Hospitals NHS Trust, Sandwell MBC and Sevacare. The target length of stay on the unit was seven days.

Rowley Regis Hospital provided a pleasant environment for the provision of intermediate care. Good leadership and good multi-disciplinary involvement in care were evident with particularly good input by therapy staff. The units actively 'pulled' patients from acute wards and, prior to admission, ensured that they had all relevant information about patients. The Rapid Response Team could also refer patients into all three wards. Patients had good care plans which clearly identified which member of staff was responsible for taking action. Patients were mostly dressed and sitting out of bed. The Macarthy Unit was clearly focussed on social care and re-ablement with a target length of stay of seven days. Average length of stay on Henderson Ward was 30 days.

Good Practice

1 Use of the ten 'safety steps' was embedded on all the units. The safety standards were visible and being actively used by staff.

Immediate Risks: No immediate risks were identified.

Concerns: No concerns were identified.

Further Consideration

1 The units at Rowley Regis Hospital appeared well-staffed, were quiet and with had empty beds at the time of the review, especially on the Macarthy Unit. Sickness levels were reported to be high (13%) with sickness and vacancies being covered by agency staff.

2 Reviewers were told that the Macarthy Unit did not have an Operational Policy because it was a pilot project. Reviewers considered that an operational policy for the unit should be in place so that staff were clear about processes and responsibilities. Later information suggested that an operational policy may have been available but staff were not aware of this.

3 Social work support for Sandwell residents was good but arrangements for social care assessments for Birmingham residents were reported to be more difficult. This was adding to length of stay for Birmingham residents.

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INTEGRATED CARE SERVICES (ICARES)

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

General Comments and Achievements

'ICARES' provided:

- Primary Care Assessment and Treatment Service (PCAT)
- 'Own Bed Instead' (OBI)
- Single Point of Access/ibeds for community services
- Integrated Locality Teams of therapists and community matrons

PCAT was a multi-disciplinary ambulatory care service for admission avoidance for Sandwell residents, based at Rowley Regis Hospital. The service accepted referrals from GPs and provided home- or clinic-based assessment and, if appropriate, care. The service was staffed by GPs, nurses, therapists and health care assistants (HCAs). The service operated seven days a week between 8am and 8pm and aimed to keep patients at home with intensive support for up to 72 hours. PCAT could access 'step up' beds if required.

'Own Bed Instead' was a pilot project providing 'wrap round' enhanced intermediate care services 24/7 to support people at home, either to avoid admission or to achieve earlier return home following an acute hospital stay. Ten 'virtual beds' were provided. OBI could provide care for up to four weeks following which patients could be referred to social services for assessment for a further six weeks of re-ablement. Staff working in the service were passionate about the potential to provide good care at home.

'ICARES' response times were within three hours for urgent referrals (including admission avoidance), within three days for case management or complex referrals and within 15 days for routine or community rehabilitation referrals.

Good Practice

1 PCAT followed up all patients who had been re-admitted to hospital within 30 days of discharge in order to try and avoid further re-admissions. The ambulatory care 'LACE' index score[1] on the bed management system was used for identifying patients who were followed up by telephone to ensure their plan of care was being followed.

[1] LACE Index: **L**ength of Stay, **A**cuity of the admission, **C**o-morbidities, **E**mergency Department visits in the last six months

Immediate Risks: No immediate risks were identified.

Concerns: No concerns were identified.

Further Consideration

1 Staff at PCAT considered that a busy day was when they received approximately 30 calls. The service usually received between 15 and 20 calls per day. Reviewers considered that this level of referral was very low for the remit of the service and were surprised that referrals was not much higher.

2 PCAT has a single phone number but was not clear to the reviewers how to access it.

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CITY HOSPITAL WARDS D43 AND D47 (provided in partnership with Midland Heart)

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

General Comments and Achievements

These two wards were reviewed as Intermediate care beds.

Ward D43 was a 24-bedded unit for patients who were medically fit for discharge from hospital. Ward D47 provided intermediate care 'flexi-beds' with care provided by Sandwell and West Birmingham Hospitals NHS Trust in partnership with Midland Heart. The service had found that its patients were more ill and with more complex needs than had been envisaged when the unit was set up.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Medication 'to take out'**

Acute hospital discharge documentation, including an electronic discharge summary, was completed before patients were admitted to wards D43 and D47. Medication 'to take out' was also supplied. Medication could then be changed while the patient was on D43 or D47 or some of the 'to take out' medication was used. A GP visited the wards each day and a pharmacist attended two or three times a week. When the services were opened, the GP could not amend the electronic discharge summary. Medication changes were supposed to be recorded on a hand-written sheet which was then attached to the front of the discharge summary when the patient left the unit. Reviewers were given several examples of when this had not happened and patients leaving D43 and D47 could be on medication which was different to the electronic discharge summary previously sent to their GP or with insufficient medication for their care immediately following transfer. This problem had been recognised by the Trust and, by the time of the review GPs on wards D43 and D47 had been trained in use of the IT system and could amend the discharge letter. Reviewers considered that ongoing monitoring was needed to ensure the problem had been fully resolved.

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INTERMEDIATE CARE SERVICE: BIRMINGHAM COMMUNITY HEALTHCARE NHS TRUST

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

General Comments and Achievements

Intermediate care services provided by Birmingham Community Healthcare NHS Trust comprised:

- Rapid Response Team
- 'Own Bed Instead'

The Rapid Response Team for the West Birmingham Locality was based at Fort Dunlop. The team comprised a clinical team lead, nurses, physiotherapists, occupational therapists, support workers, liaison nurse and a mental health nurse. The team also had access to social worker and non-clinical case managers. The service linked well with integrated multi-disciplinary teams who provided longer-term health care in people's homes. The service was available seven days a week and patients would remain on the team's caseload for 5-10 days. Referrals were received via the Urgent Care Bureau.

'Own Bed Instead' was a pilot project providing 'wrap round' enhanced intermediate care services 24/7 to support people at home, either to avoid admission or to achieve earlier return home following an acute hospital stay. Ten 'virtual beds' were provided. OBI could provide up to four calls a day plus night care provision for up to four weeks. Night care provision was provided by Birmingham City Council's night care team. The team had an allocated social worker to ensure there were no delays in accessing social care. Staff working in the service were passionate about the potential to provide good care at home.

Good Practice

1 The Rapid Response and 'Own Bed Instead' Teams worked well together to provide an integrated, flexible and responsive approach to the care of patients so that admission to hospital could be avoided or patients could return home more quickly. The impressive impact on patient care was demonstrated by key performance indicators and by several scenarios.

Immediate Risks: No immediate risks were identified.

Concerns: No concerns were identified.

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CARE HOMES

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

RYLAND VIEW NURSING HOME

Reviewers were unable to visit these facilities but met representatives from the home. Ryland View was a care home with nursing and had 10 intermediate care beds. Ryland View had daily GP reviews and offered a step down pathway from acute wards. The home also had support from the Primary Care Assessment Team (PEAT).

HALL GREEN RESIDENTIAL HOME

Reviewers were unable to visit these facilities but met representatives from the home. Hall Green was a care home, had 19 intermediate care beds and was able to offer low impact rehabilitation. The remainder of the bed capacity was commissioned for care of patients with dementia. Hall Green had input from a GP twice weekly and did not have support from PEAT. Staff said that they had good communication and working relationships with the discharge teams at Sandwell and City Hospitals.

Hall Green undertook a four month pilot in early 2015 whereby a GP with a special interest in dementia was allocated to the home. This had shown demonstrable improvements in the care of residents, ambulance calls to the home dropped by 40%, medication management improved and information available for residents was improved.

WATERSIDE NURSING HOME

Waterside Nursing home provided a self-assessment for the review. Unfortunately, due to a misunderstanding, the reviewing team did not visit the facility and staff from Waterside did not attend the meeting arranged for care home representatives. From the self-assessment it was clear that the Home provided intermediate care and took direct referrals from acute wards with a verbal handover from the nurses or therapy staff on the ward. Weekly GP reviews and multi-disciplinary team meetings were in place plus a daily review of each resident by the registered nurse and occupational therapist.

ALLERTON COURT

Allerton Court residential care home provided 12 enhanced assessment beds.

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COMMISSIONING

General Comments and Achievements

NHS Sandwell and West Birmingham Clinical Commissioning Group, working with Sandwell Metropolitan Borough Council and Birmingham City Council commissioned a good range of intermediate care services. This range of services offered care for people with health and/or social care needs.

The CCG was working hard to develop a 'Sandwell and West Birmingham' approach to transfer from acute hospital care and intermediate care, despite the difficulty of working with two local authorities and two Better Care Fund schemes. The CCG was actively working towards embedding 'discharge to assess' and single assessment processes.

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

Immediate Risks: No immediate risks were identified.

Concerns

1 Concerns identified for provider services will require commissioner support and monitoring to ensure these issues are addressed, in particular:

   a. Pathways of Care: see health and social care economy, Concern 1

   b. Delays in Patient Pathways: see health and social care economy, Concern 2

   c. Overview of Patient Pathway: see health and social care economy, Concern 3

   d. Health and social care review and learning; see health and social care economy, Concern 4

   e. Electronic screen on the Acute Medical Unit: see Acute Trust, Concern 1

   f. Medication 'to take out': see Intermediate Care Services, City Hospital Wards D43 and D47 (provided in partnership with Midland Heart), Concern 1

Further Consideration

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

2 The health and social care economy did not yet have an intermediate care strategy. The range of services in place and being piloted appeared more to be a response to short-term pressure than part of a longer-term strategic plan. Reviewers suggested that the development of a needs-based strategy would be helpful and would help commissioners to plan coherently for future need, including for care of patients with higher acuity.

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APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Visiting Team

Fiona Burton	Assistant Director of Nursing	South Warwickshire NHS Foundation Trust
Joan Dyer	Matron Inpatient Services	Walsall Healthcare NHS Trust
Bie Grobet	General Manager- Integrated Adult Services	South Warwickshire NHS Foundation Trust
Karen Hanson	Divisional Manager for Medicine	The Dudley Group NHS Foundation Trust
Susan Jinks	Compliance Lead	Walsall Healthcare NHS Trust
Marsha Jones	Matron for Patient Flow	Worcestershire Acute Hospitals NHS Trust
Dawn Llewellyn	Community Matron	Burton Hospitals NHS Foundation Trust
Elizabeth Malpass	Advanced Nurse Practitioner	Staffordshire & Stoke on Trent Partnership NHS Trust
Mark Pulford	Patient Representative	
Donna Roberts	Clinical Team Leader, Intermediate Care / Rapid Response	Walsall Healthcare NHS Trust
Dr Narinder Sahota	General Practitioner	Walsall
Dave Sanzeri	Head of Commissioning: Long Term Conditions and Community Services	NHS Stoke on Trent CCG
Hilary Sullivan	Head of Discharge	Burton Hospitals NHS Foundation Trust
Jason Wiles	Head of Clinical Practice – Paediatrics	West Midlands Ambulance Service NHS Foundation Trust

WMQRS Team

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

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APPENDIX 2 COMPLIANCE WITH THE QUALITY STANDARDS

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

Table 1 - Percentage of Quality Standards met

Service	Number of Applicable QS	Number of QS Met	% met
Transfer from Acute Hospital Care and Intermediate Care			
Primary Care	2	0	0
Acute Trust: Sandwell & West Birmingham Hospitals NHS Trust	23	10	43
Intermediate Care Services: Sandwell & West Birmingham Hospitals NHS Trust	66	39	59
Leasowes Intermediate Care Unit, Rowley Regis Community Hospital	(33)	(18)	(55)
Sandwell 'Own Bed Instead' (OBI) Team	(33)	(21)	(64)
Intermediate Care Service: Birmingham Community Healthcare NHS Trust	32	23	72
Commissioning	4	1	25
Health and Social Care Economy	**127**	**73**	**57**

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

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

Topic Sections: Each section covers the following topics:

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

PRIMARY CARE

Ref	Standard	Met? Y/N	Reviewer Comments
SA-101	**Patients at High Risk of Admission** Patients at high risk of admission to an acute hospital should have a 'Patient Passport' or equivalent patient-held record that covers: a. Diagnoses b. Allergies c. Medication d. Care package (or equivalent) e. Name and contact details of GP f. Name and contact details of main carer/s g. Advice for the patient and their carers on likely problems and what to do in an emergency h. Advice to emergency services on likely problems and recommendations for their management i. Advice for acute hospital services on the most appropriate ward (if admission is required)	N	Patient passports were not yet in place across the health economy. Some information was accessible via System One within Sandwell and Graphnet within Birmingham.
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	Staff on the acute wards reported that they were not always able to access summary medical records. Intermediate care teams could access summary medical records.

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ACUTE TRUST – SANDWELL & WEST BIRMINGHAM HOSPITALS NHS TRUST

Ref	Standard	Met? Y/N	Reviewer Comments
SM-101	**Planned Admissions** All patients awaiting a planned admission to hospital should be offered written information about arrangements for leaving the hospital and returning to their usual place of residence.	Y	Some information leaflets were available on elective surgery but nothing specifically about discharge. Leaflets with information for patients with learning disabilities or for the use of interpreters were not easily available.
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	A number of A3 posters were displayed about leaving hospital on the Acute Medical Ward (AMU) and other wards. AMU had an Advanced Nurse Practitioner who provided nurse-led discharge. On the Ambulatory Care Unit, pathways were printed on the wall in the style of the London Underground map. Reviewers thought that this was an excellent model of communication and information. Discharge advice cards were available on the wards visited. The surgical wards had information leaflets for surgical site infections and how to obtain help after discharge.
SM-103	**Discussion with Families** Members of the multi-disciplinary team should be easily available to families for discussions about the patient's condition and plans for care on leaving hospital. Information on how to arrange a discussion should be clearly displayed in all ward areas.	N	Reviewers were unable to see any evidence in the areas visited about how to arrange a discussion. The Board rounds observed included clinical staff and did not involve families or carers. The perception given to reviewers was that meetings focussed on capacity issues.
SM-104	**Patients at High Risk of Re-Admission** Patients at high risk of re-admission should have their 'Patient Passport' or equivalent patient-held record (QS SA-101) updated during the course of their admission.	N	Patient passports or equivalent patient held records were not in use across the health economy. Re-admission data was collected on a dashboard and high risk of re-admission patients were discussed at multi-disciplinary best interests meetings.

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

Ref	Standard	Met? Y/N	Reviewer Comments
SM-199	**Involving Patients and Carers** The service should have: a. Mechanisms for receiving regular feedback from patients and carers about transfer of care from the acute hospital b. Examples of changes made as a result of feedback and involvement of patients and carers	N	A Patient and Public involvement website was accessible on the Trust intranet, but this did not appear to have any information. The Trust website had some advice for patients but not how to give feedback. Suggestion boxes were seen on some wards but they had no suggestion cards available for people to use. Staff talked about handing out 'Family and Friends' cards but there was no information available on the feedback from this collection and staff were not aware of how the information collected would be fed back.
SM-201	**Multi-Disciplinary Teams** A multi-disciplinary team to coordinate discharge planning should be available on each ward including: a. Staff with occupational therapy and physiotherapy competences with time allocated daily (7/7) for discharge planning, essential pre-discharge assessments and active pre-discharge rehabilitation b. Senior decision-maker review of patients' fitness for discharge at least daily (7/7) c. Nurse with competences in 'event-led' discharge from 9am to 8pm daily (7/7) d. Someone identified to coordinate discharge planning and preparation for discharge from 9am to 8pm daily (7/7) e. Access to social services staff available to undertake social care assessment within 24 hours of request f. Access to pharmacy services and medication 'To Take Out' available within four hours of request	Y	Ward board rounds observed worked well. The rounds were consistently attended by consultants, therapy staff and social workers. A proactive approach to discharge planning was evident in the rounds witnessed by reviewers. Input from nursing teams appeared limited on some wards.
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.	Y	A 'trusted assessor' model was in place on some of the acute wards but this was not consistently in place in all areas causing frustration for all involved. There did not appear to be a set standard for assessments for intermediate care beds.
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	From discussion with staff groups not all had been provided with training covering the hospital transfer of care, local intermediate care services and any agreed local enabling agreements.

Ref	Standard	Met? Y/N	Reviewer Comments
SM-301	**Support Services** Access to the following support services should be available daily (7/7): a. Appropriate staff to undertake a home assessment within 24 hours of request b. Patient transport able to respond within four hours of request c. 'Simple' equipment available within four hours of request d. Supply of sufficient dressings and continence aids for 72 hours available within four hours of request e. All equipment, including beds and hoists, available within 24 hours of request f. 'Simple' adaptations available within 24 hours of request g. Voluntary sector 'settling home' support able to respond by the end of the next working day and continue for up to five days h. 'Simple' assistive technology available within 24 hours of request i. Medicines reconciliation (7/7)	Y	All elements of the Quality Standard were met within the timescales stated.
SM-302	**Short-Term Care at Home** Additional health and social care support should be available within four hours of request, comprising up to four visits per day for at least 72 hours after return home.	Y	The number of teams and initiatives that were providing intermediate care and care at home was not always clear to the staff who met with the reviewing team. 'Own bed instead' were able to provide night visits and district nurses were able to provide night-sitting for a set number of days post discharge.
SM-499	**IT System** 'Trusted assessors' and ward-based staff responsible for coordinating discharge planning (QS SM-201) should have electronic access to: a. Health and social care records of patients from the main areas served by the hospital b. 'Patient Passports' (if electronic)	N	Multiple IT systems were in use and accessed by community staff and intermediate care services, but none of the systems inter-faced with each other. Some staff were still using Fax machines to send referrals to the 'ibed' hub.
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	Handover sheets were available from the appendix in the Transfer of Care Guideline and there was a Junior Doctor handover utilised through the eBMS (electronic bed management system).

Ref	Standard	Met? Y/N	Reviewer Comments
SM-596	**Transfer of Care Guidelines** Transfer of care guidelines for both simple and complex discharge pathways should be in use covering at least: a. Ensuring each patient has an expected date of discharge, ideally within 12 hours of admission b. 'Event-led' discharge c. Discussion with patients and carers about the Transfer of Care Plan d. Multi-disciplinary review for complex discharges or where discharge destination is unclear, ideally within 24 hours of admission e. Single assessment process f. Transport options including patient transport service, relatives, taxis or care home transport g. Development, agreement and giving the patient, GP and, where appropriate, carers a copy of the of the Transfer of Care Plan: i. Expected date of discharge ii. Essential pre-discharge assessments iii. Care after leaving the acute hospital, including self-care iv. Medication required on leaving the acute hospital v. Who is taking medical responsibility for care after leaving the acute hospital vi. Further investigations, treatment, rehabilitation and re-ablement to be carried out after leaving hospital, and who will arrange these, including separately identifying any of these which the GP is expected to arrange vii. Possible complications and what to do if these occur, including in an emergency viii. Transport ix. Equipment supply or loan x. Dressings and continence aids xi. Who to contact with queries or for advice xii. Date by which their care should be reviewed, who is expected to undertake this review and how to access a review more quickly if required h. How to access funding decisions on specialist care not normally available in the local area i. Latest time when patients can normally be discharged home or to care homes j. Handover of the Transfer of Care Plan to services providing after-hospital care, including intermediate care services k. Informing the GP, the person taking medical responsibility for the patient and any other relevant services that the patient has left hospital, ideally within four hours of transfer of care l. Contingency plan when capacity in intermediate care services is not available	N	Multi-disciplinary review for complex discharges, or where discharge destination is unclear, was not possible within 24hrs of admission. There was no information covering 'h', 'i' and 'l'. Discharge summaries were generated with the relevant information and a copy was given to the patients and /or carers, well as being sent to the GP.

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

Ref	Standard	Met? Y/N	Reviewer Comments
SM-602	**Intermediate Care** A protocol on access to local intermediate care services should be in use on each ward covering at least: a. Criteria for acceptance by each local intermediate care service and time limit for provision of the service (if applicable) b. Type of care, rehabilitation and re-ablement provided and, in particular, whether the service is able to support: i. 24/7 on-site care (community hospital or care home) ii. Overnight care (night-visiting or night sitting) iii. Intravenous therapy iv. PEG feeds v. Care for dementia or significant cognitive impairment vi. VAC therapy and other complex wound care c. 'Trusted Assessor' (QS SM-202) or other arrangements for agreement of patient suitability d. Arrangements for handover of the patient's Transfer of Care Plan	Y	Intravenous therapy, PEG feeds and VAC (vacuum assisted closure) therapy were provided by the District Nursing teams.
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 covering 'a', 'b', and ' c' were all collated by the Trust.
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 yet have a rolling programme of audit as defined by 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).	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.

Ref	Standard	Met? Y/N	Reviewer Comments
SM-798	**Multi-disciplinary Review and Learning** Each ward should have multi-disciplinary arrangements for the reviewing of, and implementation of learning from, positive feedback, complaints, outcomes, incidents and 'near misses' relating to transfer of care from the acute hospital.	N	A number of staff across community and acute areas discussed with the reviewers that they never had any feedback on incidents or complaints reported. They were also unaware of patient experience feedback.
SM-799	**Document Control** All policies, procedures and guidelines should comply with Trust (or equivalent) document control procedures.	N	A number of documents seen by reviewers were out of date and had passed their review dates, some by more than 12 months.

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INTERMEDIATE CARE SERVICE – SANDWELL & WEST BIRMINGHAM HOSPITALS NHS TRUST

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

Ref	Standard	Leasowes Intermediate Care Unit Rowley Regis Community Hospital		Sandwell 'Own Bed Instead' (OBI) Team	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
SN-101	**Service Information** Each service should offer patients and their carers written information covering: a. Organisation of the service b. Care and therapeutic interventions offered by the service c. If beds: routines, visiting times and how to get refreshments d. Staff and facilities available e. How to contact the service for help and advice, including out of hours f. Who to contact with concerns about the service g. 'After intermediate care', including information about the length of time for which the service will be provided and the options for, and process of transfer to, longer-term care (if required) h. Sources of further advice and information	Y	All areas had a leaflet standardised for use. Information was also displayed in all the areas visited. The environments used pictorial information for those who may benefit.	Y	Own Bed Instead (OBI) had an information leaflet for their service.

Ref	Standard	Leasowes Intermediate Care Unit Rowley Regis Community Hospital		Sandwell 'Own Bed Instead' (OBI) Team	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
SN-103	**Care Plan** Each patient and, where appropriate, their carer and appropriate members of the multi-disciplinary team should discuss and agree their Care Plan and should have easy access to a written record covering at least: a. Agreed goals, including life-style goals b. Self-management c. Medication d. Planned care and therapeutic interventions e. Early warning signs of problems, including acute exacerbations, and what to do if these occur f. Expected date of discharge from the service g. Name of care coordinator h. Name of doctor taking medical responsibility for their care i. Who to contact with queries or for advice j. Planned review date and how to access a review more quickly, if necessary	Y	Nursing records were kept at the bedside and included goals. The EDD (estimated date of discharge) was clearly displayed at the bedside at Rowley Regis but not at Leasowes. Patient information was clear about care planning and date of discharge. EDD were documented electronically.	y	All patients were reviewed and a care plan agreed the following day after discharge. Care plans had set timescales for the service provided.
SN-104	**Review of Care Plan** A formal review of the patient's Care Plan should take place as planned and, at least, weekly. This review should involve the patient, their carer, where appropriate, and appropriate members of the multi-disciplinary team. The outcome of the review should be recorded in the Care Plan.	Y	Weekly multi-disciplinary team (MDT) meetings were in place at all the bedded areas visited. The MDT witnessed by reviewers identified actions and responsibility for communicating the MDT decisions to the patients and carers.	Y	Weekly multi-disciplinary team reviews were held where care plans and goals were reviewed and adjusted.

Ref	Standard	Leasowes Intermediate Care Unit Rowley Regis Community Hospital		Sandwell 'Own Bed Instead' (OBI) Team	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
SN-105	**Contact for Queries and Advice** Each patient and, where appropriate, their carer should have a contact point within the service for queries and advice. If advice and support is not immediately available then the timescales for a response should be clear, and advice on what to do in an emergency should be given. Response times should be no longer than the end of the next day.	Y		Y	Details of who to contact for queries and advice were documented on the initial assessment record.
SN-106	**Care Coordinator** Each patient should have a nominated individual responsible for planning and coordinating their care, including planning their longer-term care.	N	Patients were not allocated a named individual as the areas had adopted a multi-disciplinary team approach. Rowley Regis: the Medically Fit for Discharge ward had a Healthcare Assistant coordinator (Band 3) who coordinated admissions and discharges.	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	All communication aids were easily available.
SN-108	**Patients at High Risk of Re-Admission** Patients at high risk of re-admission should have their 'Patient Passport' or equivalent patient-held record (QS SA-101) updated during the course of their intermediate care.	N	Patient passports were not in use across the Health Economy.	N	Patient passports were not in use across the Health Economy.

Ref	Standard	Leasowes Intermediate Care Unit Rowley Regis Community Hospital		Sandwell 'Own Bed Instead' (OBI) Team	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
SN-196	**'After Intermediate Care' Plan** Patients and, when appropriate, their carers should be involved in discussing and agreeing the plan for their care after leaving the intermediate care service, and should be given a written summary of their 'After Intermediate Care' Plan, which should include: a. Expected date of discharge from the intermediate care service b. Care after leaving intermediate care, including self-care c. Medication d. Who is taking medical responsibility for care after leaving intermediate care e. Further investigations, treatment, rehabilitation and re-ablement to be carried out after leaving intermediate care, and who will arrange these, including separately identifying any of these which the GP is expected to arrange f. Possible complications and what to do if these occur, including in an emergency g. Transport (if required) h. Equipment supply or loan i. Dressings and continence aids j. Who to contact with queries or for advice k. Date by which their care should be reviewed, who is expected to undertake this review and how to access a review more quickly if required This 'After Intermediate Care' Plan should be copied to the patient's GP and to all services involved in providing ongoing care.	N	Patients did receive a copy of the discharge summary but it did not include all the elements in the Quality Standard.	N	There were no 'after care' guidelines for intermediate care patients from the 'Own Bed Instead' teams.

Ref	Standard	Leasowes Intermediate Care Unit Rowley Regis Community Hospital		Sandwell 'Own Bed Instead' (OBI) Team	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
SN-197	**General Support for Patients and Carers** Patients and carers should have easy access to the following services, and information about these services should be easily available: a. Interpreter services, including British Sign Language b. Independent advocacy services c. Complaints procedures d. Social workers e. Benefits advice f. Spiritual support g. *HealthWatch* or equivalent organisation h. Relevant voluntary organisations providing support and advice	Y		Y	The team were able to assist patients to access these services if required.
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	N	Reviewers were told that carers were not routinely given information in all areas. Information was visible in all the areas visited and did direct carers to staff for further information.	Y	The team were able to offer support and signpost carers to carers' assessments during the time of the care package they provided.
SN-199	**Involving Patients and Carers** The service should have: a. Mechanisms for receiving regular feedback from patients and carers about the treatment and care they receive b. Examples of changes made as a result of the feedback and involvement of patients and carers	Y	A range of mechanisms were in place. Post-discharge visits were also undertaken to gain patient and carer views.	Y	The 'Own Bed Instead' team had conducted a brief patient survey during their pilot and were about to embark on a more detailed and structured survey on their service and the outcomes achieved.

Ref	Standard	Leasowes Intermediate Care Unit Rowley Regis Community Hospital		Sandwell 'Own Bed Instead' (OBI) Team	
		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	Leasowes: A lead GP and Manager were in place. Rowley Regis: each area had a Ward Manager and there were nominated GPs who provided cover.	Y	The lead therapist was the nominated lead for the 'Own Bed Instead' team.

Ref	Standard	Leasowes Intermediate Care Unit Rowley Regis Community Hospital		Sandwell 'Own Bed Instead' (OBI) Team	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
SN-202	**Staffing Levels and Skill Mix** Sufficient health and care staff with appropriate competences should be available for: a. The number of patients usually cared for by the service and the usual case mix of patients b. The service's role in the patient pathway and expected timescales c. The assessments, care and therapeutic interventions offered by the service Staffing should include: i. At least two registered healthcare professionals at all times the service is operational ii. A registered nurse available 24/7 in bedded units and daily (7/7) in other services iii. Appropriate therapists for the needs of the patients daily (7/7) iv. Access to social services staff available to undertake social care assessments within 24 hours of request v. Medical staff (QS SN-205) Cover for absences should be available so that the patient pathway is not unreasonably delayed, and patient outcomes and experience are not adversely affected, when individual members of staff are away.	Y	Leasowes: Staffing had been reviewed and increased to reflect the acuity of the patients. The ratio was 2:4 trained for day shifts and 2:2 at night. Social workers and Therapists were available 7/7. Therapy staff worked across all the intermediate care units and they were very visible in the areas visited. Staff who met the reviewing team commented that the principle of 'safety first' ensured additional staff resource would always be made available.	Y	Staffing consisted of: 1 wte Case Manager who accepted and triaged the referrals. 1 wte Physiotherapist and 1 wte Occupational Therapist who provided a 7/7 service between them.

Ref	Standard	Leasowes Intermediate Care Unit Rowley Regis Community Hospital		Sandwell 'Own Bed Instead' (OBI) Team	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
SN-203	**Service Competences and Training Plan** The competences expected for each role in the service should be identified. A training and development plan for achieving and maintaining competences should be in place. If provided by the service, the competence framework should cover: a. Intravenous therapy b. PEG feeds c. Care for patients with dementia or significant cognitive impairment d. VAC therapy and other complex wound care	Y	Competences were in place for PEG (percutaneous endoscopic gastrostomy) feeds and for the care of patients with dementia. The bedded intermediate care services did not undertake intravenous therapy or VAC (vacuum assisted closure) therapy. PCAT (Primary Care Assessment and Treatment unit) could deliver intravenous therapies.	N	Competences covering 'c' were not seen by reviewers. 'a, b and d 'were not provided by the 'Own Bed Instead' team.
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	93% staff at Leasowes were up to date with mandatory training.	Y	

Ref	Standard	Leasowes Intermediate Care Unit Rowley Regis Community Hospital		Sandwell 'Own Bed Instead' (OBI) Team	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
SN-205	**Medical Staff** The service should have the following medical staffing: a. A nominated lead doctor with responsibility for coordinating medical input to the service b. A doctor available for emergencies 24/7 c. A doctor or other registered health professional with authorisation to prescribe who can attend within two hours of request, for conditions where hospital admission may be avoided d. Medical review of patients: i. Community hospitals: Daily (7/7) ii. Other intermediate care services: As appropriate for the usual case mix of patients and at least weekly.	N	Leasowes: 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, was not possible outside normal working hours. All other aspects of the Quality Standard was met. Rowley Regis: Reviewers suggested that the Service Level Agreement could be more explicit about medical cover as in reality there was a GP on the site till 7pm each day.	Y	The 'Own Bed Instead' team were able to access the patients GP and out of hours cover when required.
SN-299	**Administrative, Clerical and Data Collection Support** Administrative, clerical and data collection support should be available.	Y		Y	Administrative support was available for the team.

Ref	Standard	Leasowes Intermediate Care Unit Rowley Regis Community Hospital		Sandwell 'Own Bed Instead' (OBI) Team	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
SN-301	**Clinical Support Services** Timely access to an appropriate range of clinical support services should be available, including: a. Imaging b. Pathology, including microbiology c. Pharmacy, including medication supply and medicines management advice d. Appropriate staff to undertake a home assessment within 24 hours of request e. Infection control (7/7 and on call 24/7) f. Tissue viability (7/7) g. Falls prevention (next working day) h. Continence service (7/7) i. Mental health team (crisis response within four hours) j. Counselling	Y	Reviewers were told that there were delays in accessing mental health teams for other mental health assessments.	N	The 'Own Bed Instead' team were unable to access a, b, and c. There was some availability of d, e, f and g but not h, i and j.

Ref	Standard	Leasowes Intermediate Care Unit Rowley Regis Community Hospital		Sandwell 'Own Bed Instead' (OBI) Team	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
SN-302	**Support Services for Patients Returning Home** Access to the following support services for patients returning home should be available daily (7/7): a. Appropriate staff to undertake a home assessment within 24 hours of request b. Medication 'To Take Out' available within four hours of request c. Patient transport able to respond within four hours of request d. 'Simple' equipment available within four hours of request e. Supply of sufficient dressings and continence aids for 72 hours available within four hours of request f. All equipment, including beds and hoists, available within 24 hours of request g. 'Simple' adaptations available within 24 hours of request h. Additional health and social care support within four hours of request, comprising up to four visits per day for up to 72 hours after return home i. Voluntary sector 'settling home' support able to respond by the end of the next working day and continue for up to five days j. 'Simple' assistive technology available within 24 hours of request	Y	At both Leasowes and Rowley Regis pharmacy services were provided, as well as arrangements with local pharmacies and the use of FP10's which ensured that access to medication was available within four hours of request. At Leasowes there was good access to assistive technology, for example, mattress sensors and entry and exit detectors.	Y	The 'Own Bed Instead' team were able to access all elements of this Quality Standard for the service they provided.

Ref	Standard	Leasowes Intermediate Care Unit Rowley Regis Community Hospital		Sandwell 'Own Bed Instead' (OBI) Team	
		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	All the areas visited were spacious. Some of the bedded areas followed spring summer and autumn themes and had magnetic patient boards with patient safety alert symbols. Reviewers remarked that at both Leasowes and Rowley Regis the ambience was calm and particularly suitable for Reablement.	Y	Care was provided in the patient's own home and any equipment required was accessible and suitable.
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 health economy.	N	Multiple systems were in use across the health economy.
SN-501	**Initial Assessment Guidelines** Guidelines on initial assessment should be in use that ensure that an initial assessment is undertaken within 30 minutes of transfer to the intermediate care service, or within four hours if intermediate care is provided in the home, covering at least: a. Assessment of pressure ulcers, nutrition, hydration and cognition b. Initial review of the Transfer of Care Plan to ensure its appropriateness for the intermediate care service	N	The Trust Guidelines on initial assessment timescales were for the initial assessment to be commenced within 1 hour and completed within 24hrs.	Y	Documents covering the initial assessment were in use and reviewers were told that initial assessments could be undertaken within four hours of transfer to the service.

Ref	Standard	Leasowes Intermediate Care Unit Rowley Regis Community Hospital		Sandwell 'Own Bed Instead' (OBI) Team	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
SN-502	**Clinical Guidelines** Guidelines on management of the usual case mix of patients referred to the service should be in use covering at least: a. Pain b. Depression c. Skin integrity d. Falls and mobility e. Continence f. Delirium and dementia g. Nutrition and hydration h. Sensory loss i. Medicines management j. Catheter care k. Spasticity management l. Care of patients with diabetes, COPD, heart failure and other long-term conditions m. Activities of daily living n. Health promotion, including smoking cessation, healthy eating, weight management, exercise, alcohol use, sexual and reproductive health, and mental and emotional health and well-being	Y		Y	Guidelines were available on the intranet for Sandwell & West Birmingham Hospitals NHS Trust.

Ref	Standard	Leasowes Intermediate Care Unit Rowley Regis Community Hospital		Sandwell 'Own Bed Instead' (OBI) Team	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
SN-597	**Transfer of Care Guidelines** Transfer of care guidelines for both simple and complex discharge pathways should be in use covering at least: a. Ensuring each patient has an expected date of discharge from the service b. Planning transfers of care from intermediate care including: i. Discussion with patients and carers about the 'After Intermediate Care' Plan ii. Availability for patient and carer queries iii. Multi-disciplinary review for complex or uncertain discharges iv. Single assessment process v. Transport options including patient transport service, relatives, taxis or care home transport vi. 'After Intermediate Care' Plan (QS SN-196) c. Agreement of 'After Intermediate Care' Plan and handover to services providing long-term care (if required) d. Informing the GP, the person taking medical responsibility for the patient and any other relevant services that the patient has left intermediate care, ideally within four hours of transfer of care	N	The discharge policy was in the process of being updated to cover all systems across the health economy. The available policy did not cover the systems in place or reflect the good practices and processes seen by the reviewers. Reviewers noted that information about 'Choice Letters' was limited.	Y	These were available for 'Own Bed Instead' on the Sandwell & West Birmingham Hospitals NHS Trust intranet.

Ref	Standard	Leasowes Intermediate Care Unit Rowley Regis Community Hospital		Sandwell 'Own Bed Instead' (OBI) Team	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
SN-598	**More Complex Transfers of Care** Guidelines should be in use covering: a. Transfer of care to other local authority or Clinical Commissioning Group areas covering at least social care assessments, intermediate care services available, patient transport and equipment supply or loan b. Transfer to a care home for long-term care c. NHS continuing care assessments and place-finding d. Liaison with palliative and end of life care services e. Patients and/or carers who do not agree an 'After Intermediate Care' Plan or who unreasonably delay their transfer of care	N	Guidelines were not yet in place but in practice all aspects of the Quality Standard were undertaken.	N	Guidelines were not accessible for all aspects of this Quality Standard.
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	All aspects of Quality Standard were in place. A good Policy for Physical Intervention (Restraint) was available on the Trust intranet.	Y	All aspects of Quality Standard were in place. A good Policy for Physical Intervention (Restraint) was available on the Trust intranet.

Ref	Standard	Leasowes Intermediate Care Unit Rowley Regis Community Hospital		Sandwell 'Own Bed Instead' (OBI) Team	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
SN-601	**Operational Policy** The service should have an operational policy describing the organisation of the service including, at least, arrangements for: a. Admission of patients to the service who meet the agreed criteria b. Initial assessment within 30 minutes of transfer, or within four hours if the patient has returned home c. On admission: i. Requesting a Summary Medical Record from the patient's GP if this is not sent with the patient (QS SA-601) ii. Identifying agencies involved in the patient's care and, if necessary, informing them of the admission d. Agreement of Care Plan within 24 hours of transfer to intermediate care e. Start of therapeutic interventions within 24 hours of transfer to intermediate care f. Setting and reviewing expected date of discharge from the service g. Daily review of all patients h. Review of Care Plans at least weekly, including medical review i. Allocation of a care coordinator for each patient (QS SN-106) j. Giving the patient and, where appropriate, their carer information at each stage of the patient journey k. Responding to patients' and carers' queries or requests for advice l. Multi-disciplinary discussion of appropriate patients m. Developing and agreeing an 'After Intermediate Care' Plan for each patient (QS SN-196) within seven days of admission n. Ensuring that an 'After Intermediate Care' checklist (or equivalent) is included in each patient's notes showing their stage on the transfer of care pathway and actions required o. Updating the 'Patient Passport' (QS SA-101) for people at high risk of re-admission or issuing one if not available p. Communication with the patient's GP q. Maintenance of equipment (QS SN-401) r. Responsibilities for IT systems (QS SN-499)	N	A number of different operational policies were in use but these did not cover all the areas defined in the Quality Standard. As SN-501 initial assessment was expected within 1 hour and completion by 24 hours.	N	The Operational Policy did not have the standards as stated in the Quality Standard.

Ref	Standard	Leasowes Intermediate Care Unit Rowley Regis Community Hospital		Sandwell 'Own Bed Instead' (OBI) Team	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
SN-701	**Data Collection** Regular collection and monitoring of data should be in place, including: a. Referrals to the service, including source and appropriateness of referrals b. Number of assessments and therapeutic interventions undertaken by the service c. Outcome of assessments and therapeutic interventions d. Length of care by the service e. Proportion of patients achieving their expected date of discharge from the service f. Number and destination of transfer of care from the service g. Key quality and performance indicators	N	Some data were seen but it was not clear from the report that it covered all the areas of the Quality Standard.	N	The data for both 'Own Bed Instead' services was incomplete against the template provided.
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	Not all areas had a rolling programme of audit as defined by the Quality Standard.	N	Not all areas had a rolling programme of audit as defined by the Quality Standard.
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	Joint Key Performance Indicators were evident and evidence provided.
SN-797	**Health and Social Care Review and Learning** The service should have a mechanism for influencing and receiving feedback from the local Health and Social Care Review and Learning Group on transfer of care from acute hospitals and intermediate care (QS SZ-798).	N	A formal group that met to discuss, review and share learning from discharge planning regularly, was not yet in place. There were some individual operational groups.	N	A formal group that met to discuss, review and share learning from discharge planning regularly, was not yet in place. There were some individual operational groups.

Ref	Standard	Leasowes Intermediate Care Unit Rowley Regis Community Hospital		Sandwell 'Own Bed Instead' (OBI) Team	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
SN-798	**Multi-disciplinary Review and Learning** The service should have multi-disciplinary arrangements for a. Review of, and implementation of learning from, positive feedback, complaints, outcomes, incidents and 'near misses' b. Review of, and implementation of learning from, published scientific research and guidance c. Ongoing review and improvement of service quality, safety and efficiency	N	Multi-disciplinary review and learning as defined by the Quality Standard was not yet in place on the units. Teams did have governance meetings monthly and quality half days monthly for shared learning.	N	Staff who met with the reviewers articulated that there were no feedback mechanisms in place from complaints or incident reporting.
SN-799	**Document Control** All policies, procedures and guidelines should comply with Trust (or equivalent) document control procedures.	N	Some documents reviewed were out of date or awaiting review. The information accessed via the Trust intranet would benefit from clearer archiving as some information opened was not up to date e.g. access to training had dates up until 2014.	N	Many documents reviewed were out of date or awaiting review.

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INTERMEDIATE CARE SERVICE – BIRMINGHAM COMMUNITY HEALTHCARE NHS TRUST

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

Ref	Standard	Own Bed Instead Team (OBI)	
		Met? Y/N	Reviewer Comments
SN-101	**Service Information** Each service should offer patients and their carers written information covering: a. Organisation of the service b. Care and therapeutic interventions offered by the service c. If beds: routines, visiting times and how to get refreshments d. Staff and facilities available e. How to contact the service for help and advice, including out of hours f. Who to contact with concerns about the service g. 'After intermediate care', including information about the length of time for which the service will be provided and the options for, and process of transfer to, longer-term care (if required) h. Sources of further advice and information	N	It was not clear if patients were given written information about 'g' - 'after intermediate care'. Patients were given a contact number to ring once discharged and could access the single point of access service for urgent advice.
SN-103	**Care Plan** Each patient and, where appropriate, their carer and appropriate members of the multi-disciplinary team should discuss and agree their Care Plan and should have easy access to a written record covering at least: a. Agreed goals, including life-style goals b. Self-management c. Medication d. Planned care and therapeutic interventions e. Early warning signs of problems, including acute exacerbations, and what to do if these occur f. Expected date of discharge from the service g. Name of care coordinator h. Name of doctor taking medical responsibility for their care i. Who to contact with queries or for advice j. Planned review date and how to access a review more quickly, if necessary	Y	From the template care plan seen, all the information defined in the Quality Standard was covered.

Ref	Standard	Own Bed Instead Team (OBI)	
		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	Compliance was based on self-assessment. In practice the patient's care plan was reviewed at each intervention.
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	The template care plan included a space for documenting the care coordinator.
SN-107	**Communication Aids** Communication aids should be available to enable patients with communication difficulties to participate in decisions about their care.	Y	Reviewers were told that there was easy access to communication aids.
SN-108	**Patients at High Risk of Re-Admission** Patients at high risk of re-admission should have their 'Patient Passport' or equivalent patient-held record (QS SA-101) updated during the course of their intermediate care.	N	Patient passports or equivalent patient held records were not in use across the health economy. The Community teams did have patient-held records and the rapid response teams and 'Own Bed Instead' patients who were of high risk of admission would be referred to the Integrated Multidisciplinary teams.

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

Ref	Standard	Own Bed Instead Team (OBI)	
		Met? Y/N	Reviewer Comments
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	A carer support team could be accessed at the Trust. There was also some good information directing carers to the Birmingham Carers Hub and the Carers UK helpline.
SN-199	**Involving Patients and Carers** The service should have: a. Mechanisms for receiving regular feedback from patients and carers about the treatment and care they receive b. Examples of changes made as a result of the feedback and involvement of patients and carers	Y	Mechanisms were in place to receive regular feedback. Regular patient satisfaction surveys were completed and action plans developed to address any issues highlighted. The patient membership leaflet was very clear about how to influence the services provided. The Building Bridges Toolkit for capturing patients' feedback and the manager's guide to 'Ensuring Patients and Carers Influence Service Reviews, Planning and Redesign' were comprehensive.
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	Own Bed Instead Team (OBI)	
		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	Community services used a capacity tool which was reviewed twice daily to provide flexible city-wide working. Medical cover for community was via the patients GP with consultant advice available from Hall Green (though the team tended to access the Advanced Nurse Practitioner). The community team received 200 - 300 referrals per month and delivered all care including 'night sits' and 10 virtual beds. For intermediate care, a new peripatetic model was being developed to ensure appropriate cover, particularly at short notice.
SN-203	**Service Competences and Training Plan** The competences expected for each role in the service should be identified. A training and development plan for achieving and maintaining competences should be in place. If provided by the service, the competence framework should cover: a. Intravenous therapy b. PEG feeds c. Care for patients with dementia or significant cognitive impairment d. VAC therapy and other complex wound care	Y	A Trust-wide training matrix was used in conjunction with roles specifications. All breeches for training were escalated to line managers.

Ref	Standard	Own Bed Instead Team (OBI)	
		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	Essential to Role training included all the listed training apart from Privacy and Dignity. Privacy and Dignity was part of the '6 C's nursing and healthcare assistant (HCA) training. The Trust was also implementing a 'dignity champion' role.
SN-205	**Medical Staff** The service should have the following medical staffing: a. A nominated lead doctor with responsibility for coordinating medical input to the service b. A doctor available for emergencies 24/7 c. A doctor or other registered health professional with authorisation to prescribe who can attend within two hours of request, for conditions where hospital admission may be avoided d. Medical review of patients: i. Community hospitals: Daily (7/7) ii. Other intermediate care services: As appropriate for the usual case mix of patients and at least weekly.	Y	Staff would access the patient's local GP surgery in the first instance and then the Clinical Medical Assessment Unit (CMAU) to access a sub-acute bed or consultant review. The 'Own Bed Instead' team had access to the Sandwell and West Birmingham Primary Care Assessment and Treatment unit (PCAT).
SN-299	**Administrative, Clerical and Data Collection Support** Administrative, clerical and data collection support should be available.	Y	

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

Ref	Standard	Own Bed Instead Team (OBI)	
		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	Staff had access to appropriate equipment. Care was provided in patients' homes.
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 place. The Trust was in the process of implementing RiO.
SN-501	**Initial Assessment Guidelines** Guidelines on initial assessment should be in use that ensure that an initial assessment is undertaken within 30 minutes of transfer to the intermediate care service, or within four hours if intermediate care is provided in the home, covering at least: a. Assessment of pressure ulcers, nutrition, hydration and cognition b. Initial review of the Transfer of Care Plan to ensure its appropriateness for the intermediate care service	N	Guidelines covering initial assessment were not yet in place. Rapid Response assessments were undertaken within two hours.
SN-502	**Clinical Guidelines** Guidelines on management of the usual case mix of patients referred to the service should be in use covering at least: a. Pain b. Depression c. Skin integrity d. Falls and mobility e. Continence f. Delirium and dementia g. Nutrition and hydration h. Sensory loss i. Medicines management j. Catheter care k. Spasticity management l. Care of patients with diabetes, COPD, heart failure and other long-term conditions m. Activities of daily living n. Health promotion, including smoking cessation, healthy eating, weight management, exercise, alcohol use, sexual and reproductive health, and mental and emotional health and well-being	N	Guidelines covering Falls and Mobility or Delirium were not seen. All other clinical guidelines were in place.

Ref	Standard	Own Bed Instead Team (OBI)	
		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	Y	Transfer of care guidance was in place for intermediate care.
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	A range of information covered the requirements of the Quality Standard.

Ref	Standard	Own Bed Instead Team (OBI)	
		Met? Y/N	Reviewer Comments
SN-599	**Care of Vulnerable People** Guidelines for the care of vulnerable adults should be in use covering, in particular: a. Identification and care of vulnerable people b. Individualised care plans for people identified as being particularly vulnerable c. Restraint and sedation d. Missing patients e. Mental Capacity Act and Deprivation of Liberty Safeguards f. Safeguarding g. Information sharing h. Palliative care i. End of life care j. 'Do not resuscitate'	Y	

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

Ref	Standard	Own Bed Instead Team (OBI)	
		Met? Y/N	Reviewer Comments
SN-701	**Data Collection** Regular collection and monitoring of data should be in place, including: a. Referrals to the service, including source and appropriateness of referrals b. Number of assessments and therapeutic interventions undertaken by the service c. Outcome of assessments and therapeutic interventions d. Length of care by the service e. Proportion of patients achieving their expected date of discharge from the service f. Number and destination of transfer of care from the service g. Key quality and performance indicators	Y	
SN-702	**Audit** The services should have a rolling programme of audit of: a. Achievement of expected timescales for the patient pathway b. Compliance with evidence-based clinical guidelines (QS SN-500s) c. Compliance with standards of record keeping	Y	
SN-703	**Key Performance Indicators** Key performance indicators (QS SN-701) should be reviewed regularly with Trust (or equivalent) management and with commissioners.	Y	
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.
SN-798	**Multi-disciplinary Review and Learning** The service should have multi-disciplinary arrangements for a. Review of, and implementation of learning from, positive feedback, complaints, outcomes, incidents and 'near misses' b. Review of, and implementation of learning from, published scientific research and guidance c. Ongoing review and improvement of service quality, safety and efficiency	N	Multi-disciplinary review and learning as defined by the Quality Standard was not yet in place in the team. Other Trust governance mechanisms were in place to review incidents and sharing of information. A newsletter was distributed to all staff.

Ref	Standard	Own Bed Instead Team (OBI)	
		Met? Y/N	Reviewer Comments
SN-799	**Document Control** All policies, procedures and guidelines should comply with Trust (or equivalent) document control procedures.	Y	

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COMMISSIONING

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

Ref	Standard	Met? Y/N	Reviewer Comments
SZ-602	**Local Enabling Agreements** Health and social care commissioners should have local enabling agreements covering: a. Care package continuity during hospital admission b. Flexibility of re-start following hospital admission c. 'Discharge to assess' d. Cross-boundary agreements e. Single assessment process f. Arrangements for assessment and transfer of care for patients not resident in the local area, and reciprocal arrangements for local patients admitted to hospitals outside the local area	N	Local enabling agreements were not seen. There were no formal cross-boundary agreements in place. In practice, arrangements were in place to manage continuity and restarting of care packages, and 'discharge to assess' beds had been commissioned by both local authorities.
SZ-701	**Quality Monitoring** Commissioners should monitor key quality and performance indicators for: a. Transfer of care from acute hospitals (QS SM-701) b. Intermediate care services (QS SN-701)	N	Key Performance Indicators were identified, but the reports seen suggested that data were not always completed to allow effective monitoring.
SZ-798	**Health and Social Care Review and Learning Group** Arrangements for transfer of care from acute hospitals and intermediate care should be discussed with all relevant local services at least annually in order to review positive feedback, complaints, outcomes, incidents and 'near misses', identify and address problems, and identify improvements that could be made.	N	A Health and Social Care Review and Learning Group was not yet in place. Some meetings were held with the CCG and local councils but these did not include all relevant local services.

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