WM QRS West Midlands Quality Review Service

NHS

Transfer from Acute Hospital Care and Intermediate Care

Herefordshire Health and Social Care Economy

Visit Date: 22nd and 23rd March 2016 Report Date: June 2016

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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 22nd and 23rd March 2016. 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 Herefordshire 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:

- Wye Valley NHS Trust
- Herefordshire County Council
- NHS Herefordshire Clinical Commissioning Group

Social care is fundamental to the pathway for transfer from acute hospital care and intermediate care, and some aspects of this report cover providers and commissioners of social care in Herefordshire, 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 action by both health and/or local authority commissioners of services. 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 Herefordshire Clinical Commissioning Group.

ACKNOWLEDGEMENTS

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

ABOUT WEST MIDLANDS QUALITY REVIEW SERVICE

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

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

HEREFORDSHIRE: TRANSFER FROM ACUTE HOSPITAL CARE AND INTERMEDIATE CARE

SERVICES REVIEWED

This review looked at the following aspects of the Transfer from Acute Hospital Care and Intermediate Care pathway for the Herefordshire health and social care economy:

Pathway	Provider	Quality Standards	Notes
Primary care	-	Primary care	24 GP practices and other primary care services
The County Hospital	Wye Valley NHS Trust	Acute Trust-wide	220 acute beds. Reviewers visited the Emergency Department, Acute Admissions Unit, Frailty Unit, and orthopaedic and respiratory / cardiology wards
Leominster Community Hospital	Wye Valley NHS Trust	Intermediate care	26 general adult beds including 'step-down' rehabilitation beds
Bromyard Community Hospital	Wye Valley NHS Trust	Intermediate care	19 general adult beds including 'step-down' rehabilitation beds
Hillside Intermediate Care Centre	Wye Valley NHS Trust	Intermediate care	22 beds; recently reconfigured to a community hospital
Ross on Wye Community Hospital	Wye Valley NHS Trust	Intermediate care	32 general adult beds including 'step-down' rehabilitation beds. Reviewers were not able to visit this hospital because of an infectious disease outbreak
Commissioning	NHS Herefordshire Clinical Commissioning Group	Commissioning	
Other services: The following services involved in the Transfer from Acute Hospital Care and Intermediate Care pathway were available in Herefordshire, but detailed reviews of compliance with Quality Standards were not undertaken. General issues of relevance to these services are included in this report.			
Neighbourhood Teams	Wye Valley NHS Trust	-	Reviewers met two representatives from these teams. A review against intermediate care Quality Standards could have been undertaken for these teams but insufficient evidence was available for a full review of compliance
Hospital at Home	Wye Valley NHS Trust	-	A range of home-based interventions, including antibiotic therapy, was provided by this team
Complex Discharge Team.	Wye Valley NHS Trust		The role of this team was to support staff in managing those discharges that required input from multiple agencies and those who needed social care input to facilitate their discharge.
Logan Jack Unit, Kington	Blanchworth Care	-	10 intermediate care beds, with opportunity for two palliative care patients as part of the 10
Ledbury Health and Care Centre	Shaw Health Care	-	14 intermediate care beds, with opportunity for two palliative care patients as part of the 14

Pathway	Provider	Quality Standards	Notes
Rapid Response Team	Herefordshire Council	-	Community-based re-ablement provision
RAAC (Rapid Assessment Access to Care) beds	Multiple providers	-	'Discharge to assess' nursing home beds. The number in use at the time of the visit was unclear
Hospice at Home	Wye Valley NHS Trust		This service had commenced in January 2016
Community Falls, Tissue Viability, Manual Handling and Continence Services	Wye Valley NHS Trust	-	Reviewers did not meet representatives of these services, although several staff expressed appreciation of the support available.

Reviewers were due to meet social workers and representatives from transport services but these services did not attend. Reviewers did not meet any representatives from the Logan Jack Unit or the Ledbury Health and Care Centre and so were not able to comment on this part of the intermediate care pathway. Reviewers met two representatives from the Neighbourhood Teams.

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Review Visit Findings

General Comments and Achievements

Throughout this review visit the staff who met the visiting team were kind, caring, welcoming and open. Reviewers saw examples of good clinical practice, and many staff with enthusiasm and ideas about how to improve the care provided and with commitment to making the necessary changes. Patient feedback indicated that patients and carers were very satisfied with the care they received. Staff were so busy delivering care in a highly pressured system that they had little time to reflect or develop and implement improvements.

A good range of community services was available, including the Neighbourhood Teams, which comprised district nurses and allied health professionals. Other community services included Hospital at Home, Rapid Response (social care re-ablement service), Virtual Ward run by Community Matrons and Hospice at Home. Monthly quality dashboards were in place, and integration with mental health services was in progress. Neighbourhood Care Teams staff had competences in catheter care, compression bandaging and support for patients on intravenous antibiotics. Two 'Leg Clubs' were run, supported by volunteers.

Several new services had started during the year prior to this review, including Hospital at Home, Hospice at Home and the Complex Discharge Team. The Hillside unit was being re-configured into a community hospital, and changes to the configuration of beds in the County Hospital were planned. Although staff were working hard and progress was being made, a coherent, prioritised programme was not evident from discussions with front-line staff. A 'Special measures news' publication updated staff on progress being made, but this mostly described changes that had already been made. Staff mentioned a range of activities that were in progress, but reviewers did not gain a clear understanding of the further changes that were planned, their priority and how the system would ensure full implementation.

A 'One Herefordshire' transformation programme had started work with a formal structure for collaboration across health and social care agencies. This programme had four work-streams:

- Supportive communities, including health and well-being
- Acute hospital, with particular emphasis on seven-day working and partnerships with other acute hospitals
- Urgent care, including redesign of the urgent care pathway
- Community collaboration, especially looking at the skills, capacity and resilience of community services.

Health and social care services in Herefordshire had been through a time of significant leadership change. Health services had also received several reviews prior to this peer review visit, including two Care Quality Commission

inspections and a review of length of stay by the Emergency Care Improvement Programme. The findings of this review re-iterate and reinforce many of the previous findings. With the aim of supporting the 'One Herefordshire' programme of work, this report is written as a single health and social care economy report following the Transfer from Acute Hospital Care and Intermediate Care pathway.

Good Practice

1 The Stroke Ward at the County Hospital had a proactive, multi-disciplinary approach to care, with a well-organised 'board round' and good Care Plans in place for patients with stroke. Patients had a clearly identified expected date of discharge, and the discharge process was well led by the stroke unit physiotherapist. Good occupational therapist support was also available for patients with stroke.

2 A good Chronic Obstructive Pulmonary Disease (COPD) pathway document was in use in all services. This goal-oriented document provided clear advice on the actions to be taken at each stage in the pathway. The document was patient-friendly in its use of language and images.

3 Patients on antibiotics who were cared for by community services were recorded on an 'antibiotic tracker', and a weekly meeting was held with a consultant microbiologist to review their care. The Hospital at Home service was able to support patients needing antibiotics up to four times a day, and this had been shown to save 971 bed days in the nine months since the service started.

4 The Hospital at Home teams provided rapid support at home for patients discharged from acute hospital care. Over the nine months in which it had been operational, the team had achieved a 31% reduction in Emergency Department attendances for patients under the care of the team. The Hospital at Home service was also planning to take over the out-of-hours district nursing service so that a wider range of interventions could be offered.

5 A good end of life pathway was in place and this appeared to be working well on most of the wards visited. Staff who met the visiting team were confident in the use of the end of life plan. Several patients seen by reviewers had DNACPR forms, and these travelled with patients who were transferred to community hospitals. 'Ceilings of care' were written in patients' notes in the County Hospital and these notes went with the patients to community hospitals.

Immediate Risks: No immediate risks were identified

Concerns

1 **Admission Avoidance**

Reviewers saw little evidence of admission avoidance options or work with patients at high risk of admission, including those in nursing homes, in order to prevent admission. Community hospitals could, in theory, admit 'step up' patients but at the time of the review all beds were occupied by 'step down' patients. GPs could refer patients directly to the Hospital at Home team but this option did not appear to be regularly used.

2 **Urgent and Emergency Care 'Portals'**

The urgent and emergency care 'portals' did not have a clear focus on early discharge and 'turning patients round quickly'. Reviewers commented particularly on the following services:

a. **Emergency Department, including Rapid Assessment Area**

The Emergency Department team was providing care for 165 patient attendances per day in a department designed for 120 per day. At the time of the review all GP referrals were being routed through the Emergency Department. Approximately 50% of nursing posts were filled with bank or agency staff. The Department did not have daily physiotherapy and occupational therapy staff allocated to work with patients and, if possible, avoid admission (a respiratory physiotherapist was available 8.30am to 4.30pm at weekends). Links between the Emergency Department and other services did not appear to be working well. In-reach by acute medicine or specialty-specific teams was not welcomed due to the limited space available. The Emergency Department had a separate IT

system that did not link with other hospital systems. This limited the exchange of information with the rest of the hospital. A part-time Patient Flow Nurse had been appointed shortly before the review visit to liaise between the Emergency Department and wards, but the impact of this post was not yet evident.

b. **Acute Admissions Unit**

The Acute Admissions Unit was functioning as a general medical ward as well as an acute admissions unit. Approximately 10 beds were occupied by long-stay patients. The organisation and staffing of the unit also did not reflect an acute medical admissions facility. The unit did not have dedicated junior medical staff, and the consultant responsible for admissions changed each day. Patients admitted under other consultants stayed with that consultant, and so at least three different ward rounds were happening on the day of the review visit. It was difficult for senior nursing staff to support consultant rounds that were happening at the same time. Approximately 50% of nursing posts were filled with bank or agency staff. Reviewers were told that nursing staff with appropriate competences were not always available on each shift to undertake male catheterisation. The unit did not have physiotherapy or occupational therapy with time allocated for work on the unit. Ward rounds were organised so that the on call consultant and junior medical staff started in the Emergency Department, then went to the Clinical Assessment Unit and then to the Acute Admissions Unit. There was no set time for the ward round to reach the Acute Admissions Unit and it could be late in the morning. This limited the time available for action to be taken.

c. **Patient Pathways**

Reviewers saw at least two examples of patients going 'backwards' in the patient pathway, one being moved back to the Acute Admissions Unit from a specialty ward and one going back to the Frailty Unit. 'Backwards' movement along the pathways further undermined the focus of the urgent and emergency care 'portals'.

3 Capacity Pressures within the County Hospital

Capacity pressures within the County Hospital were leading to inefficiencies and poorer quality of patient care. Reviewers commented specifically on the care of respiratory patients, who received good care and good discharge planning on the respiratory ward. Respiratory patients on other wards did not have the same quality of care and were likely to have a longer length of stay and poorer outcomes. Medical outliers on surgical wards were leading to cancellation of elective surgery and other delays in the elective pathway. At weekends the only therapy support available was a respiratory physiotherapist from 8.30am to 4.30pm and an occupational therapist on the orthopaedic ward from 8.30am to 12.30pm. Most wards did not have therapy support at weekends.

4 Discharge Planning within Acute Services

a. **Proactive discharge planning, including use of Expected Date of Discharge**

With the exception of the stroke and respiratory wards, reviewers found little focus on discharge throughout the parts of the County Hospital that they visited: pre-admission clinics, for example, for hip and knee replacement did not include discharge planning as part of their discussion, all entry 'portals' appeared to assume that patients would be admitted, Expected Date of Discharge was not routinely recorded until the patient was medically fit for discharge, social workers would not accept referrals until the patient was medically fit for discharge, drugs 'to take out' were not ordered until the electronic discharge summary had been fully completed, and transport was not routinely ordered in advance. This sequential discharge planning, rather than processes going on in parallel, was also highlighted in the Emergency Care Improvement Programme report into lengths of stay.

b. **Discharge documentation**

Ward nursing documentation at the County Hospital was long and complex, with a page for each type of assessment. Medical and nursing notes were kept separately, with therapists writing in the

medical notes. Except on the stroke ward, none of the notes seen by reviewers had a clear summary of the plan of care, including discharge planning. Elective orthopaedic nursing notes had a discharge plan on the back page but none were filled in in the notes seen by reviewers. Two discharge policies were made available to reviewers, one of which was out of date. Care pathways had been developed for patients with heart failure or COPD, and one was planned for patients with dementia. Reviewers did not see evidence of a generic pathway with associated documentation. The documentation seen by reviewers appeared to focus on the problem on admission and was not clear about action that needed to be taken after discharge.

c. **Monitoring**

Bed managers had access to a system with several coloured 'buttons' that indicated various stages along the patient pathway. In general, ward staff did not have a clear list of the patients who were medically fit for discharge on their ward, or those who were likely to be ready to be discharged the next day. The Trust had four bed managers but much of their time was taken up in trying to find beds, rather than helping staff to 'get ahead' with discharge planning.

d. **Staff awareness**

The discharge process was highly dependent on nurses who knew about the local systems and services that were available. The Trust had recently undertaken significant overseas recruitment and some shifts were covered by bank and agency staff. It was difficult for inexperienced and agency staff quickly to understand the processes that should be followed.

5 Response from Other Services

a. **Pharmacy response**

The County Hospital pharmacy department had a clear two hour target for supply of drugs 'to take out (TTO)' but was only achieving this for 70% of requests. Pharmacy staff commented that TTO requests were mostly received in the afternoon, with little forward planning for discharges planned on the next day. This finding links with the points above about proactive discharge planning and use of expected date of discharge.

b. **Social services response**

Reviewers were told that social workers would not respond to a request for an assessment until a patient was medically fit for discharge, and then in the County Hospital it could be two to three days before the patient was actually assessed. In community hospitals, reviewers were told that it was two to three days until the referral was acknowledged, and that it could be several weeks before an assessment took place.

c. **Nursing home response**

'Trusted assessor' arrangements were not in place (except for 'discharge to assess' beds, which were mostly used for patients awaiting continuing health care assessments), and reviewers were told that nursing homes could take up to five days to come and assess a patient. Nursing homes would not assess patients at weekends and did not admit patients after 3pm on a Friday.

d. **Integrated Urgent Care Co-ordination Centre (IUCCC)**

The IUCCC acted as a 'call centre' and coordinated placement of patients in intermediate care. This arrangement was not respected by ward staff. Considerable time was taken up by completing relevant paperwork on the phone to non-registered IUCCC staff. Ward staff said that it would have been much quicker for them to complete the paperwork themselves and send it to the IUCCC. The IUCCC used faxes to communicate information to staff in community hospitals. Reviewers were told that clinical handover between staff would soon stop and staff would be reliant on the faxed information. Staff were concerned about the loss of the handover, especially as the faxed

information was often of poor quality and could be incorrect if there had been a delay between the initial referral and the actual transfer.

e. **Equipment**

Some staff reported that there were no delays with supply of equipment whereas others said that the response time was seven days and was only less if they chased for the equipment to be available earlier.

f. **Transport**

Reviewers did not meet representatives of the transport service but were told that transport home could be difficult. The transport service had limited capacity at weekends and so patients could not always be transferred.

6 Community hospitals

At Bromyard Community Hospital, documentation was well-organised and notice boards were well-maintained. All of the community hospitals visited by staff had caring, compassionate staff, and a reduction in length of stay was reported. The environment at the Hillside unit was particularly good and staff had a strong focus on rehabilitation. Reviewers were concerned, however, about the following aspects of care in the community hospitals visited:

a. **Care Plans and Discharge Planning**

Reviewers did not find a strong focus on discharge planning, and considered that there was potential further to reduce length of stay. Community hospital staff did not have access to the electronic discharge summary from acute hospital care. Care Plans were not clearly documented and updated. Care Plans that were in place were not goal-oriented and did not appear to have been discussed with the patient. Some of the patient notes were poorly maintained and not clearly legible. Most of the notes seen by reviewers did not record Expected Date of Discharge or relate achievement of goals to the patient's discharge plan. Medical notes were separate from nursing notes. The discharge summary was in a different format from that used in the acute hospital and contained relatively little information.

b. **Range of Care Available**

Community hospitals did not admit patients needing intravenous antibiotics. In practice, therefore, patients could receive more support and care at home than was available in the community hospitals.

c. **Promoting Self-Care and Independence**

Many of the patients in the community hospitals were not in their own clothes, were not moving around and had few opportunities for socialisation. A day room was available at Leominster Community Hospital but this did not appear to be being used. Reviewers considered that there was the potential significantly to increase the focus on self-care and independence.

d. **Weekends**

On Saturdays and Sundays there was no medical presence in the community hospitals (other than for emergencies), no therapy input and no mental health services input. Reviewers were given several examples of patients who were re-admitted to acute hospital care at the weekend when this could have been avoided by more active therapeutic intervention in the community hospital. Patient flow at weekends (admissions, rehabilitation, discharge planning and discharges) appeared very limited.

e. **Medical and pharmacy input**

GPs attended the community hospital daily on weekdays but the role expected was not clearly defined. It was not clear that GPs would return to the community hospital, for example, in order to

avoid a patient being admitted to acute hospital care. The role of the GPs in supporting active discharge planning was not clear. Multi-disciplinary team meetings took place only weekly, with a 'huddle' meeting on a Friday to consider any actions required before the weekend. Pharmacy staff attended the community hospitals only once a week, which also gave them little opportunity to input to discharge planning.

Further Consideration

1 Arrangements for clinical handover within Wye Valley NHS Trust were very varied. Reviewers saw evidence of many different clinical handovers which did not use a standard system or process. Information was sometimes written down, but this was not always the case.

2 A seven day a week Complex Discharge Team had been created in February 2016. At the time of the review, this team comprised 3.2 w.t.e band 7 nurses, 1.4 w.t.e administrative staff and 2.0 w.t.e social workers. The role of this team was "to educate and support staff in managing those discharges that have input from multiple agencies and those who need social care input to facilitate their discharge". The team had re-started a '14 day length of stay' meeting which provided multi-disciplinary discussion, including with Neighbourhood Care Teams, for patients with long lengths of stay and more complex needs. Reviewers were surprised that, given the resources available, the team did not undertake assessments, including nursing home, Decision Support Tool and continuing health care assessments.

3 The Frailty Unit team had strong leadership and good ideas and had developed a model of care that would achieve good outcomes. The team was clear about the role of the unit and how it could improve care. The unit was not, however, being used as they expected, and patients who did not meet the admission criteria were being placed on the unit. Reviewers suggested that, for the Frailty Unit to function effectively, bed managers and senior staff needed to give a higher priority to ensuring the unit could function as planned. This situation was not helped by the fact that Herefordshire had only 1.5 w.t.e. geriatricians whose time was very stretched, which had an impact on the time available to provide help and support to the unit.

4 The staffing model for allied health professionals was not consistent across the wards (acute and community) visited. The allocation of registered staff of different disciplines, those with extended roles and therapy / rehabilitation assistants varied between wards in a way that did not appear to be related to the needs of the patients on the wards. Reviewers suggested that, with the exception of the stroke ward, it may be possible for therapists to be more proactive in supporting multi-disciplinary working. For example, it may be possible for therapy staff (or nurses with mental health expertise) to contribute to the nursing rota in the Emergency Department and Acute Admissions Unit. There may also be the potential for developing multi-skilled roles in order to address the shortage of therapy staff at weekends.

5 Patient feedback mechanisms consisted largely of the Friends and Family Test, complaints and compliments. Patient feedback was all collected by Trust employees, and reviewers suggested that use of more independent feedback mechanisms, for example, through use of volunteers, may provide a fuller picture of patients' and carers' views.

6 Neighbourhood Care Teams did not identify a care coordinator for their patients, and the contact point for queries and advice was not clear. Further work to ensure compliance with relevant Quality Standards may be helpful. Some ongoing problems of communication with GPs and practice nurses were also reported.

7 The arrangements for out of hospital care for people with tracheostomies were not yet in place. All of the community service representatives who met the visiting team said that they did not provide care for patients with tracheostomies. Patients with longstanding tracheostomy / laryngectomy who were self-caring were admitted to a general ward at the County Hospital. The number of patients would be small, but reviewers were surprised that arrangements for care of this patient group did not appear to be in place in the community hospitals.

8 A health and social care economy 'review and learning' group was not yet in place. The benefits of a group looking particularly at complaints, incidents and positive feedback at the interface between different

services may be helpful in order to improve coordination across the Transfer from Acute Hospital Care and Intermediate Care pathway.

9 Reviewers were struck by the impact that increased car parking charges and reduced car parking spaces was having on staff morale. Reviewers suggested that the Trust may wish to consider ways in which this issue could be addressed so as to avoid negative consequences for recruitment and retention of staff.

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SUMMARY AND NEXT STEPS

Reviewers were conscious that many of the findings of this visit echoed those of previous Herefordshire reviews. The overall impression gained by reviewers was of caring staff but with, in general, systems and processes that were out of date and not yet fit for purpose. Patient flow through the 220 acute beds and over 120 intermediate care beds was not working effectively and the whole system appeared 'clogged'. Staff were therefore spending time 'fire-fighting' rather than being able to tackle the underlying problems, including the need for cultural change. Reviewers met many staff who were capable and interested in improving services, but the need for priorities in tackling the issues identified in this report was clear. With the aim of being helpful, reviewers suggested the following priorities for action:

1 Develop and implement a standard handover template, or adopt one already in use in another area. Ensure this is implemented across all hospital and community services.

2 Develop and implement a standard transfer of care template, or adopt one already in use in another area. Ensure this is implemented across all hospital and community services (except where a condition-specific pathway has already been agreed).

3 Ensure the Acute Admissions Unit functions as such, with a dedicated multi-disciplinary team (including medical staff) responsible for all patients in the unit. The planned re-configuration of beds may provide the opportunity for radically altering the culture and operation of this unit.

4 Support the Frailty Unit in functioning according to the planned model by protecting this unit from other admissions whenever possible.

5 Increase the number of beds for respiratory patients so that most respiratory patients are cared for on a specialist respiratory ward.

6 Use and publicise ward and community hospital-level data on achievement of expected timescales for all stages along the patient pathway. Use data to maintain a focus on the discharge process. (Appendix 4 of the WMQRS Quality Standards for Transfer from Acute Hospital Care and Intermediate Care provides an appropriate set of timescales that could be used.)

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APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Executive Lead

Sarah Bloomfield	Director of Nursing and Quality	The Shrewsbury & Telford Hospital NHS Trust

Visiting Team

Dr Philip Brammer	Respiratory Consultant	The Dudley Group NHS Foundation Trust
Karen Dawson	Service Manager – MICATS	Staffordshire and Stoke on Trent Partnership NHS Trust
Philip Fewtrell	Quality Manager – Senior Nursing Team	The Shrewsbury & Telford Hospital NHS Trust
Lauren Higgins	In-reach Community Matron	Walsall Healthcare NHS Trust
Carole Roberson	Lead for Corporate Nursing (Community Services)	Worcestershire Health & Care NHS Trust
Dr Narinder Sahota	Assistant Medical Director	NHS England Birmingham, Solihull and the Black Country
Judith Whalley	Patient Representative	
Jacquie Whitaker	Business Manager to the Medical Director	Sandwell & West Birmingham Hospitals NHS Trust

WMQRS Team

Jane Eminson	Director	West Midlands Quality Review Service
Sarah Broomhead	Assistant Director	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
County Hospital – All Wards	23	5	22
Community Hospitals	33	4	12
Commissioning	4	0	0
Health and Social Care Economy	**62**	**9**	**15**

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

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

Topic Sections: Each section covers the following topics:

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

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PRIMARY CARE

Ref	Quality 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	Some patients had a yellow community folder, which was designed as a 'patient passport', but this was not in general use for patients at high risk of admission and was not always taken with the patient when admitted to hospital. People with learning disabilities had a 'patient passport', and one was being developed for people with dementia.
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	The notes seen by reviewers did not include summaries of the patient's medical records.

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COUNTY HOSPITAL – ALL WARDS

Ref	Quality 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	Good information was available for patients needing hip and knee replacements.

Ref	Quality Standard	Met? Y/N	Reviewer Comments
SM-102	**Information about Leaving Hospital** Each ward should clearly display information for patients, carers and staff about arrangements for transfer of care on leaving the hospital, covering at least: a. The process of transfer of care b. Additional support available in the patient's usual place of residence c. Intermediate care options, criteria for accessing these and time limits on their provision (if applicable) d. How to access a discussion with medical and/or nursing staff about the patient's condition and plans for care on leaving hospital	N	Some information was available and there were specific pathways for stroke and Chronic Obstructive Pulmonary Disease patients and some other patient groups.
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	Information was not clearly displayed in the acute wards visited.
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-held records (yellow folders) were available for some patients but were not always brought into hospital with the patient and were not updated during their hospital stay.

Ref	Quality Standard	Met? Y/N	Reviewer Comments
SM-196	**Transfer of Care Plan** Patients and, when appropriate, their carers should be involved in discussing and agreeing the plan for their care after leaving the hospital and should be given a written summary of their Transfer of Care Plan, which should include: a. Expected date of discharge b. Essential pre-discharge assessments c. Care after leaving the acute hospital, including self-care d. Medication required on leaving the acute hospital e. Who is taking medical responsibility for care after leaving the acute hospital f. Further investigations, treatment, rehabilitation and re-ablement to be carried out after leaving hospital, and who will arrange these, including separately identifying any of these which the GP is expected to arrange g. Possible complications and what to do if these occur, including in an emergency h. Transport i. Equipment supply or loan j. Dressings and continence aids k. Who to contact with queries or for advice l. Date by which their care should be reviewed, who is expected to undertake this review and how to access a review more quickly if required This Transfer of Care Plan should be copied to the patient's GP and to all services involved in providing after-hospital care.	N	Several different Transfer of Care Plans were in use. A discharge checklist was also in place. The Transfer of Care Plans were not completed in most of the case notes seen by reviewers, and most did not have evidence of an Expected Date of Discharge or of discharge planning from an early stage in the hospital stay.
SM-198	**Carers' Needs** Carers should be offered advice and written information on: a. How to access an assessment of their own needs b. Benefits available, including carers' allowance (if applicable), and how to access benefits advice c. Services available to provide support	Y	
SM-199	**Involving Patients and Carers** The service should have: a. Mechanisms for receiving regular feedback from patients and carers about transfer of care from the acute hospital b. Examples of changes made as a result of feedback and involvement of patients and carers	Y	The Friends and Family Test was used and this information was shared through governance and service unit performance meetings. The Patient Experience Team also coordinated complaints and compliments information and shared this with ward teams. Service unit improvement plans included actions in response to complaints, and the Patient Experience Team monitored whether action had been taken.

Ref	Quality Standard	Met? Y/N	Reviewer Comments
SM-201	**Multi-Disciplinary Teams** A multi-disciplinary team to coordinate discharge planning should be available on each ward including: a. Staff with occupational therapy and physiotherapy competences with time allocated daily (7/7) for discharge planning, essential pre-discharge assessments and active pre-discharge rehabilitation b. Senior decision-maker review of patients' fitness for discharge at least daily (7/7) c. Nurse with competences in 'event-led' discharge from 9am to 8pm daily (7/7) d. Someone identified to coordinate discharge planning and preparation for discharge from 9am to 8pm daily (7/7) e. Access to social services staff available to undertake social care assessment within 24 hours of request f. Access to pharmacy services and medication 'To Take Out' available within four hours of request	N	'a': Occupational therapy and physiotherapy staffing at weekends was not sufficient to support discharge planning, pre-discharge assessments and rehabilitation across the whole hospital. 'b': This was met on weekdays. An on-call senior registrar was available at the weekends and a weekend forecast plan highlighted potential weekend discharges. Many of the community services and intermediate care facilities did not accept weekend discharges. 'c': See main report in relation to Complex Discharge Team. 'd' and 'e' were not yet met (see main report). 'f': Pharmacy had a target of 90% of drugs 'to take out' being available within two hours but was achieving this in only 70% of cases.
SM-202	**'Trusted Assessors'** A member of staff 'trusted' and with competences to assess for local intermediate care services, including intermediate care in community hospitals, in care homes or at home, should be available to each ward daily (7/7) and able to respond on the same day to requests received by 12 noon.	N	Trusted assessors were not yet in place. The Hospital at Home team attended daily ward rounds in the hospital whenever possible and could be contacted for advice. Reviewers were told of significant delays in nursing home assessments (see main report).
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	Training was not yet in place, although there were plans for this to be added to the induction for new doctors and agency medical staff. Training for staff was made more difficult by the complexity of the documentation and of the available community services.

Ref	Quality Standard	Met? Y/N	Reviewer Comments
SM-301	**Support Services** Access to the following support services should be available daily (7/7): a. Appropriate staff to undertake a home assessment within 24 hours of request b. Patient transport able to respond within four hours of request c. 'Simple' equipment available within four hours of request d. Supply of sufficient dressings and continence aids for 72 hours available within four hours of request e. All equipment, including beds and hoists, available within 24 hours of request f. 'Simple' adaptations available within 24 hours of request g. Voluntary sector 'settling home' support able to respond by the end of the next working day and continue for up to five days h. 'Simple' assistive technology available within 24 hours of request i. Medicines reconciliation (7/7)	N	'a' was met. 'b' was available but was not always able to respond within four hours at weekends. 'c' was met'. 'd' was met for elective wards. 'e', 'f', 'h' and 'i' were not yet met. 'g' was met.
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 Hospital at Home team and local authority Rapid Response Teams provided this service. A Hospice at Home service had started in January 2016.
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	This Quality Standard was not yet met.
SM-595	**Ward and Consultant Handover** The latest version of their Transfer of Care Plan should be handed over to the new ward or consultant whenever patients are transferred to another ward within the acute hospital or to the care of another consultant and the Transfer of Care Checklist (QS SM-601) updated.	N	Transfer of Care Plans were not yet in place for all patients. Several different handover sheets were in use within the hospital.

Ref	Quality 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	Two discharge policies were available including a 'Transfer of Patients Policy', but that was out of date. These policies did not cover all the requirements of the Quality Standard. Some Transfer of Care Plan templates had been developed for particular patient groups (heart failure and Chronic Obstructive Pulmonary Disease) or were in development (dementia).

Ref	Quality 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 detailing the expected process were not yet in place. The Complex Discharge Team supported more complex transfers of care.
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	'a' was not met. 'b' and 'c' were met. 'd': A discharge checklist was in use but not until the patient was ready for discharge. It was not used proactively to plan the discharge. 'e': 'Patient passports' were not updated during acute hospital stays. 'f': Reviewers did not see evidence of robust arrangements for rapid access following discharge. 'g': Agreements were in place but many of the staff who met the visiting team were not aware of them.

Ref	Quality Standard	Met? Y/N	Reviewer Comments
SM-602	**Intermediate Care** A protocol on access to local intermediate care services should be in use on each ward covering at least: a. Criteria for acceptance by each local intermediate care service and time limit for provision of the service (if applicable) b. Type of care, rehabilitation and re-ablement provided and, in particular, whether the service is able to support: i. 24/7 on-site care (community hospital or care home) ii. Overnight care (night-visiting or night sitting) iii. Intravenous therapy iv. PEG feeds v. Care for dementia or significant cognitive impairment vi. VAC therapy and other complex wound care c. 'Trusted Assessor' (QS SM-202) or other arrangements for agreement of patient suitability d. Arrangements for handover of the patient's Transfer of Care Plan	N	This information was not easily available on the wards visited.
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	'a' did not appear to be routinely collected. Data covering 'b' and 'c' were available, and monthly service unit performance indicator dashboards were circulated to all wards, but ward staff who met the visiting team were not aware of them, or of their own ward's performance.
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	Ward-level audit as expected by the Quality Standard was not yet in place. An analysis of length of stay and reasons for delays had been undertaken by the Emergency Care Improvement Programme team.
SM-797	**Health and Social Care Review and Learning** Each ward should have a mechanism for influencing, and receiving feedback from, the local Health and Social Care Review and Learning Group on transfer of care from acute hospitals and intermediate care (QS SZ-798).	N	A health and social care review and learning group (or equivalent) was not in place at the time of the review.

Ref	Quality 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	Reviewers were told that ward meetings were held that met the requirements of the QS. Reviewers did not see notes of these meetings or evidence of multi-disciplinary involvement in them.
SM-799	**Document Control** All policies, procedures and guidelines should comply with Trust (or equivalent) document control procedures.	N	A Trust policy and process was in place covering document control, but several policies were out of date and identified as due for review.

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COMMUNITY HOSPITALS

Ref	Quality Standard	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	Information about 'after intermediate care' was not easily available. Some care notes did include an expected date of discharge but this was not routinely communicated to the patients.

Ref	Quality Standard	Met? Y/N	Reviewer Comments
SN-103	**Care Plan** Each patient and, where appropriate, their carer and appropriate members of the multi-disciplinary team should discuss and agree their Care Plan and should have easy access to a written record covering at least: a. Agreed goals, including life-style goals b. Self-management c. Medication d. Planned care and therapeutic interventions e. Early warning signs of problems, including acute exacerbations, and what to do if these occur f. Expected date of discharge from the service g. Name of care coordinator h. Name of doctor taking medical responsibility for their care i. Who to contact with queries or for advice j. Planned review date and how to access a review more quickly, if necessary	N	Based on the notes seen by reviewers, Care Plans were not in place for all patients. Where Care Plans did exist these did not include evidence of discussion with patients about agreed goals and self-management plans. An assessment process for activities of daily living and care needs was in place. Some nursing documentation was held at the bedside in Leominster Community Hospital but not at Bromyard. Medical notes were kept separately from nursing documentation. A review of care planning documents was planned.
SN-104	**Review of Care Plan** A formal review of the patient's Care Plan should take place as planned and, at least, weekly. This review should involve the patient, their carer, where appropriate, and appropriate members of the multi-disciplinary team. The outcome of the review should be recorded in the Care Plan.	N	Multi-disciplinary meetings were held weekly and 'huddle' meetings took place on Fridays to identify any actions required over the weekend. Robust arrangements for regular review of Care Plans were not yet in place (partly because Care Plans were not robust). Review of Care Plans was not evident in any of the case notes seen by reviewers.
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.	N	Information on how to contact the ward was available, but timescales for responding were not clearly identified.
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	At Leominster Community Hospital a board at the patient's bedside identified their GP's name. Patients did not have a nominated individual responsible for planning and coordinating their care.
SN-107	**Communication Aids** Communication aids should be available to enable patients with communication difficulties to participate in decisions about their care.	Y	

Ref	Quality Standard	Met? Y/N	Reviewer Comments
SN-108	**Patients at High Risk of Re-Admission** Patients at high risk of re-admission should have their 'Patient Passport' or equivalent patient-held record (QS SA-101) updated during the course of their intermediate care.	N	Some patients at high risk of admission had a 'yellow folder'. These were not always in place and were not always taken with the patient on admission to hospital.
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	Discharge documentation did contain some actions for the patient and relatives but included limited other information and did not cover the requirements of an 'After Intermediate Care' plan as expected by the Quality Standard. Reviewers saw no evidence that plans had been discussed with patients and their carers although this may happen in practice.
SN-197	**General Support for Patients and Carers** Patients and carers should have easy access to the following services, and information about these services should be easily available: a. Interpreter services, including British Sign Language b. Independent advocacy services c. Complaints procedures d. Social workers e. Benefits advice f. Spiritual support g. *HealthWatch* or equivalent organisation h. Relevant voluntary organisations providing support and advice	N	These services were available, although limited information about them was evident in the community hospitals visited by reviewers.

Ref	Quality Standard	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	
SN-199	**Involving Patients and Carers** The service should have: a. Mechanisms for receiving regular feedback from patients and carers about the treatment and care they receive b. Examples of changes made as a result of the feedback and involvement of patients and carers	N	Friends and Family Test arrangements were in place and complaints and compliments were received. Some areas displayed the percentage of feedback received. Reviewers were told that action plans were developed, but there was little evidence of this in the community hospitals visited. Staff who met the visiting team were not aware of the responses or of any action taken as a result.
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	All community hospitals had a lead nurse. Leominster and Bromyard Community Hospitals also had a lead GP.

Ref	Quality Standard	Met? Y/N	Reviewer Comments
SN-202	**Staffing Levels and Skill Mix** Sufficient health and care staff with appropriate competences should be available for: a. The number of patients usually cared for by the service and the usual case mix of patients b. The service's role in the patient pathway and expected timescales c. The assessments, care and therapeutic interventions offered by the service Staffing should include: i. At least two registered healthcare professionals at all times the service is operational ii. A registered nurse available 24/7 in bedded units and daily (7/7) in other services iii. Appropriate therapists for the needs of the patients daily (7/7) iv. Access to social services staff available to undertake social care assessments within 24 hours of request v. Medical staff (QS SN-205) Cover for absences should be available so that the patient pathway is not unreasonably delayed, and patient outcomes and experience are not adversely affected, when individual members of staff are away.	N	Nurse staffing levels were satisfactory in all the community hospitals visited. Therapy staff were available only on Mondays to Fridays. Social workers did not respond within 24 hours of referral and reviewers were told of delays of two to three days following referral. Medical support was through a GP who visited daily Monday to Friday. Medical support was through the GP out of hours service at weekends.
SN-203	**Service Competences and Training Plan** The competences expected for each role in the service should be identified. A training and development plan for achieving and maintaining competences should be in place. If provided by the service, the competence framework should cover: a. Intravenous therapy b. PEG feeds c. Care for patients with dementia or significant cognitive impairment d. VAC therapy and other complex wound care	N	A Trust-wide mandatory training matrix was in place and training required for roles within the service was identified. 'a' and 'd' were not provided by the community hospitals. Mandatory training records for staff in community hospitals were not available and so reviewers were unable to establish whether appropriate training had been completed.

Ref	Quality Standard	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)	N	There was no evidence for 'f' or 'i'. Staff said that all other mandatory training had been completed, although the Trust's self-assessment said that compliance figures varied. Evidence of completion of mandatory training for staff in community hospitals was not available to reviewers.
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	'c' and 'd' were not met by the arrangements in place at the time of the visit. None of the community hospitals had medical input at weekends except for emergencies, when the GP out of hours service would be called.
SN-299	**Administrative, Clerical and Data Collection Support** Administrative, clerical and data collection support should be available.	N	Administrative tasks were being undertaken by clinical staff. The Trust was looking at the proportion of clinical time being spent on non-clinical duties.

Ref	Quality Standard	Met? Y/N	Reviewer Comments
SN-301	**Clinical Support Services** Timely access to an appropriate range of clinical support services should be available, including: a. Imaging b. Pathology, including microbiology c. Pharmacy, including medication supply and medicines management advice d. Appropriate staff to undertake a home assessment within 24 hours of request e. Infection control (7/7 and on call 24/7) f. Tissue viability (7/7) g. Falls prevention (next working day) h. Continence service (7/7) i. Mental health team (crisis response within four hours) j. Counselling	N	'e', 'f' and 'h' were available only on Mondays to Fridays. Other aspects of the Quality Standard were met.
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	'b': drugs 'to take out' were usually available on the same day, but not on Sundays, although staff said that drugs could be couriered from the County Hospital. 'c': Transport was not always available within four hours of request, especially at weekends.
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	Bariatric patients were cared for at Bromyard Community Hospital following assessment at the County Hospital. Appropriate equipment was then ordered.

Ref	Quality Standard	Met? Y/N	Reviewer Comments
SN-499	**IT System** IT systems for storage, retrieval and transmission of patient information should be in use for patient administration, clinical records, outcome information and other data to support service improvement, audit and revalidation.	N	Multiple IT systems were in use. Community hospital staff could access out-patient letters and pathology results but not the electronic discharge system. The Trust was planning to implement an electronic patient record that would also cover community hospitals.
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 were not in place as required by the Quality Standard. In practice, initial assessments were completed, and staff in community hospitals did have access to acute hospital notes.
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	Clinical Guidelines were seen for 'a', 'c', 'g', 'i', and 'l' (diabetes and respiratory conditions). Some other policies may have been available but were difficult to identify because of the way in which policies and guidelines were indexed.

Ref	Quality Standard	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	Two discharge policies were available including a 'Transfer of Patients Policy' but that was out of date. These policies did not cover all the requirements of the Quality Standard.
SN-598	**More Complex Transfers of Care** Guidelines should be in use covering: a. Transfer of care to other local authority or Clinical Commissioning Group areas covering at least social care assessments, intermediate care services available, patient transport and equipment supply or loan b. Transfer to a care home for long-term care c. NHS continuing care assessments and place-finding d. Liaison with palliative and end of life care services e. Patients and/or carers who do not agree an 'After Intermediate Care' Plan or who unreasonably delay their transfer of care	N	Guidelines covering more complex transfers of care were not in place.

Ref	Quality Standard	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'	N	Guidelines for restraint and information sharing were not seen by reviewers.

Ref	Quality Standard	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	Operational policies were in the process of being updated and did not include admission and discharge criteria. Admission and discharge criteria and arrangements appeared to be different in the different community hospitals.
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	The Trust was unable to provide any information regarding this Quality Standard at the time of the visit.

Ref	Quality Standard	Met? Y/N	Reviewer Comments
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	Some self-audits had been undertaken but these did not cover the requirements of this QS. Some of the audits seen by reviewers appeared to show 100% compliance although this was not reflected in the care documentation seen by reviewers.
SN-703	**Key Performance Indicators** Key performance indicators (QS SN-701) should be reviewed regularly with Trust (or equivalent) management and with commissioners.	N	The Trust was unable to provide any information regarding this Quality Standard at the time of the visit. Some performance information was shared at Clinical Quality Review Meetings with the CCG.
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	The Trust was unable to provide any information regarding this Quality Standard at the time of the visit.
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. Uni-disciplinary review meetings did take place.
SN-799	**Document Control** All policies, procedures and guidelines should comply with Trust (or equivalent) document control procedures.	N	A Trust policy and process was in place, but several policies were out of date and identified as due for review.

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COMMISSIONING

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

Ref	Quality Standard	Met? Y/N	Reviewer Comments
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	Clinical quality review meetings were in place and performance information was shared. This information did not cover all the requirements of the Quality Standard.
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 economy review and learning group was not yet in place. These issues were discussed in a range of other forums.

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