This report covers patients discharged from intermediate care services during 2011/12 and organisational level data relating to the period 2011/12 and, for comparison, 2010/11.


The report is available for download at www.nhsbenchmarking.nhs.uk/icsurvey.aspx

Prepared in partnership with:

The NHS Benchmarking Network is the in house benchmarking service of the NHS promoting service improvement through benchmarking and sharing good practice.

The British Geriatrics Society (BGS) is a professional association of doctors practising geriatric medicine, old age psychiatrists, general practitioners, nurses, therapists, scientists and others with a particular interest in the medical care of older people and in promoting better health in old age. The society, working closely with other specialist medical societies and age-related charities, uses the expertise of its members to inform and influence the development of health care policy in the UK and to ensure the design, commissioning and delivery of age appropriate health services.

The society strives to promote better understanding of the health care needs of older people. It shares examples of best practice to ensure that older people are treated with dignity and respect and that wherever possible, older people live healthy, independent lives.

The Royal College of Physicians is to promote and maintain the highest standards of clinical care. One of the ways it does this is through engaging Fellows and Members in all parts of the UK in national clinical audit across a range of conditions and services, in hospitals and in community settings. The College’s clinical audit work has a particular focus on the needs of frail elderly people and those with chronic conditions and improvements are delivered through partnerships with other professional bodies, patient groups and voluntary sector organisations.

The Royal College of Nursing (RCN) is the voice of nursing across the UK and is the largest professional union of nursing staff in the world. The RCN promotes the interest of nurses and patients on a wide range of issues and helps shape healthcare policy by working closely with the UK Government and other national and international institutions, trade unions, professional bodies and voluntary organisations.

AGILE is a Professional Network of the Chartered Society of Physiotherapy and membership is open to therapists working with older people - whether qualified physiotherapists, assistants, students or associate members of an allied profession. Within AGILE our mission is to deliver the highest possible physiotherapy practice with older people.

The aims of AGILE are to promote high standards in physiotherapy with older people through education, research and efficient service delivery, to provide a supportive environment for its members by facilitating the exchange of ideas and information and to encourage, support and co-ordinate relevant activities regionally and nationally.
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The provision and commissioning of intermediate care services has featured repeatedly in recent English Health Policy. It is now 12 years since the National Service Framework for Older People made Intermediate Care Services a priority and set out working definitions. 3 years since the Department of Health refreshed the guidance in its document Halfway Home and over 2 years since Transforming Community Services separated commissioning and provision of community health services. More recently as part of the comprehensive spending review, new monies have been transferred from NHS capital expenditure into re-ablement services and to help in reducing delayed transfers of care and there are new responsibilities for post-discharge designed to reduce readmission and ongoing work on developing new currencies to incentivise rehabilitation and more joined up management of patients with long-term conditions. Integration (between health and social care or between primary, secondary, mental health and community health services) is increasingly on the radar, strengthened by the NHS Futures Forum’s report to government, the Health and Social Care Act 2012 and the Social Care White Paper. Meanwhile the NHS Commissioning Board and NHS Outcomes Framework have a range of new levers to incentivise better recovery from acute illness and better management of patients with long-term conditions to ensure that they remain well and independent.

The NHS must also meet an efficiency challenge of £15-20bn, posed in large part by population ageing and the rising number of patients with long-term conditions. To deliver this, we need to minimise the current large variations in admissions, bed days, delayed transfers, readmissions and long-term care placements between localities and get the “rest as good as the best”.

A big part of the solution is the use of intermediate care services, whether “bed based” or “home based” to maintain health, respond effectively to crises and ensure older people are only in acute hospital beds when they need to be there, to ensure their discharge is properly planned and supported so they can leave hospital sooner but also more safely and crucially to give patients every chance to return to their previous level of functional independence and minimise long term dependency on care.

Despite this obvious central importance of intermediate care to health and social care systems, it has been poorly described and poorly understood when compared to acute hospital activity covered by PBR tariff. This national intermediate care audit makes an invaluable contribution to our understanding and takes us a major step forward towards really knowing what goes on in the “black box”. It also provides a road-tested methodology for local providers and commissioners better to understand what is happening in their own patch. The audit has many virtues: It has been delivered by a genuinely interdisciplinary range of organisations and professions. It provides rich data at organisational level across a range of services nationally – both for “bed based” and “home based services”, for “step up” and “step down” and crucially, because this is about patients and their families, it describes in detail what happens at the level of the individual – for several thousand patients. It has certainly enhanced my own understanding of intermediate care services and I am sure will be of wide use to the whole sector in shining a spotlight on this previously poorly investigated area. I commend the report and hope that it is only the start of a journey.”
2: Executive summary

Key findings:

- The audit highlights wide variation in service models being used nationally with differences evident in the extent of multi-agency integration, the scale of services provided, and how intermediate care sits within the full range of health and community services, in each local health economy.

- The service user cohort for intermediate care has an average age of 81 years, with 42% of the service users in the audit sample over 85 years of age.

- 79% of service users had one or more long term conditions that might potentially influence rehabilitation outcome.

- People with dementia are not systematically excluded from intermediate care but may be under represented amongst intermediate care service users.

- Residents of care homes were infrequent users of intermediate care.

- 72% of bed based and 82% of home based service users maintained their level of independence (measured as their type of care setting) following intermediate care and 24% of bed and 13% of home based service users moved to a more dependent setting.

- Services are jointly commissioned by health organisations and local authorities in 58% of health economies.

- Around one third of bed based capacity is used for step up provision and two thirds for step down, whilst the reverse is true for home based services.

- The investment in intermediate care averaged £1.9 million per 100,000 population in 2011/12, with an average of 58% spent on bed based and 42% invested in home based services.

- All levels of the audit suggest average lengths of stay of 27-30 days for bed based and 24-29 days for home based provision. Service users with lengths of stay over 90 days, accounted for 9% of bed based days and 21% of home based days.

- The cost of an intermediate care bed day reported by commissioners ranged from an average of £136 in residential care homes to an average of £252 per bed day in community hospitals.

- The mean number of admissions to bed based services was 259 per 100,000 weighted population and the mean number accepted into home based services was 725 per 100,000 weighted population.

- The largest staff group within intermediate care services are unqualified health workers.

- The nursing patient ratios and skill mix are in line with Royal College of Nursing recommendations for basic, safe care but below those levels recommended for ideal, good quality care.

- Social care is represented in the workforce in 45% of bed and 50% of home based services, but overall social care staff make up 8% of the bed based service workforce and 24% of the home based workforce.

- Mental health workers are rarely included in the establishment of intermediate care teams.
Introduction

This is the first report of the National Audit of Intermediate Care presenting findings from data collected in respect of 2011/12.

The audit is a partnership project between the British Geriatrics Society, the Association of Directors of Adult Social Services, AGILE - Chartered Physiotherapists working with older people, the College of Occupational Therapists - Specialist Section Older People, the Royal College of Physicians (London), the Royal College of Nursing and the NHS Benchmarking Network. A Steering Group comprising representatives from the partner and participating organisations guided the audit. Project management, data collection, analysis and event management were provided by the NHS Benchmarking Network.

The audit has been established using a subscription model with commissioners able to register on behalf of their health economies and an option for providers to sign up independently, should their commissioner decline to participate.

The National Audit of Intermediate Care builds on pilot studies carried out by the British Geriatrics Society/Older People’s Specialists’ Forum and the NHS Benchmarking Network to measure intermediate care service provision and performance against standards derived from Department of Health guidance and provide national comparative data for bed and home based intermediate care services.

To meet the challenge of NHS cost saving targets over the next four years, unnecessary hospital admissions and long acute hospital stays will need to be significantly reduced. Intermediate care provides alternative, community based services to better meet the needs particularly of older people and enable more efficient patient flows through the health and social care system.

The audit aims to take a whole system view of the effectiveness of intermediate care services and the contribution made to demand management across health and social care systems in England, Wales and Northern Ireland.

The audit includes bed and home based intermediate care services provided by a range of health and social care providers including acute trusts, community service providers, local authorities and independent providers. These services are provided in a range of health and social care settings including service users’ own homes, general hospitals, community hospitals, nursing and residential care homes.

This is the first year of the National Audit of Intermediate Care. It is intended to run the audit annually in order that:

- the quality, performance and development of intermediate care services can be monitored over time
- NHS organisations not able to contribute in the first year can have the opportunity to participate in the audit
- the audit can be refined and developed, for example, with the introduction of a standardised Patient Reported Outcome Measure for intermediate care
- additional information can be collected to reflect emerging policy priorities.
Objectives

The objectives of the National Audit of Intermediate Care are:

1. To develop quality standards for key metrics within the intermediate care audit, based on published Department of Health best practice guidance and the standards used in the pilot audits.

2. To develop a set of patient outcome measures and to determine if the measures could be case mix adjusted.

3. To assess performance against the agreed quality standards and outcome measures.

4. To summarise national data and provide local benchmarked results on key performance indicators.

5. To potentially inform future policy development within the Department of Health (DH) and the NHS Commissioning Board.

With reference to objective 2, it was established at the pilot audit stage that intermediate care services do not currently collate information against any nationally standardised outcome measures. Further work is therefore required to develop and implement a Patient Reported Outcome Measure (PROM), so that performance against the measure could be compared in future iterations of the audit. It is intended to develop such a measure in the second year of the audit (see section 10.2).
4: Methodology

4:1 Scope

Many definitions of intermediate care have been proposed. For the purposes of the audit, the definition of intermediate care provided by the Department of Health (Intermediate Care - Halfway Home, DH 2009) is used; “a range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living”. The guidance makes clear that intermediate care services must involve multi-disciplinary team working. Many service models for intermediate care have been described and the nomenclature can be confusing. In this audit, the typography proposed by Brophy et al and highlighted by the DH (Intermediate Care - Halfway Home, DH 2009) has been used. This typography classifies intermediate care services as a spectrum between a health dominated, and a social services dominated provision. For the purposes of the audit, the Steering Group decided to exclude homecare re-ablement services on the basis that they are at the social services end of the intermediate care spectrum and the associated practicality of their identification in a health care mediated audit. The audit therefore includes only services which have a clinical health element.

The proposed audit has both organisational and patient level components. The organisational level is a necessary element because this is an audit of a service rather than a condition. An understanding of the organisational and service framework within which patient care is being provided is key to reaching conclusions on how patient outcomes can be optimised.

4:2 Eligibility and recruitment

All commissioners and providers of intermediate care across the NHS in England, Wales and Northern Ireland were invited to participate in the audit. Letters inviting organisations to register were sent to the Boards of all PCT clusters, PCTs and Trusts in the NHS, together with a detailed proposal for the audit. Organisations were asked to complete a registration form, with commissioners registering on behalf of their whole health economy asked to list the providers covered by their subscription.

4:3 Data collection

The data collection process was managed by the NHS Benchmarking Network with data collection taking place between 20 February 2012 and 4 May 2012. Data was requested for 2011/12, and, for comparison on some activity and finance metrics, 2010/11.

All data collection was via a bespoke web based data entry audit tool, completed directly by participants. The website and data base are hosted within the NHS secure N3 network.
Access to the tool was controlled via unique identifiers and passwords assigned to each organisation registered to participate in the audit. Data could be saved in sections during as well as at the end of an input session.

The audit tool included guidance on how to complete the audit and assistance with definitions. Data collection was also supported by a telephone helpline to deal with specific queries. Over 250 queries were received by the helpline, enabling the NHS Benchmarking Network team to provide advice on issues such as whether or not a service should be included as intermediate care and how to manage data entry for particular service configurations. These issues are considered further in (section 5.4).

No patient identifiable data was collected.

4:4 Audit structure and content

The audit was structured with organisational and patient level components. The organisational level audit included separate sections for commissioners and providers of intermediate care. Users were directed automatically to either the commissioner or provider audit through the login process.

Commissioners were asked to provide a response covering all intermediate care services commissioned in their health economy. Questions for commissioners covered the following topics:

- Quality standards (based on Intermediate Care - Halfway Home, DH 2009)
- Commissioning partners and providers
- Services commissioned
- Access criteria
-Intermediate care funding
- Bed based activity
- Home based activity

Providers taking part in the audit were asked to define the intermediate care services provided under separate service specifications, indicating whether each service provided bed or home based care. Questions were then completed under the following categories for each service identified:

- Quality standards (based on Intermediate Care - Halfway Home, DH 2009)
- Services provided
- Funding
- Activity
- Workforce

For each intermediate care service, participating providers were then requested to complete 10 patient level audits for 10 consecutive discharges from the service (including patients who died) during 2011/12.

The audit content was developed by the Steering Group which includes representation from partner and participating organisations. The organisational level questions drew on experience from a benchmarking study undertaken by the NHS Benchmarking Network in 2010. The questions for the patient level audit were developed from the pilot study undertaken by the Older People’s Specialists’ Forum and the British Geriatrics Society in 2009.
4:5 Other data sources

In addition to the data collected via the audit tool, Hospital Episodes Data was acquired from the Hospital Episodes Statistics (HES) database held by The Health and Social Care Information Centre. These data was utilised to assess the wider impact of intermediate care services on secondary care utilisation (see section 7.4).

Data on PCT registered and weighted populations were extracted from the 2011-12 PCT Recurrent Revenue Allocations Expositions Book (DH) for use in the calculation of benchmarks per 100,000 population within the analysis of the commissioner data.
5: Participation and data quality

5:1 Participation

Although involvement in the audit was voluntary, there was a high level of engagement in the audit with a total of 62 commissioning organisations (Primary Care Trusts, Clinical Commissioning Groups and Local Authorities) participating. Of these, 58% stated that intermediate care was jointly commissioned in their area between the PCT and local authority with the local authority taking the lead commissioner role in 8 cases.

112 providers participated and between them identified, and provided data for, 327 intermediate care services (167 bed based and 160 home based). Whilst the average number of services identified was 2.9, the range was from 1 to 19 intermediate care services per provider.

3,150 patient level audits were submitted against 320 intermediate care services; 1,585 from bed based and 1,565 from home based services.

5:2 Completeness of data

Within the organisational level audit, participants were able to indicate if they could not complete the data by entering “n/a” in a text field or “-1” in a numeric field.

The level of completeness of the audit was generally high as summarised in the tables below. The exception was the completion by commissioners of finance and activity data, which is discussed further under Commentary: use of resources (commissioner view) in section 7.3.

Data completeness for commissioner level audit was as follows:

<table>
<thead>
<tr>
<th>Section</th>
<th>Sub section</th>
<th>Number of commissioners contributing to section</th>
<th>Section % completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality standards</td>
<td>Governance</td>
<td>60</td>
<td>100.00%</td>
</tr>
<tr>
<td></td>
<td>Participation</td>
<td>58</td>
<td>100.00%</td>
</tr>
<tr>
<td></td>
<td>Pathways</td>
<td>61</td>
<td>100.00%</td>
</tr>
<tr>
<td></td>
<td>Performance</td>
<td>60</td>
<td>100.00%</td>
</tr>
<tr>
<td></td>
<td>Strategy</td>
<td>58</td>
<td>100.00%</td>
</tr>
<tr>
<td>Services commissioned</td>
<td></td>
<td>62</td>
<td>97.21%</td>
</tr>
<tr>
<td>Access</td>
<td></td>
<td>62</td>
<td>100.00%</td>
</tr>
<tr>
<td>Funding</td>
<td></td>
<td>56</td>
<td>81.48%</td>
</tr>
<tr>
<td>Bed activity</td>
<td></td>
<td>57</td>
<td>73.68%</td>
</tr>
<tr>
<td>Home activity</td>
<td></td>
<td>60</td>
<td>62.50%</td>
</tr>
</tbody>
</table>
Data completeness for the provider audit was as follows:

<table>
<thead>
<tr>
<th>Service type</th>
<th>Section</th>
<th>Number of services contributing to section</th>
<th>Section % completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed based</td>
<td>Quality standards</td>
<td>167</td>
<td>100.00%</td>
</tr>
<tr>
<td>Bed based</td>
<td>Service provided</td>
<td>167</td>
<td>99.04%</td>
</tr>
<tr>
<td>Bed based</td>
<td>Funding</td>
<td>160</td>
<td>81.56%</td>
</tr>
<tr>
<td>Bed based</td>
<td>Activity</td>
<td>160</td>
<td>84.91%</td>
</tr>
<tr>
<td>Bed based</td>
<td>Workforce</td>
<td>163</td>
<td>94.04%</td>
</tr>
<tr>
<td>Home based</td>
<td>Quality standards</td>
<td>160</td>
<td>100.00%</td>
</tr>
<tr>
<td>Home based</td>
<td>Service provided</td>
<td>160</td>
<td>100.00%</td>
</tr>
<tr>
<td>Home based</td>
<td>Funding</td>
<td>154</td>
<td>82.31%</td>
</tr>
<tr>
<td>Home based</td>
<td>Activity</td>
<td>153</td>
<td>82.78%</td>
</tr>
<tr>
<td>Home based</td>
<td>Workforce</td>
<td>157</td>
<td>93.90%</td>
</tr>
</tbody>
</table>

Data completeness for the patient level audit was as follows:

<table>
<thead>
<tr>
<th>Service type</th>
<th>Section</th>
<th>Number of patient records in section</th>
<th>Section % completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed based</td>
<td>Demographics</td>
<td>1,536</td>
<td>99.91%</td>
</tr>
<tr>
<td>Bed based</td>
<td>Admission information</td>
<td>1,530</td>
<td>100.00%</td>
</tr>
<tr>
<td>Bed based</td>
<td>Assessment process</td>
<td>1,521</td>
<td>99.74%</td>
</tr>
<tr>
<td>Bed based</td>
<td>Patient care</td>
<td>1,498</td>
<td>99.98%</td>
</tr>
<tr>
<td>Bed based</td>
<td>Discharge process</td>
<td>1,585</td>
<td>100.00%</td>
</tr>
<tr>
<td>Home based</td>
<td>Demographics</td>
<td>1,517</td>
<td>100.00%</td>
</tr>
<tr>
<td>Home based</td>
<td>Admission information</td>
<td>1,511</td>
<td>100.00%</td>
</tr>
<tr>
<td>Home based</td>
<td>Assessment process</td>
<td>1,499</td>
<td>99.85%</td>
</tr>
<tr>
<td>Home based</td>
<td>Patient care</td>
<td>1,490</td>
<td>99.93%</td>
</tr>
<tr>
<td>Home based</td>
<td>Discharge process</td>
<td>1,565</td>
<td>100.00%</td>
</tr>
</tbody>
</table>
5:3 Data validation

The audit tool contained validation controls so that data that did not comply with format controls could not be saved (e.g. numeric and text fields). Further built in checks ensured analysed data were reconciled to totals entered. Information buttons containing data definitions to ensure consistency of data supplied were available throughout the tool.

Validation was also incorporated into the structure of the underlying data tables, for example, the use of primary keys to prevent the creation of duplicate records. During the analysis phase the number of records generated by each query was reconciled back to the expected number to check for missing or duplicate records.

Services were individually verified for all organisations showing 6 or more intermediate care services, as these were considered at higher risk of incorrect inclusion of services that did not fall within the intermediate care definition. Each service was reviewed to ensure its function fell within the audit definition of intermediate care, using information from telephone conversations and email correspondence logged by the helpline or by contacting participants directly to discuss the nature of the service with them. Those services with no data completed were removed (11 services). Otherwise, all services reviewed were found to be intermediate care and left in the audit.

Commissioner responses showing the commissioning of more than 100 beds were also individually verified to check the services commissioned complied with the definition of intermediate care and did not, for example, include general community hospital beds. All bed based services checked were found to fall within the definition of intermediate care.

In addition, review of the charts generated from the data analysis identified a number of outlying positions that may indicate incorrect data and these data items were queried directly with participants. 34 separate queries were raised with 22 provider organisations resulting in 25 data amendments and the deletion of four intermediate care services, in addition to the 11 noted above. 12 queries were raised with commissioners resulting in 11 data amendments.

5:4 Intermediate care definition and identification of services

Around one quarter of the queries received by the helpline related to the definition of intermediate care and identification of services for inclusion in the audit. Participants were provided with the definition of intermediate care noted above (section 4.1) in an information box in the audit tool and provided with the following additional guidance:

Community hospital wards/units should only be included if their main function is specified as intermediate care/rehabilitation. Services which are condition specific such as stroke or respiratory rehabilitation/early supported discharge teams should be excluded.

In discussion on the helpline, services were tested against these definitions to reach agreement regarding inclusion. In particular, more general community services such as district nursing and community matrons were excluded except where they explicitly contributed to the intermediate care function and the relevant share of funding, activity and workforce could be extracted.
Participants were asked to separate services where provided under separate service level agreements and identify each service as bed or home based. This created some difficulty for a small number of providers (four were identified via the helpline) operating very integrated bed and home service models, with service users moving seamlessly between the two. Consideration will be given to how more integrated models can be addressed specifically in future iterations of the audit. For this year, these services were asked to estimate the split between the bed and home based elements of their service in order to complete the audit.

Some issues also arose where two or more providers were involved in providing the service, for example, community rehabilitation teams providing nursing and therapy into acute or residential care home bed based units.

In these circumstances, providers were asked to define one service and submit data jointly where possible.

A number of commissioners also indicated a substantial volume of spot purchased beds. These participants were asked to calculate the equivalent number of full time beds and include this in the beds commissioned figures and to ensure the funding and activity related to the beds was included in the appropriate sections. A specific question about spot purchased beds will be included in subsequent audits.

Participants were asked to provide supplementary information to explain their service models where there was a difficulty in fitting the service into the audit structure. This additional information was reviewed as part of the data analysis and interpretation work.
6: Results: Quality standards audit

6:1 Introduction

Guidance for intermediate care services was set out by the DH in the National Service Framework for Older People (DH 2001). Further guidance, entitled Intermediate Care - Halfway Home was published by DH in 2009. The National Service Framework for Older People set out key guiding principles for the provision of intermediate care services:

- Person-centred care
- Whole system working
- Timely access to specialist care, and
- Promoting a healthy and active life.

Halfway Home updates the original guidance and sets out the definitions, service models, responsibilities for provision, charges and planning. The guidance recommends that health and local government organisations, with a shared vision, should undertake strategic planning for intermediate care jointly. The guidance recommends a core multidisciplinary intermediate care team, which is led by a senior clinician, ideally with one overall manager, and closely linked to re-ablement services in social care. The key target groups for intermediate care, people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute inpatient care, long term residential care or continuing NHS in-patient care, remain the priority.

The revised guidance builds on the old guidance through the following:

- The inclusion of:
  - adults of all ages, such as young disabled people managing their transition to adulthood;
  - homeless people and prisoners; and
  - older people with mental health needs, either as a primary or secondary diagnosis.
- A renewed emphasis on those at risk of admission to residential care.
- Timely access to specialist support as needed.

The DH guidance has been used to develop quality standards for commissioners and providers for the national audit. The following section sets out the results for the quality standards audit.
6.2 Quality standards for commissioners

Commissioner governance standards

*Halfway Home* emphasises the importance of partnership working in commissioning of intermediate care services.

63% of commissioners have a multi-agency board for intermediate care, with PCTs, local authorities, GPs and providers consistently represented. Service users are represented in 29% of respondents.

Clinical governance has been incorporated into service specifications in 92% of responses.

![Figure 6.2.1: Multi-agency board representation](image)

Commissioner strategy standards

![Figure 6.2.2: Commissioner strategy](image)

Strategic planning is undertaken jointly by health and local government in 86% of cases. A Joint Strategic Needs Assessment has been carried out for intermediate care in 29% of respondents. 47% of respondents have indicated there is a local intermediate care strategic plan covering a medium to long term (3 to 5 years). A single intermediate care manager co-ordinating all intermediate care provision across the PCT or local authority area for which the services are commissioned exists in 47% of cases.
Commissioner participation standards

The views of patients and their carers on current services and any plans for future service developments have been actively sought by 76% of commissioners. Local GP commissioners were fully involved in discussions about service design in 79% of cases. The most popular method for seeking service user views was the use of patient surveys (see figure 6.2.3), although participants were not given the option of choosing more than one methodology. This will be rectified in future iterations of the audit.

Commissioner pathway standards

61% of health economies responding have commissioned a single point of access and 66% use a shared assessment framework. The most commonly used is the Single Assessment Process (see figure 6.2.4).
**Commissioner performance management standards**

Performance goals have been set and measured for the whole of the health and social care system in 65% of cases. Of those commissioners that have set goals, 77% have set percentage reductions for admissions to long term care, 62% for repeat admissions and 62% for length of stay for certain conditions.

Goals that reflect the quality of the service and the users’ experience have been set by 77% of respondents.

Indicators to monitor the delivery of service performance have been developed and reviewed at least annually in 87% of cases. For those that monitor service performance, the use of key measures is shown below.
6:3 Quality standards for providers

**Provider participation standards**

Views of patients and their carers on current services and any plans for future service developments have been actively sought for 91% of bed based services and 83% of home based services. For both bed and home based services the most popular method used to seek views was a patient questionnaire.

**Provider clinical governance quality standards**

Multi Disciplinary Team (MDT) meetings are held once a week in 98% of bed based and 95% of home based services. In the patient level survey, 96% of patients in bed based services, and 77% of patients in home based services, were discussed in an MDT.

The frequency of clinical governance meetings is shown in figures 6.3.3 and 6.3.4. The most common frequency for clinical governance meetings is monthly (reported by 61% of bed based and 63% of home based services). 4% of home based and 7% of bed based services do not hold clinical governance meetings and, in both types of service, 2% hold meetings annually.
Systems for incident reporting for intermediate care services are in place as illustrated in figure 6.3.5 below. “Other” incident reporting systems cited by respondents included pressure sores/ulcers, safeguarding, medication errors and discharge issues.
Provider pathway standards

As reported by commissioners, the Single Assessment Process is the most commonly used assessment framework (used by 58% of bed based and 59% of home based services). However the Common Assessment Framework is much less commonly cited by providers than by commissioners. Around a third of both bed and home based services use “other” assessment frameworks, many citing a locally developed assessment tool.

Figure 6.3.6: Assessment frameworks used (bed based services)

Figure 6.3.7: Assessment frameworks used (home based services)

Figure 6.3.8 below shows compliance with care plan quality standards for bed and home based services.

Figure 6.3.8: Use of care plans

Is a care plan documented for each individual? (bed)

Is a care plan documented for each individual? (home)

Is a responsible team member identified to ensure the care plan is carried out? (bed)

Is a responsible team member identified to ensure the care plan is carried out? (home)

Do all individual care plans include a review at regular intervals within six weeks or less? (bed)

Do all individual care plans include a review at regular intervals within six weeks or less? (home)
Quick and ready access to specialist skills showed variation between the types of intermediate care services, with bed based services, on average, having better access to specialist skills. “Other” specialist services accessed included community matrons, physiotherapy, occupational therapy, social care and specialist nursing teams such as tissue viability, Macmillan palliative care, COPD/respiratory, diabetes, heart failure, falls, neurology and Parkinson’s.

![Figure 6.3.9: Access to specialist skills](diagram)

- SALT (beds)
- SALT (home)
- Mental health (beds)
- Mental health (home)
- Specialist elderly care (beds)
- Specialist elderly care (home)
- Podiatry (beds)
- Podiatry (home)
- Dietetics (beds)
- Dietetics (home)
- Continence (beds)
- Continence (home)
- Pharmacy (beds)
- Pharmacy (home)
- Other (beds)
- Other (home)
Provider workforce standards

Services are led by a senior clinician in 80% of bed based and 79% of home based services. The split of professions taking up the leadership role is shown below. Nurses lead in around half of all services. In the half of services not led by nurses, medical staff are more likely than therapists to lead bed based services (28% versus 22%) and the reverse is seen in home based services (therapists leading 34% versus doctors 11%).

Risk assessment training is mandatory in most services (90% of bed and 95% of home based services). Mental health and dementia training is less consistent with 55% of bed based and 60% of home based services stating that all members of the team have received this training.
Provider resource standards

49% of home based services are using a shared electronic patient record, compared to 30% of bed based services.

Provider performance standards

Indicators to monitor the delivery of service performance have been developed and reviewed at least annually in 90% of bed based and 88% of home based services.

Commentary: Quality standards

- **Strategic planning.** The audit revealed some weaknesses in strategic planning by commissioner organisations. A Joint Strategic Needs Assessment has been carried out for intermediate care by only one third of respondents, just over half of respondents have indicated they do not have a local intermediate care strategic plan and only around two thirds have a multi-agency board for intermediate care. *Halfway Home* emphasises the need for a shared vision and alignment of strategies between PCTs, whose responsibilities for commissioning intermediate care will be taken over by Clinical Commissioning Groups under NHS reforms, and local authority commissioners.
- **Participation.** Although less than one third of commissioners reported service user representation on intermediate care boards, three-quarters had sought service user views in commissioning services. Commissioners may feel that techniques such as patient surveys and focus groups are more effective way of engaging service users than a formal role on the board. The level of participation in the development of provider services was high.

- **Single point of access.** *Halfway Home* points to an earlier review of intermediate care, *NSF for Older People, supporting implementation: Intermediate care: moving forward*, which noted some of the key factors that had been shown to lead to successful development of the function, including having a single point of access to the service. However, ten years after the original guidance was published, only 61% of commissioners have commissioned a single point of access. Further consideration could be given by commissioners and policy makers as to the reasons for this level of uptake.

- **Evaluation.** The audit results suggest evaluation of the impact of intermediate care on whole system metrics may be limited in some areas, with around one third of respondents stating that whole system performance goals are not set for their health economy. Without systematic evaluation of intermediate care it may be increasingly difficult to make the case for further investment.

- **Frequency of clinical governance meetings.** A small proportion of services, 6% of home based and 7% of bed based services do not hold clinical governance meetings and, in both types of service, 2% hold meetings only annually. The importance of clinical governance was set out in *Medical aspects of intermediate care: Report of a Working Party*, Federation of Medical Royal Colleges, 2002.

- **Access to specialist skills.** The specialist skills listed in the audit are suggested in *Halfway Home* as those that should be readily accessible from intermediate care services. There appears to be gaps in access to specialist services, particularly podiatry and dietetics from home based services in some areas. The provision of mental health input is considered under Commentary: Workforce in (section 8.4).

- **Shared electronic patient record.** Half of home based services use a shared electronic record, compared to 30% of bed based services. This may reflect the greater degree of integration between health and social care in home based services (Commentary: Workforce section 8.4). The lack of a shared patient record in many areas may create inefficiencies in duplication of information and make it more difficult to ensure a joined up care plan for patients.
7: Results: Commissioner level audit

7.1: Overview

There were 62 participants in the commissioner level audit, comprising 4 Cluster PCT groups (15 PCTs in total), 34 PCTs, 10 Clinical Commissioning Groups, 1 local authority and 2 joint PCT/local authority submissions. The variety of commissioner organisations completing the audit reflects the ongoing reorganisation of commissioning under the NHS reforms. Although a number of PCT clusters registered for the audit, data was completed for each statutory PCT area within the cluster as services are still commissioned on these footprints. Where one PCT commissioned completely different intermediate care services with two different local authority partners, separate submissions were made. This was the case for two PCTs.

Intermediate care services were jointly commissioned in 58% of health economies.

In reviewing the commissioner audit findings, reference should be made to the comments on completeness of commissioner data in (section 5.2).

7.2: Services commissioned

**Intermediate care functions**

All commissioners participating in the audit commission step down beds, 87% commission step up/admission avoidance beds. Assessment/admission avoidance home based services are commissioned by 92% of commissioners and home based rehabilitation services by 97%.

As noted under Scope (section 4.1), the audit does not include homecare re-ablement services which are purely social care. However, to understand the wider context within which intermediate care is commissioned a question was asked regarding the commissioning arrangements for homecare re-ablement services. Partnership working on commissioning homecare re-ablement is in evidence in 52% of health economies, including 24% commissioning these services as part of intermediate care.

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**Figure 7.2.1: Commissioning arrangements for re-ablement services**

- Commissioned as part of intermediate care services
- Commissioned separately from IC jointly by LA and PCT
- Commissioned separately from IC by LA
- Not commissioned
Beds commissioned

The mean number of beds commissioned per 100,000 weighted population was 22.5 and median 20.9 beds per 100,000 weighted population, for the 57 commissioners providing data on this metric. The chart (figure 7.2.2) shows the wide variation in responses.

Figure 7.2.2: Beds commissioned per 100,000 weighted population 2011/12

The most popular setting for intermediate care beds commissioned (figure 7.2.3) was within community hospitals (53%), followed by residential care homes (16%), nursing care (14%) and acute settings 4%. Acute bed based provision was more in evidence in the provider audit responses (Section 8.2), possibly because NHS Trusts were more likely to respond to the audit than residential and nursing homes.

Figure 7.2.3: Location of beds commissioned
Service specifications

85% of commissioners stated that there was an agreed service specification for intermediate care. As shown in figure 7.2.4, 29% do not provide a guideline on how long a person should be in receipt of intermediate care, with 52% providing a guideline of a maximum of 6 weeks.

Two comments under “other” referred to periods up to 10 weeks and two service specifications aim for 2 weeks, the remaining comments under “other” referred to a typical period being up to 6 weeks.

Figure 7.2.4: Maximum stay in intermediate care

2% of respondents do not specify access criteria. For those that do, the utilisation of typical access criteria is shown below:

Figure 7.2.5: Access criteria
Halfway Home states that homeless people and prisoners should be eligible for intermediate care and services should be open to all adults over the age of 18. However, most services (63%) do not specifically include these groups of potential service users in their service specifications (figure 7.2.6). Within the audit patient sample, 1.4% were under 45 years and 6.6% between 45 and 64 years of age.

**Commentary: Services commissioned**

- **Health and social care partnership working.** The audit results suggest intermediate care is jointly commissioned in just over half of health economies, with partnership working also extending to homecare re-ablement in the majority of cases. Discussions with participants indicate a wide range of approaches to health and social care integration at both the strategic and operational levels. As noted under commissioner quality standards (section 6.2), there are some weaknesses in strategic planning and partnership working evident from the audit results.

- **Scale of intermediate care.** The mean number of beds commissioned (22.5), together with the finance and activity data shown in section 7.3, indicate the capacity of intermediate care is small relative to secondary care provision. This raises the question of whether the current scale of intermediate care is sufficient to make an impact on secondary care utilisation (see section 7.4).

- **Service specifications.** 15% of respondents do not have an agreed service specification, potentially making it difficult for commissioners to target resources and monitor performance of services in these health economies. Nearly one third of commissioners do not specify maximum lengths of stay in their service specifications. Such guidance may assist commissioners and providers in clarifying the function of intermediate care in their area and ensuring alignment with national policy. Halfway Home states intermediate care services are time limited, normally no longer than six weeks and frequently as little as one to two weeks or less.

- **Vulnerable groups.** Most commissioners do not specifically include vulnerable groups within their service specifications at present. Further discussion between commissioners and policy makers may be needed to clarify the scope of intermediate care. For example, whether it is realistic and/or desirable to include young disabled people in a service which is predominantly utilised by older people (see section 9.1 for patient sample age analysis).
7.3: Use of resources (commissioner view)

Investment levels

There is wide variation in the per capita investment in intermediate care across the 52 commissioners who provided data. The mean budget per 100,000 weighted population for 2011/12 was £1.91 million, representing growth of 3.9% from an average of £1.84 million per 100,000 weighted population in 2010/11.

21% of commissioners have formal S75 pooled budget arrangements with their local authority commissioning partners. For the 25 commissioners who provided analysis of the budget contributions, the average split for 2011/12 was 27% local authority contribution and 73% PCT contribution.

Unit costs

Commissioners provided estimates of costs per intermediate care bed day. The average position for each setting is as follows:

<table>
<thead>
<tr>
<th>Setting of bed based service</th>
<th>Number of values used in calculation</th>
<th>Mean cost per occupied bed day from data supplied by commissioners (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute hospital setting</td>
<td>6</td>
<td>£219</td>
</tr>
<tr>
<td>Community hospital</td>
<td>24</td>
<td>£252</td>
</tr>
<tr>
<td>Residential care home</td>
<td>18</td>
<td>£136</td>
</tr>
<tr>
<td>Nursing home</td>
<td>20</td>
<td>£132</td>
</tr>
</tbody>
</table>

An estimate of the average cost per person per week for home based intermediate care services was provided by 16 commissioners and showed wide variation, with a mean of £583 and median of £513 per person per week.
Activity

The mean number of referrals to bed based intermediate care services (for the 36 commissioners submitting data) was 327 per 100,000 weighted population for 2011/12, up by 5.2% from 311 referrals per 100,000 weighted population in 2010/11. The mean number of admissions (from 45 data submissions) was 259 per 100,000 weighted population in 2011/12, suggesting an average conversion rate from referral to admission of 79%.

For home based services, the mean number of referrals to intermediate care services (for the 38 commissioners submitting data) was 815 per 100,000 weighted population for 2011/12, up by 3.6% from 786 referrals per 100,000 weighted population in 2010/11. The mean number of assessments carried out was 775 per 100,000 weighted population in 2011/12, with the mean number of service users accepted into the service being 725 per 100,000 weighted population. This suggests a conversion rate from referral to acceptance into service of 89% for home based services.
Balance of bed/home and step up/down provision

Commissioners were asked for an analysis of the total intermediate care funding between bed and home based provision. This showed a wide variation in approaches, with an average position of 58% invested in bed and 42% invested in home based services (2011/12), across the 38 commissioners providing data.

Although the investment by commissioners is slightly in favour of bed based provision, as would be expected, home based services have lower costs per service user (section 8.3), and a higher volume of service users, accounting for 71% of total intermediate care referrals. An analysis of the proportion of service users using the different types of intermediate care provision has been estimated from the referrals data above and the results from the patient level audit on the split of step up and step down provision in each type of service (Patient pathway, section 9.1) as follows:

Figure 7.3.4: Balance of bed/home and step up/step down capacity based on referrals
**Average length of stay**

The average length of stay for bed based services as reported by 46 commissioners shows a mean length of stay of 27.6 days (median 27.0 days) in 2011/12 (figure 7.3.5). The mean reported for 2010/11 was 28.8 days.

![Figure 7.3.5: Commissioner view: Average length of stay 2011/12](image)

The average duration of stay reported by 30 commissioners for home based services was 29.2 days in 2011/12. The average reported in 2010/11 was 32.2 days.

![Figure 7.3.6: Commissioner view: Average duration of service(home based services) 2011/12](image)
Commentary: use of resources (commissioner view)

- **Provision of data.** Commissioners’ ability to provide financial and activity data was limited in some instances. For example, only 16 commissioners provided a cost per week per service user for the home based services they commission. Discussion with commissioners during the data collection period and feedback received from them suggested, in a number of cases, finance and activity data had to be requested from providers in order to complete the audit. It could be inferred that this data is not being regularly reviewed and monitored by commissioners in some areas.

- **Investment levels.** Intermediate care investment levels show wide variation, highlighting the differences in approach nationally. Even the highest levels of expenditure recorded in the audit are small in relation to secondary care expenditure. As noted above (section 7.2), this raises the question of whether the current scale of intermediate care is sufficient to make an impact on secondary care utilisation.

- **Unit costs.** The analysis suggests community hospitals are the most expensive setting for intermediate care beds.

- **Balance of bed and home provision.** The results of the audit show an allocation of expenditure slightly in favour of bed (58%) over home based intermediate care provision. The variation in investment patterns across the NHS possibly reflects legacy arrangements as well as variation in the attitude of secondary care to risk when stepping down patients to intermediate care and the configuration of other community health and social care services in each geographic area.

- **Balance of step up and down provision.** An issue for both commissioners and providers is the balance of step up and down provision required within intermediate care services to meet the objectives of both admission avoidance and supporting timely discharge from hospital. The provider and patient level audits suggest around one third of bed based capacity is used for step up and two thirds for step down, with the reverse position in home based services. Further work on outcomes would be required to understand what might be an optimal configuration of capacity for intermediate care (see section 9.3).
7.4: Whole system impact

Hospital Episodes Statistics (HES) data were obtained from the Health and Social Care Information Centre on mean length of stay, emergency admissions and occupied bed days for both PCTs and provider NHS trusts in England. For each of the metrics requested, the data provided was analysed by age band. The HES data, together with PCT weighted population data from the 2011-12 PCT Recurrent Revenue Allocations Expositions Book (DH), were used to estimate potential demand for intermediate care services. The average number of emergency admissions of patients over 65 years of age per 100,000 population for 2011/12 was calculated as 3,964. One estimate suggested that 20% of admissions of older people to acute hospitals are inappropriate (Measuring appropriate use of acute beds. A systematic review of methods and results, McDonagh MS, Smith DH, Goaddard M, 2000). The estimate was also supported by work carried out in Medway & Swale Intermediate Care Strategy for Medway & Swale, Summary of Needs Assessment Phase, 2003. Based on this estimate, 793 emergency admissions per 100,000 population of patients over 65 in 2011/12 could have been inappropriate. The audit suggests a mean of 670 referrals per 100,000 weighted population to intermediate care services from home or other non-acute sources (step up) currently. Assuming the estimate of inappropriate referrals used is reasonable, this suggests step up intermediate care capacity may need to be more than doubled to deal with potential additional demand.

Further, it is suggested that up to one quarter of elderly patients admitted to hospital have post-acute care needs (An estimate of post-acute intermediate care need in an elderly care department for older people, Young J, Forster A, Green J, 2003). Using this assumption, demand for step down care is estimated as 991 service users per 100,000 population across England (although this should reduce if admission avoidance was fully implemented). The estimate of step down demand compares with a mean of 472 service users per 100,000 population referred to bed and home intermediate care services from hospital (step down), based on data from the audit. This suggests a doubling of step down intermediate care capacity may also be required to meet potential demand.
Commentary: Whole system impact

- Consideration of estimates of potential demand suggest intermediate care capacity nationally may currently be around half that required to avoid inappropriate admissions and provide adequate post-acute care for older people. Clearly, the gap between demand and capacity in a particular health economy may vary widely from this overall average position. As noted in (section 9.2), there may be scope to free up capacity in some services by reducing excessive lengths of stay.

- To support the case for further investment, more local evaluation may be required to provide evidence that increasing intermediate care capacity does impact favourably on secondary care utilisation. Ensuring a positive impact is likely to require pro-active reduction of secondary care bed capacity. This highlights the need for multi-agency working to ensure links are made across all health and social care sectors (see comments on partnership working and strategic planning under section 6, Quality Standards).
8: Results: Provider level audit

8.1: Overview

Intermediate care is a broad service sector rather than a condition specific service and therefore comprises a range of different services, depending on the local context of needs and other facilities available. The purpose of this section is to describe intermediate care provision across participating provider organisations to understand the functions of intermediate care services, the nature of intermediate care settings, the pattern of referral sources, service accessibility and access to investigations and professional assessments.

The provider level audit includes data from 327 services identified by 112 organisations completing the audit; comprising 167 bed based units and 160 home based intermediate care services.

The sample demonstrated progress towards integrated health and social care provision, with 45% of bed based services and 50% of home based services reporting social care staff as part of their workforce establishments.

8.2: Service characteristics

Service locations and functions

Bed based intermediate care units included in the study show a range of settings, the most common being community hospitals 38% (figure 8.2.1). “Other” settings included purpose built or standalone intermediate care units and units within a local authority facility.

![Figure 8.2.1: Setting of intermediate care bed based sites](image)

Community hospital sites reported the highest average number of beds per site (35) and residential care homes the lowest (19) (figure 8.2.2). The average across all types of location was 27 beds per site.

84% of bed based and 89% of home based services provide both step up and step down functions. The average split of capacity in bed based units was 35% step up and 65% step down.
Referrals

The largest source of referrals into both bed based and home based services was from acute trusts (wards) (51% and 26% respectively). Referrals to bed based services increased by 3.7% in 2011/12 compared to 2010/11 and by 10.9% to home based services.

Figure 8.2.2: Average number of beds per location

Figure 8.2.3: Source of referrals (bed based)

Figure 8.2.4: Source of referral (home based)
Service accessibility

39% of bed based units are open to new admissions 24/7, with 44% operating extended hours opening. Extended hours opening is the most common model for home based services (60%). 89% of bed based and 73% of home based services are open 365 days a year.

Access to investigations

Over 70% of both bed and home based services have same day access to blood tests, urinalysis and pulse oximetry.

Medical cover

As shown in figure 8.2.8, 37% of home based services and 4% of bed based services state that they don’t have dedicated medical cover. Service users in these services will therefore be covered by their own GP and out of hours GP services.
Commentary: Service characteristics

- **Balance of step up and down provision.** The findings suggest most services provide both functions. Within bed based services, the patient level audit (section 9.1) supports the statement that around two thirds of the capacity is for service users stepping down from hospital. Given that step up beds are not typically ring fenced (only 4% of sites in the sample were badged step up only), systemic pressures to move patients out of hospital may result in step down cases being prioritised. As noted in the commissioner level findings (section 7.3), only 10% of total intermediate care referrals are into step up beds, raising the question of whether there is sufficient bed based step up capacity in the system to make an impact on secondary care emergency admissions (section 7.4).

- **Referral sources.** The referral sources analysis suggests limited access to bed based provision from home based services and social care and a reducing proportion of referrals from GPs. This may suggest a need for commissioners and providers in some health economies to review access arrangements and patient pathways to ensure intermediate care is considered before admission to acute services or to long term care.

- **Access to investigations.** The findings suggest ease of access to investigations is very similar between bed and home based services. This supports the view that the variation in the number of patients receiving investigations between those in bed and those in home based settings reflects need rather than accessibility (Patient level section 9.2).

- **Medical cover.** The proportion of home based services without dedicated medical cover may reflect the acuity of patients in these services. However, commissioners and providers of such services need to ensure timely access to specialist medical assessment. The quality standards audit showed that 29% of bed based and 39% of home based services do not have quick and ready access to geriatrician assessment. However, further work is required to understand the extent of new roles providing first line medical review in these services such as nurses with advanced assessment skills. This will be considered in further iterations of the audit (section 10.1).
8.3: Use of resources (provider view)

This section considers how resources allocated to intermediate care by commissioners are currently being utilised by providers.

**Unit costs**

The cost per occupied bed day was calculated by dividing the total service budget by the number of occupied bed days. This data was provided for 136 bed based services for 2011/12 (figure 8.3.1). The mean cost per occupied bed day was £158.09 and the median was £159.24.

![Figure 8.3.1: Total cost per occupied bed day 2011/12 (bed based services) 2011/12](image)

The total cost per service user was calculated by dividing total service budget by number of individual service users admitted. The data required for the calculation was provided by 146 bed based services. The mean was £4,543 per service user and the median was £4,277 per service user in bed based services.

For home based services, the cost per service user was calculated by dividing the total service budget by the number of individual service users accepted into the service. Data was available for 120 home based services. The mean was £1,100 per service user and median £859 per service user. On average then, the cost per service user of home based provision is approximately a quarter of the cost of bed based provision.

**Bed occupancy**

In bed based intermediate care units, bed occupancy shows a mean of 86% and median of 88% across the 143 services providing data.
Average length of stay

Data on the average length of stay for service users was provided by 150 bed based services. The mean for 2011/12 was 27.5 days and the median 27.0 days. This compares to an average length of stay reported by commissioners of 27.6 days and an average length of stay for the patient sample in bed based services of 30.4 days. The mean average length of stay as reported by providers in 2010/11 was 28.4 days.

For home based services, the average duration of services was provided by 121 services. The range was greater than for average length of stay in bed based services. The mean for 2011/12 was 24.2 days and the median 23.0 days. This compares to an average duration of service as reported by commissioners of 29.2 days and an average length of stay for the patient sample in home based services of 26.9 days. The mean average duration of service as reported by providers in 2010/11 was 28.2 days.
Intensity of input and productivity

As a proxy for the intensity of input provided within home based services, the number of contacts per service user has also been calculated. The mean for 2011/12 was 13 contacts per service user and median 9 contacts, with wide variation across the data provided from 94 services.

A measure of the productivity of home based services has been calculated as number of contacts per whole time equivalent (wte) number of clinical staff. This data was provided by 106 home based services. The mean for 2011/12 was 630 contacts per clinical wte and the median, 485.

Commentary: Use of resources

- Throughput of service users. The cost per service user will be affected by the length of stay/duration of service and hence throughput of service users. Participants will be able to view the comparative position of their services in the online toolkit available at http://icssurvey.nhsbenchmarking.nhs.uk/. For example, where cost per service user is relatively high, participants will be able to consider whether this is due to above average lengths of stay or higher total costs. Throughput will become increasingly important as services come under pressure from increased demand but budgets remain static in real terms (see commissioner audit results showing growth in investment of 3.9% 2010/11 to 2011/12 (section 7.3).

- Length of stay. All levels of the audit suggest average lengths of stay of 27-30 days for bed based and 24-29 days for home based provision. The definition of intermediate care provided in Halfway Home states “[Services] are time-limited, normally no longer than six weeks and frequently as little as one to two weeks or less”. The patient level audit also highlights a considerable proportion of service users with excessive lengths of stay (section 9.2). Long lengths of stay may impact on throughput and hence the ability of the service to make an impact on secondary care utilisation.

- Intensity of input. The contact per service user metric is probably not yet robust enough to draw conclusions because of variation in the definition of “contact” used in community services which do not yet utilise standard currencies and tariffs. However consideration will be given in future iterations of the audit to refining the definition of a “contact” and considering whether more detailed questions could be asked on interventions undertaken within intermediate care (section 10.1).

- Productivity. As for intensity of input, this metric relies on figures provided for “contacts” which may not be consistently counted. Further consideration could be given to how productivity can be measured in future iterations of the audit.
8.4: Workforce

This section considers the staffing levels and mix of disciplines in intermediate care services.

**Staffing levels**

The number of clinical whole time equivalent (wte) staff per bed is shown at figure 8.4.1. Data was provided for 147 bed based services. The mean was 1.23 clinical wte per bed and the median, 1.24.

![Figure 8.4.1: Clinical WTE per bed 2011/12](image)

For home based services the number of clinical wtes per 100 service users was calculated (figure 8.4.2). Data was provided for 126 home based services. The mean was 3.9 clinical wtes per 100 service users and the median value was 2.3.

![Figure 8.4.2: Clinical WTE per 100 service user (home based services) 2011/12](image)
Mix of disciplines

The mix of staff disciplines for bed and home based services is shown in (figure 8.4.3). On average, the largest staff group for bed based services is unqualified health workers (36.9%), followed by nurses (32.5%). Physiotherapists and occupational therapists make up 4.7% and 5.0% of the workforce respectively. Social care is represented within bed based provision by unqualified social care staff (7.6%) and social workers (0.9%). Medical cover is provided by GPs (1.5%) and consultant geriatricians and junior medical staff, together 1.2%. Mental health workers made up 0.2% of the workforce in bed based services.

For home based services, unqualified health workers make up 24.2% of the team on average, with nurses comprising 20.3%. The next largest group is social care, 21.4% of staff being unqualified social care staff and 2.2% social workers. Physiotherapists and occupational therapists make up 10.1% and 9.2% of the workforce in home based services respectively. Overall, GPs make up 0.3% and consultant geriatricians and junior medical staff, together 0.5%, of the workforce. Mental health workers represented 0.6% of the workforce.

Nursing skill mix

The ratio of “nursing” to “unqualified health staff” for intermediate care units in community hospitals and acute settings was reported as 47:53. This is close to the ratio of registered nurses to unqualified healthcare assistants accepted by the Royal College of Nursing as the level for basic, safe care in these settings where predominantly older people are cared for. However, the RCN recommends a ratio of 65:35 for ideal, good quality care in these settings. The audit results suggest a registered nurse: patient ratio of 1:7, based on 86% bed occupancy and assuming the establishments reported include a 25% allowance for absence, leave etc. For ideal, good quality care, the RCN recommends this ratio should be between 1:5 and 1:7, assuming the unit leader/sister is supernumerary. Reference: Safe staffing for older people’s wards: RCN summary guidance and recommendations, Royal College of Nursing, March 2012.
Commentary: Workforce

- **Staffing levels.** The staff level data (clinical wte per bed and per service user for home based services) is a measure of the intensity of resources utilised within an intermediate care service. Providers need to consider their position on this metric (available through the toolkit at http://icsurvey.nhsbenchmarking.nhs.uk), in the light of their position on productivity/use of resources measures. For example, a higher relative level of staffing may result in lower length of stay, greater throughput and therefore lower costs per service user. However, where staff levels are high and higher productivity is not in evidence, the cost per service user may appear relatively expensive.

  Performance on outcome measures will also be an important part of the story for each service line. For example, are higher staffing levels justified by better than average outcomes as measured by discharge destination i.e. fewer service users being readmitted to acute care and more going home?

- **Social care.** As noted in (section 8.1), social care is represented in the workforce in 50% of home based services, with social care staff making up 24% of the total workforce. Social care is less evident in bed based services. Although 45% of services report the presence of social care workers within their establishment, social care staff make up only 9% of the total workforce in bed based services.

  This may reflect the different roles of social care in bed and home based services, with social care staff carrying out assessment and organising care packages for service users being discharged from bed based units but more likely to be delivering care and re-ablement interventions in home based services.

- **Medical cover.** Medical cover is discussed under (section 8.2) Commentary: Service characteristics.

- **Mental health.** The data suggests mental health workers are rarely included in the establishment in intermediate care teams. In addition, only 55% of bed based and 60% of home based services report that all members of the team have received training in mental health and dementia care (see Quality Standards section 6.3). However, 71% of bed based and 59% of home based services report they have “ready and quick access” to specialist mental health skills. Whilst this reliance on external support may reflect the fact that currently only 12% of patients in the patient level audit are recorded as having dementia, consideration might be given to whether this approach contributes to an under representation of dementia in intermediate care (see section 9.1, patient level audit).
8.5: Outcomes

Intermediate care services do not currently utilise a standardised outcome measure that could be used to compare performance nationally. The development of a Patient Reported Outcome Measure is a target for the second year of the audit (see section 10.2).

In this first iteration of the audit, discharge destination is taken as a proxy outcome measure. This is explored further in the patient level audit (section 9.3).

Bed based services reported that, on average, the discharge destination of 66.5% of service users was home, 14.8% acute care, 9.5% went to a care home and 3.0% died (unknown 5.6%). For home based services, 68.5% remained at home, 8.4% were admitted to acute care, 3.1% to a care home and 2.4% died (unknown 15.2%).

![Figure 8.5.1: Destination on discharge (% of bed based service users)](image1)

![Figure 8.5.2: Destination on discharge (% of home based service users)](image2)

**Commentary: Outcomes**

- There was a high proportion of destination “unknown” cases particularly in the data provided by home based services. Given that destination at discharge is an important outcome measure, the completeness and accuracy of data collection requires review by some participating providers.

- Both bed and home services show similarly low patient mortality rates. This will reflect careful patient selection and/or urgent transfers to acute care for patients who deteriorate.
9: Results: Patient level audit

9.1: Service user characteristics

Data were submitted for 3,150 service users, drawn from 320 services, of whom 1,585 was users of bed based services and 1,565 was users of home based services.

In reviewing the patient level audit findings, reference should be made to the comments on data contributions and completeness in (section 5.2).

Age profile

92% of users were aged 65 or over and 42% were over 85 years of age. The mean age was 81 years (82 years bed based, 79 years home based) (figure 9.1.1). 64% of users were female (66% bed based, 62% home based).

![Figure 9.1.1: Patient sample age bands as % each IC service type](image)

Reasons for admission

The reasons listed for admission, if not specifically described as rehabilitation, were related to functional problems such as falls and immobility - these categories accounted for 71% of the total. A primary medical problem was cited as the reason for admission in 15% of users (17% home-based, 12% bed-based). End of life care, purely social and primary mental health were infrequently cited admission reasons (figure 9.1.2).

![Figure 9.1.2: Admission reason as % each IC service type](image)
**Long term conditions prevalence**

The underlying diagnoses or organ systems affected listed was typical of people of this age requiring rehabilitation and showed little difference between bed based and home based (figure 9.1.3). 79% were reported as having one or more, and 43% two or more, of the long term conditions listed in the audit (figure 9.1.4).

Although few patients used services for primary mental health reasons, 12% were recorded as having dementia, with similar proportions in both service types (13% bed based, 11% home based).

![Figure 9.1.3: Long term conditions as % each IC service type](image)

![Figure 9.1.4: Number of long term conditions per patient as % each IC service type](image)

**Patient pathway**

Most users had previously lived in the community, usually in their own home: 1% lived in nursing homes and 2% in residential homes. 21% of bed-based service users had come from their usual place of residence at home or in a care home (“step-up”), whereas (67%) came from an acute hospital (“step-down”) and 5% transferred from A&E. For home-based services, 52% were “stepped-up” in their usual place of residence, 31% were “stepped down” from an acute hospital and 6% transferred from A&E.
Commentary: Service user characteristics

- Intermediate care services largely cater for older people in need of rehabilitation. There was little difference between the age, gender or admission reason between the bed and home based services.

- People with dementia were not systematically excluded from either type of intermediate care services (12% were recorded to have this condition). However, given that the community prevalence of dementia is 20% and the prevalence in general hospitals is 31% in this age group (Living Well with Dementia, DH 2009 and Who cares wins, Royal College of Psychiatrists, 2009), there is likely to be under-representation of people with dementia, which raises questions about where or whether rehabilitation services for people who also have dementia are provided.

- Residents of care homes were infrequent users of intermediate care services. Given that surveys of the needs of care homes document a deficiency in rehabilitation provision; this raises questions about whether intermediate care services contribute to this disadvantage (Quest for Quality: Inquiry into the quality of healthcare support for older people in care homes, British Geriatrics Society, 2011).

- Although the patient characteristics of those using bed based and home based services are similar; this should not be extrapolated to deduce that the patients’ needs could equally well be met by either form of service, as these data do not take account of severity of disability or home circumstances which would have a bearing upon the place where rehabilitation can be delivered.

- Step up (potentially hospital avoiding) and step down (potentially expediting discharge) episodes of care were observed in both bed based and home based services. However, it cannot be assumed that all such episodes of care, or all days within them, would otherwise have been spent in a hospital if the intermediate care service had not been present.

- Only a few patients transfer to intermediate care from A&E, although higher levels are reported at the provider level (section 8.2) which may suggest issues with activity recording. This suggests links between intermediate care services and A&E may not be well developed.
9.2: Service received

Waiting times

For bed based services, 13% of service users waited 3 days or more between referral and assessment for intermediate care services. For home based services providing both step up and step down services (accounting for 88% of all home based services in the sample), 22% of service users waited 3 or more days.

The average wait times between assessment and admission to/commencement of the intermediate care service are shown in figure 9.2.2. For bed based services, 19% of service users waited 3 days or more between assessment and admission. For home based services providing both step up and step down services, 17% of service users waited 3 or more days.
Length of stay

Service users were recorded to be in intermediate care services for a mean of 30.4 days (range 0-234) for bed based and a mean of 26.9 days (range 0-750) for home based services.

24% of bed based and 44% of home based service users had stays of up to two weeks and 85% of bed based and 86% of home based service users had stays of up to six weeks.

Users with lengths of stay of 90 days or more accounted for 9% of bed based days incurred and 21% of home based days.

Assessments

A range of professionals were involved in the assessment of service users, the most frequent of which were nurses, physiotherapists and occupational therapists. Higher rates of assessment were seen in bed based services, most notably assessment of users by doctors which was uncommonly recorded for home based service users.

Figure 9.2.3: Patient length of stay

Figure 9.2.4: Patient assessments by staff discipline as % each IC service type
Medical diagnostic tests and investigations were mainly recorded for users of bed based services.

![Figure 9.2.5: Patients receiving investigations as % each IC service type]

Standardised assessments of a range of domains of health were used in the assessment of a minority of service users, with the exception of the Waterlow score (to risk assess for pressure sores) in bed based services.

![Figure 9.2.6: Assessments tools used as % each IC service type]

96% of bed-based users and 77% of home-based users were discussed by a multi-disciplinary team, and 96% and 91% respectively had rehabilitation goals set.
Complications

Medical complications recorded are shown in the figure 9.2.7. Higher rates were seen in users of bed-based services. The most common complications are falls, urinary tract infections and delirium.

Figure 9.2.7: Patients with complications as % each IC service type
Commentary: Service received

- Individual patient data confirm the wide variation in lengths of stay reported in the provider level data. Lengths of stay for a considerable proportion of users, in both types of services, exceed the guideline of normally no longer than 6 weeks duration (Halfway Home, DH 2009). A considerable proportion of users have very short lengths of stay, less than 1 week, (especially those of home based services) which may indicate minor service user needs. Given that those who spend 90 days or more account for 9% of bed based days and 21% of home based days, there may be significant efficiencies to be gained by reducing the proportion having excessive lengths of stay.

- The difference in the type and number of medical investigations and diagnostics between the bed based and home based services could be an artefact if those reporting on home based services were not aware of diagnostic tests arranged by their GPs. However, as many bed based services in the sample were community hospitals, it may be genuine and related to need rather than availability.

- The low proportion of users assessed using standardised scales reflects the fact that these are not in widespread use in rehabilitation in the UK, and the fact that no minimum rehabilitation dataset is required by expectation or regulation. The absence of such scales makes it harder for providers to demonstrate that a comprehensive assessment of users was undertaken. The higher proportion of use of the assessment for pressure sores is likely to represent institutional risk assessment policies and the Commissioning for Quality and Innovation (CQIN) payment framework.

- Bed based services (many of which were community hospitals) lend themselves, and have been traditionally organised, to provide multi-disciplinary assessment. There may be a number of reasons why a lower proportion of home based users were discussed by a multi-disciplinary team, including logistics and differences in the level of service user needs.

- Recording of medical input, in particular, tends to be associated with bed based services although this may be an artefact as the users’ GPs may be in attendance (as discussed in section 8.2) but this may not be recorded as part of the intermediate care service.

- Delirium, falls and urinary tract infections were more common in bed based services: whether this is due to case-mix, ascertainment bias or the hazards of institutional settings is not known. It cannot be concluded from these results that home based services are safer. It indicates that the workforce of intermediate care services should be skilled and trained in the prevention and treatment of these conditions.
9.3: Outcomes

Patient pathways

The pathway for each service user was mapped from:

- the service user’s previous address (i.e. before the entire episode of care; to)
- the pre-intermediate care location; to
- the intermediate care type (bed or home based); to
- discharge destination after intermediate care.

The analysis confirmed the findings of the provider level audit that the bed based intermediate care is predominantly used for step down care. The most common pathway was from home to acute care then to intermediate care and then home (45%). 5% followed this pathway but instead of going home went back to acute care, 4% to residential care and 3% to nursing care. Use of bed based services for admission avoidance was less common with 13% following a pathway from home to intermediate care bed and back home afterwards.

As highlighted in the provider level audit, home based services are most often used for step up care. The most common pathway is for service users to receive intermediate care at home and remain at home afterwards (39%), similarly 2% received the service whilst in residential care and 1% whilst living with family. 24% of service users came from home into acute care, then returned home with intermediate care (“stepped down”) and remained at home afterwards.
As a proxy outcome measure the chart below compares the service user’s location before entire episode and final location. The outcome is then coded as follows:

- **Blue** = dependency of setting reduced (e.g. residential home to living with family)
- **Gold** = dependency of setting maintained (e.g. home to home)
- **Red** = dependency of setting increased (e.g. home to acute care)

This shows 72% of bed based and 82% of home based services users maintained their level of independence (measured as their type of care setting) following intermediate care and 24% of bed and 13% of home based service users moved to a more dependent setting.

**Commentary: Outcomes**

- Given the age profile and co-morbidities present in the patient sample (section 9.1), the high proportions of patients maintained in their home environments is reassuring. The raw figures for these outcomes should be interpreted with caution, as these rates will depend upon the case mix (sicker or more complex patients will have worse outcomes) and the length of stay (the longer the individual stays in a service, the greater the opportunity for death, hospitalisation or institutionalisation to occur).

- Given the importance and frequency of these undesirable outcomes, it would appear to be good practice for individual services to examine deaths, transfers to hospital and to institutions in suitable clinical governance meetings.

- Given the limitations of existing data on outcomes, it is intended to develop a PROM for use in future iterations of the audit and to consider whether the measure could be case mix adjusted (section 10.2).
10: Audit developments

10.1: Future iterations

As noted in (section 3), it is intended that there will be annual iterations of the National Audit of Intermediate Care. A number of the revisions to the current audit questions have been suggested or highlighted through the data collection and validation processes, discussion on the telephone helpline and from feedback received from participants via a feedback form circulated to participants in early June 2012. A number of key themes for the amendments are now emerging and can be summarised as follows:

- the possible inclusion of homecare re-ablement services
- changing the structure of the audit questionnaire to better reflect the full range of service models including:
  - integrated health and social care
  - integrated bed and home based services
  - integration of intermediate care with community service teams
  - use of spot purchased beds
  - provision of rehabilitation support into care homes
- more in depth analysis of specialist mental health input into intermediate care services
- separation of rapid response teams with different questions
- exploration of interventions delivered within intermediate care services
- analysis of effectiveness of intermediate care services
- prevention of admissions to long term care
- further exploration of staffing skill mix and use of extended roles.

10.2: Patient Reported Outcome Measure (PROM) development

Patient Reported Outcome Measures “are measures of a patient’s health status or health-related quality of life. They are typically short, self-completed questionnaires, which measure the patients’ health status or health related quality of life at a single point in time”. Reference: Guidance on the routine collection of Patient Reported Outcome Measures (PROMs), DH, 2008. Collection and reporting of PROMs is a key priority set out in the Government’s July 2010 White Paper, Equity and excellence: Liberating the NHS.

The National Audit of Intermediate Care is considering the development of a PROM for intermediate care which could be implemented by participating organisations, allowing data to be collated and analysed at the national level as part of future iterations of the audit. The PROM would be developed with audit participants and would meet the following criteria:

- Nationally / internationally validated and agreed measure
- Completed by patients, or their representatives
- Case mix adjusted
- Reporting thresholds agreed
- Pre- and post- intervention / treatment completion of questionnaire
- Questionnaires and the administration based on extensively piloted methodologies and research base

Further information about the development of the PROM will be provided on the National Audit for Intermediate Care web page www.nhsbenchmarking.nhs.uk/icsurvey.aspx
11: Discussion

- **Variation in service provision.** Intermediate care covers a spectrum of health and social care provision characterised by multi-disciplinary team working and a flexible but time limited duration. These services operate both at the interface between health and social care and between the primary, community and secondary health care sectors. The audit highlights the wide variation in service models being used nationally with differences evident in the extent of multi-agency integration, the scale of services provided, and how intermediate care sits within the full range of health and community services, in each local health economy.

- **Partnership working** between health and social care was evident both from the commissioning arrangements, with services jointly commissioned in 58% of health economies, and from the provider side, with social care represented in 45% of bed based and 50% of home based services. However, approximately one third of respondents do not have a multi-agency board and only 21% use Section 75 funding arrangements. Although these commissioning arrangements are for local Health & Wellbeing Boards to decide, a shared vision and alignment of strategies will be needed to address the demand and capacity issues highlighted in the report.

- **Strategic planning and evaluation.** The audit highlighted some weaknesses in strategic planning by commissioners with further work required on the development of Joint Strategic Needs Assessments and strategic plans. The results also suggested evaluation of the impact of intermediate care on whole system metrics may be limited in some areas. Without systematic evaluation of the effectiveness of intermediate care it may be increasingly difficult to make the case for further investment in services.

- **Demand and capacity.** The mean number of intermediate care beds commissioned (22.5), the average investment levels (£1.9 million per 100,000 weighted population) and the average total number of admissions into bed and home based services (984 per 100,000 weighted population), indicate the overall capacity of intermediate care is small relative to secondary care provision. Estimates of potential demand for intermediate care services compared to the capacity identified in the audit, suggest overall capacity may currently be less than half of potential demand. Clearly, the gap between demand and capacity in a particular health economy may vary widely from this overall average position. This raises the question of whether the current scale of intermediate care is sufficient to make an impact on secondary care utilisation including emergency admissions and acute lengths of stay.
Function of intermediate care. Intermediate care has dual objectives of preventing unnecessary acute hospital admissions and supporting timely discharge for those stepping down from hospital. All health economies covered in the audit commission both step up (admission avoidance) and step down intermediate care services. Based on the audit results, the split of capacity in bed based provision is approximately two thirds step down and one third step up and this is reversed in home based services. Given that step up beds are not typically ring fenced, systemic pressures to move patients out of hospital may result in step down cases being prioritised and step up bed capacity being limited.

Lengths of stay. All levels of the audit suggest average lengths of stay of 27-30 days for bed based and 24-29 days for home based provision. Lengths of stay for a considerable proportion of individual service users in the patient level audit, in both types of services, exceed the guideline of normally no longer than 6 weeks duration (Halfway Home, DH 2009). Given that those who spend 90 days or more account for 9% of bed based days and 21% of home based days, there may be significant efficiencies to be gained by reducing the proportion having excessive lengths of stay.

Contract monitoring and performance management. 15% of respondents do not have an agreed service specification against which performance can be monitored and nearly one third of commissioners don’t specify maximum lengths of stay in their specifications. Further, commissioners ability to provide financial and activity data was limited in some instances. This may suggest a lack of regular performance monitoring and management in these health economies.

Outcomes. Intermediate care services do not currently utilise a standardised outcome measure that could be used to compare effectiveness of services nationally. Discharge destination has been considered as a proxy measure in the report.
The National Audit of Intermediate Care is a subscription audit managed by the NHS Benchmarking Network working in partnership with British Geriatrics Society, the Association of Directors of Adult Social Services, AGILE, the College of Occupational Therapists- Specialist Section Older People, the Royal College of Physicians (London) and the Royal College of Nursing.

We would like to express our thanks to NHS Wirral and NHS Somerset who host the NHS Benchmarking Network and provided Finance and IT support to the audit.

Also thanks to Webweavers Design Solutions for fantastic work on the web based data entry tool and online toolkit (contact: jackie@webweaversdesigns.co.uk).

Thank you to the Health and Social Care Information Centre and Northgate Information Solutions for provision of Hospital Episodes Statistics data.

Finally many thanks to all the participants in the audit, including management, clinical, informatics and finance staff, for their support and hard work in completing the audit tool.
## Glossary of terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Definitions</th>
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<tbody>
<tr>
<td>Intermediate care</td>
<td>A range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living</td>
</tr>
<tr>
<td>Bed based services</td>
<td>Intermediate care services delivered in bed based settings including within community hospitals, units based within acute hospitals, residential and nursing homes and other locations</td>
</tr>
<tr>
<td>Home based services</td>
<td>Intermediate care services delivered in services user’s own place of residence</td>
</tr>
<tr>
<td>Step up</td>
<td>Intermediate care function to receive patients from home/community settings to prevent unnecessary acute hospital admissions or premature admissions to long term care</td>
</tr>
<tr>
<td>Step down</td>
<td>Intermediate care function to receive patients from acute care for rehabilitation and to support timely discharge from hospital</td>
</tr>
<tr>
<td>Weighted population</td>
<td>The population of a defined geographic area (in this report usually a PCT) adjusted to take account of the need for health services of that population, reflecting age distribution and levels of deprivation in the area</td>
</tr>
<tr>
<td>PBR</td>
<td>Payment by Results - a methodology introduced by DH to reimburse hospitals in England for the activity they carry out, based upon a national tariff of fixed prices that reflect national average costs</td>
</tr>
</tbody>
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14: References

- Royal College of Psychiatrists. Who cares wins: Improving the outcome for people admitted to the general hospital: Guidelines for the development of Liaison mental Health Services for Older people. Royal College of Psychiatrists, 2009.
Appendix 1

Service model illustrations

NHS Birmingham & Solihull Cluster / Birmingham Community Healthcare NHS Trust

The Benefit of Community Unit Models of IC provision

Birmingham Community Healthcare NHS Trust (BCHC) runs and staffs two Community Unit wards on acute hospital sites within Heart of England NHS Foundation Trust (HEFT). Each Community Unit provides a period of intensive multi-disciplinary assessment and support with decision making for vulnerable and frail older adults facing significant changes to their care and/or accommodation. Being outside an acute care environment enables people to regain their independence whilst identifying the areas where support is required.

The nursing and care services are supported with joint Health and Social Care identified funding. Each Community Unit is twinned with the corresponding Intermediate Care Centre across Birmingham that provides further rehabilitation opportunities and management support.

When people have completed their period of assessment and agreed their required services with the multi-disciplinary team, they move into the local authority funded interim phase and are proactively assisted to relocate to their long term services as soon as possible. The joint funding of the service means that eligible people automatically transfer to the responsibility of the local authority without having to move location thereby avoiding the issue of delayed transfers.

Evaluation:

Diversion from long term care:
Community Units exceeded their performance targets for all the outcomes for individuals but particularly a greater percentage of people were enabled to return home than in the original nursing home pilot (46% compared with a target of 43%). This is an important outcome for the local authority with its drive to optimise independent living in people’s own homes.

Delayed transfers of care from HEFT:
The Units have enabled HEFT to meet both their weekly and year to end delayed discharge targets for delays of no more than 3.5% of available adult beds (2011/12 figures).

Financial:
The local authority gained 1893 days of interim care in the Community Units during the running of the pilot. The unit costs of these interim care beds proved to be £106 per day which compares favourably with an average cost of £79 to £104 in the independent sector.

Excess bed days and length of stay at HEFT:
Once open, the Community Units assisted in the reduction of excess bed days to the August 2009 levels and have maintained a reduction of 1,500 to 2,000 excess bed days thereafter. The original evaluation showed that 1,289 fewer hospital spells attracted excess bed day costs, a projected year end reduction of 1,718 spells.

For further information, please contact: Gary Crellin, Associate Director (Inpatient Care) Birmingham Community Healthcare NHS Trust on 0121 466 6139 or gary.crellin@bhamcommunity.nhs.uk
National Audit of Intermediate Care

NHS Worcestershire / Worcestershire Adult & Community Services / Worcestershire GP Practices

Development of the Single Point of Access (SPA)

A single point of access was developed in 2008 to improve access, efficiency and effectiveness of intermediate care services. The SPA was originally piloted in 2008 and was then rolled out countywide in 2011, coinciding with the development of new Intermediate Care Teams in these catchment areas. Now the new model is embedded within primary care and community services, the SPA working group, which consists of health and social care commissioners, social care and health care providers and senior managers, have identified a number of key areas for development to reflect the future vision and direction.

- To rename the service to the “Worcestershire Health and Social Care Access Service” (WHASCAS) to reflect the move towards a more integrated health and social care service. The SPA for health and social care became a fully integrated in and out of hours service in April 2012. The service includes the social care Emergency Duty Team, the Rapid Response and Intermediate Care Social Work Team, the Rapid Response Nursing Team as well as the existing social care Access Centre staff and the health Single Point of Access team. The SPA is now providing an integrated rapid response health and social care service.

- To facilitate access to assessment services to prevent hospital admission by providing care as close to home as possible. The service offers an assessment of need (either by the social worker or jointly with health colleagues) and quick access to a range of support options including, UUPS, intermediate care in resource centres and interim care packages at home. Once stabilised, any ongoing care needs are assessed by the appropriate Community Social Work team who will complete any assessment and support planning for longer term needs.

- To support failed discharges and potential re admissions. WHASCAS will in partnership with primary health care, intermediate care and virtual ward teams assess needs of the individual and provide services at or as close to home as possible to avoid an inappropriate readmission to hospital.

- To facilitate access to health and social care services via 24 hr SPA providing an integrated, centrally coordinated night support service, which facilitates access to consistent and appropriate night services, across the county.

For further information, please contact: Ruth Davoll, Clinical Development, NHS Worcestershire on 01905 760000 or ruth.davoll@worcestershire.nhs.uk
Re-admission Avoidance Scheme (RAS)

Since September 2011, the intermediate care services have extended their role to identify, assess and provide support to patients with long-term conditions who are at risk of hospital re-admission within 42 days. The focus has been as follows:

- Identifying patients at risk of re-admission or admission, based on known risk factors and clinical judgement
- Maintaining a register of such patients that is accessible to all stakeholders 24/7 via 111 (Urgent Care)
- Co-ordinating the provision of appropriate services in the community to monitor and support such patients (and create extra capacity where necessary)
- Providing a single contact number to aid the flows of information between key health and social care professionals
- Patients with an acute exacerbation of their COPD (Chronic Obstructive Pulmonary Disease) follow a specific pathway for the first 7-10 days and then stepped down to the generic re-admission avoidance

Homerton University Hospital NHS Foundation Trust

Intermediate Care Geriatrician

This post was appointed in April 2010 and commenced in September. It was jointly funded by the then PCT (now CCG) and the Trust. The main aspect of the role was to engage with inpatient teams initially at least weekly and more flexibly with community teams, offering IC services in order to improve outcomes for older people. Many opportunities for change were agreed, culminating in the local health economy recognising the need for a clinically led network coordinating strategic service priorities for older people, which has become the Frail Older People’s Board (FOPB).

Key strategies for the FOPB include the following:

- Intermediate care as an integrated care pathway
- EOLC + advanced care planning
- Improving acute care of frequent attenders, heart failure pathway and cellulitis pathway
- Promotion of an integrated approach to dementia care
- Promotion of the established falls pathway and to review outcomes
- Borough based integrated continence pathway
- Catheter care pathway – supported by catheter CNS clinics

The main changes developed:

- 3 integrated multi-professional community intermediate care teams interfacing to provide joined up patient care
- Phone advice service for GPs to access urgent assessment or to coordinate admission prevention strategies
- Rapid access MDT clinic accessible daily to see urgent patients
- Urgent and non-urgent joint domiciliary visits with GPs and/or MDTs for decisions around physical health needs MCA, DOLs, EOLC, advanced care planning and VAP
- Geriatric consultant presence daily Monday to Friday on Acute Care Unit and in the observation ward in A&E for admission avoidance

For further information, please contact: Wendy Lyons, Intermediate Care and Community Rehabilitation Services Manager, County Durham & Darlington NHS Foundation Trust on 0191 387 6509 or w.lyons@nhs.net

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Appendix 2

National Audit of Intermediate Care
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RCGP clinical champion for dementia

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The Royal College of Nursing  
Older People’s Forum  
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