Agenda Item:

6

Dorset Health Scrutiny Committee

Dorset County Council

Date of Meeting	16 November 2015
Officer	Director for Adult and Community Services
Subject of Report	**Seven Day Services, Dorset County Hospital NHS Foundation Trust**
Executive Summary	This update follows a previous brief presented to the Dorset Health Scrutiny Committee in March 2015 and a short report submitted in September 2015. There is a national drive for health providers to work toward seven day services. Ten clinical standards have been produced by NHS England and will be used to measure and evidence progress (see Appendix A). Seven Day Service is supported locally by the Dorset Clinical Commissioning Group and Dorset County Hospital, with a commitment to deliver 5 of the 10 clinical standards by 31 March 2016. In July, 2015, Monitor, the NHS Trust Development Authority and NHS England took advice from the Academy of Medical Royal Colleges about which standards would have most impact on reducing mortality and therefore have become the immediate focus. These are: • Standard 2: Time to Consultant Review • Standard 5: Access to Diagnostics • Standard 6: Access to Consultant-directed Interventions • Standard 8: On-going Review • In addition the Trust has added Standard 4: Shift Handovers The remaining 5 standards will be delivered by March 2017.

Impact Assessment: *Please refer to the protocol for writing reports.*	Equalities Impact Assessment: Not applicable.
	Use of Evidence: Report provided by Dorset County Hospital NHS Foundation Trust.
	Budget: Not applicable.
	Risk Assessment: Having considered the risks associated with this decision using the County Council's approved risk management methodology, the level of risk has been identified as: Current Risk: ~~HIGH~~/~~MEDIUM~~/LOW (Delete as appropriate) Residual Risk ~~HIGH~~/~~MEDIUM~~/LOW (Delete as appropriate)
	Other Implications: Not applicable.
Recommendation	That the Committee consider and comment on the progress made in delivering seven-day services at Dorset County Hospital.
Reason for Recommendation	The work of the Health Scrutiny Committee contributes to the County Council's aim to protect and improve the health, wellbeing and safeguarding of all Dorset's citizens.
Appendices	A – NHS Services Seven Days a Week, Clinical Standards B – Audit data, September 2015 C – NHSIQ Case studies
Background Papers	Report to Dorset Health Scrutiny Committee, 8 September 2015: http://www1.dorsetforyou.com/COUNCIL/commis2013.nsf/MIN/EC89FC12AC84B6FD80257EAF0045A7C0?OpenDocument Report to Dorset Health Scrutiny Committee, 10 March 2015: http://www1.dorsetforyou.com/Council/COMMIS2013.nsf/MIN/BE4256ED6618623980257DF9003A54F8?OpenDocument
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Dorset County Hospital NHS
NHS Foundation Trust

Seven Day Services Report 21st Oct 2015

1) Background

This update follows the previous brief presented at the March 2015 committee meeting and a short report submitted in September 2015.

There is a national drive for health providers to work toward seven day services. 10 clinical standards have been produced by NHS England and will be used to measure and evidence progress[1], see Appendix A.

Seven Day Service is supported locally by the Dorset Clinical Commissioning Group and the hospital. Dorset County Hospital is committed to deliver 5 of the 10 clinical standards by 31 March 2016. In July, 2015, Monitor, the NHS Trust Development Authority and NHS England took advice from the Academy of Medical Royal Colleges about which standards would have most impact on reducing mortality and therefore have become the immediate focus. These are:

- Standard 2: Time to Consultant Review
- Standard 5: Access to Diagnostics
- Standard 6: Access to Consultant-directed Interventions
- Standard 8: On-going Review

In addition the Trust has added Standard 4: Shift Handovers

The remaining 5 standards will be delivered by March 2017. These are:

- Standard 1: Patient Experience
- Standard 3: Multi-disciplinary Team (MDT) review
- Standard 7: Mental health
- Standard 9: Transfer to community, primary and social care
- Standard 10: Quality improvement

2) Situation

Work has been in progress for over 12 months. A recent audit took place in September 2015 to measure progress toward compliance of the standards. The results are below. The detailed findings are at Appendix B.

Standard	Theme	Target	Current
2	Time to Consultant Review	100%	62%
5	Access to Diagnostics	100%	64%
6	Access to Consultant-directed Interventions	100%	80%
8	On-going Review	100%	100%
4	Shift Handovers	100%	Needs baseline

[1] http://www.england.nhs.uk/wp-content/uploads/2013/12/forum-summary-report.pdf

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3) Action Plans

The following action plans are designed for the Trust to meet the standards by 31 March 2016.

Standard 2 - Time to Consultant Review & Standard 8 On-going Review
These 2 standards are closely linked, therefore action plans are combined. The Trust ensures all patients are always reviewed on admission and during their stay by a senior doctor, who may not be a consultant. The Trust view is that this interpretation will be used in the future.

A new consultant has been appointed for Respiratory Medicine and another for General Medicine. They will start work in December 2015. This will provide more robust cover to wards and improve review times.

Daily ward round have also been introduced in other areas to reduce the time patients wait to see a consultant.

Standard 5 - Access to Diagnostics & Standard 6 Access to Consultant-directed Interventions
The demand for some services over the weekend is low; pathology services for example. Providing consultant cover every day would require more consultants than are employed and would be prohibitively expensive. Therefore, the Trust is working with other health providers in the county to provide access to diagnostics and interventions seven days a week. This will be achieved by sharing resources to provide cover.

Standard 4 - Shift handover – Hospital at Night
A project group has been formed to meet this standard. They will baseline current performance and will develop an action plan.

4) National Case Studies

The Trust has made good progress in 2 particular in 2 areas:

- Standard 2: Time to first consultant review
- Standard 9: Transfer to community, primary and social care

Seven day consultant review for emergency admissions at Dorset County Hospital NHS Foundation Trust
Auditing of time of Consultant Review for Emergency Admissions at Dorset County Hospital NHS Foundation Trust changes clinical practice.

Seven day social care to support people to go home from hospital
Health and social care working together to ensure patients get home to the right place at the right time to reduce the number of inappropriate residential home placements

This was recognised and reported on by the national NHS Improving Quality team.

Case studies were produced and are at Appendix C.

There is still a requirement to obtain a baseline for shift handovers to ensure compliance; an action plan can then be formed on the back of this.

Dorset County Hospital NHS
NHS Foundation Trust

5) Ongoing Risks and Assurance

The main risk to delivery is staffing vacancies; doctors are in very short supply. To cover some of these gaps locums or agency staff are used. However, the cost of agency and locum staff is high and this puts additional pressure on the Trust's finances.
A re-audit of the five Clinical Standards will take place in March 2016 using the seven day services self-assessment online tool. We can then measure improvements made and identify any areas that will require further investment of time to achieve compliance.
Mortality performance within the Trust is monitored closely and reported regularly within the Trust. It is also reported external to the wider NHS to compare Trusts against each other. This provides early warning of any negative changes to our performance and allows for remedial action.

6) Recommendation

The Trust will continue to implement current actions to comply with current five standards by March 2016. Progress will be monitored and reported internally to Transformation Board and externally to NHS England.

Audit all ten standards March 2016 to confirm compliance of current five standards and obtain baseline for remaining five standards.

The Trust will report progress again to the Dorset Health Scrutiny Committee in May 2016. Progress and review action plans for remaining five standards to be fully compliant by March 2017.

Julie Pearce
Chief Operating Officer
Dorset County Hospital NHS Foundation Trust

NHS Services, Seven Days a Week Forum

Clinical Standards

No.	Standard	Adapted from source
	Patient Experience	
1	**Standard:** Patients, and where appropriate families and carers, must be actively involved in shared decision making and supported by clear information from health and social care professionals to make fully informed choices about investigations, treatment and on-going care that reflect what is important to them. This should happen consistently, seven days a week. **Supporting information:** • Patients must be treated with dignity, kindness, compassion, courtesy, respect, understanding and honesty at all times. • The format of information provided must be appropriate to the patient's needs and include acute conditions. • With the increasing collection of real-time feedback, it is expected that hospitals are able to compare feedback from weekday and weekend admissions and display publically in ward areas.	NICE (2012): Quality standard for patient experience in adult NHS services (QS15) RCS (2011): *Emergency Surgery, Standards for unscheduled surgical care*
	Time to first consultant review	
2	**Standard:** All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of arrival at hospital. **Supporting information:** • All patients to have a National Early Warning Score (NEWS) established at the time of admission. • Consultant involvement for patients considered 'high risk' (defined as where the risk of mortality is greater than 10%, or where a patient is unstable and not responding to treatment as expected) should be within one hour. • All patients admitted during the period of consultant presence on the	NCEPOD (2007): *Emergency Admissions: A journey in the right direction?* RCP (2007): *Acute medical care: The right person, in the right setting – first time* RCS (2011): *Emergency Surgery, Standards for unscheduled surgical care* RCP (2012): *Delivering a 12-hour, 7-day consultant presence on the acute medical unit*

No.	Standard	Adapted from source
	acute ward (normally at least 08.00-20.00) should be seen and assessed by a doctor, or advanced non-medical practitioner with a similar level of skill promptly, and seen and assessed by a consultant within six hours. • Standards are not sequential; clinical assessment may require the results of diagnostic investigation. • A 'suitable' consultant is one who is familiar with the type of emergency presentations in the relevant specialty and is able to initiate a diagnostic and treatment plan. • The standard applies to emergency admissions via any route, not just the Emergency Department. • For emergency care settings without consultant leadership, review is undertaken by appropriate senior clinician e.g. GP-led inpatient units.	
	Multi-disciplinary Team (MDT) review	
3	**Standard:** All emergency inpatients must be assessed for complex or on-going needs within 14 hours by a multi-professional team, overseen by a competent decision-maker, unless deemed unnecessary by the responsible consultant. An integrated management plan with estimated discharge date and physiological and functional criteria for discharge must be in place along with completed medicines reconciliation within 24 hours. **Supporting information:** • The MDT will vary by specialty but as a minimum will include Nursing, Medicine, Pharmacy, Physiotherapy and for medical patients, Occupational Therapy. • Other professionals that may be required include but are not limited to: dieticians, podiatrists, speech and language therapy and psychologists and consultants in other specialist areas such as geriatrics. • Reviews should be informed by patients existing primary and community care records. • Appropriate staff must be available for the treatment/management plan	RCP (2007): *Acute medical care: The right person, in the right setting – first time* RCS (2011): *Emergency Surgery, Standards for unscheduled surgical care* NICE (2007): *Technical patient safety solutions for medicines reconciliation on admission of adults to hospital*

No.	Standard	Adapted from source
	to be carried out.	
	Shift handovers	
4	**Standard:** Handovers must be led by a competent senior decision maker and take place at a designated time and place, with multi-professional participation from the relevant in-coming and out-going shifts. Handover processes, including communication and documentation, must be reflected in hospital policy and standardised across seven days of the week. **Supporting information:** • Shift handovers should be kept to a minimum (recommended twice daily) and take place in or adjacent to the ward or unit. • Clinical data should be recorded electronically, according to national standards for structure and content and include the NHS number.	RCP (2011): *Acute care toolkit 1: Handover* RCP (2013): *Future Hospital Commission*
	Diagnostics	
5	**Standard:** Hospital inpatients must have scheduled seven-day access to diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, bronchoscopy and pathology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hours for urgent patients • Within 24 hours for non-urgent patients **Supporting information:** • It is expected that all hospitals have access to radiology, haematology, biochemistry, microbiology and histopathology • Critical patients are considered those for whom the test will alter their management at the time; urgent patients are considered those for whom	RCP (2007): *Acute medical care: The right person, in the right setting – first time* RCS (2011): *Emergency Surgery, Standards for unscheduled surgical care* AOMRC (2012): *Seven day consultant present care* RCR (2009): *Standards for providing a 24-hour radiology diagnostic service* NICE (2008): *Metastatic spinal cord compression*

No.	Standard	Adapted from source
	the test will alter their management but not necessarily that day. • Standards are not sequential; if critical diagnostics are required they may precede the thorough clinical assessment by a suitable consultant in standard 2. • Investigation of diagnostic results should be seen and acted on promptly by the MDT, led by a competent decision maker. • Where a service is not available on-site (e.g. interventional radiology/endoscopy or MRI), clear patient pathways must be in place between providers. • Seven-day consultant presence in the radiology department is envisaged. • Non-ionizing procedures may be undertaken by independent practitioners and not under consultant direction.	
	Intervention / key services	
6	**Standard:** Hospital inpatients must have timely 24 hour access, seven days a week, to consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear protocols, such as: • Critical care • Interventional radiology • Interventional endoscopy • Emergency general surgery **Supporting information:** • Standards are not sequential; if an intervention is required it may precede the thorough clinical assessment by a suitable consultant in standard 2. • Other interventions may also be required. For example, this may include: o Renal replacement therapy	NCEPOD (1997): *Who operates when?* NCEPOD (2007): *Emergency admissions: A journey in the right direction?* RCP (2007): *Acute medical care: The right person, in the right setting – first time* RCS (2011): *Emergency Surgery, Standards for unscheduled surgical care* British Society of Gastroenterology AoMRC (2008): *Managing urgent mental health needs in the acute trust*

No.	Standard	Adapted from source
	o Urgent radiotherapy o Thrombolysis o PCI o Cardiac pacing	
	Mental health	
7	**Standard:** Where a mental health need is identified following an acute admission the patient must be assessed by psychiatric liaison within the appropriate timescales 24 hours a day, seven days a week: • Within 1 hour for emergency* care needs • Within 14 hours for urgent** care needs **Supporting information:** • Unless the liaison team provides 24 hour cover, there must be effective collaboration between the liaison team and out-of-hours services (e.g. Crisis Resolution Home Treatment Teams, on-call staff, etc.) * An acute disturbance of mental state and/or behaviour which poses a significant, imminent risk to the patient or others. ** A disturbance of mental state and/or behaviour which poses a risk to the patient or others, but does not require immediate mental health involvement.	RCPsych PLAN (2011): *Quality Standards for Liaison Psychiatry Services*
	On-going review	
8	**Standard:** All patients on the AMU, SAU, ICU and other high dependency areas must be seen and reviewed by a consultant twice daily, including all acutely ill patients directly transferred, or others who deteriorate. To maximise continuity of care consultants should be working multiple day blocks. Once transferred from the acute area of the hospital to a general ward patients should be reviewed during a consultant-delivered ward round at least once every 24 hours, seven days a week, unless it has been determined that this	RCP (2007): *Acute medical care: The right person, in the right setting – first time* RCS (2011): *Emergency Surgery, Standards for unscheduled surgical care* AOMRC (2012): *Seven day consultant present care*

No.	Standard	Adapted from source
	would not affect the patient's care pathway. **Supporting information:** • Patients, and where appropriate carers and families, must be made aware of reviews. Where a review results in a change to the patient's management plan, they should be made aware of the outcome and provided with relevant verbal, and where appropriate written, information. • Inpatient specialist referral should be made on the same day as the decision to refer and patients should be seen by the specialist within 24 hours or one hour for high risk patients (defined as where the risk of mortality is greater than 10%, or where a patient is unstable and not responding to treatment as expected). • Consultants 'multiple day blocks' should be between two and four continuous days. • Ward rounds are defined as a face-to-face review of all patients and include members of the nursing team to ensure proactive management and transfer of information. • Once admitted to hospital, patients should not be transferred between wards unless their clinical needs demand it. • The number of handovers between teams should be kept to a minimum to maximise patient continuity of care. • Where patients are required to transfer between wards or teams, this is prioritised by staff and supported by an electronic record of the patient's clinical and care needs. • Inpatients not in high dependency areas must still have daily review by a competent decision-maker. This can be delegated by consultants on a named patient basis. The responsible consultant should be made aware of any decision and available for support if required.	RCP (2013): *Future Hospital Commission*
	Transfer to community, primary and social care	
9	**Standard:** Support services, both in the hospital and in primary ,community and mental	AOMRC (2012): *Seven day consultant present care*

No.	Standard	Adapted from source
	health settings must be available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken. **Supporting information:** • Primary and community care services should have access to appropriate senior clinical expertise (e.g. via phone call), and where available, an integrated care record, to mitigate the risk of emergency readmission. • Services include pharmacy, physiotherapy, occupational therapy, social services, equipment provision, district nursing and timely and effective communication of on-going care plan from hospital to primary, community and social care. • Transport services must be available to transfer, seven days a week. • There should be effective relationships between medical and other health and social care teams.	
	Quality improvement	
10	**Standard:** All those involved in the delivery of acute care must participate in the review of patient outcomes to drive care quality improvement. The duties, working hours and supervision of trainees in all healthcare professions must be consistent with the delivery of high-quality, safe patient care, seven days a week. **Supporting information:** • The review of patient outcomes should focus on the three pillars of quality care: patient experience, patient safety and clinical effectiveness. • Attention should be paid to ensure the delivery of seven day services supports training that is consistent with General Medical Council and Health Education England recommendations and that trainees learn how to assess, treat and care for patients in emergency as well as elective settings. • All clinicians should be involved in the review of outcomes to facilitate	GMC (2010): Generic standards for specialty including GP training

No.	Standard	Adapted from source
	learning and drive quality improvements.	

7 Day Services Self Assessment - Submitted 04/09/15

Case studies reviewed for 2) Time to first Consutlant review and 8) On-Going review.

Answers for 5) Diagnostics and 6) Intervention and Key Services by Service/Department Managers or Consultansts.

2) Time to first Consultant Review

Time to First Consultant Review - *All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours of arrival at hospital.*

- *All patients to have "National Early Warning Score" (NEWS) established at time of admission*
- *Consultant involvement for patients considered "high risk"*
- *All patients admitted during period of consultant presence on the acute ward (normally at least 08.00-20.00) seen and assessed by a doctor, or advanced non-medical practitioner with a similar level of skill promptly and seen and assessed by a consultant within six hours.*

We suggest that, in order to evidence Clinical Standard 2, Trusts complete a case-note review of ten sets of case notes against each of the specialities relevant to the organisation.
These should be emergency patients admitted within the last 3 months with 5 sets of case notes being from week day admissions and 5 sets of case notes covering both days at the weekend.
Case Note Review Proforma - this will be helpful in undertaking the case note review.

2.1 What percentage of patients admitted as an emergency (not just through the emergency department) receive a thorough clinical assessment by a suitable consultant (seven days a week) within 14 hours of arrival at hospital?

Calculated Average	Cardiology	General Medicine	General Surgery	Geriatric Medicine	Gynaecology
62%	60%	80%	60%	70%	20%
Intensive Care	**Obstetrics**	**Paediatrics**	**Psychiatry**	**Respiratory Medicine**	**Trauma And Orthopaedics**
100%	Don't Know	80%	Not applicable	100%	50%

2.1.1 What issues are preventing a higher percentage of patients receiving a clinical assessment?

2.2 Approximately, what percentage of patients on admission are established with a "National Early Warning Score" (NEWS)?

Calculated Average	Cardiology	General Medicine	General Surgery	Geriatric Medicine	Gynaecology
100%	100%	100%	100%	100%	100%
Intensive Care	**Obstetrics**	**Paediatrics**	**Psychiatry**	**Respiratory Medicine**	**Trauma And Orthopaedics**
100%	Not applicable	100%	Not applicable	100%	100%

2.3 Are consultants involved for patients considered 'high risk' (defined as where the risk of mortality is greater than 10%, or where a patient is unstable and not responding to treatment as expected)?

All Specialties	Cardiology	General Medicine	General Surgery	Geriatric Medicine	Gynaecology
○ Yes-within 1 hr	◉ Yes-within 1 hr	◉ Yes-within 1 hr	◉ Yes-within 1 hr	◉ Yes-within 1 hr	◉ Yes-within 1 hr
○ Yes-within 2 hrs	○ Yes-within 2 hrs	○ Yes-within 2 hrs	○ Yes-within 2 hrs	○ Yes-within 2 hrs	○ Yes-within 2 hrs
○ Yes-within 3 hrs	○ Yes-within 3 hrs	○ Yes-within 3 hrs	○ Yes-within 3 hrs	○ Yes-within 3 hrs	○ Yes-within 3 hrs
○ Yes-within 4 hrs	○ Yes-within 4 hrs	○ Yes-within 4 hrs	○ Yes-within 4 hrs	○ Yes-within 4 hrs	○ Yes-within 4 hrs
○ No	○ No	○ No	○ No	○ No	○ No
○ Don't Know	○ Don't Know	○ Don't Know	○ Don't Know	○ Don't Know	○ Don't Know
○ Not applicable	○ Not applicable	○ Not applicable	○ Not applicable	○ Not applicable	○ Not applicable

Intensive Care	Obstetrics	Paediatrics	Psychiatry	Respiratory Medicine	Trauma And Orthopaedics
◉ Yes-within 1 hr	◉ Yes-within 1 hr	◉ Yes-within 1 hr	○ Yes-within 1 hr	◉ Yes-within 1 hr	◉ Yes-within 1 hr
○ Yes-within 2 hrs	○ Yes-within 2 hrs	○ Yes-within 2 hrs	○ Yes-within 2 hrs	○ Yes-within 2 hrs	○ Yes-within 2 hrs
○ Yes-within 3 hrs	○ Yes-within 3 hrs	○ Yes-within 3 hrs	○ Yes-within 3 hrs	○ Yes-within 3 hrs	○ Yes-within 3 hrs
○ Yes-within 4 hrs	○ Yes-within 4 hrs	○ Yes-within 4 hrs	○ Yes-within 4 hrs	○ Yes-within 4 hrs	○ Yes-within 4 hrs
○ No	○ No	○ No	○ No	○ No	○ No
○ Don't Know	○ Don't Know	○ Don't Know	○ Don't Know	○ Don't Know	○ Don't Know
○ Not applicable	○ Not applicable	○ Not applicable	◉ Not applicable	○ Not applicable	○ Not applicable

2.4 Approximately, what percentage of patients admitted during the period of consultant presence on the acute ward (normally at least 08.00-20.00) are seen and assessed by a doctor, or advanced non-medical practitioner with a similar level of skill?

Calculated Average	Cardiology	General Medicine	General Surgery	Geriatric Medicine	Gynaecology
100%	100%	100%	100%	100%	100%
Intensive Care	**Obstetrics**	**Paediatrics**	**Psychiatry**	**Respiratory Medicine**	**Trauma And Orthopaedics**
100%	100%	100%	Not applicable	100%	100%

2.5 Approximately, what percentage of patients admitted during the period of consultant presence on the acute ward are seen and assessed by a consultant within 6 hours admission to the acute ward?

Calculated Average	Cardiology	General Medicine	General Surgery	Geriatric Medicine	Gynaecology
70%	30%	80%	60%	20%	70%
Intensive Care	**Obstetrics**	**Paediatrics**	**Psychiatry**	**Respiratory Medicine**	**Trauma And Orthopaedics**
100%	100%	100%	Not applicable	100%	40%

5) Diagnostics

Diagnostics - *Hospital inpatients must have scheduled seven-day access to diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, bronchoscopy and pathology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week:*

- *Within 1 hour for critical patients*
- *Within 12 hours for urgent patients*
- *Within 24 hours for non-urgent patients*

5.1 On which days are the following diagnostic services available to all hospital inpatients?

Service Name	All Week	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Biochemistry	☑	☑	☑	☑	☑	☑	☑	☑
Bronchoscopy	☐	☑	☑	☑	☑	☑	☐	☐
Chemical Pathology	☑	☑	☑	☑	☑	☑	☑	☑
Computerised Tomography	☑	☑	☑	☑	☑	☑	☑	☑
Echocardiography	☐	☑	☑	☑	☑	☑	☐	☐
Haematology	☑	☑	☑	☑	☑	☑	☑	☑
Histopathology	☐	☑	☑	☑	☑	☑	☐	☐
Magnetic Resonance Imaging	☐	☑	☑	☑	☑	☑	☑	☐
Microbiology	☐	☑	☑	☑	☑	☑	☑	☐
Radiology	☑	☑	☑	☑	☑	☑	☑	☑
Therapeutic Lower GI Endoscopy	☑	☑	☑	☑	☑	☑	☑	☑
Therapeutic Upper GI Endoscopy	☑	☑	☑	☑	☑	☑	☑	☑
Ultrasound	☑	☑	☑	☑	☑	☑	☑	☑
X-Ray	☑	☑	☑	☑	☑	☑	☑	☑

Access for in-patients may be on-site, or via a formal network arrangement with another site

5.2 Are consultant-directed diagnostic tests and completed reporting available seven days a week for the following:

	Within 1 Hour For Critical* Patients				Within 12 Hours For Urgent** Patients				Within 24 Hours For Non-Urgent Patients			
	Yes	No	Dont know	N/A	Yes	No	Dont know	N/A	Yes	No	Dont know	N/A
All Specialties	○	○	○	○	○	○	○	○	○	○	○	○
Cardiology	●	○	○	○	○	○	○	●	○	●	○	○
General Medicine	●	○	○	○	●	○	○	○	○	●	○	○
General Surgery	●	○	○	○	○	○	●	○	○	●	○	○
Geriatric Medicine	●	○	○	○	●	○	○	○	○	●	○	○
Gynaecology	○	●	○	○	●	○	○	○	○	●	○	○
Intensive Care	●	○	○	○	●	○	○	○	●	○	○	○
Obstetrics	●	○	○	○	●	○	○	○	○	●	○	○
Paediatrics	○	●	○	○	○	●	○	○	○	●	○	○
Psychiatry	○	○	○	●	○	○	○	●	○	○	○	●
Respiratory Medicine	●	○	○	○	●	○	○	○	○	●	○	○
Trauma And Orthopaedics	○	●	○	○	○	●	○	○	○	●	○	○

** Critical patients are considered those for whom the test will alter their management at the time*

*** Urgent patients are considered those for whom the test will alter their management but not necessarily that day*

5.3 Are investigations of diagnostic results seen and acted on promptly by the MDT, led by a competent decision maker?

All Specialties	Cardiology	General Medicine	General Surgery	Geriatric Medicine	Gynaecology
○ Yes	○ Yes	○ Yes	● Yes	○ Yes	● Yes
○ No	○ No	● No	○ No	● No	○ No
○ Dont know	○ Dont know	○ Dont know	○ Dont know	○ Dont know	○ Dont know
○ Not applicable	● Not applicable	○ Not applicable	○ Not applicable	○ Not applicable	○ Not applicable

Intensive Care	Obstetrics	Paediatrics	Psychiatry	Respiratory Medicine	Trauma And Orthopaedics
● Yes	● Yes	● Yes	○ Yes	○ Yes	● Yes
○ No	○ No	○ No	○ No	● No	○ No
○ Dont know	○ Dont know	○ Dont know	○ Dont know	○ Dont know	○ Dont know
○ Not applicable	○ Not applicable	○ Not applicable	● Not applicable	○ Not applicable	○ Not applicable

5.3.1 If "no" is answered to any of the above, please detail the specialty and reason why below

General Medicine:
Geriatric Medicine:
Respiratory Medicine:

5.4 Where an interventional radiology service is not available on-site are there formal agreed patient pathways in place between providers?

All Specialties	Cardiology	General Medicine	General Surgery	Geriatric Medicine	Gynaecology
Yes	Yes	Yes	Yes	Yes	Yes
No	No	No	No	No	No
Dont know	Dont know	Dont know	Dont know	Dont know	Dont know
Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable

Intensive Care	Obstetrics	Paediatrics	Psychiatry	Respiratory Medicine	Trauma And Orthopaedics
Yes	Yes	Yes	Yes	Yes	Yes
No	No	No	No	No	No
Dont know	Dont know	Dont know	Dont know	Dont know	Dont know
Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable

5.4.1 If "no" is answered to any of the above, please detail the specialty and reason why below

5.5 Where an endoscopy service is not available on-site are there formal agreed patient pathways in place between providers?

All Specialties	Cardiology	General Medicine	General Surgery	Geriatric Medicine	Gynaecology
Yes	Yes	Yes	Yes	Yes	Yes
No	No	No	No	No	No
Dont know	Dont know	Dont know	Dont know	Dont know	Dont know
Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable

Intensive Care	Obstetrics	Paediatrics	Psychiatry	Respiratory Medicine	Trauma And Orthopaedics
Yes	Yes	Yes	Yes	Yes	Yes
No	No	No	No	No	No
Dont know	Dont know	Dont know	Dont know	Dont know	Dont know
Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable

5.5.1 If "no" is answered to any of the above, please detail the specialty and reason why below

5.6 Where an MRI service is not available on-site are there formal agreed patient pathways in place between providers?

All Specialties	Cardiology	General Medicine	General Surgery	Geriatric Medicine	Gynaecology
(•) Yes	(•) Yes	(•) Yes	(•) Yes	(•) Yes	(•) Yes
( ) No	( ) No	( ) No	( ) No	( ) No	( ) No
( ) Dont know	( ) Dont know	( ) Dont know	( ) Dont know	( ) Dont know	( ) Dont know
( ) Not applicable	( ) Not applicable	( ) Not applicable	( ) Not applicable	( ) Not applicable	( ) Not applicable

Intensive Care	Obstetrics	Paediatrics	Psychiatry	Respiratory Medicine	Trauma And Orthopaedics
(•) Yes	(•) Yes	(•) Yes	(•) Yes	(•) Yes	(•) Yes
( ) No	( ) No	( ) No	( ) No	( ) No	( ) No
( ) Dont know	( ) Dont know	( ) Dont know	( ) Dont know	( ) Dont know	( ) Dont know
( ) Not applicable	( ) Not applicable	( ) Not applicable	( ) Not applicable	( ) Not applicable	( ) Not applicable

5.6.1 If "no" is answered to any of the above, please detail the specialty and reason why below

5.7 Is there a consultant presence in the radiology department?

	All Week	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Radiology	☐	☑	☑	☑	☑	☑	☐	☐

Access for in-patients may be on-site, or via a formal network arrangement with another site

5.7.1 If this isn't every day why is this?

Consultants on call over weekend

6) Intervention / Key Services

Intervention / Key Services - *Hospital inpatients must have timely 24 hour access, seven days a week, to consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear protocols, such as:*

- *Critical care*
- *Interventional radiology*
- *Interventional endoscopy*
- *Emergency general surgery*

6.1 When are the following interventions available to hospital inpatients?

	All Week	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Cardiac Pacing	☑	☑	☑	☑	☑	☑	☑	☑
PCI	☐	☑	☑	☑	☑	☑	☐	☐
Renal Replacement Therapy	☑	☑	☑	☑	☑	☑	☑	☑
Thrombolysis	☑	☑	☑	☑	☑	☑	☑	☑
Urgent Radiotherapy	☑	☑	☑	☑	☑	☑	☑	☑

Access for in-patients may be on-site, or via a formal network arrangement with another site

6.1.1 Please add any further details below

6.2 Do inpatients have 24 hour access to consultant-directed interventions, seven days a week?

	Yes – all on site	Yes – all off site	Yes – combination	No	Don't know
Cardiac Pacing*	○	○	○	◉	○
Critical Care	○	○	◉	○	○
Emergency General Surgery	○	○	◉	○	○
Interventional Endoscopy	○	○	◉	○	○
Interventional Radiology	○	○	◉	○	○
PCI*	○	○	○	○	○
Renal Replacement Therapy*	○	○	◉	○	○
Thrombolysis*	○	○	◉	○	○
Urgent Radiotherapy*	○	◉	○	○	○

Access for in-patients may be on-site, or via a formal network arrangement with another site

** Note that these options are only selectable if "All Week" is ticked in the corresponding row of the table above (6.1).*

6.2.1 Are formally agreed protocols in place for the following?

Cardiac Pacing	○ Yes ○ No ○ Dont know
Critical Care	○ Yes ○ No ○ Dont know
Emergency General Surgery	○ Yes ○ No ○ Dont know
Interventional Endoscopy	○ Yes ○ No ○ Dont know
Interventional Radiology	○ Yes ○ No ○ Dont know
PCI	○ Yes ○ No ○ Dont know
Renal Replacement Therapy	○ Yes ○ No ○ Dont know
Thrombolysis	○ Yes ○ No ○ Dont know
Urgent Radiotherapy	○ Yes ○ No ○ Dont know

8) On-Going Review

On-Going Review - *All patients on the AMU, SAU, ICU and other high dependency areas must be seen and reviewed by a consultant twice daily, including all acutely ill patients directly transferred, or others who deteriorate. To maximise continuity of care consultants should be working multiple day blocks.*

Once transferred from the acute area of the hospital to a general ward patients should be reviewed during a consultant-delivered ward round at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway.

We suggest that, in order to evidence Clinical Standard 8, Trusts complete a case-note review of ten sets of case notes against each of the specialities relevant to the organisation.
These should be patients admitted within the last 3 months with 5 sets of case notes being from week day admissions and 5 sets of case notes covering both days at the weekend.
Case Note Review Proforma - this will be helpful in undertaking the case note review.

8.1 Are all patients on the acute medical unit, acute surgical unit, intensive care unit and other high dependency units seen and reviewed by a consultant twice daily (including all acutely ill patients directly transferred, or others who deteriorate)?

Acute Medical Unit	(•) Yes	( ) No	( ) Dont know	( ) Not applicable
Acute Surgical Unit	(•) Yes	( ) No	( ) Dont know	( ) Not applicable
Intensive Care Unit	(•) Yes	( ) No	( ) Dont know	( ) Not applicable
Other High Dependency Units	(•) Yes	( ) No	( ) Dont know	( ) Not applicable

8.2 Once transferred from an acute area of the hospital to a general ward are patients reviewed, as part of a consultant-delivered ward round at least once every 24 hours, seven days a week (unless it has been determined that this would not affect the patient's care pathway)?

All Specialties	Cardiology	General Medicine	General Surgery	Geriatric Medicine	Gynaecology
( ) Yes	( ) Yes	(•) Yes	(•) Yes	( ) Yes	( ) Yes
( ) No	(•) No	( ) No	( ) No	(•) No	(•) No
( ) Dont know	( ) Dont know	( ) Dont know	( ) Dont know	( ) Dont know	( ) Dont know
( ) Not applicable	( ) Not applicable	( ) Not applicable	( ) Not applicable	( ) Not applicable	( ) Not applicable

Intensive Care	Obstetrics	Paediatrics	Psychiatry	Respiratory Medicine	Trauma And Orthopaedics
(•) Yes	(•) Yes	(•) Yes	( ) Yes	( ) Yes	( ) Yes
( ) No	( ) No	( ) No	( ) No	(•) No	(•) No
( ) Dont know	( ) Dont know	( ) Dont know	( ) Dont know	( ) Dont know	( ) Dont know
( ) Not applicable	( ) Not applicable	( ) Not applicable	(•) Not applicable	( ) Not applicable	( ) Not applicable

8.3 Are patients (and where appropriate carers and families) made aware of reviews done by consultants on AMU, SAU, ICU and other high dependency areas?

Yes

8.4 Where a review results in a change to the patient's management plan, are they (and where appropriate carers and families) made aware of the outcome and provided with relevant verbal, and where appropriate written, information?

All Specialties	Cardiology	General Medicine	General Surgery	Geriatric Medicine	Gynaecology
○ Yes	◉ Yes	◉ Yes	◉ Yes	◉ Yes	◉ Yes
○ No	○ No	○ No	○ No	○ No	○ No
○ Dont know	○ Dont know	○ Dont know	○ Dont know	○ Dont know	○ Dont know
○ Not applicable	○ Not applicable	○ Not applicable	○ Not applicable	○ Not applicable	○ Not applicable

Intensive Care	Obstetrics	Paediatrics	Psychiatry	Respiratory Medicine	Trauma And Orthopaedics
◉ Yes	◉ Yes	◉ Yes	○ Yes	◉ Yes	◉ Yes
○ No	○ No	○ No	○ No	○ No	○ No
○ Dont know	○ Dont know	○ Dont know	○ Dont know	○ Dont know	○ Dont know
○ Not applicable	○ Not applicable	○ Not applicable	◉ Not applicable	○ Not applicable	○ Not applicable

8.4.1 If "no" is answered to any of the above, please detail the specialty and reason why below

8.5 Are inpatient specialist referrals made on the same day as the decision to refer (every day of the week)?

All Specialties	Cardiology	General Medicine	General Surgery	Geriatric Medicine	Gynaecology
○ Yes	○ Yes	○ Yes	◉ Yes	○ Yes	○ Yes
○ No	◉ No	◉ No	○ No	◉ No	◉ No
○ Dont know	○ Dont know	○ Dont know	○ Dont know	○ Dont know	○ Dont know
○ Not applicable	○ Not applicable	○ Not applicable	○ Not applicable	○ Not applicable	○ Not applicable

Intensive Care	Obstetrics	Paediatrics	Psychiatry	Respiratory Medicine	Trauma And Orthopaedics
◉ Yes	◉ Yes	◉ Yes	○ Yes	○ Yes	○ Yes
○ No	○ No	○ No	○ No	◉ No	◉ No
○ Dont know	○ Dont know	○ Dont know	○ Dont know	○ Dont know	○ Dont know
○ Not applicable	○ Not applicable	○ Not applicable	◉ Not applicable	○ Not applicable	○ Not applicable

8.5.1 If "no" is answered to any of the above, please detail the specialty and reason why below

This does not happen at weekends.

If "yes", are patients also seen by the specialist within 24 hours or one hour for high risk patients (defined as where the risk of mortality is greater than 10%, or where a patient is unstable and not responding to treatment as expected)?

8.5.2 Twenty-four hours

All Specialties	Cardiology	General Medicine	General Surgery	Geriatric Medicine	Gynaecology
○ Yes	○ Yes	○ Yes	◉ Yes	○ Yes	○ Yes
○ No	○ No	○ No	○ No	○ No	○ No
○ Dont know	○ Dont know	○ Dont know	○ Dont know	○ Dont know	○ Dont know
○ Not applicable	○ Not applicable	○ Not applicable	○ Not applicable	○ Not applicable	○ Not applicable

Intensive Care	Obstetrics	Paediatrics	Psychiatry	Respiratory Medicine	Trauma And Orthopaedics
◉ Yes	◉ Yes	◉ Yes	○ Yes	○ Yes	○ Yes
○ No	○ No	○ No	○ No	○ No	○ No
○ Dont know	○ Dont know	○ Dont know	○ Dont know	○ Dont know	○ Dont know
○ Not applicable	○ Not applicable	○ Not applicable	○ Not applicable	○ Not applicable	○ Not applicable

8.5.3 One hour for high risk patients

All Specialties	Cardiology	General Medicine	General Surgery	Geriatric Medicine	Gynaecology
○ Yes	○ Yes	○ Yes	◉ Yes	○ Yes	○ Yes
○ No	○ No	○ No	○ No	○ No	○ No
○ Dont know	○ Dont know	○ Dont know	○ Dont know	○ Dont know	○ Dont know
○ Not applicable	○ Not applicable	○ Not applicable	○ Not applicable	○ Not applicable	○ Not applicable

Intensive Care	Obstetrics	Paediatrics	Psychiatry	Respiratory Medicine	Trauma And Orthopaedics
◉ Yes	◉ Yes	◉ Yes	○ Yes	○ Yes	○ Yes
○ No	○ No	○ No	○ No	○ No	○ No
○ Dont know	○ Dont know	○ Dont know	○ Dont know	○ Dont know	○ Dont know
○ Not applicable	○ Not applicable	○ Not applicable	○ Not applicable	○ Not applicable	○ Not applicable

8.6 Where patients are required to transfer between wards or teams, is this prioritised by staff and supported by an electronic record of the patient's clinical and care needs?

All Specialties	Cardiology	General Medicine	General Surgery	Geriatric Medicine	Gynaecology
○ Yes	○ Yes	○ Yes	○ Yes	○ Yes	○ Yes
◉ No	◉ No	◉ No	◉ No	◉ No	◉ No
○ Dont know	○ Dont know	○ Dont know	○ Dont know	○ Dont know	○ Dont know
○ Not applicable	○ Not applicable	○ Not applicable	○ Not applicable	○ Not applicable	○ Not applicable

Intensive Care	Obstetrics	Paediatrics	Psychiatry	Respiratory Medicine	Trauma And Orthopaedics
○ Yes	○ Yes	○ Yes	○ Yes	○ Yes	○ Yes
◉ No	◉ No	◉ No	◉ No	◉ No	◉ No
○ Dont know	○ Dont know	○ Dont know	○ Dont know	○ Dont know	○ Dont know
○ Not applicable	○ Not applicable	○ Not applicable	○ Not applicable	○ Not applicable	○ Not applicable

8.6.1 If "no" is answered to any of the above, please detail the specialty and reason why below

The entire care plan is not recorded electronically, only partially.

8.7 Do those inpatients not in high dependency area have a daily review by a competent decision-maker?

PLEASE NOTE – This can be delegated by consultants on a named patient basis. The responsible consultant should be made aware of any decision and available for support if required

All Specialties	Cardiology	General Medicine	General Surgery	Geriatric Medicine	Gynaecology
○ Yes	◉ Yes	◉ Yes	◉ Yes	◉ Yes	◉ Yes
○ No	○ No	○ No	○ No	○ No	○ No
○ Dont know	○ Dont know	○ Dont know	○ Dont know	○ Dont know	○ Dont know
○ Not applicable	○ Not applicable	○ Not applicable	○ Not applicable	○ Not applicable	○ Not applicable

Intensive Care	Obstetrics	Paediatrics	Psychiatry	Respiratory Medicine	Trauma And Orthopaedics
◉ Yes	◉ Yes	◉ Yes	○ Yes	◉ Yes	◉ Yes
○ No	○ No	○ No	○ No	○ No	○ No
○ Dont know	○ Dont know	○ Dont know	○ Dont know	○ Dont know	○ Dont know
○ Not applicable	○ Not applicable	○ Not applicable	◉ Not applicable	○ Not applicable	○ Not applicable

8.7.1 If "no" is answered to any of the above, please detail the specialty and reason why below

Seven day consultant review for emergency admissions at Dorset County Hospital NHS Foundation Trust

Auditing of time of Consultant Review for Emergency Admissions at Dorset County Hospital NHS Foundation Trust changes clinical practice

At a glance

- Junior doctors at Dorset County Hospital NHS Foundation Trust undertook 2 Consultant review audits, against the clinical standard for review of patients within 14 hours of admissions to identify areas for improvement
- A key driver for the initiative was the requirement to meet a CQINN
- The audit was designed and conducted by junior doctors and included all emergency admission for surgery, medicine and paediatrics
- The audit cycle produced an increase in compliance with the clinical standard from 59% in surgery and 64% in medicine to 88% and 89% respectively.

Dorset County Hospital NHS Foundation Trust identified consultant review of emergency admissions as an area of concern identified via the trust's Quality Committee who were seeking assurance that we were meeting the trust objective in 2014/15.

As a result junior doctors designed an audit to establish whether the hospital was compliant in providing consultant review within 14 hours of decision to admit The purpose of the audit was also to highlight whether there was a difference in the level of consultant review at weekends compared to week days.

How the improvement were made

Junior doctors co-designed the audit methodology and data collection methods. The base line audit period was selected to incorporate a Bank Holiday weekend and ran from 00:1 on 21st May 2014 to 24:00 on 27th May 2014.

The sample was identified by extracting data from the patient administration system for all emergency admissions to Dorset County Hospital during the audit period. Where possible the notes of each patient were reviewed by the auditors and a simple audit proforma was completed for each.

Completed proformas were collected by the audit department and the data collated onto a spreadsheet. Where possible, any notes that had been missed, due to patient movement or discharge, were then follow up and audited by the patient safety coordinators.

The proforma included details of:

- Division and specialty
- recording of early warning scores on admission,
- number of hours from referral to emergency medical until to be seen by a competent clinical decision maker
- number of hours from admission till consultant review (excluding initial assessment if made by the Consultant)

- nature of review eg. Consultant-led ward round, documented or SpR to Consultant phone call/discussion documented
- The initial May audit did not include paediatrics but the re-audit in October 2014 did include paediatrics
- Whether patient was discharged from the emergency medical unit

What was achieved?

- The audit conducted in May 2014 included 3012 patients admitted during the audit period, using the codes for the emergency admission form the patient administration system. Of these 263 notes were audited.
- The audit conducted in October 2014 included 229 patients admitted to Dorset Count Hospital during the audit period, with a total of 259 patient records audited.

Standard	N	May 2014	October 2014
100% of adult emergency patients should have their case reviewed by a Consultant within 14 hours of being admitted to Dorset Count Hospitals	Medicine	64%	88%
	Surgery	59%	89%
	Paediatric	-	92%

What was the impact?

- The May 2014 audit identified non-compliance with the standard but greater compliance in October 2014
- The audit in May demonstrated they were not meeting the standard, with 64% medical and 59% surgical patient being reviewed by a Consultant within the time frame. This increased to 88% and 89% respectively, with 92% with paediatrics.
- Analysis of the first audit identified variation in ward round practices and initiated investigation into prioritisation of patients,
- There were no changes in job plans or recruitment of consultants.

Top Tips

- Auditing of practice is in itself a useful tool to raise awareness of practice and change behaviours.
- Junior doctors are a useful resource for auditing clinical standards to change behaviours in colleagues.
- Empower junior doctors to identify and make improvements to consultants working practices such as consultant reviews and ward roundprocedure .

Seven day social care to support people to go home from hospital

Health and social care working together to ensure patients get home to the right place at the right time to reduce the number of inappropriate residential home placements

At a glance

- Dorset County Council have worked in partnership with Dorset County Hospital to reduce the number of placements of patient in residential care from the hospital
- A seven day service, known as the 'alternative offer', was provided to in-reach into hospital to assess all patients with the potential for residential care in hospital and provide them an alternative offer of a 7 day care package at home
- The service is provided by a social worker and therapy support worker who assesses and tailors care packages to meet individual needs.
- As a result assessment waits have reduced from 21 to 5 days and there has been a
- reduction in residential home placements by 50%.

Dorset County Hospital NHS Foundation Trust and Dorset County Council identified that 47% of residential care placements were made from a hospital setting. Although a lot of these placements were made on a temporary basis, getting a person home once they had been in residential care was difficult. In addition, delays in assessments of up to 21 days for patients requiring potential residential placement. . There was recognition that during this time patients often lost their independence and confidence and could experience a reduction in their mobility due to unfamiliar surroundings.

To overcome these issues Dorset County Council and Dorset County Hospital piloted a service where a social worker care manager and therapist assessed any person in hospital identified as requiring residential care, and supported them with a range of 7 day care packages at home which could be adjusted as their care needs changed.

How the improvements were made

The 'Alternative offer' pilot service was set up from the 1st October 2013 to the 31st March 2014 to evaluate the operational model and impact.

The service was funded including a designation social care manager, physiotherapist, roaming night care service, reablement hours, telecare installation, and equipment. This was an investment of £467, 400.

Key performance indicators were used to baseline the service which included delayed discharges, length of stay, placements in care homes and patient and carer satisfaction and targets set.

Staff were given the opportunity to provide feedback on their experience and to reflect on what worked well and what may need to change, and case studies were used to analyse the effectiveness of the approach and make further refinements to the operating model. All patient were asked to complete a patient experience survey, which incorporated the friends and family test.

What was achieved

Quote: 'The emphasis must always be about the person, there is a need to be honest about the risks with family and be willing to share the risk. When considering residential care it is important to understand balancing the risks of residential care against focusing the risks of returning home'. Staff member

Baseline data was collected against performance indicators which demonstrated improvements to enable the service to be sustained and commissioned

Feedback from staff and analysis of case studies identified adjustments to the service.

Key learning included;

- the need to reinforce messages with ward staff to at an early stage to set the expectation that people would be cared for at home and not in residential care as a default;
- identified capacity issues with double care packages and reablement;
- The roaming night service is crucial to provide carers and families for the reassurance that someone will be available at night. However this needs a change in culture of staff to refer into service.
- Staff felt more satisfied witnessing more people being empowered to make their own decisions in their own home about long term choices of care.

What was the impact?

Quote: 'I consider myself very fortunate to have benefited from this service, it allowed me to return home 4 weeks earlier that had the service not been available. This earlier discharge resulted in an improvement in my wellbeing and self -esteem and probably a more swift resolution to my health needs.' Patient

- During 2013/14 a 50% reduction in residential placements of people in care homes with a 75% patient and carer satisfaction level was achieved.
- Residential placements per annum have reduced from 3.5% in 2013/14 to 2.5% 2014/15.
- Prior to implementation of services people could wait on average 21 days for identification and assessment of care at home, this has now reduced to 5 to 7 days.
- 97.5% of the 40 patients surveyed said that they were either likely or extremely likely to recommend the service to friends and family if they need similar care.

Top Tips

- Piloting of the service enables a stronger case for change, sustained funding and confidence of system in the service
- Hospital staff are key in ensuring that they manage expectations of patients in hospital by talking to patients early regarding helping a patient to get home and give them confidence in the services available
- Investment in the roaming night care service and reablement capacity is key
- The support of the therapy staff is a key enabler to help care for a person at home

The ability for social care to follow the patient home means there is no disruption to continuity of care with locality social workers