National Audit of Intermediate Care_Report, 2013 (pp.56, 74, 90)

Book · November 2013

2 authors:

Steven Mark Brian Ariss
The University of Sheffield
48 PUBLICATIONS **449** CITATIONS
SEE PROFILE

Pamela Enderby
The University of Sheffield
194 PUBLICATIONS **3,155** CITATIONS
SEE PROFILE

National Audit of Intermediate Care **Report** 2013

This report covers organisational level data relating to the period 2012/13 and, for comparison, 2011/12. Service user and patient reported experience data was collected between May and August 2013. The report is available to download on the following page:

www.nhsbenchmarking.nhs.uk/National-Audit-of-Intermediate-Care/year-two.php

Published: November 2013, NHS Benchmarking Network

Document reference: NAIC2013

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 **Association of Directors of Adult Social Services (ADASS)** represents Directors of Adult Social Services in councils in England. As well as having statutory responsibilities for the commissioning and provision of social care, ADASS members often also share a number of responsibilities for the commissioning and provision of housing, leisure, library, culture, arts and community services within their Councils.

The **College of Occupational Therapists Specialist Section for Older People (COTSS-OP)** is passionate about older peoples' independence, well-being and choice. COTSS-OP provides professional and clinical information on all aspects of occupational therapy practice related to older people. Through Clinical Forums, the COTSS-OP aims to encourage evidence based practice and provide guidance on occupational therapy intervention in the areas of: acute and emergency care, intermediate care, dementia, falls, mental health and care homes.

The core mission of 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.

The Patients Association's motto is 'Listening to Patients, Speaking up for Change'. This motto is the basis on which all Patients Association campaigns are built. Via the Helpline, stories about health and social care from thousands of patients, family members and carers are captured every year. This knowledge is used to campaign for real improvements to health and social care services across the UK. In addition, the Helpline provides valuable signposting and information for patients and supports them as they navigate health and social care services. Our joint CARE campaign with the Nursing Standard aims to tackle poor care and the causes of poor care. The campaign aims to highlight the complex causes of poor care and identify how these causes can be addressed.

The **Royal College of Speech and Language Therapists (RCSLT)** promotes the art and science of speech and language therapy – the care for individuals with communication, swallowing, eating and drinking difficulties. The RCSLT is the professional body for speech and language therapists in the UK; providing leadership and setting professional standards. The College facilitates and promotes research into the field of speech and language therapy, promotes better education and training of speech and language therapists and provides information for members and the public about speech and language therapy.

NHS England create the culture and conditions for health and care services and staff to deliver the highest standard of care and ensure that valuable public resources are used effectively to get the best outcomes for individuals, communities and society for now and for future generations.

Contents

1: Foreword

Professor John Young,
National Clinical Director for Integration and Frail Elderly, NHS England

I have been closely involved with the National Audit of Intermediate Care since its inception in 2008. The journey has been challenging but highly rewarding. The audit now covers about half the NHS – remarkable when you consider the commitment required by local staff to collect and submit the data, and particularly because the audit is voluntary. Thank you to all of you who have such a commendable curiosity to learn about the performance of your services.

The audit is important because it describes services that are otherwise relatively hidden from view in our conventional perception of health and social care. Yet intermediate care, or "care closer to home," has been quietly developing during the last ten years or so. The focus has always been that of older people with co-morbidities/frailty – just the group that is now so much in the forefront of health and social care thinking. And intermediate care services have always been a platform to develop new ways of working – particularly multi-agency working – and so it is highly relevant to our current interest in service integration. In a very real way, intermediate care occupies the middle ground and so facilitates a genuinely whole system approach. These services offer clear alternatives to our dominant system response of hospital care: step up care for admission avoidance; step down care for early hospital discharges. The current health and social care climate is one that has, for the first time, fully embraced the concept of whole systems working. More than ever before, therefore, the time of intermediate care services is now! This audit lays out where we are, and the nature of the journey ahead.

Patient experiences of intermediate care services

There are many ways of benchmarking services like intermediate care but arguably the foundation stone should be that of the care experiences of the service users. Thus the novel introduction of the Patient Reported Experience Measure (PREM) in the audit is brave and highly informative. It was carefully developed and presented in the form of 'I' statements as recommended by National Voices. So did intermediate care pass this fundamental test? It depends! It depends on how high we aspire to set the bar. I suggest we set it at 95% of patients reporting positive experiences. High? Possibly, but this still means one in 20 people are reporting a negative aspect of care. Against this standard, intermediate care as a whole is not yet delivering the type of service experience patients hope for. Precious data like these are rarely available on this scale to other health and social care services. Service providers now have important new information to inform patient-centred improvements.

Intermediate care capacity

"The hospital is full" has become a dependable barometer for the NHS and is increasingly popularised by our media. "The community and social care is full" is arguably a more truthful statement. In a whole system, we are vulnerable to the weakest link. This audit has demonstrated that the current provision of intermediate care is around half of that required to avoid inappropriate admissions and provide adequate post-acute care for older people. Moreover, the 2013 audit showed that intermediate care capacity appears stuck – there has been no change compared to the previous 2012 audit.

Perhaps this is unsurprising because the audit also found clear evidence of weak local strategic planning processes. This is likely to be the explanation for the long waiting times to access these services by patients

(3.4 days for bed-based services; 4.8 days for home-based and 4.2 days for enabling services). Delays are counterproductive for older people who rapidly deteriorate when held in a queue. Also, the person will inevitably spend longer in the intermediate service whilst their capabilities are brought up to previous baseline; and so more capacity is utilised (unproductively) in intermediate care. Strategically planned, adequate intermediate care capacity should be an essential step for local health and social care commissioners if the whole system is to function optimally.

Integration

It has now been fully recognised that the current situation of silo working and fragmented health and social care services must be rectified. It is unhelpful for our patients, and causes unnecessary hardships, as they find themselves bumped around the system, or simply stuck. National Voices on behalf of service users have provided a laudably simple definition of integration: care that is "person centred and co-ordinated" (http://www.england.nhs.uk/wp-content/uploads/2013/05/nv-narrative-cc.pdf).

So how is intermediate care doing in respect of integration? A mixed picture is presented in the audit – probably a fair reflection of some progress, but much more work to do. The crisis response teams and home based services appear to be well integrated into the wider health and social care systems with referrals received from primary, secondary, community and social care sources. There do however appear to be opportunities for re-ablement services to become more integrated with the whole system (43% state that they are currently operating separately from intermediate care services). There is evidence that the services are running in parallel with the 'health' intermediate care being underpinning by 'health' referrals and a trivial number of referrals from the social care sector, whereas social sector referrals comprise an important source of work for the enabling services. Perhaps this parallel service provision is unsurprising given that the Section 75 pooled budget funding opportunities has been taken up by only 32% commissioners in the audit (albeit up from 21% in the 2012 audit).

Where does mental health fit in? Not at all, it seems. The proportion of mental health trained staff in any of the service models audited is so small as to be miniscule, and training in dementia care – surely essential for staff working with older people? – is deficient as only about half the staff has received this training. So, strategically and operationally, the integration agenda has yet to be addressed.

I hope next year's audit will show across the board improvements in these key areas. My thanks go to Claire Holditch and her team at the NHS Benchmarking Network for delivering such a complex but important piece of work.

2: Executive summary

The National Audit of Intermediate Care provides a unique overview of intermediate care commissioning and provision in England. This is the second year of the audit. In 2012, the audit focused on health based bed and home intermediate care services. In 2013, the study has been extended to cover crisis response and social care re-ablement services. This has enabled us to paint a comprehensive picture of the services which support, typically older, people after leaving hospital or when they are at risk of being sent to hospital. The key finding from the audit remains the very wide variation between service configuration, size and performance in different localities. As the population of frail/elderly people grows and the pressure on hospitals increases, the challenge of getting commissioning and service provision of intermediate care up to the level of the best performers becomes increasingly urgent.

With the focus on quality of service provision in the 2013 audit, two Patient Reported Experience Measures (PREMs) were developed for use in bed and home based/re-ablement services. In addition, a service user questionnaire including two clinical outcome measures was developed for bed based services, replacing last year's patient level audit. The results suggest, generally, good patient experiences and positive clinical outcomes for service users. This chimes with work undertaken by the Patients Association to create a patient voices video for intermediate care. Many services users were very grateful for the service they received. Whilst these results are encouraging and reflect the commitment and compassion of front line staff, some results from the PREM and from the organisational sections of the audit, suggest there is room for improvement in areas such as involvement of the service user in decision making and addressing waiting times.

The key themes evident from the results of the 2013 iteration of the audit are summarised below:

Variation in commissioning

The average investment in 2012/13 in health based intermediate care was £1.9 million per 100,000 weighted population, and re-ablement services £0.7 million per 100,000 weighted population, but there were large variations. As in 2012, the 2013 audit has highlighted wide variation in the extent of multi-agency commissioning, the scale of services provided and how intermediate care sits within the full range of health and social care services within each local area.

Integration at the strategic/commissioner level

There is evidence of increased integration at the commissioner level of the health and social care system. In the 2013 audit sample, intermediate care services were jointly commissioned in 74% of health economies compared to 58% in 2012 and the use of formal Section 75 pooled budget has increased from 21% to 32%. Multi-agency boards are in place in 70% of areas compared to 63% in 2012 and strategic planning for intermediate care is undertaken jointly by health and local government for 90% of participants (86% in 2012).

Diversity of provision

Intermediate care services were typically delivered by small local teams: the average number of intermediate care services per provider was 2.6, but the range was up to 22 different services. The audit covered approximately half the country and identified 535 different services at the registration stage. The task of quality assuring all these services is challenging and also raises concerns about fragmentation of services, potentially unclear routes in and out of services and lack of economies of scale.

Capacity of intermediate care

Last year, we calculated intermediate care capacity needed to approximately double to meet potential demand. With the exception of two CCGs who have doubled investment, there is little evidence nationally that investment and capacity have increased in 2013. The pressure to fill existing intermediate care capacity with people leaving hospital appears to have worsened in 2013. Step up bed based capacity aimed at avoiding hospital admissions is even more limited than highlighted in 2012. This raises the question of whether the current scale of intermediate care and the pace of change, particularly in admission avoidance capacity, is sufficient to make an impact on reducing the use of acute hospital beds by frail elderly people.

Links between intermediate care services and acute hospitals

In research studies, most of the effective models for preventing people being admitted to hospital involved identifying potential patients in hospital emergency departments (ED), yet only 3% of home based intermediate care referrals, 1% of re-ablement referrals and 18% of crisis response referrals, came from EDs in the audit. Further, 20% of bed based services reported an average waiting time from referral to commencement of service of 4 days or more, with two-thirds of service users waiting in wards in acute hospitals. These delays may be the result of process and/or capacity issues, but represent a lost opportunity to reduce hospital lengths of stay, as well as creating a poor care experience for service users that may impact on the effectiveness of their rehabilitation (*An estimate of post-acute intermediate care need in an elderly care department for older people,* Young J, Forster A, Green J, 2003). Both these points suggest the potential for closer links and clearer pathways between intermediate care and acute hospitals.

Appropriateness of staff mix to clinical needs

The nursing skill mix is in line with Royal College of Nursing recommendations for basic, safe care but below those levels recommended for ideal, good quality care. Mental health workers are rarely included in the establishment of intermediate care teams. In addition, only 51% of home based services report that all members of the team have received training in mental health and dementia care and only 34% of re-ablement services have "ready and quick access" to specialist mental health skills.

The proportion of home based services relying on the service user's own GP for medical cover appears high (71%) when reviewed against the levels of care being provided by these services. The gold standard for effective frailty management is the process known as "comprehensive geriatric assessment" (CGA) which is known to reduce mortality, institutionalisation and hospital admission, and which requires a fully staffed interdisciplinary team (British Geriatrics Society. *Comprehensive Assessment of the Frail Older Patient*. BGS, 2010). Given the uneven and incomplete nature of the teams suggested by the skill mix data from the audit, it is possible that the full benefits of CGA are not being realised and that outcomes could be better if more complete teams were in place routinely.

3: Introduction and terminology

This is the second report of the National Audit of Intermediate Care presenting findings from data collected in respect of 2012/13 and, for comparison 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, the Patients Association, the Royal College of Speech and Language Therapists, and the NHS Benchmarking Network. A Steering Group (Appendix 1) 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.

Terminology and audit scope

The term 'intermediate care' can sometimes also be referred to as 'rapid response', 'rehabilitation', 're-ablement' and 'enablement'. These terms are used to mean different things in different areas around the country. This could create difficulties for anyone trying to collect information about this subject and to consider the national picture for intermediate care services. So to help us in this project, we have developed an explanation of intermediate care with the help of the Patients Association and Plain English Campaign (see below).

The explanation we have developed is consistent with the definition of intermediate care provided by the Department of Health (*Intermediate Care - Halfway Home,* DH 2009); "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".
This definition has been used to decide which health and social care services should be included in the National Audit of Intermediate Care (NAIC).

What is intermediate care?

Intermediate care services are provided to patients, usually older people, after leaving hospital or when they are at risk of being sent to hospital. The services offer a link between places such as hospitals and people's homes, and between different areas of the health and social care system – community services, hospitals, GPs and social care.

What are the aims of intermediate care?

There are three main aims of intermediate care and they are to:

- Help people avoid going into hospital unnecessarily;
- Help people be as independent as possible after a stay in hospital; and
- Prevent people from having to move into a residential home until they really need to.

Where is intermediate care delivered?

Intermediate care services can be provided to people in different places, for example, in a community hospital, residential home or in people's own homes.

How is intermediate care delivered?

A variety of different professionals can deliver this type of specialised care, from nurses and therapists to social workers. The person or team providing the care plan will depend on the individual's needs at that time.

For the purpose of the audit in 2013, intermediate care services were divided into four service categories:

- **Crisis response** – services providing short-term care (up to 48 hours only)
- **Home based intermediate care** – services provided to people in their own homes by a team with different specialties, but mainly health professionals, such as a nurses and therapists.
- **Bed based intermediate care** – services delivered away from home, for example, in a community hospital.
- **Re-ablement** – services to help people live independently again provided in the person's own home by a team of mainly social care professionals.

The main features of these four service categories are set out in a table in Appendix 3. This table was given to participating provider organisations to help them decide how to categorise their services for the purposes of the audit.

We recognise that as health and social care services become more joined up, it will become more difficult to separate the 'home based intermediate care' and 're-ablement' element of services. We will review these categories for future rounds of the audit.

NAIC 2013

The results of the first year of the study (the National Audit of Intermediate Care 2012) were published in September 2012. The 2012 study comprised an organisational level audit, covering commissioning arrangements, service models, finance, activity, workforce and outcomes together with a patient level audit providing data on the patient cohort and what actually happens to service users in intermediate care. The findings of the 2012 audit provided a unique picture of how intermediate care services have developed nationally and highlighted the wide variation in service models.

The content of NAIC 2013 builds on the learning from the first year of the project. We considered feedback received from participants and agreed on the following developments for 2013:

- An emphasis on quality and identifying what works best in intermediate care
- Continuing to examine variation and effective use of resources in intermediate care
- The extension of the scope of the audit to include re-ablement services (social care services without a health element were not included in the first year of the audit)
- Development of clinical outcome measures for bed based intermediate care
- Development of Patient Reported Experience Measures ("PREM"s) for bed based, home based and re-ablement services
- Development of detailed case studies of high performing intermediate care services.

Objectives

The objectives of the National Audit of Intermediate Care are:

- 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
- To develop a set of patient outcome measures and to determine if the measures could be case mix adjusted
- To assess performance against the agreed quality standards and outcome measures
- To summarise national data and provide local benchmarked results on key performance indicators
- To potentially inform future policy development within the Department of Health (DH) and NHS England.

4: Methodology

4.1: Eligibility, recruitment and registration

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 CCGs, LAs, Health & Wellbeing Boards and Trusts in the NHS, together with a detailed proposal for the audit.

The audit operates 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.

Organisations were asked to register online, with commissioners asked to list the providers covered by their subscription. Providers were then requested, via automated emails, to go online and register the services they wished to be included in the audit under the four service categories discussed in section 3 above.

4.2: Audit structure and content

The audit content was developed by the Steering Group which includes representation from partner and participating organisations. A workshop was held on 5th December 2012 with a wider group of audit participants to consult on the audit structure and content for 2013. This group became the NAIC Participant Reference Group (Appendix 2) which provided input on the NAIC 2013 scope and developments via email.

The audit was structured with organisational and service user level components. As in the first year of the study, the organisational level audit included separate sections for commissioners and providers of intermediate care.

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)
- Services commissioned
- Access criteria
- Intermediate care funding
- Bed based activity
- Home based activity
- Re-ablement activity

As part of the registration process, providers were asked to list their intermediate care services, indicating the service category for the purpose of the audit; crisis response, bed based intermediate care, home based intermediate care or re-ablement. As noted above, these service categories were developed by the Steering Group and the defining features of each category were sent out in a table given to participants (see Appendix 3). The table describes exclusions from the audit, for example, condition specific services such as stroke rehabilitation teams and general community hospital wards.

Questions (which varied to some extent for each of the four service categories) were then completed for each service identified under the following sections:

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

For NAIC 2013, the format and content of the service user level audit was changed from that of the patient level audit undertaken in 2012. Following feedback from participants, the Steering Group decided to focus on outcomes and devised the following components for the audit:

- For bed based services, a six page service user questionnaire, focusing on clinical

outcome measures, to be completed by clinicians for 50 consecutive services users discharged from the service.

- Also for bed based services, a two page Patient Reported Experience Measure to be detached from the service user questionnaire and handed to the 50 consecutive service users for completion and return.
- A two page Patient Reported Experience Measure designed for home based intermediate care and re-ablement services. Each service was sent 250 PREM forms.

4.3: Development of the service user questionnaires and PREM

Service user questionnaire

The service user questionnaire for bed based services was developed by the Steering Group using a questionnaire developed by the University of Sheffield as a starting point (Enderby, P.M., Ariss, S.M., Smith, S.A., Nancarrow, S.A., Bradburn, M.J., Harrop, D., et al. *Enhancing the Efficiency and Effectiveness of Community Based Services for Older People: a Secondary Analysis to Inform Service Delivery*. NIHR Health Services and Delivery Research Programme; 2012). It was decided to focus on outcome measures and keep other questions to a minimum to make the form as short and easy to use as possible. The outcome measures included are as follows:

1. Discharge destination: Questions were included on the service user's normal living arrangements and discharge destination so that change in the dependency level of living arrangements could be used as a proxy outcome measure. This approach was used successfully in NAIC 2012.

2. Level of Care: The "Level of Care" scale was developed by the University of Sheffield (Enderby P & Stevenson J. *What is Intermediate Care? Looking at Needs. Managing Community Care,* 2000) and is used in the audit as a measure of the acuity of the needs of the service user on admission and discharge. The change in Level of Care is calculated to provide a clinical outcome measure for each service user. The scale has also been used in the organisational level audit to give an overall measure of the level of care each service is providing.

3. Modified Barthel Index (Shah, S. *Modified Barthel Index or Barthel Index (Expanded).* In S. Salek. (Ed). Compendium of quality of life instruments, Part II, (1998)): There was much debate in the Steering Group about which standardised clinical outcome measure to use. It was agreed that none of the many tools commonly used in intermediate care services was ideal. The Modified Barthel Index was chosen as it is evidence based, well used and understood and is less crude that the original Barthel and therefore more likely to register small changes in functioning. It was however noted by the Steering Group that the Modified Barthel Index focuses on activities of daily living and does not address, for example, social participation.

In choosing these tools for inclusion in the audit, the Steering Group is not endorsing the use of these particular tools over other possible tools. The Group is merely making a practical suggestion that services standardise around a commonly accepted and utilised tool, as a way of moving the agenda on the measurement and comparison of effectiveness forward. The outcome measures used in NAIC 2013 will be reviewed by the Steering Group following feedback from participants on ease of use and relevance.

The service user questionnaire was designed to be used prospectively to overcome some of the technical limitations of retrospective samples identified in 2012. The sample size was increased to 50 (from 10 for the patient level audit in 2012), so that conclusions could be drawn at the individual service level.

A draft of the service user questionnaire was piloted by Central Manchester Intermediate Care Service, Bolton Intermediate Care Service and Halton Rapid Access and Rehabilitation Service (RARS). Feedback from the pilot sites was used to refine the questions and develop the instruction booklets for participants.

Patient Reported Experience Measure (PREM) development

The Steering Group considered whether the development of a case mix adjusted Patient Reported Outcome Measure would be feasible for intermediate care. The Group has concluded that this would be technically difficult to achieve because of the very wide range of underlying medical conditions present within the intermediate care service user cohort (NAIC 2012). The Steering Group therefore decided to focus on the development of a Patient Reported Experience Measure (PREM) for use within the NAIC 2013.

Two, slightly different, forms were developed for use in bed based and home based intermediate care/re-ablement services. The development of the PREM forms was led by the University of Leeds, Health Institute, utilising a Delphi process. The NAIC Steering Group, wider Participant Reference Group and the Picker Institute acted as the panel of experts for the process.

In the first round, an inpatient questionnaire from the Picker Institute was modified to create a 41 item long list of potential questions. The panel were asked to comment as to whether the questions were suitable for bed and/or home-based intermediate care/re-ablement and to add any additional questions. From the responses, two separate questionnaires were produced, a 45 item questionnaire for bed-based care and a 40 item questionnaire for home-based.

The questionnaires were circulated to the same panel as before who were asked to select the 20 questions from each questionnaire they thought were most important. The questionnaires were then refined into two 15 item versions, with an additional open question "Please would you tell us one thing we could improve that would have made our service better for you".

At this stage, feedback was requested on the questionnaires from patients and Ambassadors by the Patients Association, who also tested the PREM with five patients who were receiving or have had community or bed based intermediate care, via telephone interviews.

Finally, the wording of the questions was changed to reflect an "I" rather than "you" statement following advice from the Department of Health on the approach adopted by National Voices.

The results of the PREM were aggregated for home based IC services, bed based IC services, and re-ablement services and are included in sections 10.5, 11.6 and 12.5 of this report respectively. The open question was initially analysed using a software package which searches for key words. This was then further evaluated by two researchers reviewing all the comments independently and then comparing results. The results of the open question analysis are included following the results of the PREM in the relevant sections of the report.

4.4: Data collection

The data collection process was managed by the NHS Benchmarking Network with data collection for the organisational level audit taking place between 13 May 2013 and 12 July 2013. Data was requested for 2012/13, and, for comparison on some activity, finance and workforce metrics, 2011/12. The previous year's data was requested again (rather than used from NAIC 2012) due to the re-configuration of the NHS at the commissioner level and the additional service categories used in 2013, at the provider level of the audit.

Data collection for the organisational level audit was via a bespoke web based data entry audit tool, completed directly by participants. The website and database are hosted within the NHS secure N3 network by Cheshire & Merseyside CSU on behalf of the NHS Benchmarking Network. Access to the tool was controlled via unique identifiers and passwords assigned to individuals as part of the registration process.

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 300 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.

The data collection for the service user level audit was via paper forms completed by clinicians (for the bed based service user questionnaire) and services users for the PREM forms between May and August 2013. Service users were provided with freepost envelopes to return the PREM forms. All forms were returned to the Data Capture Company who scanned and collated the data and provided a data file to the NHS Benchmarking Network for inclusion in the audit analysis.

No patient identifiable data was collected in any section of the audit.

4.5: Other data sources

Data on PCT registered and weighted populations were extracted from the *2011-12 PCT Recurrent Revenue Allocations Expositions Book* (DH) for use in the estimation of weighted populations for Clinical Commissioning Groups.

A literature review was undertaken to explore the relationship between different team characteristics and patient outcomes in intermediate care (Smith, Harrop, Enderby and Fowler-Davies. *Exploring Differences between Different Intermediate Care Configurations. A Review of the Literature,* 2013).

The literature review involved searching 20 databases. All publications yielded were independently assessed for inclusion in this review against predetermined criteria aimed at exploring the relationship between different team characteristics and patient outcomes. The purpose of the review was to identify the evidence that exists of the impact of these team level factors in services dealing with older patients with multiple morbidities.

The results of the review are summarised in section 13.2.

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 92 commissioning groups registered (compared to 62 in 2012). Some organisations registered jointly or in clusters; the total number of Clinical Commissioning Groups covered was 107 and Local Authorities, 19.

267 providers were identified by commissioners and 202 of these subsequently registered to participate (compared to 112 provider participants in 2012). The registered providers between them initially identified 535 intermediate care services. Whilst the average number of services identified was 2.6, the range was from 1 to 22 intermediate care services per provider. Data was provided by 410 of the services registered by providers (55 crisis response, 130 home based intermediate care services, 176 bed based services and 49 re-ablement services).

It should be noted that commissioners responding in 2013 (largely CCGs) are not the same entities as responded in 2012 (largely PCTs) reflecting the change in structure of the NHS. Both the areas covered by each organisation and the geographical coverage of the audit as a whole may have changed. Comparison between the two years of the audit will therefore take into account both the NAIC 2012 results (covering 2011/12) and the data requested in NAIC 2013 for the previous year (2011/12).

120 bed based services returned a total of 3,715 service user forms and 1,832 completed PREM forms were received direct from service users in 131 bed based services. 2,983 completed home based PREM forms were received from service users in 95 home based services. 1,644 completed home based PREM forms were received from service users in 48 re-ablement 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 by providers was generally high as summarised in the tables in Appendix 5. Commissioner data was less complete which is discussed further under Commentary: commissioner level audit in section 7.4.

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). 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.

Work was undertaken with participants via the helpline throughout the registration and data collection phases to ensure services complied with the audit definition of intermediate care and were included in the correct service categories.

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. 133 separate queries were raised with providers and 36 queries were raised with commissioners.

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 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.

This year has seen the publication of *Integrated Care and Support: Our Shared Commitment* (National Collaboration for Integrated Care and Support). This document sets out a vision for integrated care which is highly pertinent to intermediate care services, which are at the forefront of greater integration between health and social care at both the commissioning and service provision levels.

Halfway Home was used to develop quality standards for commissioners and providers for the national audit last year. For 2013, the quality standards were reviewed by the Steering Group and minor amendments made to clarify some of the questions and to reflect the inclusion of social care re-ablement services in the audit. The following section sets out the results for the quality standards audit for 2013.

6.2: Results: Quality standards for commissioners

As explained in section 5.1 above, in comparing the 2013 results for quality standards to 2012, it should be noted that the sample of commissioners completing the audit in the two periods was different. In addition to the switch from PCTs to CCGs, there is a greater involvement of Local Authority commissioners this year.

Commissioner governance and strategy standards

The recent document *Integrated Care and Support Our Shared Commitment* sets out the agenda for health and social care integration in England. Intermediate care services are at the forefront of delivering joined up services to meet service users' needs at critical times of transition. The audit provides an insight into progress with partnership working in the planning, development and operation of these important services.

The responses for governance and strategy standards are as follows:

Table 6.2.1: Governance and strategy quality standards	NAIC 2012 % stating Yes	NAIC 2013 % stating Yes
Is there a multi-agency board for intermediate care?	63%	70%
Has clinical governance or quality assurance been incorporated into service specifications? (note 1)	92%	81%
Is strategic planning for intermediate care undertaken jointly by health and local government?	86%	90%
Has a Joint Strategic Needs Assessment that addresses the need for intermediate care been carried out? (note 2)	29%	46%
Is there a local intermediate care strategic plan?	47%	48%
Is there a single intermediate care manager co-ordinating all intermediate care provision across the CCG or Local Authority area for which the services are commissioned?	47%	34%

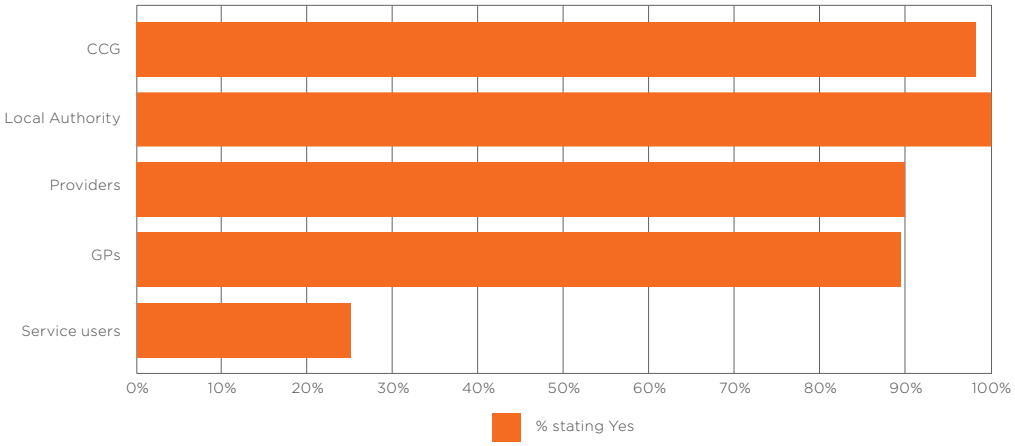
(1) The phrase "or quality assurance" was added for NAIC 2013 (2) The question has been changed since 2012 when the wording was "Has a JSNA been carried out for intermediate care?". This may have resulted in more participants giving a positive response where intermediate care is included within a document with a wider scope.

Of those that had carried out a JSNA that addresses the need for intermediate care, 50% had undertaken the assessment during 2012/13, 33% in 2011/12, 3% in 2010/11 and 14% more than three years ago.

Of those that have a local intermediate care strategic plan (48% as shown in the table above), 66% had updated the plan in 2012/13, 24% in 2011/12, 5% in 2010/11 and 5% more than three years ago.

The profile of Board representation was similar to last year (see figure 6.2.1).

Figure 6.2.1: Multi-agency board representation



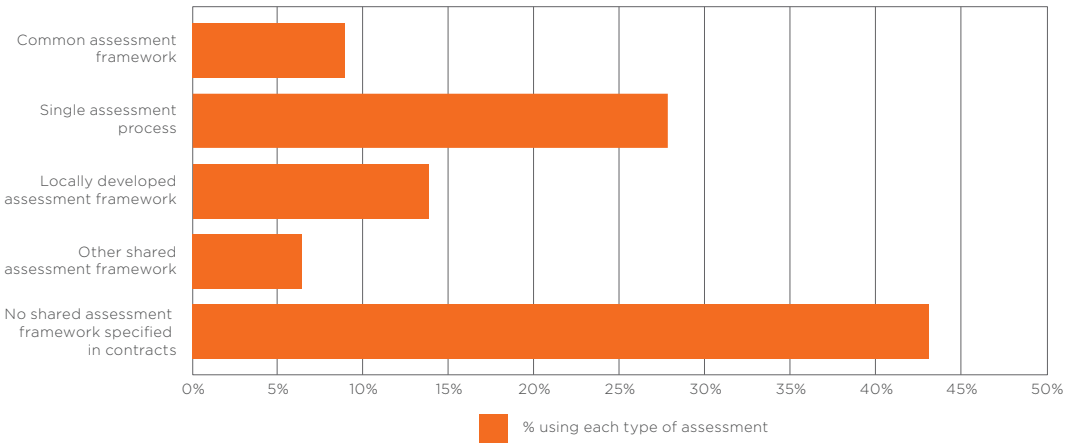
Commissioner participation standards

The views of patients and their carers on current services and any plans for future service developments have been actively sought by 85% (NAIC 2012 76%) of commissioners. The most popular method for seeking service user views was patient surveys (used by 79% of respondents). Focus groups were used by 56% and board representation by 17%.

Commissioner pathway standards

62% (NAIC 2012 61%) of health economies responding in 2013 have commissioned a single point of access and 57% (NAIC 2012 66%) use a shared assessment framework. The most commonly used framework is the single assessment process (see figure 6.2.2).

Figure 6.2.2: Assessment framework used (commissioner response)



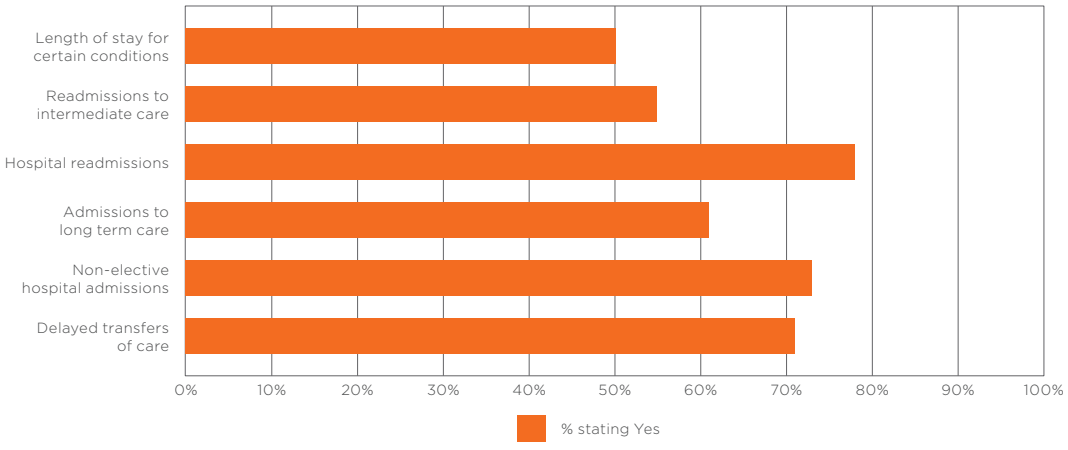
Commissioner performance management standards

Halfway Home emphasises the importance of commissioners monitoring performance at both a strategic level, in terms of the impact of intermediate care investment on the whole health and social care economy, and at the operational level, by regularly reviewing service performance.

Table 6.2.2: Performance management quality standards	NAIC 2012 % stating Yes	NAIC 2013 % stating Yes
Have performance goals been set and measured for the whole of the health and social care system?	65%	66%
Have goals that reflect the quality of the service and the users' experience been set?	77%	67%
Have indicators to monitor the delivery of service performance been developed and reviewed at least annually for each intermediate care service you commission?	87%	57%

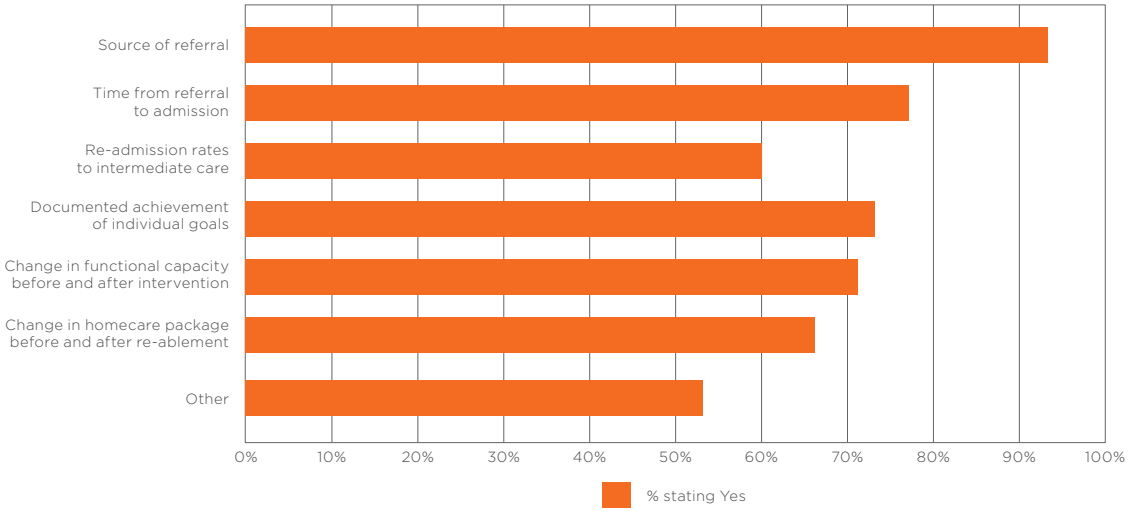
For the commissioners that have set whole system performance goals, the common metrics utilised are set out in figure 6.2.3.

Figure 6.2.3: Whole system performance goals



Where commissioners monitor the delivery of service performance of individual intermediate care services, the use of key measures is shown in figure 6.2.4:

Figure 6.2.4: Key measures monitored



6.3: Results: Quality standards for providers

As for commissioners, in comparing the quality standards results for providers with last year, it should be noted that the sample of providers in 2013 is different from the NAIC 2012 sample. A greater number of providers completed the audit this year. In addition, the service categories used in the audit have been changed from two (bed and home in 2012) to four in 2013; crisis response, bed, home and re-ablement.

Provider participation standards

Levels of service user participation in service development remain high, as shown in table 6.3.1:

Table 6.3.1: Views of patients and their carers on current services and any plans for future service developments have been actively sought	NAIC 2012 % stating Yes	NAIC 2013 % stating Yes
Crisis response services	N/A	92%
Home based IC services	83%	87%
Bed based IC services	91%	92%
Re-ablement services	N/A	87%

As in 2012, the most popular method used to seek views in all four categories of service was a patient questionnaire (over 96% of all services).

Provider clinical governance quality standards

Research would suggest that intermediate care provided by multidisciplinary teams is effective (Smith, Harrop, Enderby and Fowler-Davies. *Exploring Differences between Different Intermediate Care Configurations. A Review of the Literature*, 2013).

Table 6.3.2: Are multi-disciplinary team (MDT) meetings held once a week?	NAIC 2012 % stating Yes	NAIC 2013 % stating Yes
Crisis response services	N/A	80%
Home based IC services	95%	87%
Bed based IC services	98%	93%
Re-ablement services	N/A	57%

The frequency of clinical governance meetings is considered as a proxy for good governance. As defined in *Halfway Home* clinical governance includes risk management, clinical audit, critical incident reporting and staff training. For 2013, 66% to 68% of bed, home and crisis response services reported holding clinical governance meetings monthly, with 8% to 10% holding quarterly meetings. Re-ablement services are less likely to hold monthly meetings (45%), but more likely to use quarterly meetings (17%). The proportion of services holding no clinical governance or assurance meetings were 4% for crisis response, 5% for home based, 6% for bed based and 19% for re-ablement services.

Systems for incident reporting for intermediate care services are in place as illustrated in table 6.3.3 below. For bed and home services, the profile of responses is similar to last year, with generally high levels of compliance for relevant incidents.

Table 6.3.3: Incident reporting systems % stating Yes	Crisis response	Home based IC	Bed based IC	Re-ablement
Emergency transfer	94%	84%	92%	55%
Falls	96%	96%	98%	95%
Hospital acquired infection	82%	77%	93%	44%
Medical error	100%	92%	99%	91%
Pressure sores	98%	95%	98%	76%
Safeguarding concerns	100%	100%	100%	100%
Unexpected death whilst in service	96%	98%	100%	95%
Other	88%	84%	85%	57%

Provider pathway standards

Although 43% of commissioners do not specify the use of a shared assessment framework (figure 6.2.2 above), such frameworks are used in most services according to providers (see table 6.3.4 below). Locally developed assessment frameworks are favoured by providers, contrary to the commissioner view (section 6.2 above) which cites the single assessment process as the most popular methodology. This may reflect a difference in the use of the terminology between commissioners and providers.

Table 6.3.4: Assessment frameworks used % stating Yes	Crisis response	Home based IC	Bed based IC	Re-ablement
Common assessment framework	8%	18%	13%	17%
Single assessment process	28%	22%	26%	30%
Locally developed assessment framework	54%	52%	43%	40%
Other shared assessment framework	6%	0%	8%	4%
No shared assessment framework used	4%	7%	10%	9%

Table 6.3.5 shows compliance with care plan quality standards for each service category.

Table 6.3.5: Use of care plans % stating Yes	Crisis response	Home based IC	Bed based IC	Re-ablement
Is an intermediate care plan documented for each individual?	94%	97%	98%	97%
Is a responsible team member (or key worker) identified to ensure the care plan is carried out?	92%	96%	93%	95%
Do all individual care plans include a review at regular intervals within six weeks or less?	84%	97%	98%	95%

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 (table 6.3.6). As might be expected, re-ablement has the lowest rates of access to specialist health skills. The pattern for bed and home services was similar to NAIC 2012.

Table 6.3.6: Access to specialist skills % stating Yes	Crisis response	Home based IC	Bed based IC	Re-ablement
Speech and language therapy	62%	53%	76%	42%
Mental health and dementia care	72%	53%	78%	53%
Specialist elderly care (geriatrician)	54%	45%	74%	34%
Podiatry	56%	43%	71%	46%
Dietetics	56%	48%	77%	34%
Continence advice	76%	72%	83%	57%
Pharmacy	74%	58%	92%	61%
GP with Special Interest	24%	16%	53%	27%
Other	58%	40%	62%	38%

Provider workforce standards

In NAIC 2012, services were led by a senior clinician in 80% of bed based and 79% of home based services. These percentages have increased in 2013 to 96% and 94% respectively. Re-ablement shows a lower proportion of clinically led services (83%). The discipline most often taking up the leadership role varies across the service categories. Crisis response and bed based services are most commonly nurse led. Home based services are now more likely to be led by a therapist (a change from last year when nurse leadership was the most common model). Re-ablement is predominantly social care led, although therapists are also in evidence in this service category.

Table 6.3.7: Discipline of senior clinician % stating Yes	Crisis response	Home based IC	Bed based IC	Re-ablement
Medical	8%	3%	23%	4%
Nurse	60%	39%	46%	4%
Therapist	18%	43%	14%	9%
Social care/case manager	10%	8%	13%	66%
Service not clinically led	4%	6%	4%	17%

Risk assessment training is mandatory in most services (89% of all services). Mental health and dementia training is less consistent with re-ablement services showing the highest proportion of services completing training (72%) and home based services the lowest (51%).

Table 6.3.8: Staff training % stating Yes	Crisis response	Home based IC	Bed based IC	Re-ablement
Is there mandatory training in risk assessment for all staff?	88%	86%	90%	91%
Have all members of the team received training in mental health and dementia care?	60%	51%	65%	72%

Provider resource standards

40% of all services are using a shared electronic patient record and 80% have a shared paper record.

Table 6.3.9: Patient records % stating Yes	Crisis response	Home based IC	Bed Based IC	Re-ablement
Is there a shared, electronic patient record?	58%	38%	31%	53%
If not, is there a comprehensive, shared paper patient record?	78%	76%	87%	74%

Provider performance standards

Indicators to monitor the delivery of service performance have been developed and reviewed at least annually in 94% of crisis response services, 95% of home and bed services and 93% of re-ablement services. This represents an improvement over last year for bed based (90% NAIC 2012) and home based services (88% NAIC 2012).

6.4: Commentary: Quality standards

Progress with integration

The 2013 quality standards results provide evidence of increased integration at the commissioner level of the health and social care system with increases in the incidence of multi-agency boards (now in place in 70% of respondents) and 90% stating that strategic planning is undertaken jointly.

Strategic planning

As in 2012, the audit revealed some weaknesses in the quality of strategic planning by commissioner organisations. Despite clarifying the question on whether a Joint Strategic Needs Assessment that addresses the need for intermediate care has been carried out, less than half of respondents (46%) replied positively in NAIC 2013. The proportion stating that there is a local intermediate care strategic plan (only 48%), showed little improvement from 2012.

Single intermediate care manager

The proportion of respondents stating that there is a single manager coordinating intermediate care across the area has reduced from 47% (NAIC 2012) to 34% (NAIC 2013). *Halfway Home* emphasises the need for the management of intermediate care to be integrated at both the strategic and operational levels.

Participation

Although only 25% of commissioners reported service user representation on intermediate care boards, it is encouraging that 85% (up from 76% in NAIC 2012) 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.

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 highlighted the benefits of a single point of access into intermediate care services. However, more than ten years after the original guidance was published, only 62% of commissioners have commissioned a single point of access, with barely any movement since 2012 (61%). 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 still be limited in some areas, with around one third of respondents stating that whole system performance goals are not set for their health economy and no improvement since 2012. It is also disappointing that the proportion setting goals to reflect the quality of service users' experience has reduced from 77% (NAIC 2012) to 67% (NAIC 2013). Without systematic evaluation of intermediate care it will be difficult to make the case for further investment needed to build capacity.

Frequency of clinical governance meetings

A small proportion of crisis response, home based and bed based services, and a larger proportion of re-ablement services (19%), do not hold clinical governance/quality assurance meetings. 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 appear to be gaps in access to specialist services, particularly from re-ablement services but also, in relation to skills such as podiatry and dietetics, from crisis response and home based intermediate care services. This highlights a lack of co-ordination between health and social care and different parts of the health system in some areas. The provision of mental health input is considered in sections 10.6 and 11.7.

7: Results: Commissioner level audit

7.1: Introduction

In 2013, 92 commissioning groups registered to participate in the audit (compared to 62 in 2012). Some commissioning organisations registered jointly or in clusters; the total number of Clinical Commissioning Groups covered was 107 and Local Authorities, 19.

Intermediate care services were jointly commissioned in 74% of health economies.

As explained in section 5.1 above, in comparing the 2013 results for the commissioner level audit to the results from 2012, it should be noted that the sample of commissioners completing the audit in the two periods was different. In addition to the switch from PCTs to CCGs which changed the geographical areas covered by commissioners in some cases, there are more participants and a greater involvement of Local Authority commissioners this year. In anticipation of these changes, respondents to NAIC 2013 were asked to provide data for two years (2011/12 and 2012/13) for finance and activity questions. This allows the movement between the two periods for the NAIC 2013 sample of commissioners to be considered. In the following sections, we also make reference to the results for 2011/12 from NAIC 2012 where relevant. In most instances the findings are consistent between years.

In reviewing the commissioner audit findings, reference should be made to the information on the completeness of commissioner data in Appendix 5.

7.2: Results: Commissioner level audit: Services commissioned

Intermediate care functions

Of commissioners participating in the audit in 2013, 84% commission crisis response, 93% home based intermediate care, 92% commission bed based intermediate care and 88% re-ablement services.

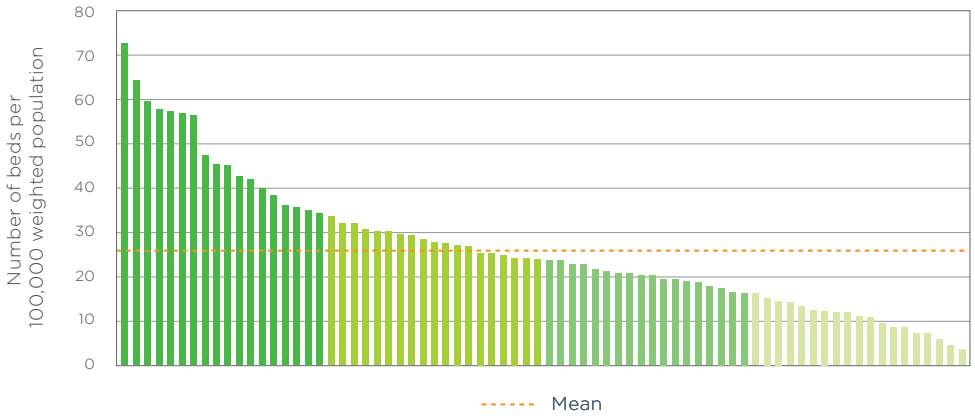
35% commission designated step up beds, 40% designated step down beds and 83% commission beds to be used flexibly between step up and step down. The ability to identify flexible use of beds was a new addition for NAIC 2013.

18% of commissioners do not provide a guideline on how long a person should be in receipt of intermediate care, with 71% providing a guideline of a maximum of 6 weeks. This is an improvement on last year (NAIC 2012) when 29% did not provide such guidance.

Beds commissioned

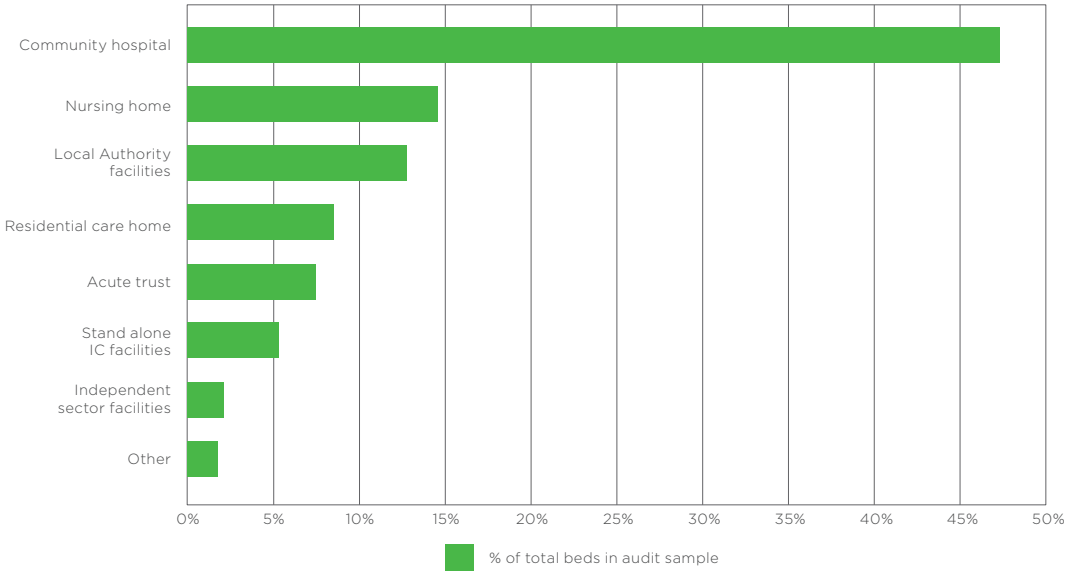
The mean number of beds commissioned per 100,000 weighted population was 26.3 (up from 22.5 reported in NAIC 2012), for the 74 commissioners providing data on this metric. The chart (figure 7.2.1) shows the wide variation in responses.

Figure 7.2.1: Beds commissioned per 100,000 weighted population



The profile of bed locations represented in the commissioner audit has changed this year reflecting the greater involvement of Local Authorities in the study. Community hospitals remain the most popular setting in the sample (47%, down from 53% in 2012). Acute settings are more in evidence this year (7% compared to 4% last year), with nursing homes (15%) at a similar level to 2012 (14%). Residential care homes have reduced from 16% (NAIC 2012) to 8% this year. Local Authority facilities (13%) and standalone facilities (5%) have been separated from "other" this year.

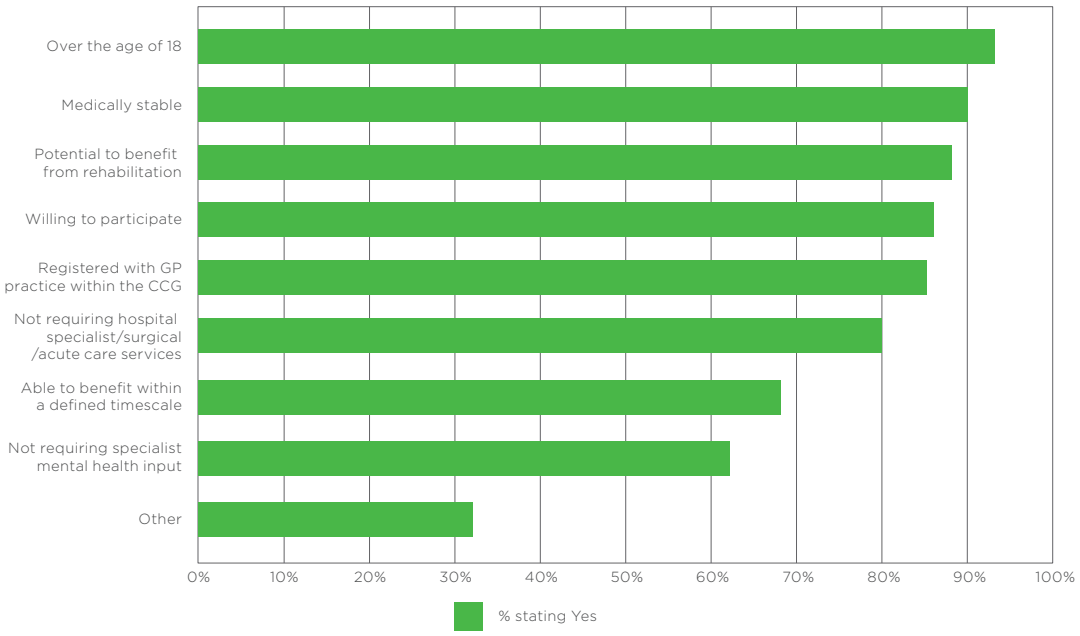
Figure 7.2.2: Location of beds commissioned



Access to services

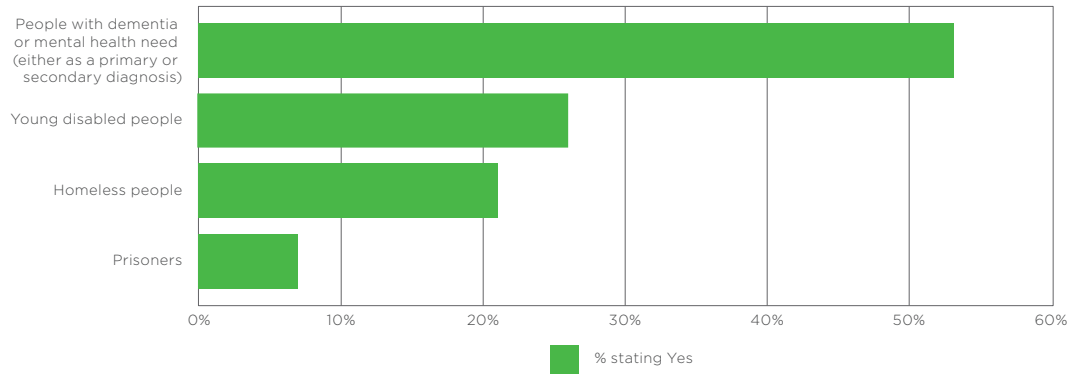
25% of respondents do not specify access criteria. For those that do, the utilisation of typical access criteria is shown in figure 7.2.3:

Figure 7.2.3: 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.
The proportion of commissioners specifically including vulnerable groups of potential service users in their service specifications has improved from 37% to 60% (although this may be due to clarification of the question in 2013). The proportion of services specifically including vulnerable groups is shown in figure 7.2.4.

Figure 7.2.4: Access for vulnerable groups



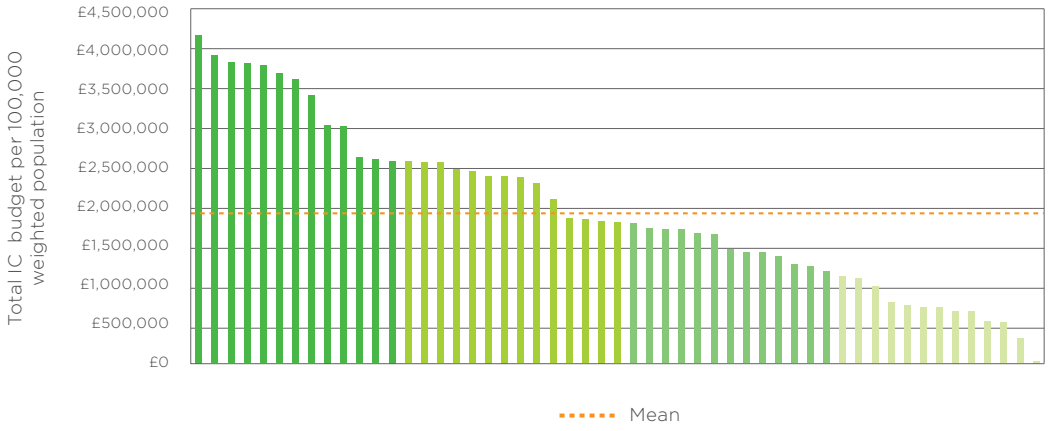
7.3: Results: Commissioner level audit: Use of resources

Investment levels

For the purposes of comparison with 2012, the mean budget per 100,000 weighted population for "health based" intermediate care (excluding re-ablement) has been calculated. As last year, investment levels by commissioners show wide variation. The mean budget per 100,000 weighted population in 2012/13 was £1.95 million. Excluding two CCGs who have increased their budget by 48% and 62% respectively, the overall growth in investment across participants who reported figures for both years in the 2013 audit was 3.0%.

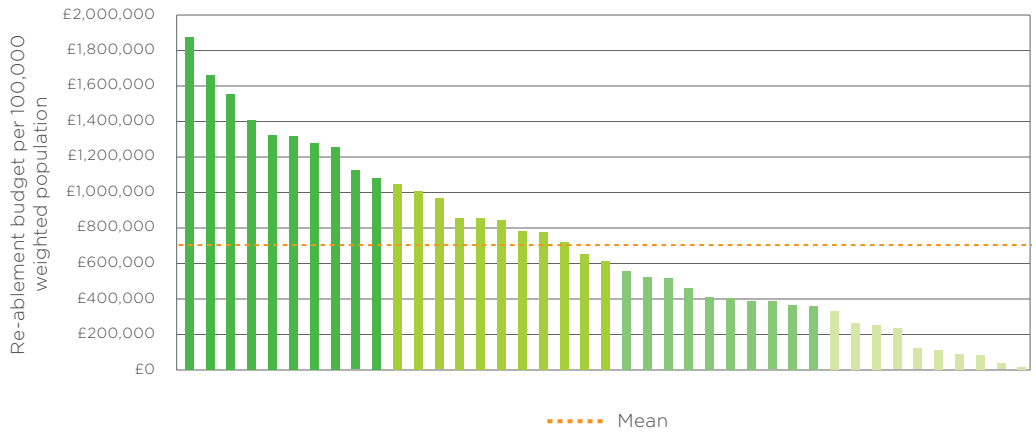
The 2012/13 figure is in line with the value reported in 2012 for 2011/12 (£1.91 million) and does not suggest any significant increase in investment in intermediate care nationally in the period.

Figure 7.3.1: Total budget for intermediate care per 100,000 weighted population



An additional question was asked in NAIC 2013 about the re-ablement budget. The mean budget per 100,000 weighted population was £0.7m for 2012/13. The overall reduction in investment in re-ablement for those who reported figures for both years was 8%.

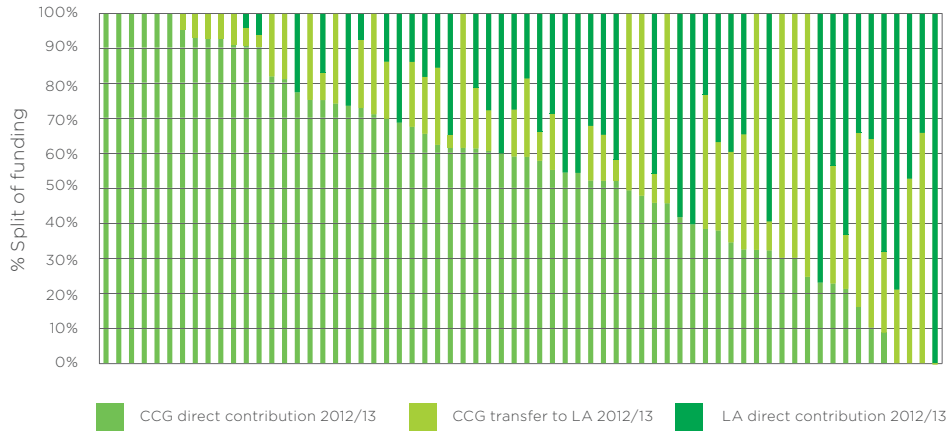
Figure 7.3.2: Re-ablement budget per 100,000 weighted population



Funding

32% of commissioners have formal S75 pooled budget arrangements with their Local Authority commissioning partners (21% NAIC 2012). For the 66 commissioners who provided analysis of the total budget contributions for intermediate care/re-ablement, the average split for 2012/13 was CCG direct contribution 58%, CCG monies transferred to Local Authority 21% and Local Authority contribution 21%.

Figure 7.3.3: Analysis of funding sources



Unit costs

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

Setting of bed based service	Number of values used in calculation	Mean cost per occupied bed day from data supplied by commissioners
Acute hospital setting	11	£260
Community hospital	31	£251
Residential care home	28	£182
Nursing home	34	£152

An estimate of the average cost per person per week for home based intermediate care services was provided by 18 commissioners and showed wide variation, with a mean of £422 per person per week for 2012/13. The value reported in 2012 for 2011/12 was £583 per person per week.

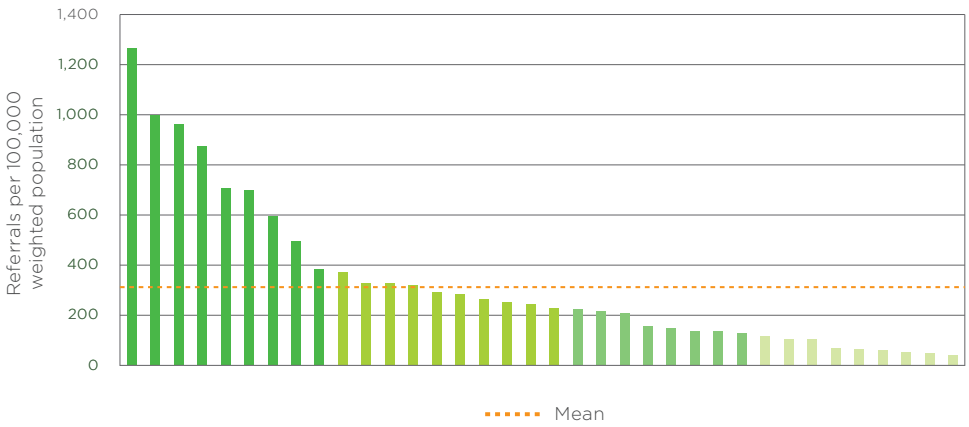
The mean cost per re-ablement episode reported by commissioners as £1,408 for 2012/13 and the mean cost of re-ablement per hour was £29. This data was not collected in NAIC 2012.

Bed based activity

The mean number of referrals to bed based intermediate care services (for the 36 commissioners submitting data) was 328 per 100,000 weighted population for 2012/13. The mean number of admissions in 2012/13 (from 55 data submissions) was 246 per 100,000 weighted population.

The 2012/13 figures are in line with the values reported in 2012 for 2011/12 (327 referrals and 259 admissions per 100,000 weighted population). As with the investment data, this does not suggest any significant increase in intermediate care activity this year.

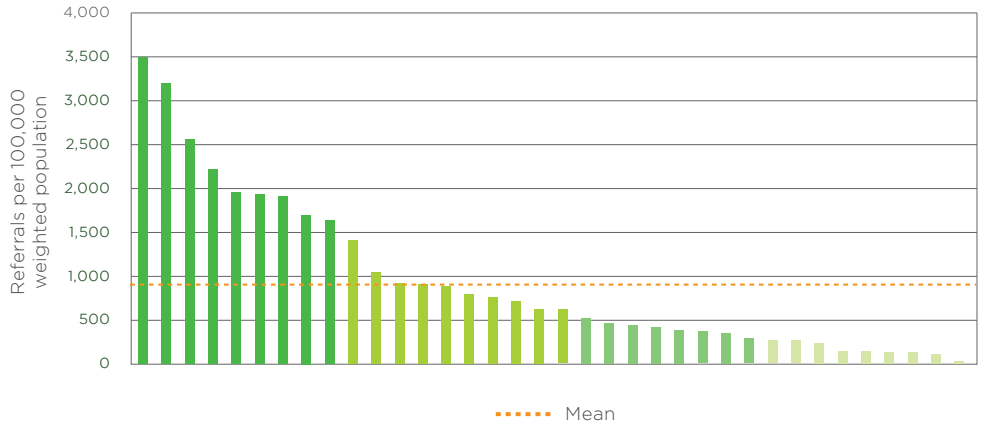
Figure 7.3.4: Referrals per 100,000 weighted population (bed based IC services)



Crisis response and home based intermediate care services activity

New questions were introduced in the commissioner level audit in 2013 on crisis response activity. The number of crisis response referrals showed very wide variation, with a mean of 943 referrals per 100,000 weighted population reported for 2012/13.

Figure 7.3.5: Referrals per 100,000 weighted population (crisis response services)

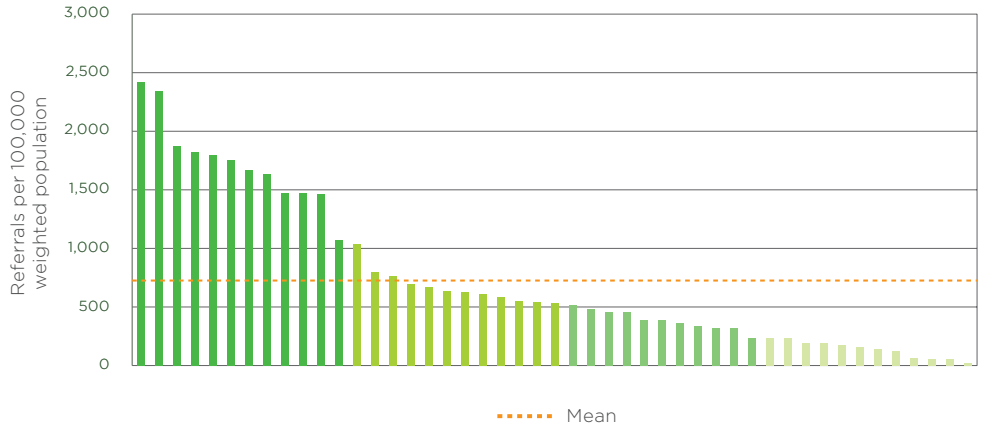


A question on the proportion of service users referred on to intermediate care from crisis response services produced a wide range of responses from 1% to 100% suggesting very different service models, with some crisis response teams acting as a gateway into intermediate care and others with a much wider remit.

For home based services, the mean number of referrals to intermediate care services (for the 47 commissioners submitting data) was 739 per 100,000 weighted population for 2012/13. The mean number of service users accepted in 2012/13 (from 44 data submissions) was 693 per 100,000 weighted population.

The 2012/13 figures are slightly below the values reported in 2012 for 2011/12 (815 referrals and 725 service users accepted per 100,000 weighted population). As with the investment and bed based activity data, this does not suggest any significant increase in intermediate care activity this year.

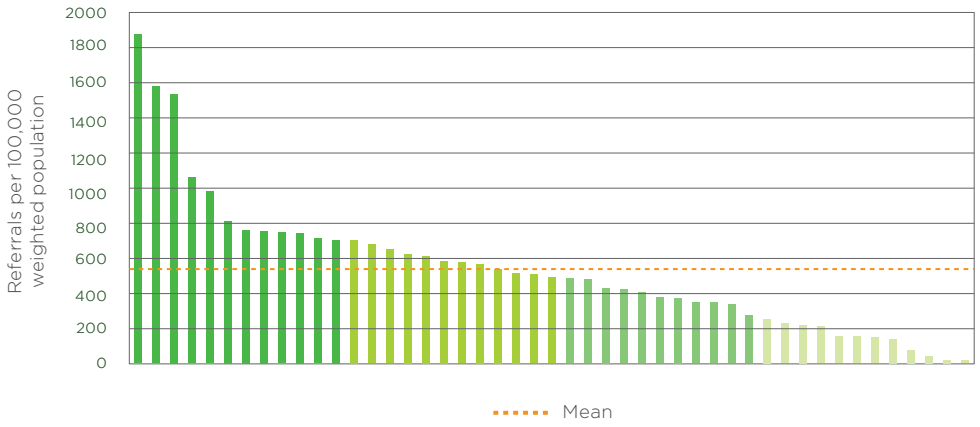
Figure 7.3.6: Referrals per 100,000 weighted population (home services)



Re-ablement services activity

For re-ablement services, the mean number of referrals (for the 47 commissioners submitting data) was 535 per 100,000 weighted population for 2012/13. The mean number of assessments undertaken in 2012/13 (from 44 data submissions) was 500 per 100,000 weighted population.

Figure 7.3.7: Referrals per 100,000 weighted population (re-ablement services)



7.4: Commentary: Commissioner level audit

Quality of commissionin

Provision of data

As in the 2012 audit, commissioners' ability to provide financial and activity data was limited in some instances. For example, only 18 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. Improvement in this area may have been hampered by the major restructuring of commissioners during the period under review.

Capacity of intermediate care

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 (NAIC 2012). Clearly, the gap between demand and capacity in a particular health economy may vary widely from this overall average position. As noted last year, there may be scope to free up capacity in some services by reducing excessive lengths of stay (see sections 10.6 and 11.7).

Progress in increasing the scale of intermediate care

As noted in the previous point, the question of whether the current scale of intermediate care is sufficient to make an impact on secondary care utilisation was raised in the audit findings last year. Although the number of beds commissioned has increased this year, the capacity of intermediate care remains small relative to secondary care provision. Other findings for 2013 suggest only small increases in investment and activity levels and do not suggest there has been any material change in resources allocated to intermediate care services since last year.

Local evaluation

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 proactive 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 progress with integration and weaknesses in strategic planning under section 6.4).

Balance of step up and down provision.

An issue for both commissioners and providers is the balance of step up and step 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 70% of bed based capacity is used for step down and 30% for step up, with the reverse position in home based services. Pressure to fill bed based capacity with step down patients appears to have increased in 2013 (section 11.7).

8: Results: Provider level audit overview

8.1: Introduction

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. To enable comparability between services, four service categories were defined for the purposes of the audit:

- **Crisis response services** providing short-term care (up to 48 hours only)
- **Home based intermediate care** services provided to people in their own homes by a team with different specialties, but mainly health professionals, such as a nurses and therapists
- **Bed based intermediate care** services delivered away from home, for example, in a community hospital
- **Re-ablement** services to help people live independently again provided in the person's own home by a team of mainly social care professionals.

The main features of these four service categories are set out in a table in Appendix 3. This table was given to participating provider organisations to help them decide how to categorise their services for the purposes of the audit.

The purpose of this section of the report is to describe and compare intermediate care provision in these four service categories across participating provider organisations using analysis from the provider and service user levels of the audit. The aim is to build a picture of intermediate care service provision nationally and to consider what has changed since last year. The study includes re-ablement services for the first time this year.

The provider level audit includes data from 410 services identified by 202 organisations completing the audit; comprising 55 crisis response, 176 bed based intermediate care, 130 home based intermediate care and 49 re-ablement services.

As explained in section 5.1 above, in comparing the 2013 results for the provider level audit to the results from 2012, it should be noted that the samples of services completing the audit in the two periods was different. The service categories have been changed (from two last year; bed based and home based), there are more participants and a greater involvement of Local Authority providers and their sub-contracted independent sector providers this year. In anticipation of these changes, respondents to NAIC 2013 were asked to provide data for two years (2011/12 and 2012/13) for finance, activity and workforce questions. This allows the movement between the two periods for the NAIC 2013 sample of services to be considered. In the following sections, we also make reference to the results for 2011/12 from NAIC 2012 where relevant. In most instances the findings are consistent between years.

9: Results: Crisis response services

9.1: Introduction

This section provides the audit results for crisis response services. For the purposes of the audit, this service category was defined by the following key features:

- **Setting:**
  Community based services provided to service users in their own home/care home.
- **Aim of service:**
  Assessment and short term interventions to avoid hospital admission.
- **Period:**
  Interventions for the majority of service users will last up to 48 hours or two working days (if longer interventions are provided the service should be included under home based intermediate care).
- **Workforce:**
  MDT but predominantly health professionals.
- **Includes:**
  Intermediate care assessment teams, rapid response and crisis resolution.
- **Excludes:**
  Mental health crisis resolution services, community matrons/active case management teams.

Crisis response was a new service category introduced into the audit for 2013. The aim was to split out services carrying out a "pure" crisis response/admission avoidance function (as defined above), which were not comparable with services also carrying out longer interventions (defined as home based intermediate care for the purpose of the audit, see section 10.1). Respondents were asked to include services which carried out both functions within home based intermediate care services.

55 crisis response services responded to the organisational level audit in 2013.

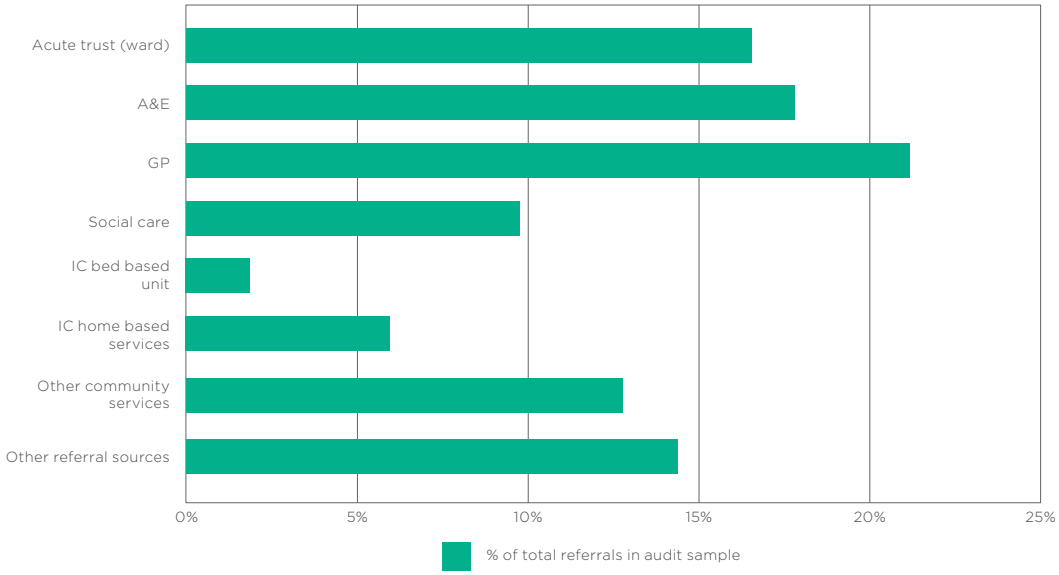
Crisis response services were not asked to complete the Patient Reported Experience Measure (PREM) audit, as the questionnaire was not suitable given the short term nature of the service.

9.2: Results: Crisis response services: Service characteristics

Referral sources

The largest source of referrals for crisis response services is from GPs (21%), followed by A&E departments (18%) and acute trust wards (16%).

Figure 9.2.1: Source of referrals (crisis response services)



Links to other intermediate care services

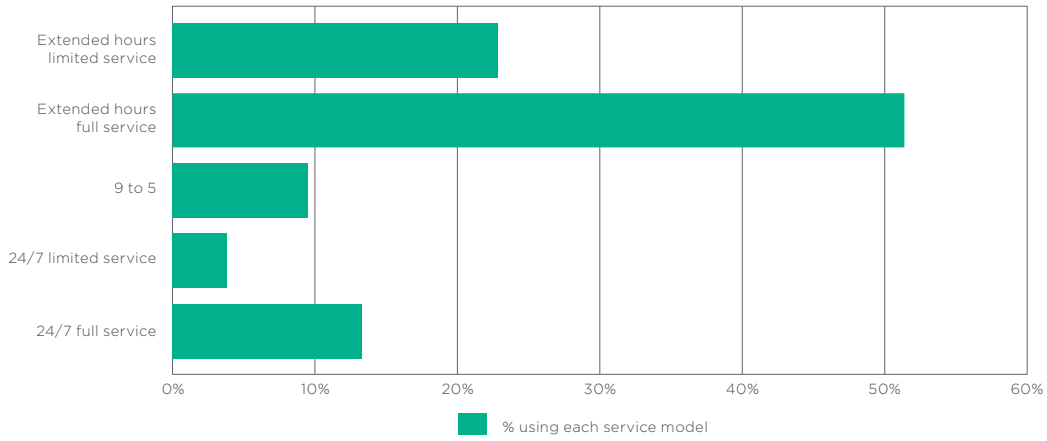
Crisis response services were asked about admitting rights to other intermediate care services to gauge how joined up the pathways are between services. 83% of services had admitting rights to bed based, 83% to home based and 79% to re-ablement services.

Service accessibility

88% of respondents have a standard for response time and the average standard response time is 2 hours.

The most common model for opening times for crisis response services was “extended hours full service” (51% of services), with 13% of services running a full service, 24/7 model. ”Extended hours” means earlier than 9am and /or later than 5pm but not 24/7. 87% of crisis response services are open 365 days a year.

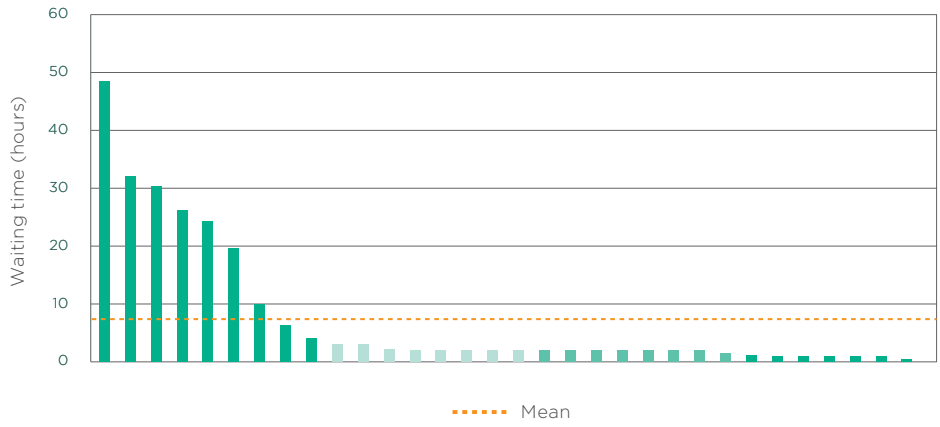
Figure 9.2.2: Hours open to new admissions (crisis response services)



Waiting times

The average waiting time from referral to assessment for crisis response services was 7.3 hours, including one respondent (out of a total of 33) stating a waiting time of zero hours. The median value is 2 hours. Four services have a waiting time from referral to assessment of more than 24 hours.

Figure 9.2.3: Average waiting time referral to assessment (crisis response services)



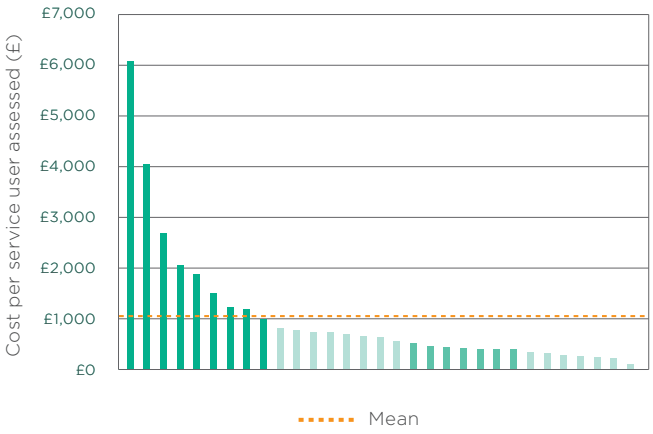
9.3: Results: Crisis response services: Use of resources

This section covers unit costs for crisis response services and factors that impact unit costs; average duration of stay and productivity.

Unit costs

For crisis response services the cost per service user was calculated by dividing the total service budget for 2012/13 by the number of individual service users assessed by the service in the period (assessments were considered to be the most accurate reflection of activity for this function). Data was available for 31 crisis response services. The mean was £1,019 per service user and the median £614 per service user.

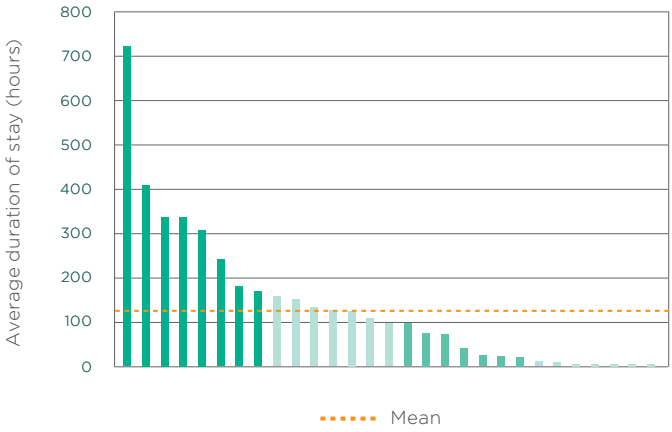
Figure 9.3.1: Cost per service user assessed (crisis response services)



Average duration of stay

For crisis response services the average duration of stay showed a wide range from 2 hours to 720 hours, with a mean of 137 hours (5.7 days) and median 96 hours (4 days). 29 participants provided data. It should be noted that services with average length of stay of more than 168 hours (7 days) were contacted during the data validation period as they did not appear to fall within the definition of crisis response used in the audit (section 9.1). Seven services were moved to home based intermediate care as part of this process but a small number opted to remain in the crisis response category.

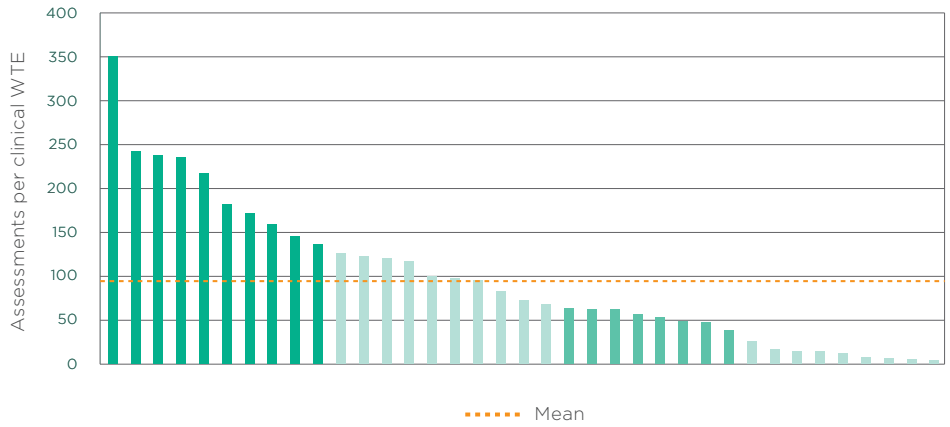
Figure 9.3.2: Average duration of stay in crisis response services



Productivity

A measure of the productivity of crisis response services has been calculated as the number of assessments per clinical whole time equivalent (wte) per annum. This data was available for 37 crisis response services. The mean reported for 2012/13 was 98 assessments per annum per clinical wte (median 73).

Figure 9.3.3: Assessments per clinical WTE (crisis response services)

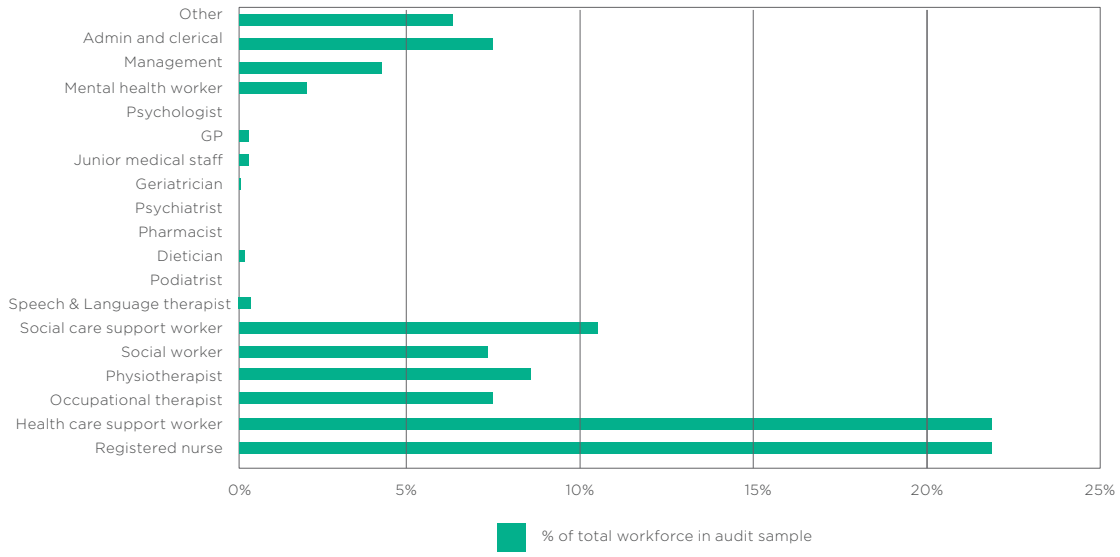


9.4: Results: Crisis response services: Workforce

Mix of disciplines

The mix of disciplines for crisis response services is shown in figure 9.4.1. The largest staff groups are health care support workers and registered nurses, both at 22.3%, followed by social care support workers (10.7%). Physiotherapists represent 8.6% of the workforce, occupational therapists 7.5% and social workers 7.5%. Mental health workers comprise 2.0% of the workforce with geriatricians 0.1% and GPs 0.2%.

Figure 9.4.1: Mix of disciplines within crisis response services



9.5: Commentary: Crisis response services

Variation in service models

Variability of data

Crisis response services showed a wide variation in responses across all metrics reviewed. This may reflect the different service models in operation; as noted in section 7.3, some teams appear to function primarily as a gateway into intermediate care services, whereas others may have a much wider remit. Further, despite the intention of including only services delivering assessments and very short term interventions up to 48 hours, participants have chosen to include services which provide longer term interventions. This may explain why the number of assessments per WTE appears lower than might be expected for services carrying out only a "pure" crisis response function and the cost per assessment appears high when compared to the cost per service uses in home based services.

Access to services

Opening times

As would be expected, crisis response services are more likely to operate extended hours and to be open 365 days a year, than home based intermediate care services.

Progress with integration

Whole system integration

The spread of referral sources suggest crisis response services are being accessed by all sections of the health system, including primary care, secondary care, community services and social care. The high proportion of crisis response services with admitting rights to other intermediate care services is also an encouraging sign of joined up working between services. Representation of social care support workers and social workers (together 18.2%) within crisis response teams is also positive indication of cross sector integration.

10: Results: Home based intermediate care services

10.1: Introduction

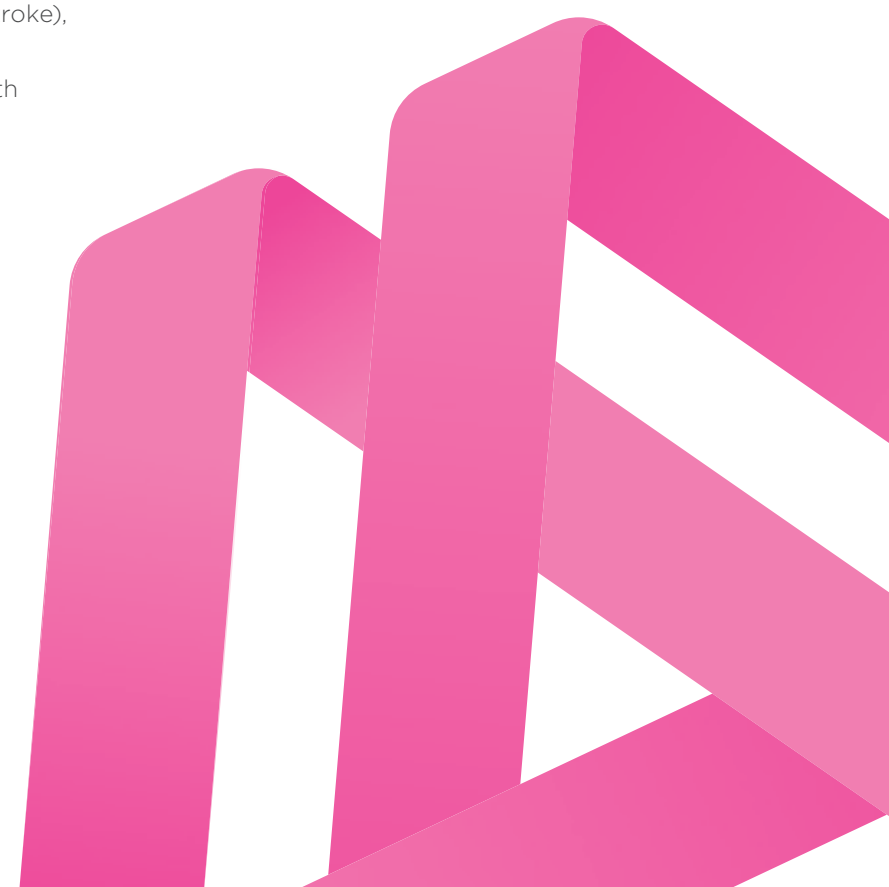
This section provides the audit results for home based intermediate care services. For the purposes of the audit, this service category was defined by the following key features:

- **Setting:**
  Community based services provided to service users in their own home/care home.
- **Aim of service:**
  Intermediate care assessment and interventions supporting admission avoidance, faster recovery from illness, timely discharge from hospital and maximising independent living.
- **Period:**
  Interventions for the majority of service users will last up to six weeks (though there will be individual exceptions).
- **Workforce:**
  MDT but predominantly health professionals and carers (in care homes).
- **Includes:**
  Intermediate care rehabilitation.
- **Excludes:**
  Single condition rehabilitation (e.g. stroke), early supported discharge, general district nursing services, mental health rehabilitation/ intermediate care.

Crisis response services that only assess and deliver very short term interventions have been separated out from home based intermediate care for NAIC 2013 (see section 9.1). However, it should be noted that 85% of the home based services included in this section state that they have an assessment/ admission avoidance function within the service.

130 home based intermediate care services responded to the organisational level audit in 2013.

In addition to the organisational level audit, home based intermediate care services took part in the Patient Reported Experience Measure (PREM) audit. The PREM audit is a new development for this year aimed at provided a standardised quality measure for intermediate care/re-ablement services. The development of the PREM form is described in section 4.3 above. 2,983 completed PREM forms were received back directly from service users of 95 home based intermediate care services. The results are included in section 10.5 below.



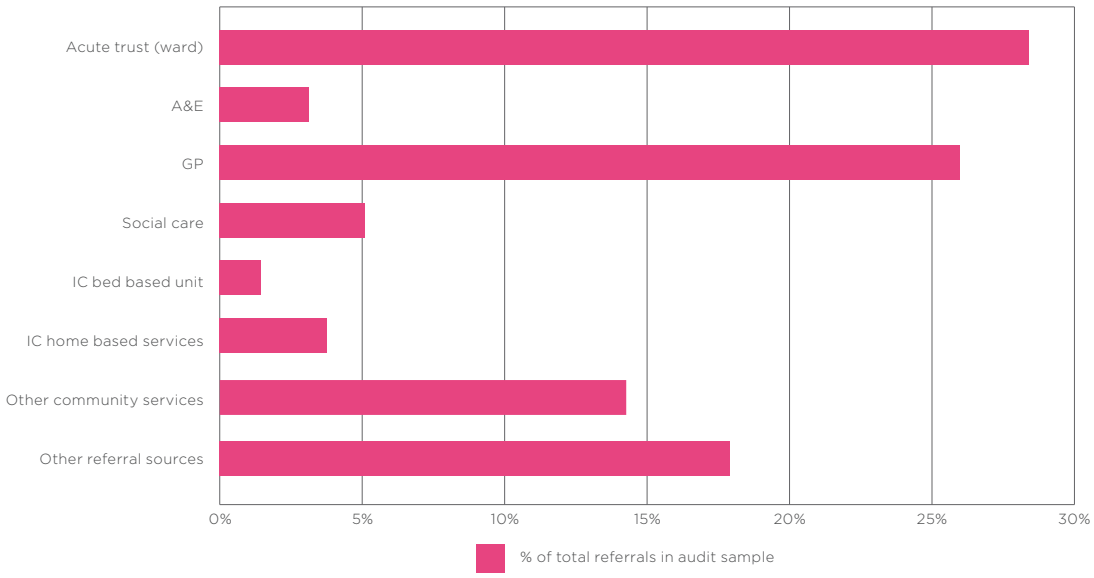
10.2: Results: Home based intermediate care services: Service characteristics

Referral sources

The largest source of referrals into home based services was from acute trusts (wards) (28%), with referrals from GPs making up 26%. These figures are in line with the split of referral sources in NAIC 2012 and are consistent with the conclusion reached last year (which also used data from the patient level audit 2012), that around one third of home based capacity is used for step down care.

Referrals to home based services increased by 13% in 2012/13 (based on data provided by the NAIC 2013 sample of services).

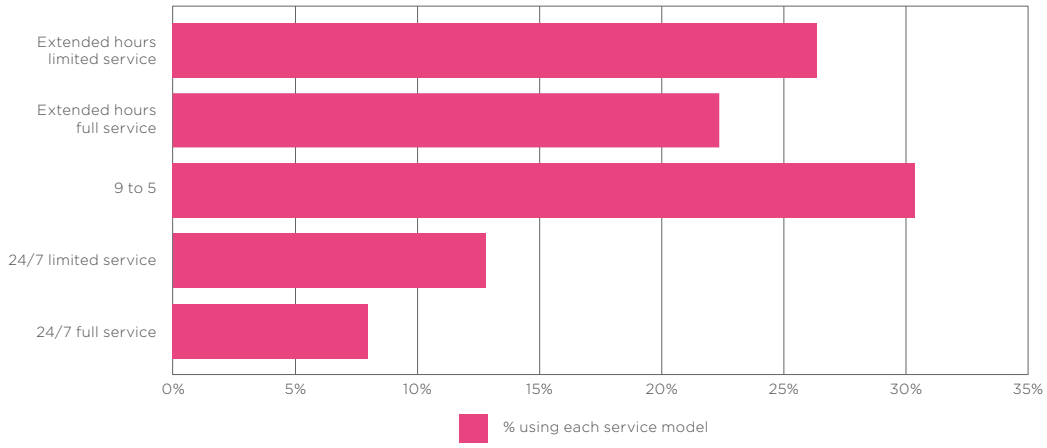
Figure 10.2.1: Source of referrals (home based IC services)



Service accessibility

Hours of opening to new admissions were looked at in more detail in NAIC 2013. “9 to 5” was the most frequently cited model (by 30% of respondents) for home based services (see figure 10.2.2). “Extended hours” means earlier than 9am and /or later than 5pm but not 24/7. 73% of home based services are open to new admissions 365 days a year.

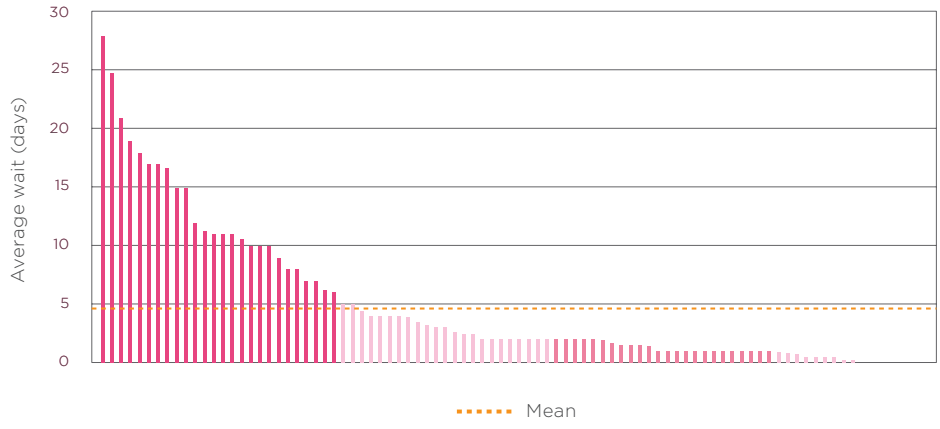
Figure 10.2.2: Hours open to new admissions (home based IC services)



Waiting times

New questions were introduced into the organisational level audit this year on waiting times. The mean average waiting time from referral to assessment for home based services was 4.8 days and the median value was 2 days (including 12 respondents stating a waiting time of zero days). 22 services (out of 94 responding) reported average waiting times of more than 7 days.

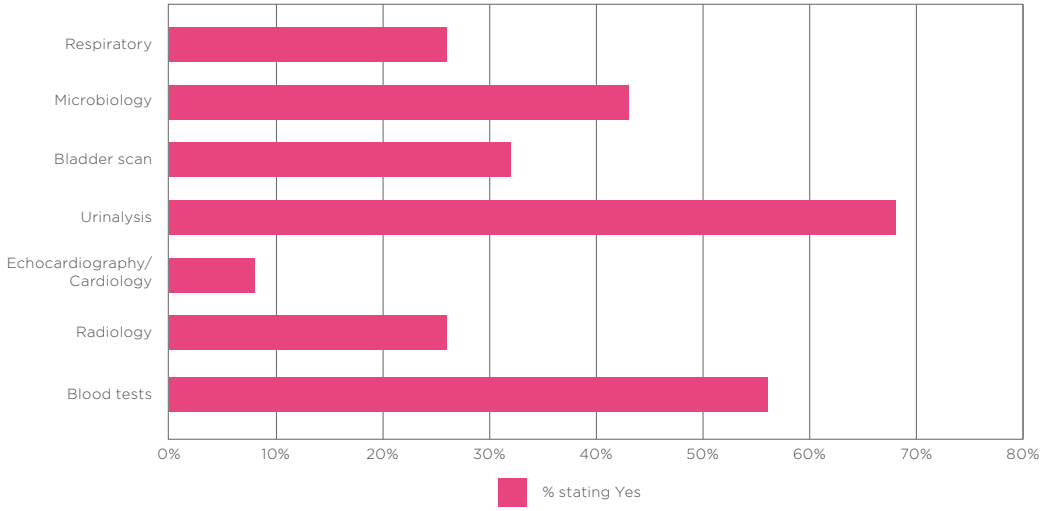
Figure 10.2.3: Average waiting time referral to assessment (home based IC services)



Access to investigations

A lower proportion of home based services reported same day access to most investigation categories compared to NAIC 2012 (for example access to blood tests has reduced from 71% to 56% and radiology from 37% to 26%).

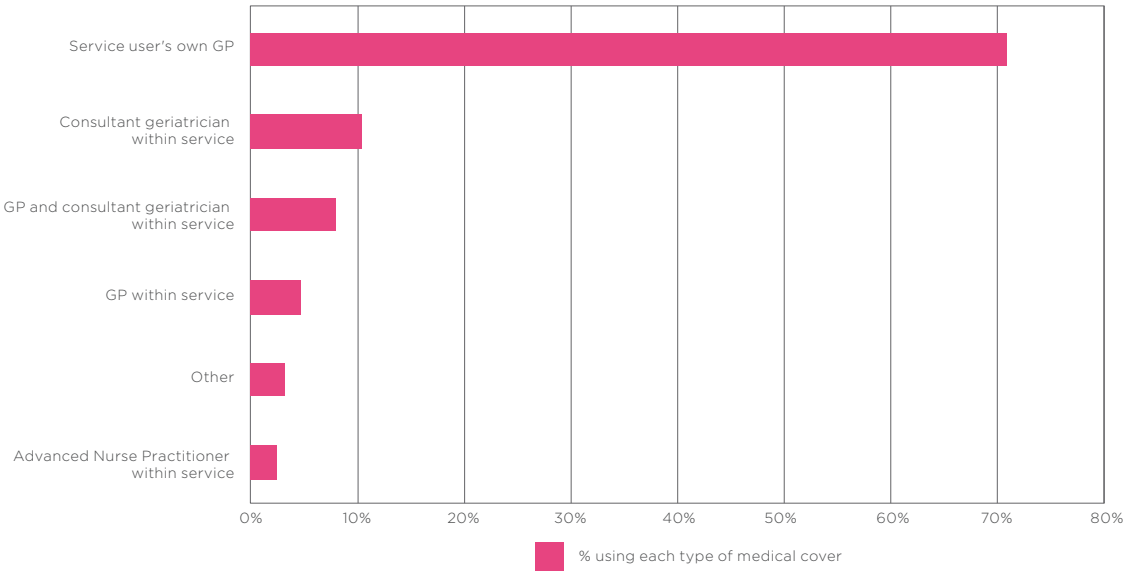
Figure 10.2.4: Same day access to investigations (home based IC services)



Medical cover

The categories of medical cover have been clarified for NAIC 2013 by replacing "No dedicated medical cover within service" with "Service user's own GP". 71% of services reported "Service user's own GP" as their model of medical cover.

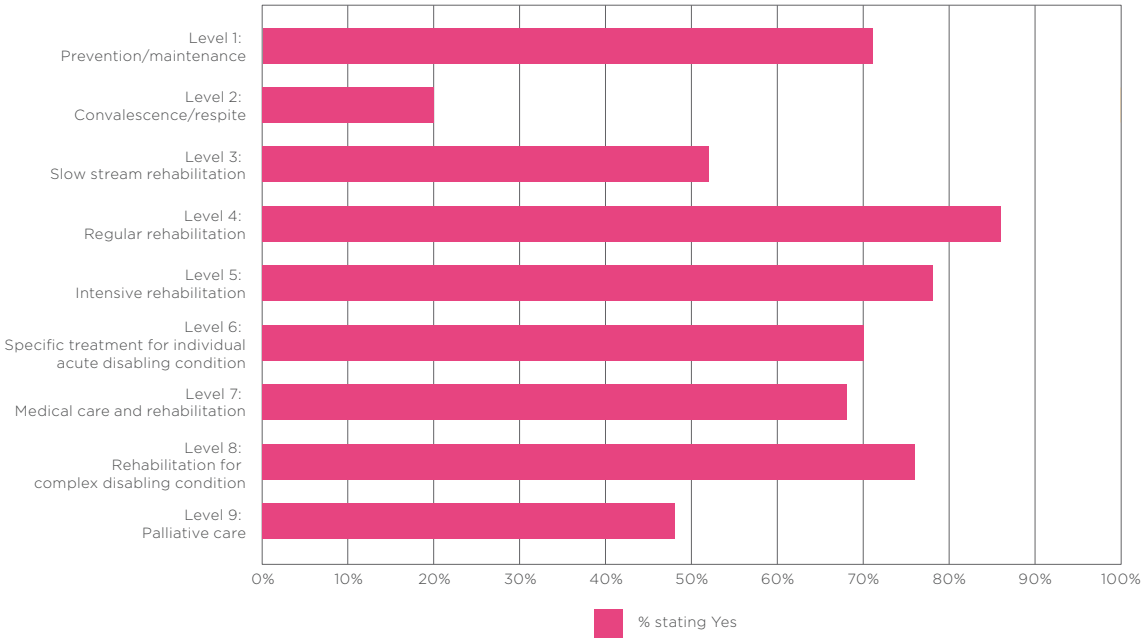
Figure 10.2.5: How is medical cover provided within home based IC services?



Levels of care

In the organisational level of the audit, home based services were asked to indicate the levels of care that best describe the core services provided. The levels of care definitions provided to participants are included at Appendix four. The results show 76% of services state that they provide the highest level of care (rehabilitation for complex disabling condition, excluding Level 9, Palliative Care).

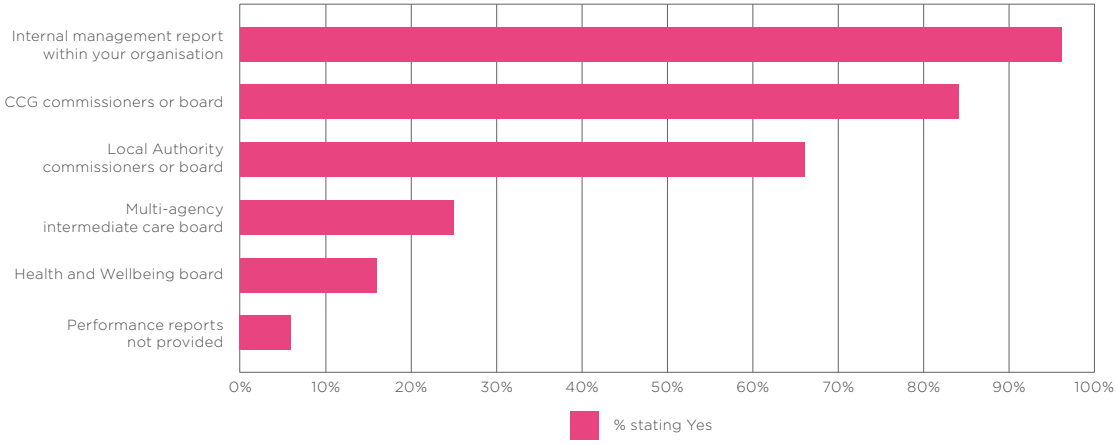
Figure 10.2.6: Levels of care (home based IC services)



Performance reporting

A new question on performance reporting was added this year to ascertain where services reported to. The purpose of this question was to gauge the flow of information across the local health and social care system. The results are shown in figure 10.2.7 below.

Figure 10.2.7: Performance reporting (home based IC services)



10.3: Results: Home based intermediate care services: Use of resources

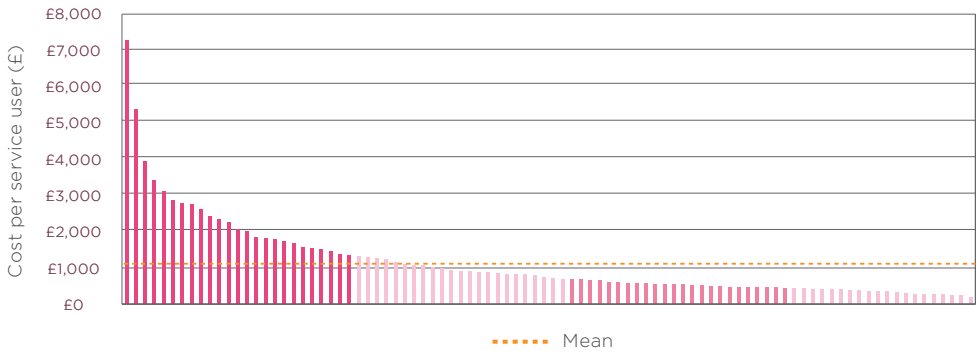
This section covers unit costs for home based services and the factors that impact unit costs; average duration of stay, intensity of input and productivity.

Unit costs

For home based services the cost per service user was calculated by dividing the total annual service budget by the number of individual service users accepted into the service in the year. Data was available for 92 home based services. The mean for 2012/13 was £1,134 per service user and median, £717. The figure reported in NAIC 2012 was £1,100 per service user.

On average then, the cost per service user of home based provision is less than a quarter of the cost of bed based provision.

Figure 10.3.1: Cost per service user home based IC services

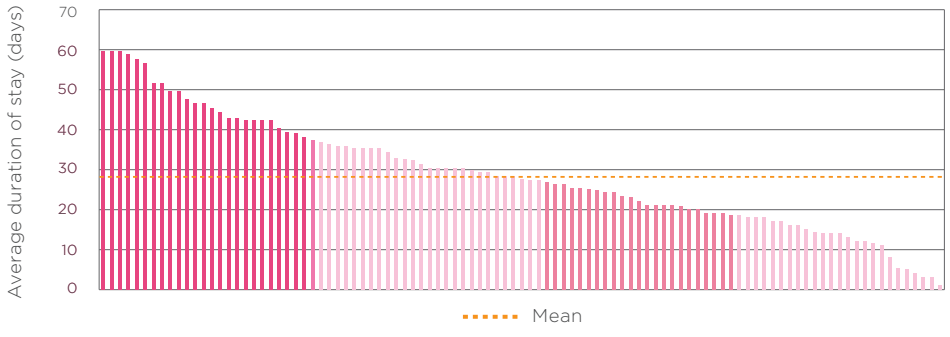


Average duration of stay

For home based services, the average duration of stay was provided by 101 services. The mean reported in NAIC 2013 for 2012/13 was 28.5 days and for 2011/12, 29.3 days. 21 services reported an average duration of stay of 42 days or more.

The mean average duration of stay reported in NAIC 2012 by providers was 24.2 days, although the 2012 patient level audit showed a value of 26.9 days. The increase between years is likely to be due to the stripping out, in NAIC 2013, of services carrying out crisis response services only, by definition these services have much shorter lengths of stay (see section 9.3).

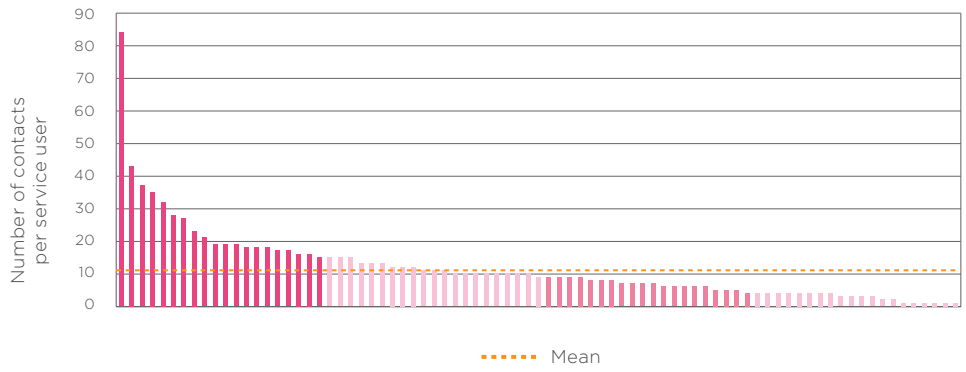
Figure 10.3.2: Average duration of stay in home based IC services



Intensity of input and productivity

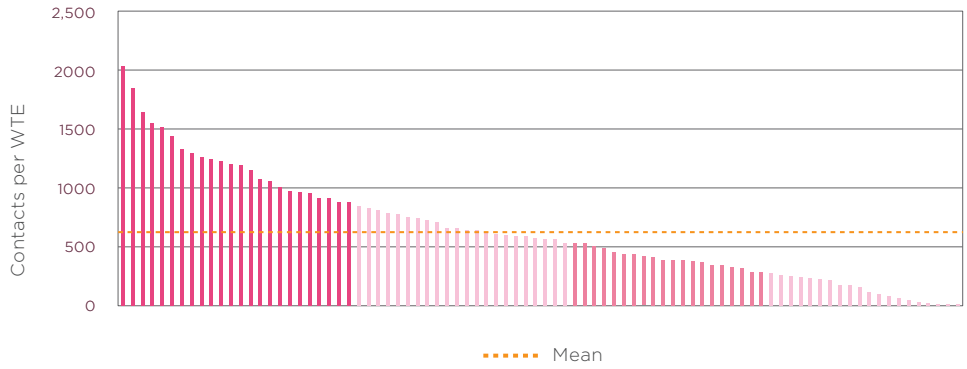
As a proxy for the intensity of input provided within home based services, the number of contacts per service user has also been calculated. The mean reported in NAIC 2013 for 2012/13 was 11.8 contacts per service user (median 9.0) and for 2011/12, the mean was 12.1, with wide variation across the data provided from 81 services. The mean reported in NAIC 2012 for 2011/12 was 13 contacts per service user.

Figure 10.3.3: Intensity of input – contacts per service user



A measure of the productivity of home based services has been calculated as the number of contacts per annum per clinical whole time equivalent (wte). This data was provided by 86 home based services. The mean reported in NAIC 2013 for 2012/13 was 640 contacts per annum per clinical wte (median 569), and for 2011/12, 568 contacts. The mean reported in NAIC 2012 for 2011/12 was 630 contacts.

Figure 10.3.4: Productivity – contacts per WTE



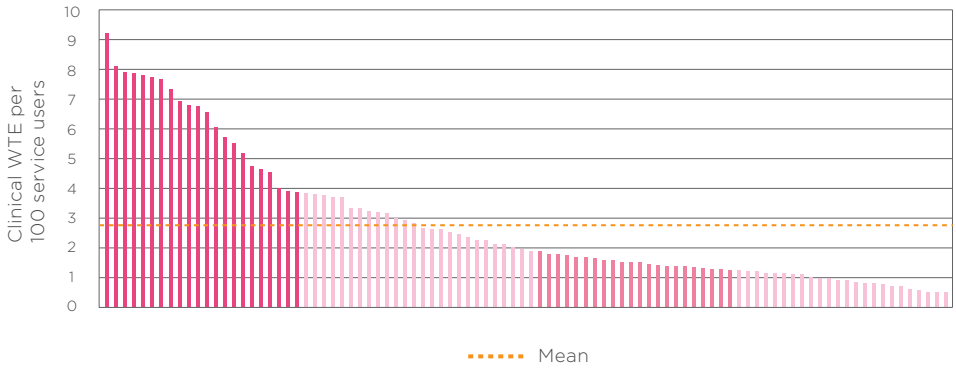
10.4: Results: Home based intermediate care services: Workforce

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

Staffing levels

For home based services the number of clinical wtes per 100 service users was calculated (figure 10.4.1). Data was provided for 94 home based services. The mean reported in NAIC 2013 for 2012/13 was 2.8 clinical wtes per 100 service users and, for 2011/12, 3.2. The mean reported in NAIC 2012 for 2011/12 was 3.9.

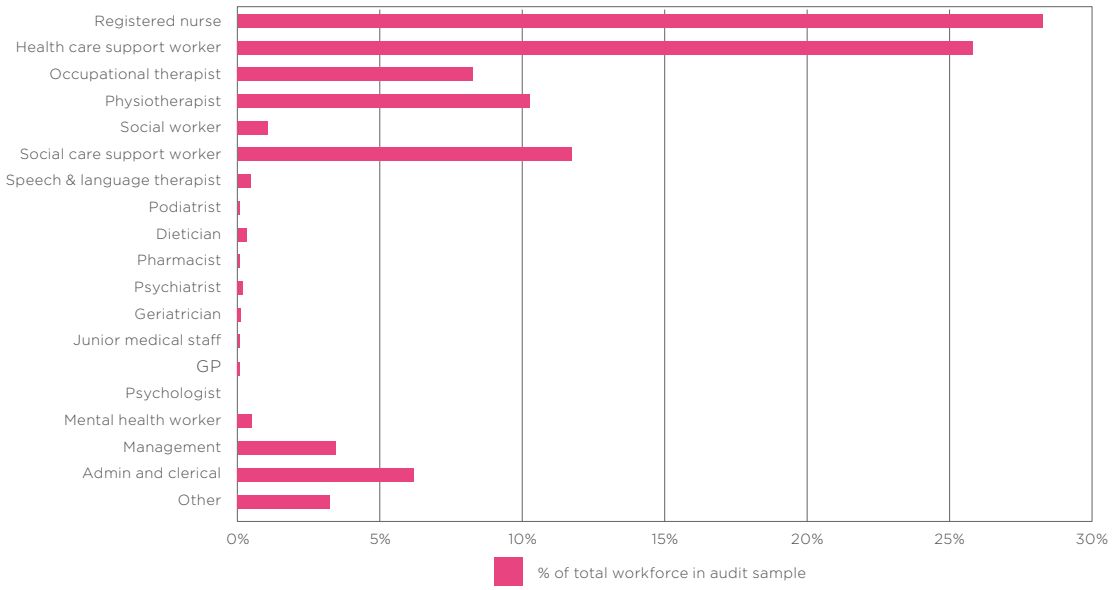
Figure 10.4.1: Clinical WTE per 100 service users (home based IC services)



Mix of disciplines

The mix of staff disciplines for home based services is shown in figure 10.4.2. For home based services reporting in 2013, registered nurses make up 28.3% of the team on average (an increase from 20.3% in NAIC 2012), with health care support workers comprising 25.8%. The next largest group is social care support workers, 11.7%. Physiotherapists and occupational therapists make up 10.3% and 8.3% of the workforce in home based services respectively. GPs make up 0.1% and consultant geriatricians 0.1% of the workforce. Mental health workers represented 0.5% of the workforce.

Figure 10.4.2: Mix of disciplines within home based IC services



10.5: Results: Home based intermediate care services: Quality and outcomes

PREM results

This section provides the results of the PREM for home based services. 2,983 completed PREM forms were received from service users in 95 services. As explained in section 4.3, where the development of the PREM form is described, the same version of the PREM was used for home based intermediate care and re-ablement services.

The collated responses were as follows:

Table 10.5.1: PREM results for home based services

PREM question	Responses (% ticking each option given)				
The length of time I had to wait for my care from the community team to start was reasonable.	Yes	No	Not answered		
	95.3%	3.4%	1.3%		
The staff that cared for me at home had been given all the necessary information about my condition or illness from the person who referred me.	Yes	Don't know	No	Not answered	
	84.3%	11.0%	3.0%	1.7%	
I was aware of what we were aiming to achieve e.g. to be mobile at home, to be independent at home, to be able to go out shopping, to understand my health better.	Yes	No	Not answered		
	94.1%	3.6%	2.3%		
I was involved in setting these aims.	Yes - always	Yes - sometimes	No	Not answered	
	77.2%	15.7%	4.2%	2.9%	
The staff let me know how to contact them if I needed to.	Yes - always	Yes - sometimes	No	Not answered	
	89.1%	5.6%	3.7%	1.6%	
The appointment times/visit times by staff were convenient for me.	Yes - always	Yes - sometimes	No	Not answered	
	82.9%	14.2%	1.7%	1.2%	
When I had important questions to ask the staff they were answered well enough.	Yes - always	Yes - sometimes	I had no need to ask	No	Not answered
	79.2%	9.8%	8.7%	0.8%	1.6%
I had confidence and trust in the staff treating or supporting me.	Yes- always	Yes - sometimes	No	Not answered	
	92.0%	6.1%	0.8%	1.1%	

PREM question	Responses (% ticking each option given)				
I was given enough information about my condition or treatment.	The right amount	Not enough	Too much	Not answered	
	86.3%	9.1%	0.6%	4.0%	
I felt involved in decisions about when my care from the community team was going to stop.	Yes - definitely	Yes – to some extent	I did not need to be involved	No	Not answered
	56.5%	22.9%	8.8%	6.8%	5.1%
I was given enough notice about when my care from the community team was going to stop.	Yes definitely	Yes - to some extent	No	Not answered	
	64.5%	20.0%	8.6%	6.9%	
Staff gave my family or someone close to me all the information they needed to help care for me.	Yes – definitely	Yes – to some extent	I did not want or need them to	No	Not answered
	60.6%	13.9%	15.9%	5.6%	4.1%
Staff discussed with me whether additional equipment or adaptions were required to support me living at home.	Yes	No – it was not necessary to discuss it	No – but I would have liked them to	Not answered	
	78.0%	16.1%	3.3%	2.7%	
Staff discussed with me whether I needed any further health or social care services after this service stopped. (e.g. services from a GP, physiotherapist or community nurse, or assistance from social services or the voluntary sector)	Yes	No – it was not applicable	No – but I would have liked them to	Not answered	
	67.1%	20.1%	9.1%	3.9%	
Overall, I felt I was treated with respect and dignity while I was receiving my care from this service.	Yes - always	Yes – some times	No	Not answered	
	95.7%	2.7%	0.6%	1.0%	

PREM open question (home based IC services)

An additional narrative question – "Please would you tell us one thing we could improve that would have made our service better for you" was asked at the end of the home based IC services' PREM. Whilst the resultant analysis has suggested that there were far more compliments and thanks expressed than complaints or issues for improvement (60% of all service users having completed this additional narrative question), just over 40% made a suggestion for improvement of the service. For home based IC services, these fall within the following broad categories (please note – these are verbatim quotes from service users):

Lack of information and poor co-ordination of care:

- 'There were so many people contacting me I was rather bewildered. So many telephone numbers and names and then it became a problem who does what. Some people came and gave no support'
- 'If the GP who called at home and then referred me to hospital, had known about this service - I wouldn't have needed to go to hospitals. So more information to GPs'

Inappropriate and unpredictable timing of visits:

- 'visits which did not coincide with when I needed the most help'
- 'They didn't come when they said were coming. Just turned up on different day'

Lack of continuity:

- 'I would have liked the same carer more often'
- 'Different faces at all but one visit.'

Poor communication and involvement in care:

- 'Treated me like a child, I felt left out; and uninvolved in my care. I did not feel the service was flexible to my needs'

Shortage of staff/too busy:

- 'Could do with more staff as sometimes the service was over stretched'

Long wait for services, and finishing too early:

- 'After 3 weeks from my discharge, we had heard nothing. My husband had to chase them up to see what the problem was. He was told, rather abruptly, that it would be a further 4 weeks – making a 7 week delay from discharge to seeing/ receiving physiotherapy',
- 'Would have liked the helpers to have remained a few days (5-7) longer'

Equipment supplied too late, not collected when not needed anymore, and not able to organise delivery collection times:

- 'Collection of equipment supplied when requested'
- 'Equipment identified to support me at home during initial assessment being put in place quickly rather than at the end of the period of one month's care. Better communication between services'

Lack of follow-up:

- 'I feel that at least there should be a visit once a month after the initial visit to monitor progress and maintain contact and support'.

Medicine management:

- 'I did not know the nurse could have had prescriptions done and faxed to my G.P. till near the end of their visits',
- 'Would have been nice if the visit/carer/ nurse could have got my prescription from the doctors and got the tablets I needed. Had to wait 1 week for family to get what I needed'

Lack of respect/dignity:

- 'Give prior warning that they are coming in the first place. They just knocked on the door and came in'
- 'I could have been informed that a male carer was coming. That was rather a surprise/shock'

Destination on discharge

Information on destination on discharge was requested in the organisational level audit for home based services. 70% of services users went home (compared to 69% in NAIC 2012), 8% went back to an acute hospital (8% in NAIC 2012), 2% to a care home (3% NAIC 2012) and 2% died (2% NAIC 2012).

10.6: Commentary: Home based intermediate care services

Quality of service provision

Patient experience

Overall, scores for the patient experience questions paint a positive picture. Areas were there appears to be room for improvement include provision of information about the service user's condition (9% responded "not enough") and managing expectations about when care was going to stop (only 65% responded "yes definitely" enough notice was given and only 57% "yes definitely" they were involved in the decision about when the service was going to stop). It is concerning that 2.7% responded "yes-sometimes" (rather than "yes-always") and 0.6% "no" when asked whether they were treated with dignity and respect. Services will be able to review the individual responses received from their own service users using the online tool which may highlight particular issues that require addressing locally.

Waiting times

Although waiting times did not appear to be a major concern for service users (95% thought the waiting time was reasonable), the average waiting time from referral to assessment for home based services of 4.8 days appears high, with some very high waiting times recorded in some services and 22 services reporting an average wait of more than 7 days. This may reflect the under capacity in the system discussed in section 7.4 above. It should be noted that evidence suggests there is a short window for rehabilitation to be effective (*An estimate of post-acute intermediate care need in an elderly care department for older people,* Young J, Forster A, Green J, 2003) and such delays may impact on the likelihood of a positive outcome for service users.

Medical cover

The proportion of home based services relying on the service user's own GP for medical cover appears high (71%) when reviewed against the Levels of Care being provided by these services (see section 10.2). 76% of services stated they were providing the highest level of care (excluding Level 9, Palliative Care), Level 8, defined as "Client needs rehabilitation for complex disabling condition". The quality standards audit (section 6.3) showed that 45% of home based services do not have quick and ready access to geriatrician assessment. The role of Advanced Nurse Practitioners as an alternative way of providing first line clinical review still appears limited (cited by only 2% of services (figure 10.2.5). Commissioners and providers need to ensure timely access to medical assessment for this service user cohort.

Access to investigations

It is disappointing that same day investigations appear less accessible in 2013 than reported by participants in NAIC 2012.

Mental Health

The data suggests mental health workers are still rarely included in the establishment in intermediate care teams. In addition, only 51% 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) and only 53% of home based services have "ready and quick access" to specialist mental health skills. Whilst these figures may reflect the fact that currently only 12% of service users have dementia (NAIC 2012), consideration might be given to whether this approach contributes to an under representation of dementia in intermediate care.

Efficient use of resources

Throughput of service users

The results show a mean cost per service user for home based intermediate care services of £1,134. The cost per service user will be affected by the 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://www.nhsbenchmarking.nhs.uk/National-Audit-of-Intermediate-Care/year-two.php. For example, where cost per service user is relatively high, participants will be able to consider whether this is due to above average duration of stay or higher 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 little growth in investment (section 7.3)).

Staffing levels

The staffing level data (clinical wte per service user for home based services) is a measure of the intensity of resources utilised within an intermediate care service and is a further factor impacting cost per service user. For example, a higher relative level of staffing may result in lower duration 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 quality measures will also be an important part of the story for each service. 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?

Length of stay

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 audit shows 21 services where the average duration of stay is 42 days or more, suggesting many service users in these services must be staying well over 6 weeks. Long lengths of stay may impact on throughput as noted above and hence the ability of the service to make an impact on secondary care utilisation.

Robustness of activity measures used in the audit

Reservations were expressed in NAIC 2012 about the use of "contacts" as a measure of activity in these metrics. The NHS Benchmarking Network's work on benchmarking Community Services suggests the use of "contacts" as a measure of activity is becoming more robust. The intensity of input and productivity metrics appear to be producing consistent results across the two years of the NAIC.

Progress with integration

Performance reporting

The level of reporting to Local Authority commissioners as well as CCG commissioners is encouraging, suggesting positive steps towards closer working between health and social care.

11: Results: Bed based intermediate care services

11.1: Introduction

This section provides the audit results for bed based intermediate care services. For the purposes of the audit, this service category was defined by the following key features:

- **Setting:**
  Service is provided within an acute hospital, community hospital, residential care home, nursing home, standalone intermediate care facility, independent sector facility, Local Authority facility or other bed based setting.
- **Aim of service:**
  Prevention of unnecessary acute hospital admissions and premature admissions to long term care and/or to receive patients from acute hospital settings for rehabilitation and to support timely discharge from hospital.
- **Period:**
  Interventions for the majority of service users will last up to six weeks (though there will be individual exceptions).
- **Workforce:**
  MDT but predominantly health professionals and carers (in care homes).
- **Includes:**
  Intermediate care bed based services.
- **Excludes:**
  Single condition rehabilitation (e.g. stroke) units, general community hospital beds not designated as intermediate care/rehabilitation, mental health rehabilitation beds.

176 bed based intermediate care services responded to the organisational level audit in 2013.

In addition to the organisational level audit, bed based intermediate care services took part in the service user/ Patient Reported Experience Measure (PREM) audit. The service user questionnaire for bed based services, including a PREM form for completion by service users, is a new development for this year aimed at providing standardised quality measures for intermediate care services. The development of the service user questionnaire and PREM form is described in section 4.3 above. 3,715 completed service user questionnaires were received from 120 participating services and 1,832 PREM forms were received back directly from service users in 131 bed based intermediate care services. The results are included in sections 11.5 and 11.6 below.

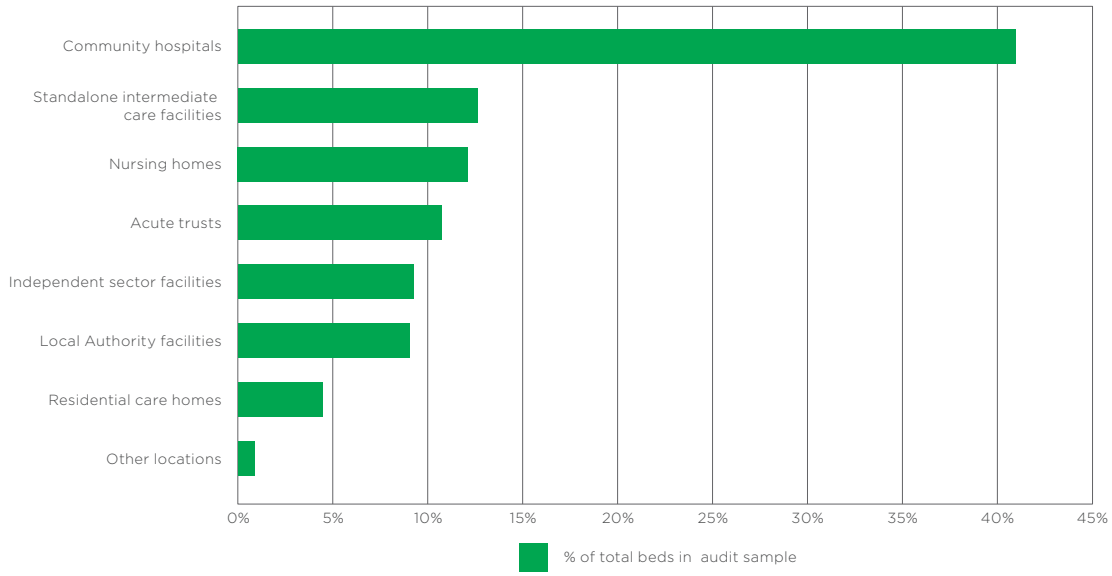
11.2: Results: Bed based intermediate care services: Service characteristics

This section describes the key features of bed based intermediate care services.

Service locations

Bed based intermediate care units included in the study show a range of settings (figure 11.2.1), the most common, as in NAIC 2012, being community hospitals 41% (38% last year). Standalone intermediate care facilities (included in "other" last year) make up 13% of the sample in 2013. Acute trust settings (11%) are better represented than last year (NAIC 2012, 7%).

Figure 11.2.1: Setting of bed based intermediate care sites



Step up and down capacity

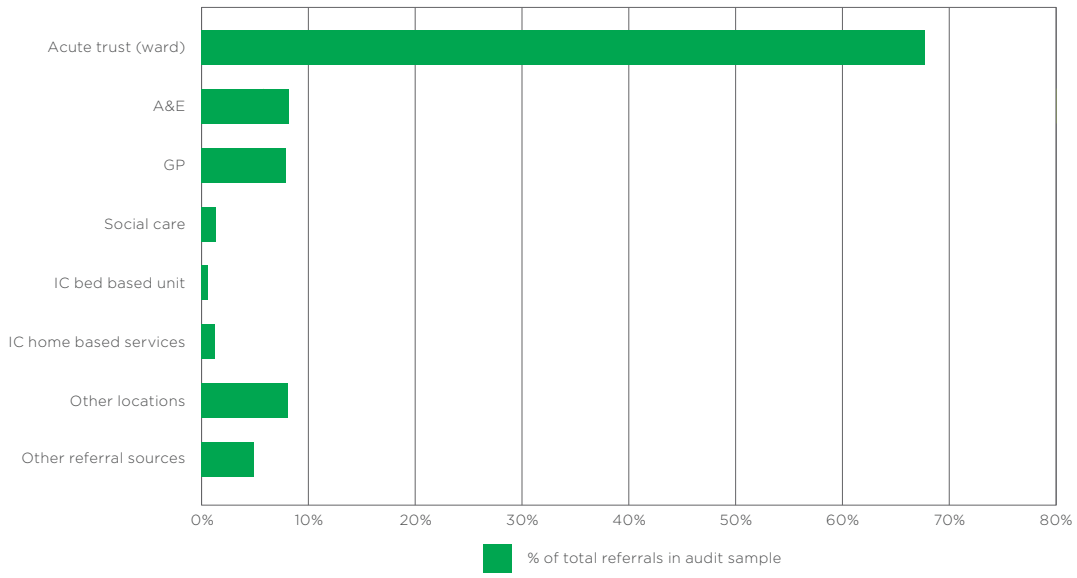
In NAIC 2013, 84% of respondents stated that beds were used flexibly between step up and step down. The average split for utilisation of capacity was 21% step up and 78% step down. This is further in favour of step down than reported in NAIC 2012 (65% used for step down) and is consistent with the increase in the proportion of referrals from acute trust wards described below.

Referral sources

The largest source of referrals into bed based services was from acute trusts (wards) (68%), greater than in the NAIC 2012 (51%). Referrals from GPs (8%) are substantially lower than reported last year (22%).

Total referrals to bed based services showed no change in 2012/13, based on figures for the two years reported by NAIC 2013 participants.

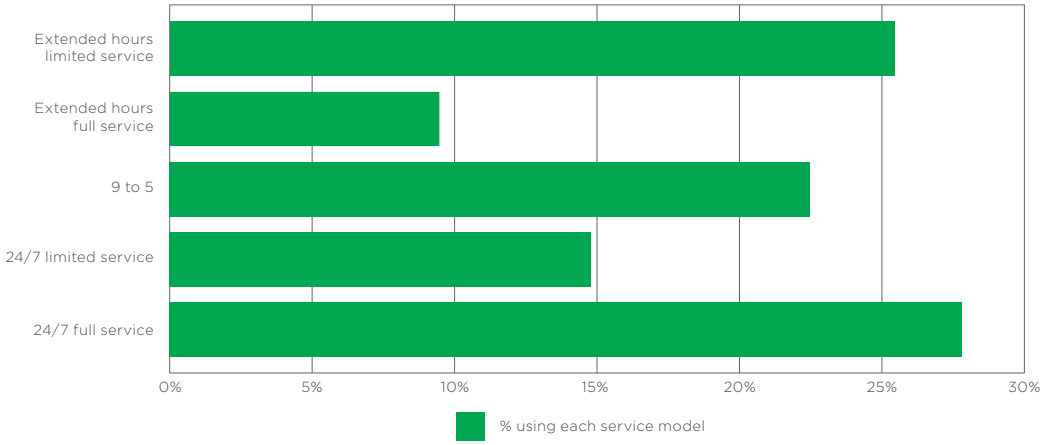
Figure 11.2.2: Source of referrals (bed based IC services)



Service accessibility

Hours of opening to new admissions were looked at in more detail in NAIC 2013. "24/7 full service" was the most frequently cited model (by 28% of respondents), as shown in figure 11.2.3. "Extended hours" means earlier than 9am and/or later than 5pm but not 24/7. As in NAIC 2012, 89% of bed based services are open to new admissions 365 days a year.

Figure 11.2.3: Hours open to new admissions (bed based IC services)

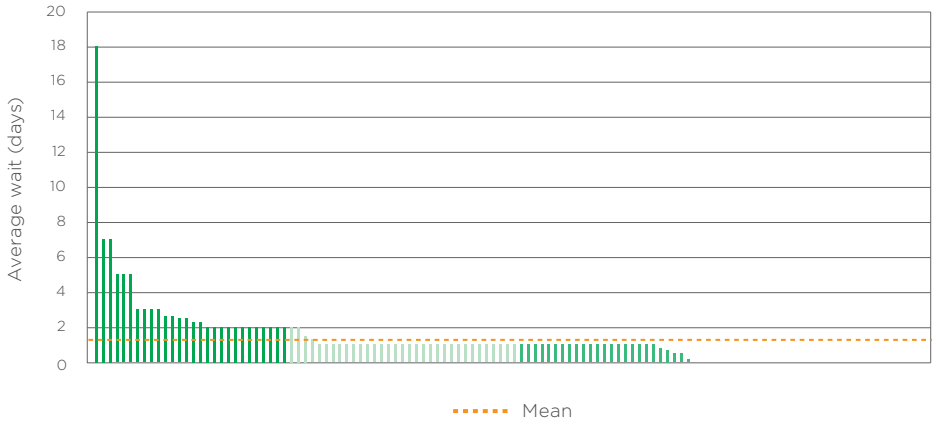


94% of bed based intermediate care services can accept service users with mild to moderate dementia.

Waiting times

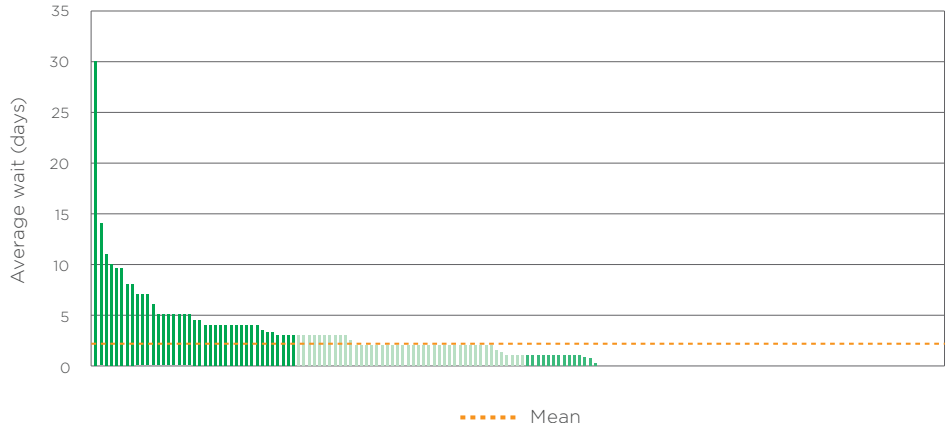
New questions were introduced into the organisational level audit this year on waiting times. The mean average waiting time from referral to assessment for bed based services was 1.3 days and median value, 1.0 day (including 32 (out of 118 respondents) stating a waiting time of zero days).

Figure 11.2.4: Average waiting time referral to assessment (bed based IC services)



The mean average time from assessment to commencement of services was 2.1 days (including 67 respondents (out of a total of 164 responses) stating a waiting time of zero days). The median average waiting time was 1.0 day and 32 services reported an average waiting time of 4 days or more.

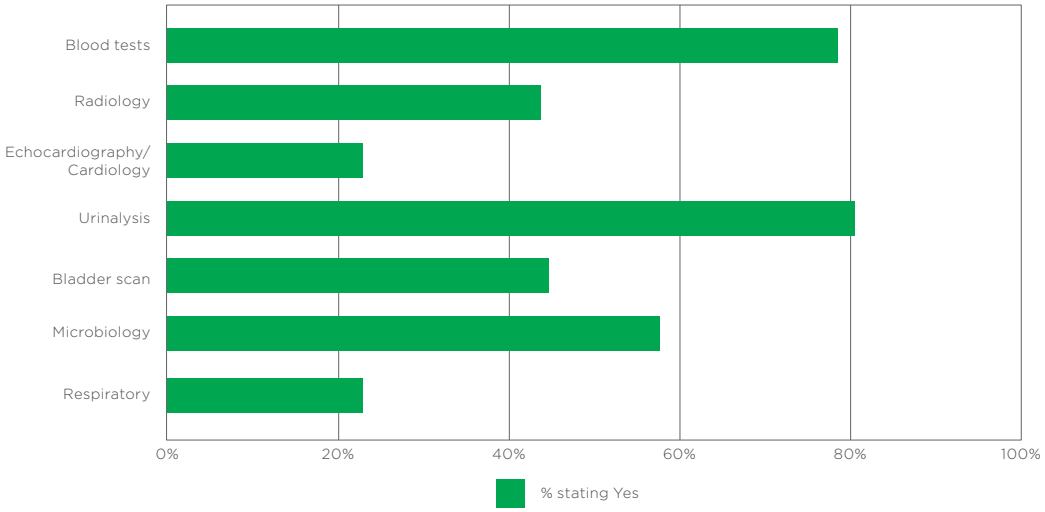
Figure 11.2.5: Average waiting time from assessment to commencement of service (bed based IC services)



Access to investigations

Access to same day investigations by bed based intermediate care services shows a similar profile to 2012.

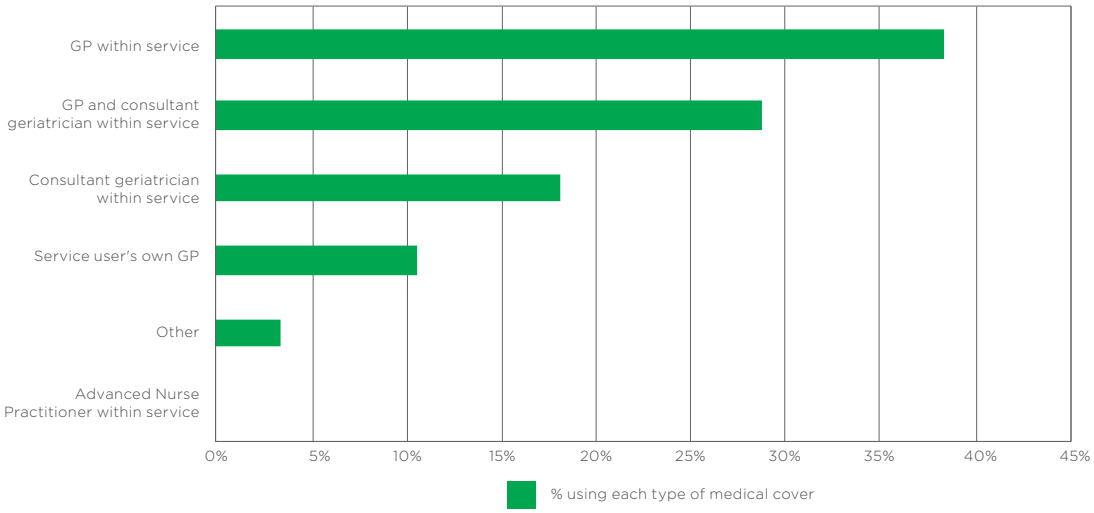
Figure 11.2.6: Same day access to investigations (bed based IC services)



Medical cover

The categories of medical cover have been clarified for NAIC 2013 by replacing "No dedicated medical cover within service" with "Service user's own GP". The most commonly cited models for bed based services were GP within service (38%) and the combined team of GP and consultant geriatrician (29%).

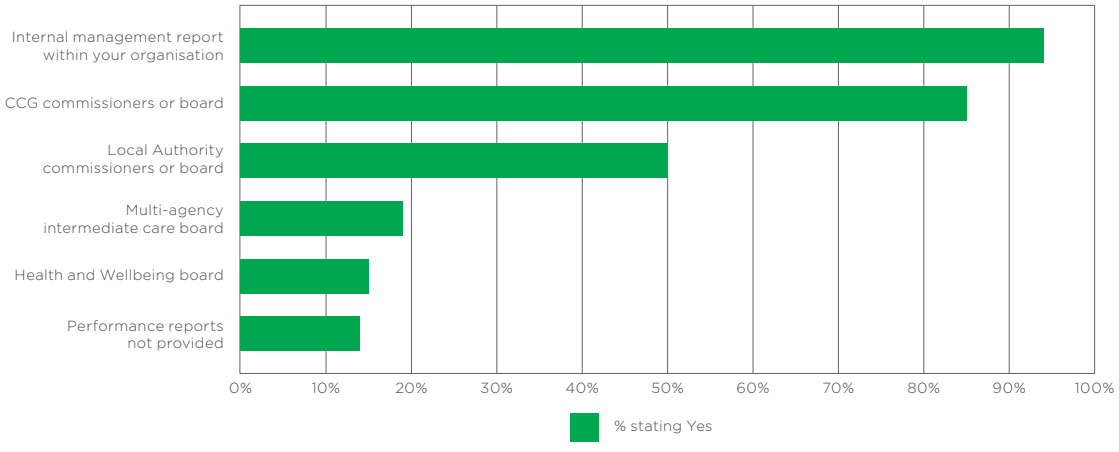
Figure 11.2.7: How is medical cover provided within bed based IC services?



Performance reporting

A new question on performance reporting was added this year to ascertain where services reported to. The purpose of this question was to gauge the flow of information across the local health and social care system. The results for bed based services are shown in figure 11.2.8 below.

Figure 11.2.8: Performance reporting (bed based IC services)



11.3: Results: Bed based intermediate care services: Use of resources

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

Unit costs

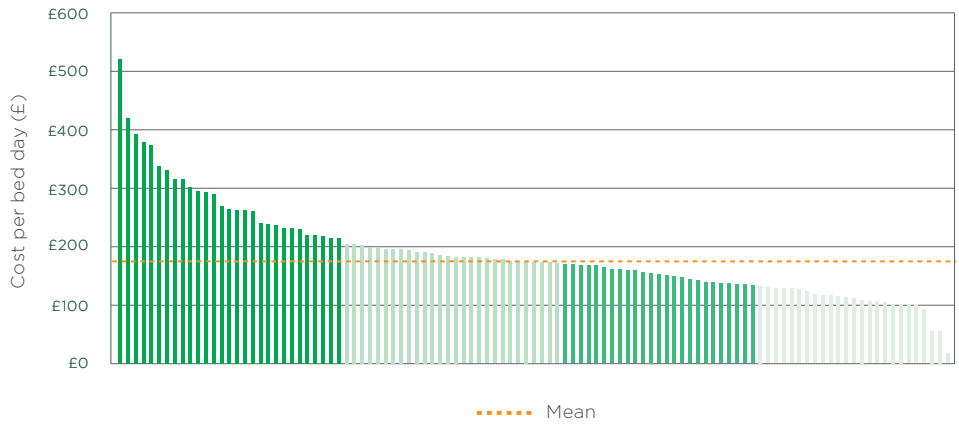
The cost per occupied bed day was calculated by dividing the total service budget by the number of occupied bed days. Note that total service budget includes direct pay and non-pay costs only (indirect costs and overhead allocation are excluded). This data was provided for 107 bed based services for 2012/13 (figure 11.3.1 below). The mean cost per occupied bed day reported in NAIC 2013 for 2012/13 was £187 and for 2011/12 £183.

The mean costs for each setting were as follows:

Table: Bed based setting	Mean cost per occupied bed day (£)	Number of values used in calculation of mean
Acute trust setting	169	16
Community hospital	196	41
Independent sector facilities	149	4
Local Authority facilities	202	15
Nursing homes	162	10
Residential care homes	203	4
Standalone intermediate care facilities	196	16

The mean cost per occupied bed day reported in NAIC 2012 for 2011/12 was £158. The increase in cost per occupied bed day appears to be due to the change in mix of bed based settings included in the audit with a greater proportion of more expensive settings; Local Authority facilities and standalone intermediate care facilities.

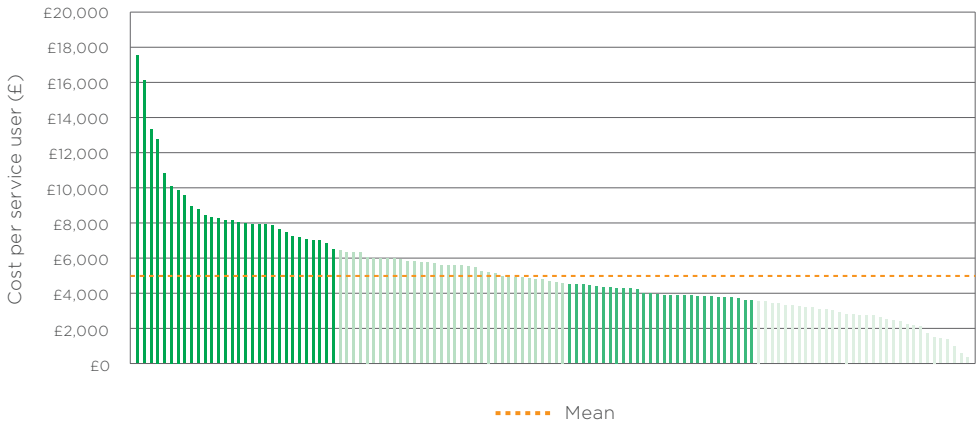
Figure 11.3.1: Cost per occupied bed day for bed based IC services



The total cost per service user was calculated by dividing the total service budget by the number of individual service users admitted. The data required for the calculation was provided by 124 bed based services. The mean reported in NAIC 2013 for 2012/13 was £5,218 per service user and for 2011/12, £5,219.

The mean reported in NAIC 2012 for 2011/12 was £4,543 per service user.

Figure 11.3.2: Cost per service user bed based IC services



Bed occupancy

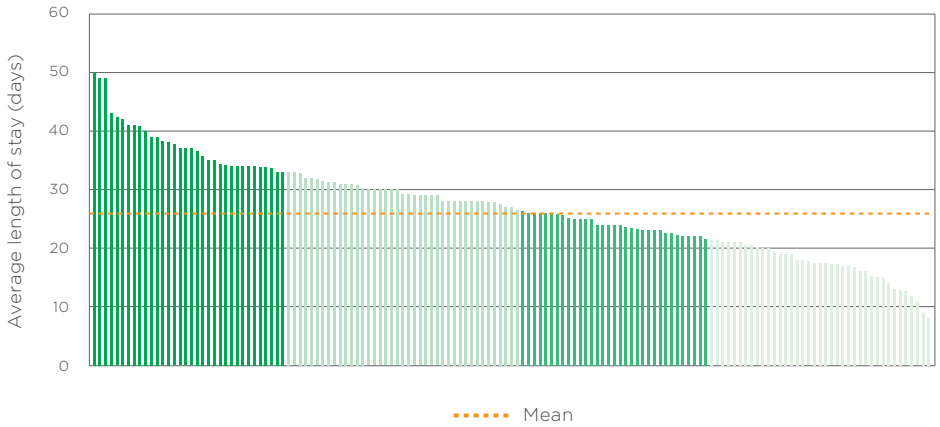
In bed based intermediate care services, bed occupancy shows a mean of 85% across the 129 services providing data. This was similar to bed occupancy reported in NAIC 2012 of 86%.

Average length of stay

Data on the average length of stay for service users was provided by 147 bed based services. The mean reported in NAIC 2013 for 2012/13 was 26.9 days and, for 2011/12, 27.5 days. Six services had an average length of stay of 42 days or more. These figures compare to an average length of stay from the service user audit of 26.0 days.

The result is close to the 27.5 days reported in NAIC 2012 by providers.

Figure 11.3.3: Average length of stay in bed based IC services



11.4: Results: Bed based intermediate care services: Workforce

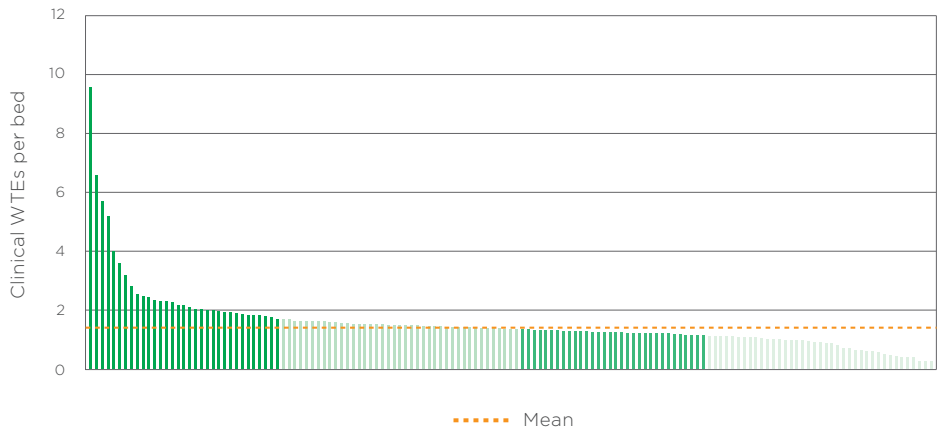
This section considers the staffing levels and mix of disciplines in intermediate care services for bed based intermediate care services.

Staffing levels

The number of clinical whole time equivalent (wte) staff per bed is shown at figure 11.4.1. Data was provided for 145 bed based services. The mean reported in NAIC 2013 for 2012/13 was 1.54 clinical wte per bed.

The mean reported in NAIC 2012 for 2011/12 was 1.23 clinical wte per bed.

Figure 11.4.1: : Clinical WTE per bed

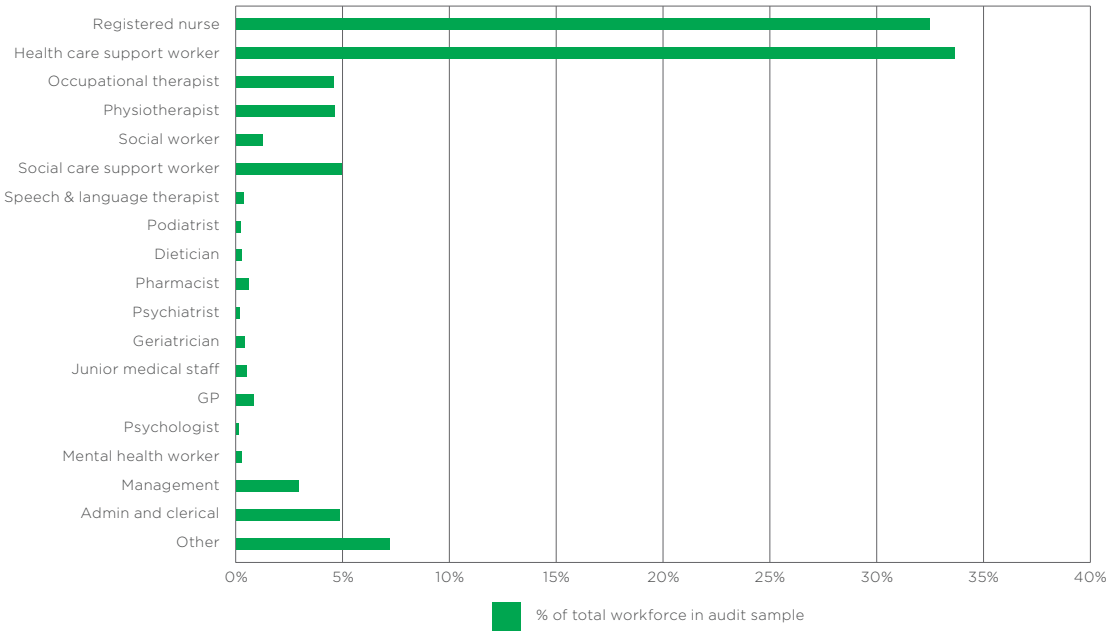


Mix of disciplines

The mix of staff disciplines for bed based services is shown in figure 11.4.2. On average, the largest staff group for bed based services is health care support workers (33.6%), followed by registered nurses (32.5%). Physiotherapists and occupational therapists make up 4.6% of the workforce each and social care support workers 5%. Medical cover is provided by GPs (0.8%), consultant geriatricians 0.4% and junior medical staff 0.5%. Mental health workers made up 0.3% of the workforce in bed based services.

The staff mix profile is similar to NAIC 2012 for bed based intermediate care services.

Figure 11.4.2: Mix of disciplines within bed based IC services



Nursing skill mix

The ratio of "nursing" to "unqualified health staff" for intermediate care units in community hospitals and acute settings was reported as 57:43, an improvement on the ratio reported last year 47:53. This is in line with 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 (*Safe staffing for older people's wards: RCN summary guidance and recommendations*, Royal College of Nursing, March 2012).

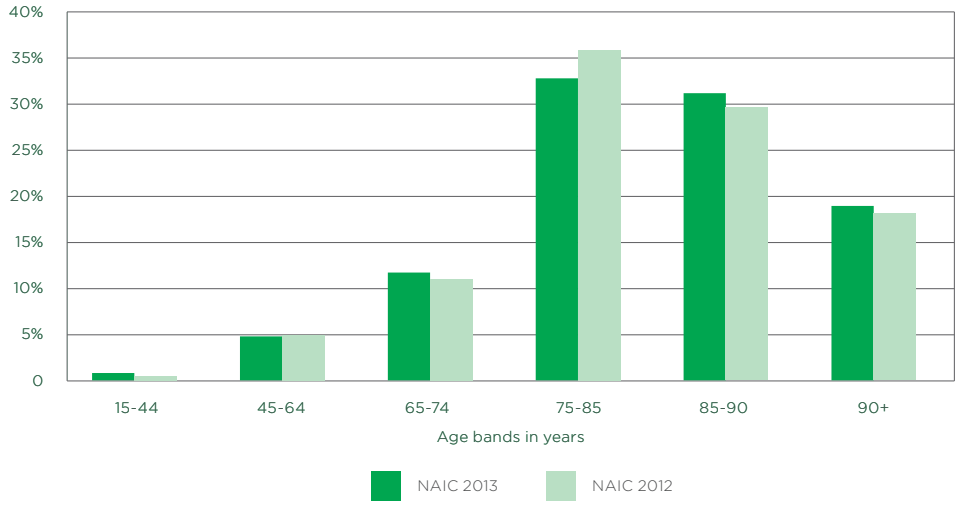
11.5: Results: Bed based intermediate care services: Service user questionnaire

This section provides the results of the service user form used this year in bed based intermediate care services (see section 4.3). Services were asked to complete forms for 50 consecutive service users. 3,715 completed service user forms were returned by 120 services, giving an average of 31 forms per service.

Age and gender profile

In NAIC 2013, 94% of service users were aged 65 and over and 50% were over 85 years of age. The mean age was 82 years. The change in service user age profile since last year is shown in figure 11.5.1. Although the mean age is the same, there has been an increase in the over 85 year category from 48% in NAIC 2012. Although this appears consistent with demographic changes, it should be noted that the age profile may be affected by the change in the nature of the bed based locations taken part in the audit this year (see section 11.2).

Figure 11.5.1: Change in service user age profile between NAIC 2012 and 2013 samples

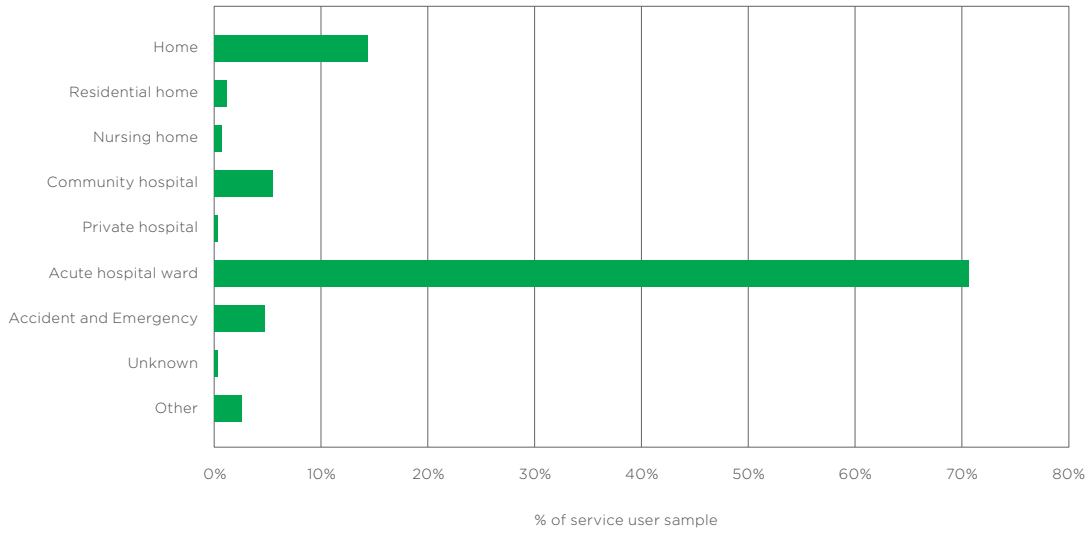


65% of service users were female in NAIC 2013 (compared to 66% in NAIC 2012).

Admission to the service

Most users normally lived in their own home (60.6% living alone and 29.6% living in their own home with others); 1.2% lived in residential care, 0.8% in a nursing home and 5.6% in sheltered housing. However, service users are most often admitted from acute hospital wards, 71% (see figure 11.5.2), an increase from NAIC 2012, 67%.

Figure 11.5.2: Admission source

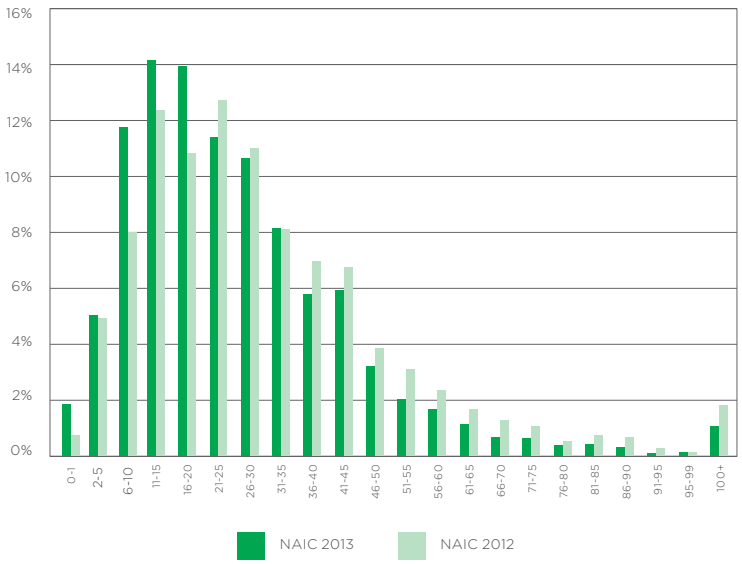


83% of referrals were admitted to the service, with 12% inappropriate referrals recorded (5% did not answer this question). Of those not accepted into the service, 58% were referred to a different service.

Length of stay

In the 2013 audit, service users were in bed based intermediate care services for a mean of 26.0 days. In the NAIC 2012 patient sample, the mean recorded was 30.4 days. The change in length of stay profile between the two years is illustrated in figure 11.5.3. Users with length of stay of 90 days or more accounted for 6% of total bed based days incurred in 2012/13.

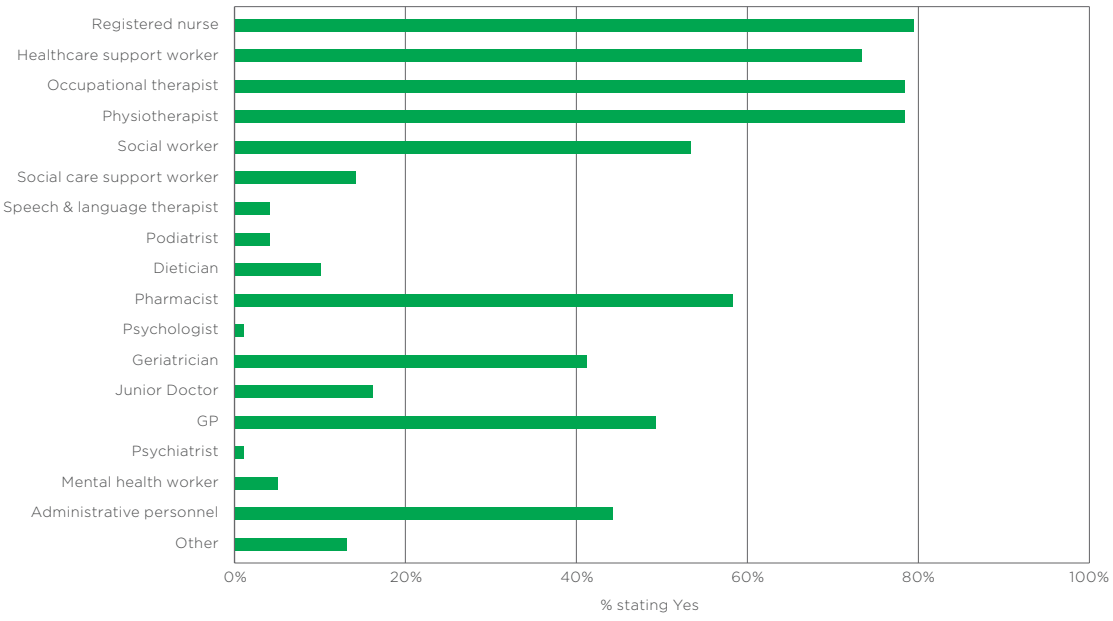
Figure 11.5.3: Service user length of stay profile



Staff contact

Staff groups most likely to be involved in delivering service users' care were registered nurses (indicated in 79% of cases), healthcare support workers (73%), occupational therapists (78%) and physiotherapists (78%). Social workers were involved in 53% of cases and social care support workers in 14% of cases. Geriatricians were indicated for 41% of the sample and GPs for 49%. Mental health workers were involved in 5% of cases and psychiatrists 1%.

Figure 11.5.4: Staff involved in delivering client care



11.6: Results: Bed based intermediate care services: Quality and outcomes

PREM results

This section provides the results of the PREM for bed based services. 1,832 completed PREM forms were received from service users in 131 services.

The collated responses were as follows:

Table 11.6.1: PREM results for bed based services

PREM question	Responses (% ticking each option given)					
The length of time I had to wait for the service was reasonable.	Yes	No	Not answered			
	94.4%	3.7%	1.9%			
The staff that cared for me in this service had been given all the necessary information about my condition or illness from the person who referred me.	Yes	Don't know	No	Not answered		
	84.3%	11.9%	2.7%	1.2%		
I was aware of what we were aiming to achieve e.g. to be mobile at home, to be independent at home, to be able to go out shopping, to understand my health better.	Yes	No	Not answered			
	96.0%	2.7%	1.3%			
I was involved in setting these aims.	Yes - always	Yes - sometimes	No	Not answered		
	69.8%	24.0%	4.5%	2.2%		
The room or ward I was in was clean.	Very clean	Fairly clean	Not very clean	Not answered		
	89.5%	9.6%	0.3%	0.6%		
I felt threatened or made to feel uncomfortable by other patients or visitors during my stay in this service.	No	Yes	Not answered			
	90.7%	8.0%	1.3%			
When I had important questions to ask the staff they were answered well enough.	Yes - always	Yes - sometimes	I had no need to ask	No	Not answered	
	73.5%	19.2%	5.7%	0.8%	0.8%	

I had confidence and trust in the staff treating or supporting me.	Yes – always	Yes - sometimes	No	Not answered		
	89.3%	9.5%	0.4%	0.8%		
I was involved as much as I wanted to be in decisions about my care and therapy.	The right amount	Too much	Not enough	Not answered		
	87.7%	0.9%	9.7%	1.8%		
I was involved in decisions about when I would go home.	Yes – definitely	Yes – to some extent	I did not need to be involved	No	Not answered	
	59.0%	28.3%	4.4%	6.4%	2.0%	
Staff took account of my family or home situation when planning going home.	Yes - completely	Yes – to some extent	It was not necessary	Don't know	No	N/A
	76.2%	14.8%	3.1%	3.2%	1.7%	1.1%
Staff gave my family or someone close to me all the information they needed to help care for me.	Yes - definitely	Yes – to some extent	I did not want or need them to	No	Not answered	
	73.5%	15.7%	5.3%	3.2%	2.8%	
Staff discussed with me whether additional equipment or adaptions were required to support me living at home.	Yes	No – it was not necessary to discuss	No – but I would have liked them to	Not answered		
	83.8%	10.0%	2.9%	3.3%		
Staff discussed with me whether I needed any further health or social care services after this service stopped (e.g. services from a GP, physiotherapist or community nurse,or assistance from social services or the voluntary sector).	Yes	No – it was not applicable	No – but I would have liked them to	Not answered		
	83.3%	8.2%	5.3%	3.2%		
Overall, I felt I was treated with respect and dignity while I was receiving this service.	Yes - always	Yes - sometimes	No	Not answered		
	93.1%	5.5%	0.3%	1.1%		

PREM open question (bed based IC services)

An additional narrative question – "Please would you tell us one thing we could improve that would have made our service better for you" – was asked at the end of the bed based IC services' PREM. Whilst the resultant analysis has suggested that there were far more compliments and thanks expressed than complaints or issues for improvement (60% of all service users having completed this additional narrative question), just over 40% made a suggestion for improvement of the service. For bed based IC services, these fall within the following broad categories (please note – these are verbatim quotes from service users):

Slow response to calls:

- 'I felt at times that when I buzzed my pendant, I was waiting for long periods of time for assistance'
- 'Sometimes more instant attention was needed but not always given'

Staffing levels too low, and specific disciplines in short supply:

- 'The physio services have far too many patients to attend to'
- 'More staff at night time'

Facilities:

- 'Rooms need updating. Sinks not for people in wheel chairs'
- 'Toilet facilities for people who have had hip and leg operations need to be discussed with patients'

Communication issues:

- 'What I found missing was the sharing of information about my health between the 2 hospitals involved and between my GP and the hospitals'
- 'It is essential that the family is given information on what is provided by the service and what is expected from the family'

Discharge too early, poorly organised or coordinated:

- 'It would have been very much less stressful if some notice had been given regarding discharge and not suddenly announced on the day of leaving'
- 'I was give one hours notice that I would be going home and my daughter had a 30 min drive to be there to meet me. There was no food etc in the house'

Disturbed by other patients, noisy staff and TVs:

- 'Disturbed at night by other patients'
- 'Being stuck in a room with some people was stressful'

Being treated with respect and dignity:

- 'Knocking at the door before entering. Makes one keep their dignity'
- 'I sometimes felt that care from male carers was inappropriate'

Food and mealtime issues:

- 'The menu was not varied and there was very little nutritional value'
- 'Not sitting at the table so long before the meal was served. Sometimes 30 mins'

Medication poorly timed, lack of information and coordination:

- 'I would like to have had explained the side effects of some of the drugs given'
- 'After transferring from the general hospital, the only pain relief that was given was paracetamol, due to the med chart not being faxed from the general hospital'

Activities:

- 'Boredom most of the time'
- 'More exercise would be helpful'

Lack of access for personal hygiene:

- 'I would have liked to be able to shower more frequently'
- 'Sometimes I had to wait for having a wash'

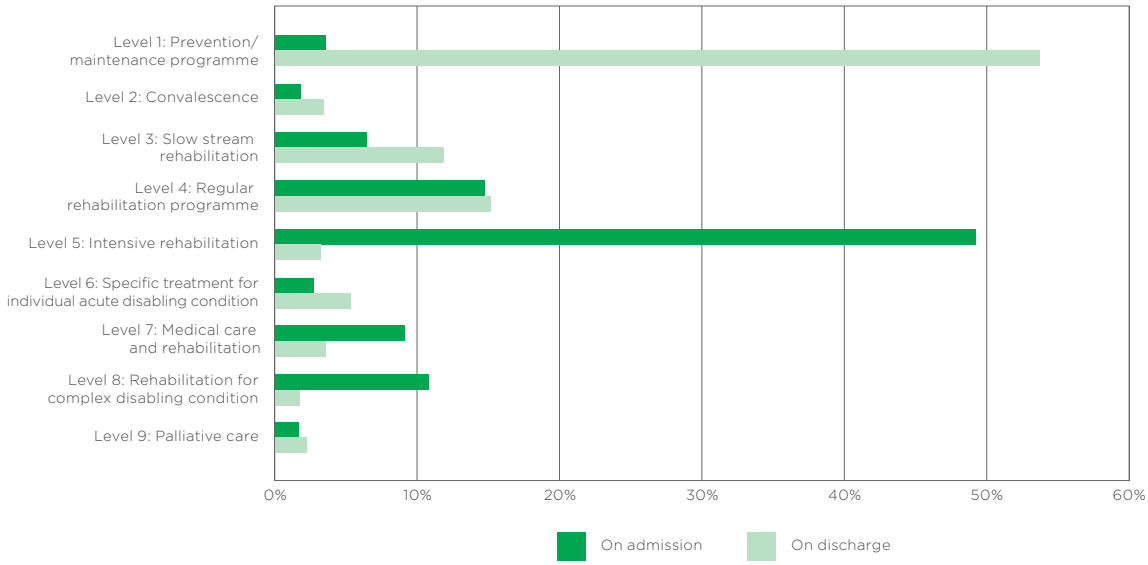
Laundry service:

- 'The cleanliness of the linen especially the towels'

Levels of care

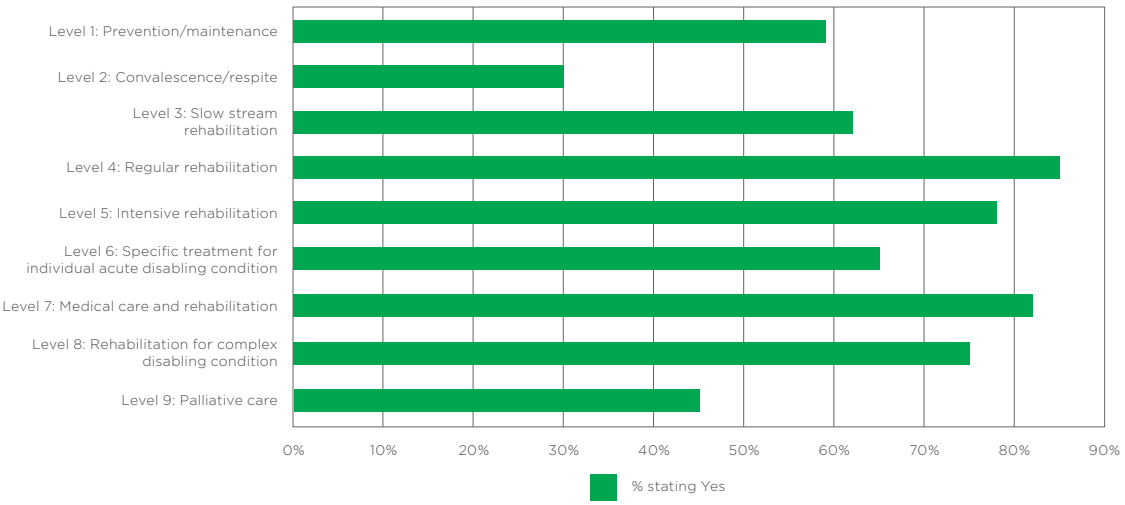
Figure 11.6.1 shows the change in level of care needed by the service user between admission and discharge from the service user questionnaires. The definitions for the levels of care, which were provided to participants, are shown at Appendix four. The most common level of care on admission was "Client needs intensive rehabilitation", 49%, and on discharge "client needs prevention/maintenance programme", 54%.

Figure 11.6.1: Levels of care (service user audit)



Services were also asked, as part of the organisational level audit, to indicate the levels of care that best describe the core services provided. 82% stated that they provide level 7, medical care and rehabilitation, and 75%, level 8, rehabilitation for complex disabling condition.

Figure 11.6.2: Levels of care (organisational level audit)



Modified Barthel Index

The average total score on the Modified Barthel Index (MBI) on admission was 57 points and on discharge, 77 points. On average then, service users had moved from a moderate dependency level to a mild dependency level. Analysis of the movement in scores for the 10 component items making up the MBI showed that, on average, improvement had been made on all items with the exception of feeding where the score was already high (on average 9, with 10 equating to "fully independent") and wheelchair, where the score remained at 3,"moderate help provided".

Patient pathways

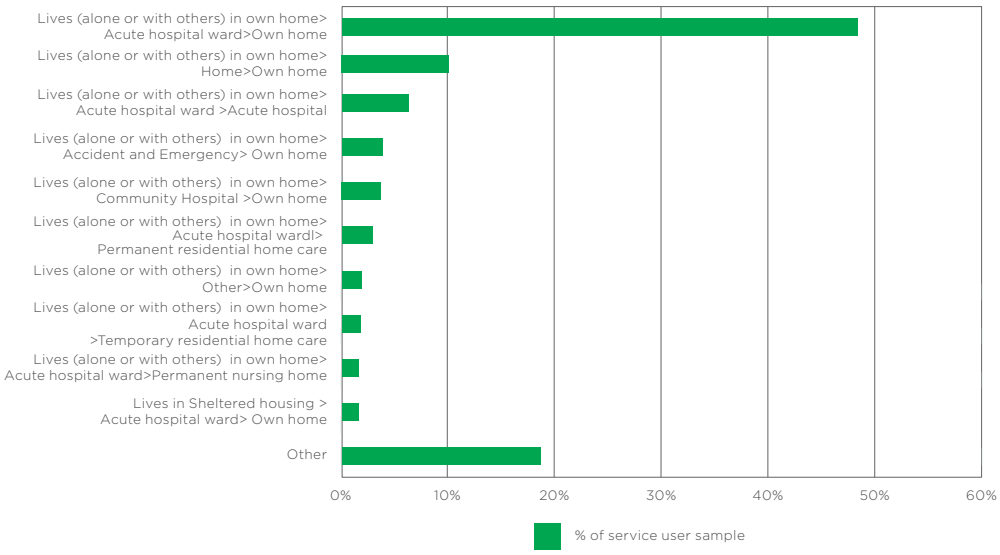
The pathway for each service user was mapped from:

- the service user's previous address i.e. before the entire episode of care; to
- the pre-intermediate care location; to
- 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 an intermediate care bed and then back home (48.2%) (figure 11.6.3). Use of bed based services for admission avoidance was less common with 10% following a pathway from home to intermediate care bed and back home afterwards.

Overall, 72.5% of service users went home after intermediate care and 9.6% went back to acute care, 7.3% to residential care, 3.5% to nursing home care, 3.0% to sheltered housing and 2.5% died.

Figure 11.6.3: Pathways for service users in bed based services



As a proxy outcome measure the service user's location before the entire episode of care (normal living arrangement) was compared with the final location. The outcome was then coded as follows:

= dependency of setting increased (e.g. home to acute care)

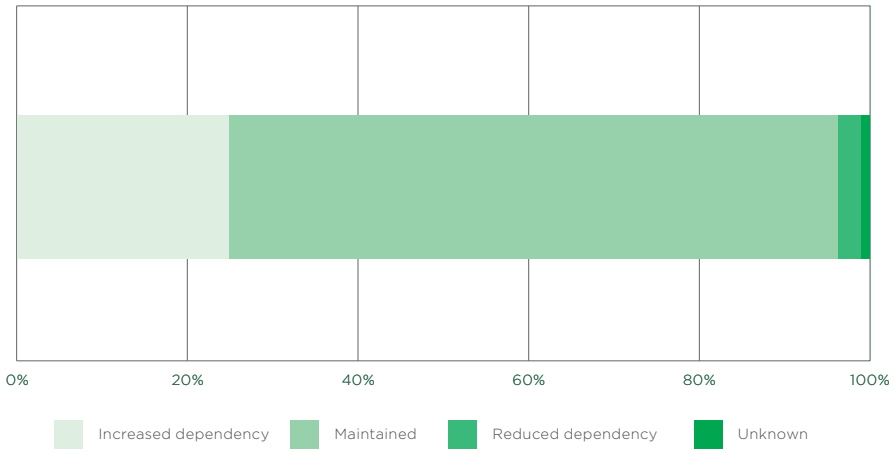
= dependency of setting maintained (e.g. home to home)

= dependency of setting reduced (e.g. residential home to living with family)

= Unknown

The analysis showed 72% of bed based service users maintained their level of independence (measured as their type of care setting) and 24% moved to a more dependent setting. This is the same result as for NAIC 2012.

Figure 11.6.4: Pathway dependency outcome for service user sample



11.7: Commentary: Bed based intermediate care services

Quality of service provision

Patient experience

As for home based services, although scores on the patient experience questions are generally good, there are areas for improvement highlighted by the PREM survey. 9.6% of service users stated the room or ward was "fairly clean" rather than "very clean" and 9.7% responded "not enough" to the question on involvement in decision making about their care. It is concerning that 5.5% responded "yes-sometimes" (rather than "yes-always") and 1.1% "no" when asked whether they were treated with dignity and respect. Services will be able to review the individual responses received from their own service users using the online tool which may highlight particular issues that require addressing locally.

Service user outcomes

The results of both the Modified Barthel Index and the levels of care suggest an overall picture of positive clinical outcomes for service users. As for the PREM, services will be able to review their own results at the individual service user level via the online tool. The levels of care data can be used to give an indication of the acuity of the caseload of each service compared to the national average. The patient pathway data can additionally be used as a proxy outcome measure. Given the age profile and co-morbidities present in the service user cohort (NAIC 2012), the high proportion of service users maintained at home is reassuring.

Waiting times.

The average waiting time from referral to assessment for bed based services of 1.3 days appears reasonable overall, although some very high waiting times are recorded in a small number of services. The mean average time from assessment to commencement of services of 2.1 days, with 20% of services at 4 days or more, is concerning given that, referral sources suggest, many of these service users will be waiting in an acute hospital bed. These delays may be the result of process and/or capacity issues, but represent a lost opportunity to reduce hospital lengths of stay, as well as creating a poor care experience for service users that may impact on the effectiveness of their rehabilitation.

Appropriateness of skill mix to clinical needs

The nursing ratios are in line with Royal College of Nursing recommendations for basic, safe care but below those recommended for ideal good, quality care. As for home based services, the data suggests mental health workers are rarely included in the establishment in intermediate care teams. Although 94% of bed based services state that they can accept service users with mild to moderate dementia, only 65% report that all members of the team received training in mental health and dementia care (section 6.3). Social care is represented in the workforce but makes up only 6.2% of the staff in bed based services. The gold standard for effective frailty management is the process known as "comprehensive geriatric assessment" (CGA) which is known to reduce mortality, institutionalisation and hospital admission, and which requires a fully staffed interdisciplinary team (*British Geriatrics Society. Comprehensive Assessment of the frail Older Patient.* BGS, 2010). Given the uneven and incomplete nature of the teams suggested by the skill mix data from the audit, it is possible that the full benefits of CGA are not being realised and that outcomes could be better if more complete teams were in place routinely. The recently published Francis Report (*The Mid Staffordshire NHS Foundation Trust Public Inquiry chaired by Robert Francis QC,* HC 947, 2013) has emphasised the importance of appropriate staffing levels and skill mix.

Capacity of intermediate care

Balance of step up and down provision The NAIC 2012 findings raised the question of whether there is sufficient bed based step up capacity in the system to make an impact on secondary care emergency admissions (NAIC 2012). Most bed based services (84%) use their capacity flexibly between step up and step down and the 2013 results for both the organisational and service user levels of the audit suggest further pressure to fill beds with service users stepping down from hospital potentially making access for admission avoidance (step up) even more difficult.

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 evidence supports that view that access to beds for admission avoidance is becoming increasingly difficult.

Efficient use of resources

Costs
Costs per occupied bed day and per service user have increased in 2013 although bed occupancy and length of stay are similar to last year, suggesting unit costs have increased compared to the NAIC 2012 sample. The increase appears to be due to the change in mix of bed based settings with a greater proportion of more expensive settings, Local Authority facilities and standalone intermediate care facilities, in this year's audit.

Throughput of service users
The cost per service user in 2012/13 was £5,218 and will be affected by the length of stay in the 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://www.nhsbenchmarking.nhs.uk/National-Audit-of-Intermediate-Care/year-two.php. As noted for home based services, 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.

Staffing levels
The staff level data (clinical wte per bed based services) is a measure of the intensity of resources utilised within an intermediate care service. Staffing levels have increased in 2013, which may be due to the change in mix of types of bed based setting noted above. As for home based services, providers need to consider their position on this metric in the light of their position on productivity/ use of resources measures. Performance on outcome measures will be a key factor in determining appropriate staffing levels.

Length of stay
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". A small number of services (6) reported an average length of stay of 42 days or more. The service user level audit also highlights a considerable proportion of service users with excessive lengths of stay (section 11.5). Long lengths of stay may impact on throughput and hence the ability of the service to make an impact on secondary care utilisation.

Progress with integration

Performance reporting
As for home based intermediate care services, the level of reporting to Local Authority commissioners as well as CCG commissioners is encouraging, suggesting positive steps towards closer working between health and social care.

12: Results: Re-ablement services

12.1: Introduction

Re-ablement services are included in the audit for the first time in 2013. For the purposes of the audit, this service category was defined by the following key features:

- **Setting:**
  Community based services provided to service users in their own home/care home.
- **Aim of service:**
  Helping people recover skills and confidence to live at home, maximising their level of independence so that their need for on going homecare support can be appropriately minimised.
- **Period:**
  Interventions for the majority of service users will last up to six weeks (though there will be individual exceptions).
- **Workforce:**
  MDT but predominantly social care professionals.
- **Includes:**
  Home care re-ablement services.
- **Excludes:**
  Social care services providing long term care packages.

There was some discussion in the Steering Group and wider Participant Reference Group as to whether re-ablement should be included as part of home based intermediate care services or as a separate service category. It was decided to define a separate service category for 2013 but to review this following completion of the audit. This decision was based on the following suppositions:

- Anecdotally, it appeared many re-ablement services still operate as separate services or separate teams within a wider intermediate care service
- Re-ablement services do not use the same currency for counting activity, tending to use "contact hours" rather than "contacts" as in predominantly health home based services (Department of Health, Care Services Efficiency Delivery (CSED) *Homecare Re-ablement; Prospective Longitudinal Study Final Report,* DH 2010).

The first supposition was tested with a question in the audit. 57% of the re-ablement services completing the audit stated the service was integral to an intermediate care service with staff operating and managed within an intermediate care team. The remaining 43% are in separate teams. This suggests there is not one model for service categorisation which will currently fit all local service configurations, so that any route taken will inevitably be a compromise. However, it should be noted that respondents were generally able to split out their re-ablement activity, finance and workforce.

The following section provides the audit results for re-ablement services. 49 re-ablement services responded to the organisational level audit.

In addition to the organisational level audit, re-ablement services took part in the Patient Reported Experience Measure (PREM) audit, using the "home" version of the PREM form. The PREM audit is a new development for this year aimed at provided a standardised quality measure for intermediate care/re-ablement services. The development of the PREM form is described in section 4.3 above. 1,644 completed PREM forms were received back directly from service users of 48 re-ablement services. The results are included in table 12.5.1 below.

12.2: Results: Re-ablement services: Service characteristics

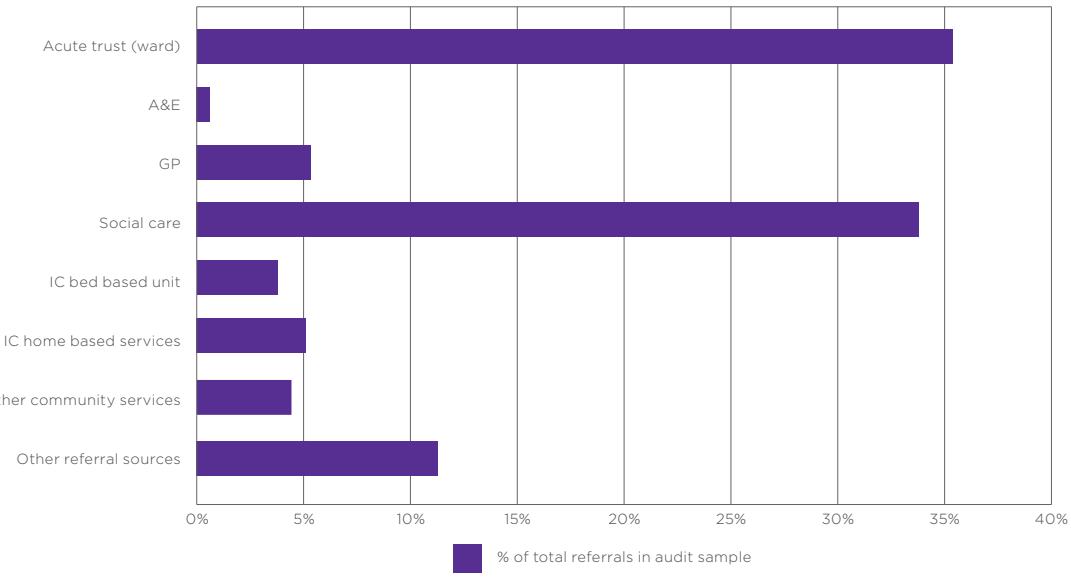
Service model

45% of re-ablement services reported operating an intake model, accepting all homecare referrals for an initial period of re-ablement. 45% use a selective model, applying referral criteria which are more selective, for example, discharge support. Services using an intake model may operate on a much larger scale than selective services and this is one reason for the large variation in activity noted in section 12.3 below.

Referral sources

The largest source of referrals into re-ablement services was from acute trusts (wards) (35%), closely followed by referrals from social care (34%). Referrals from A&E accounted for less than 1% of the total.

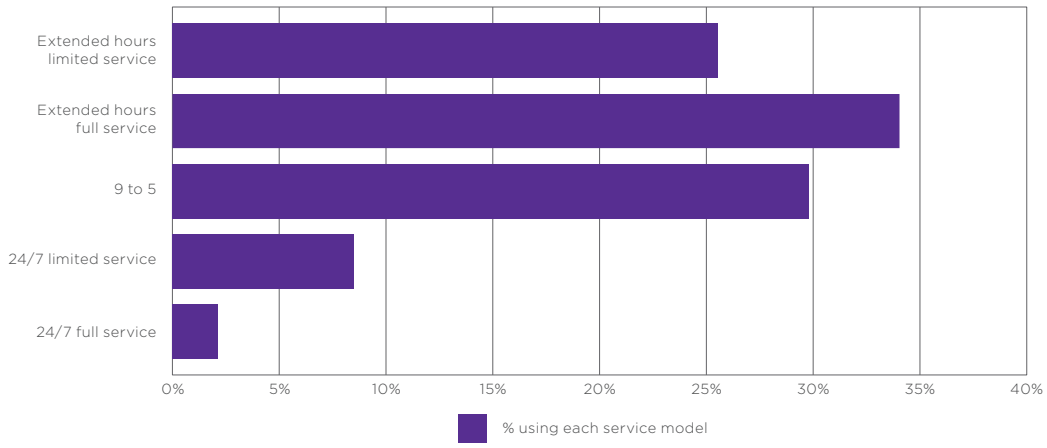
Figure 12.2.1: Source of referrals (re-ablement services)



Service accessibility

"Extended hours full service" was the most frequently cited model for re-ablement services (by 34% of respondents), closely followed by "9 to 5" (30%) (see figure 12.2.2 below). "Extended hours" means earlier than 9am and /or later than 5pm but not 24/7. 85% of services are open 365 days a year, with a further 11% open every day except weekends and bank holidays.

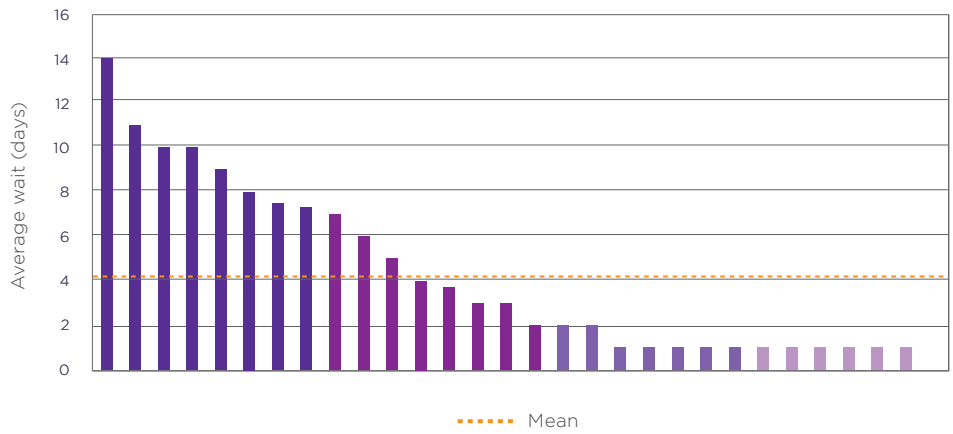
Figure 12.2.2: Hours open to new admissions (re-ablement services)



Waiting times

The mean average waiting time from referral to assessment for re-ablement services was 4.2 days and the median value, 2.5 days (including 1 respondent stating a waiting time of zero days). 15 services (out of a total of 30 respondents) reported an average waiting time of 3 days or more.

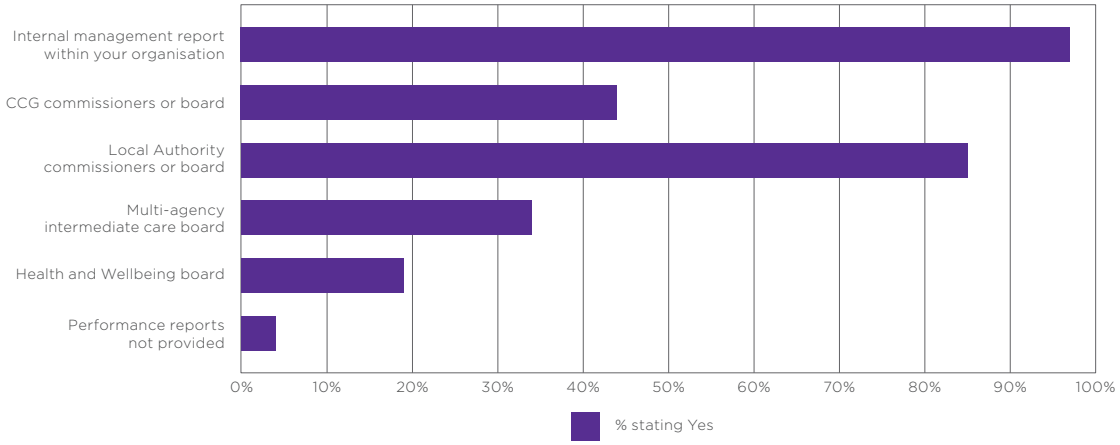
Figure 12.2.3: Average waiting time referral to assessment (re-ablement services)



Performance reporting

A new question on performance reporting was added this year to ascertain where services reported to. The purpose of this question was to gauge the flow of information across the local health and social care system. The results for re-ablement services are shown in figure 12.2.4 below.

Figure 12.2.4: Performance reporting (re-ablement services)

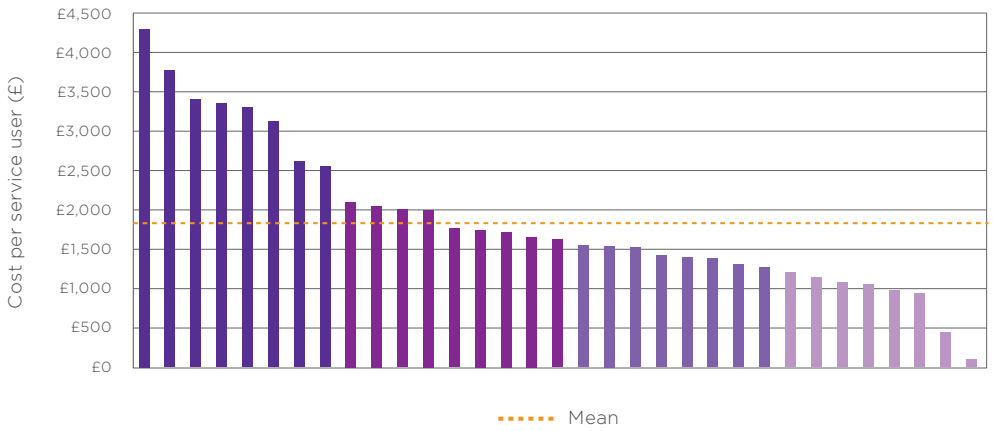


12.3: Results: Re-ablement services: Use of resources

Unit costs

For re-ablement services the cost per service user was calculated by dividing the total service budget for 2012/13 by the number of individual service users accepted into the service in the period. Data was available for 33 re-ablement services. The mean was £1,850 per service user. This is greater than the mean cost per service user of home based intermediate care of £1,134.

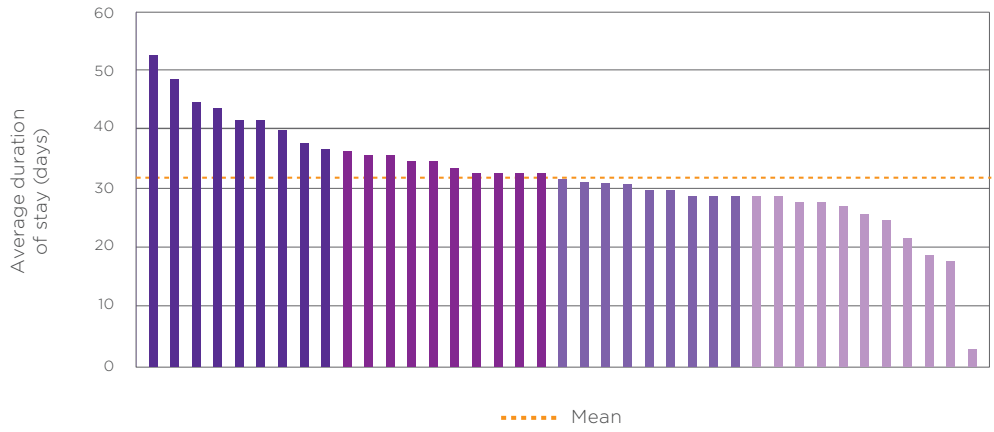
Figure 12.3.1: Cost per service user re-ablement services



Average duration of stay

For re-ablement services, the average duration of stay was provided by 39 services. The mean for 2012/13 was 32.4 days, slightly longer than home based services (28.5 days). The mean reported for 2011/12 was 32.9 days.

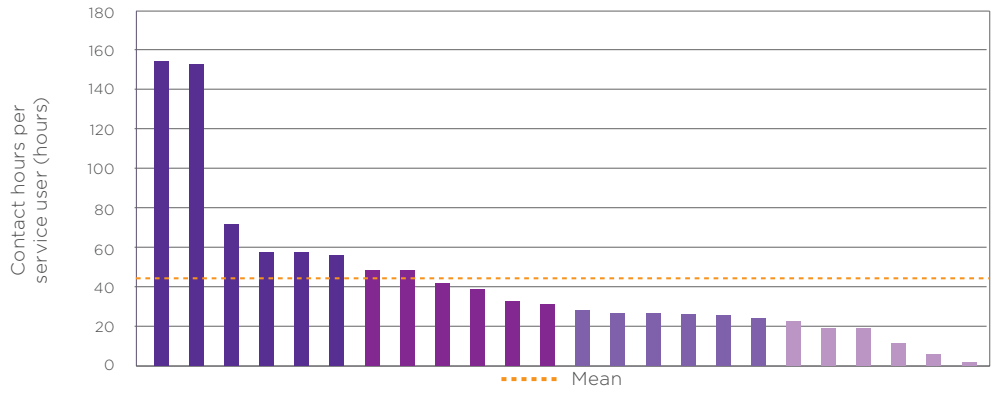
Figure 12.3.2: Average duration of stay (re-ablement services)



Intensity of input and productivity

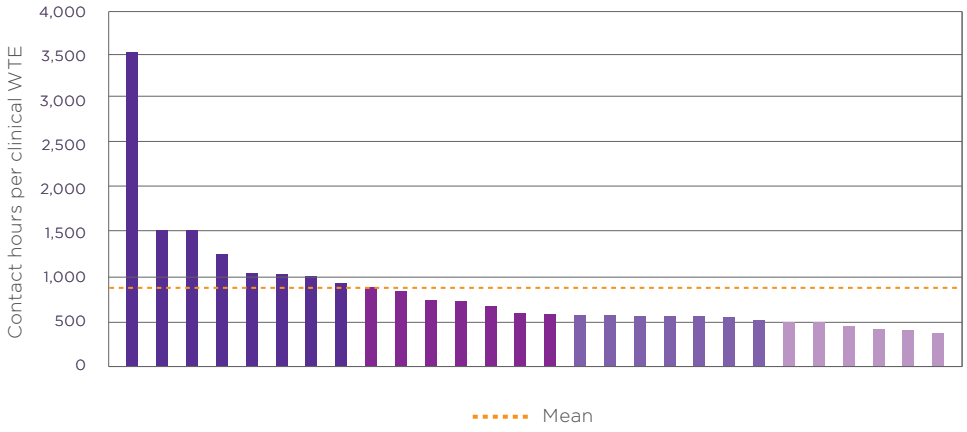
The contact hours per service user was calculated as a measure of the intensity of input of re-ablement services, the mean was 42 contact hours. The results showed wide variation (figure 12.3.3).

Figure 12.3.3: : Contact hours per service user in re-ablement services



For re-ablement services, the number of contact hours per wte per annum (excluding management and administrative staff) was calculated as a measure of productivity. The mean value was 835 contact hours per wte and median, 591.

Figure 12.3.4: Contact hours per WTE

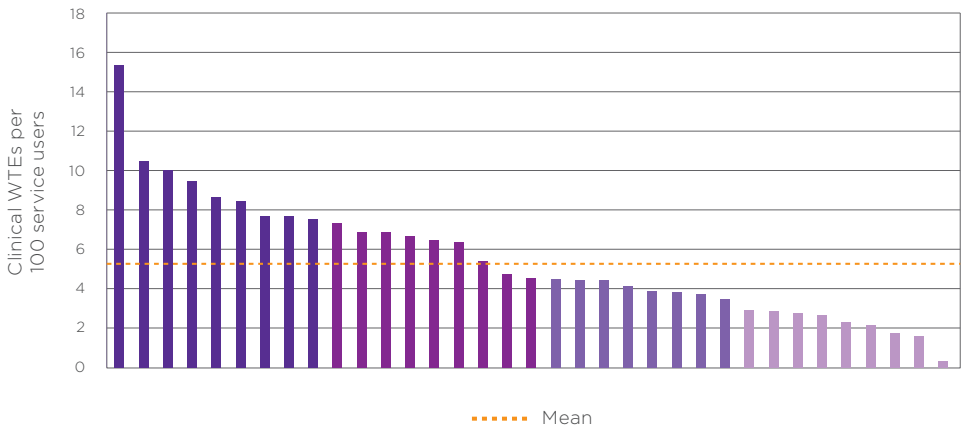


12.4: Results: Re-ablement services: Workforce

Staffing levels

For re-ablement services the number of wtes (excluding management and administrative staff) per 100 service users was calculated (figure 12.4.1). Data was provided for 35 re-ablement services. The mean was 5.5 wte per 100 service users.

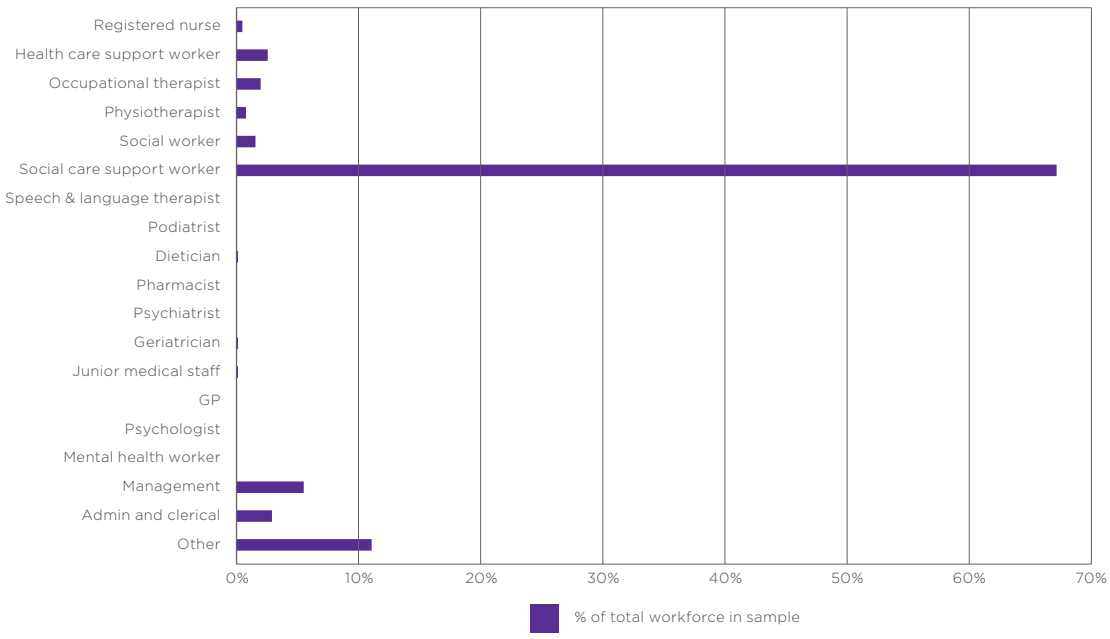
Figure 12.4.1: WTE per 100 service users (re-ablement services)



Mix of disciplines

As would be expected, social care support workers are the largest staff discipline included in re-ablement teams (67.6%). It should be noted that the high proportion of social care workers may be due to the way participants were asked to complete the audit by splitting out the re-ablement element of services where they were integrated. Health care support workers make up 3.1% of staff in re-ablement services, registered nurses 0.6%, physiotherapists 0.9% and occupational therapists 2.4%. Geriatricians and junior medical staff together accounted for 0.1%.

Figure 12.4.2: Mix of disciplines within re-ablement services

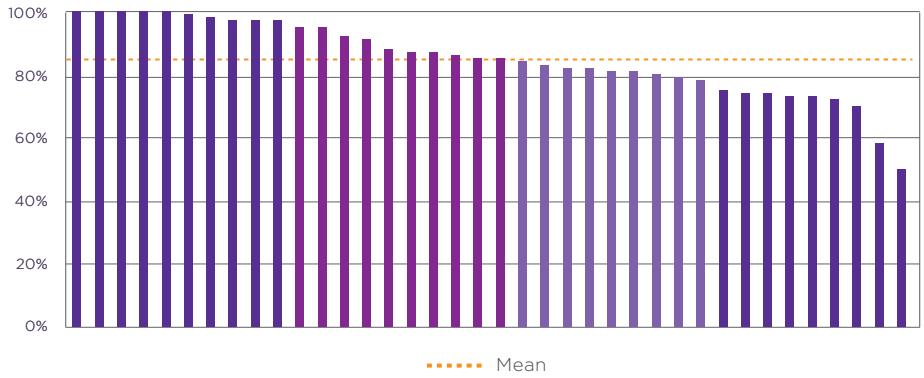


12.5: Results: Re-ablement services: Quality and outcomes

Re-ablement outcome measures

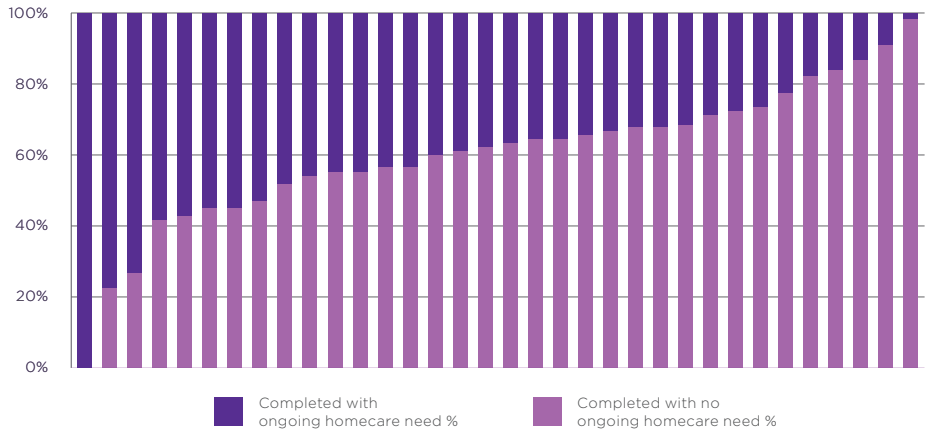
The mean percentage of service users completing re-ablement was 85%, with the range from 50% to 100%.

Figure 12.5.1: % of services users completing re-ablement



The mean percentage of service users completing re-ablement with no ongoing homecare need was 61%, with the sample again showing wide variation.

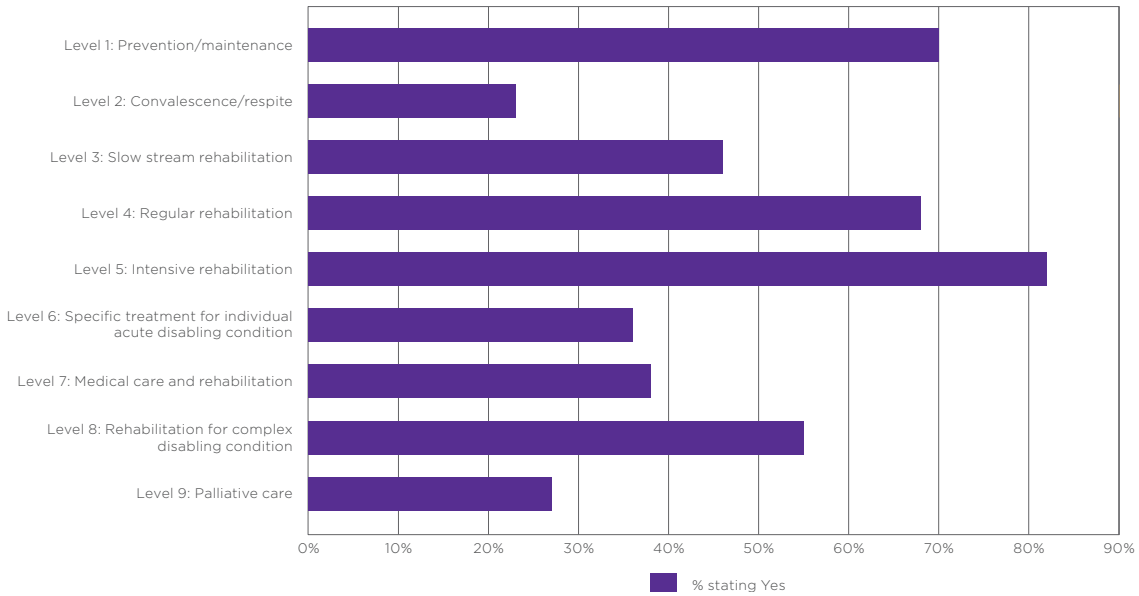
Figure 12.5.2: Re-ablement outcomes



Levels of care

In the organisational level of the audit, re-ablement services were asked to indicate the levels of care that best describe the core services provided. The levels of care definitions provided to participants are included at Appendix four. The results show 55% of services state that they provide the highest level of care, rehabilitation for complex disabling conditions, (excluding Level 9, Palliative Care).

Figure 12.5.3: Levels of care (re-ablement services)



PREM results

This section provides the results of the PREM for re-ablement services. 1,644 completed PREM forms were received from service users in 48 services. As explained in section 4.3, where the development of the PREM is described, the same version of the PREM form was used for home based intermediate care and re-ablement services.

The collated responses were as follows:

Table 12.5.1: PREM results for re-ablement services

PREM question	Responses (% ticking each option given)				
The length of time I had to wait for my care from the community team to start was reasonable.	Yes	No	Not answered		
	95.6%	2.9%	1.5%		
The staff that cared for me at home had been given all the necessary information about my condition or illness from the person who referred me.	Yes	Don't know	No	Not answered	
	82.9%	12.2%	3.5%	1.7%	
I was aware of what we were aiming to achieve e.g. to be mobile at home, to be independent at home, to be able to go out shopping, to understand my health better.	Yes	No	Not answered		
	94.3%	3.5%	0.0%		
I was involved in setting these aims.	Yes - always	Yes - sometimes	No	Not answered	
	75.4%	17.6%	4.4%	2.7%	
The staff let me know how to contact them if I needed to.	Yes - always	Yes - sometimes	No	Not answered	
	84.8%	8.5%	4.7%	2.0%	
The appointment times/visit times by staff were convenient for me.	Yes - always	Yes - sometimes	No	Not answered	
	74.6%	21.1%	2.7%	1.6%	
When I had important questions to ask the staff they were answered well enough.	Yes - always	Yes - sometimes	I had no need to ask	No	Not answered
	73.7%	11.9%	11.6%	1.1%	1.6%
I had confidence and trust in the staff treating or supporting me.	Yes- always	Yes - sometimes	No	Not answered	
	90.9%	6.7%	1.0%	1.4%	

I was given enough information about my condition or treatment.	The right amount	Too much	Not enough	Not answered	
	83.2%	0.6%	10.8%	5.5%	
I felt involved in decisions about when my care from the community team was going to stop.	Yes - definitely	Yes – to some extent	I did not need to be involved	No	Not answered
	61.6%	23.1%	4.7%	6.5%	4.1%
I was given enough notice about when my care from the community team was going to stop.	Yes definitely	Yes - to some extent	No	Not answered	
	69.3%	18.6%	7.4%	4.7%	
Staff gave my family or someone close to me all the information they needed to help care for me.	Yes - definitely	Yes – to some extent	I did not want or need them to	No	Not answered
	59.6%	14.7%	16.4%	5.2%	4.1%
Staff discussed with me whether additional equipment or adaptions were required to support me living at home.	Yes	No – it was not necessary to discuss it	No – but I would have liked them to	Not answered	
	76.3%	16.3%	4.6%	2.7%	
Staff discussed with me whether I needed any further health or social care services after this service stopped. (e.g. services from a GP, physiotherapist or community nurse, or assistance from social services or the voluntary sector)	Yes	No – it was not applicable	No – but I would have liked them to	Not answered	
	66.2%	21.4%	9.6%	2.8%	
Overall, I felt I was treated with respect and dignity while I was receiving my care from this service.	Yes - always	Yes – some times	No	Not answered	
	93.9%	3.9%	0.6%	1.6%	

PREM open question (re-ablement services)

An additional narrative question – "Please would you tell us one thing we could improve that would have made our service better for you" – was asked at the end of the re-ablement services' PREM. Whilst the resultant analysis has suggested that there were far more compliments and thanks expressed than complaints or issues for improvement (60% of all service users having completed this additional narrative question), just over 40% made a suggestion for improvement of the service. For re-ablement services, these fall within the following broad categories (please note – these are verbatim quotes from service users):

Timing of visits unpredictable (not notified if running late):

- 'Very disappointed in call times as these varied greatly from day to day'
- 'system for making appointments to fit aids – at least a.m. or p.m. not waiting all day'

Timing of visits inappropriate or inconvenient:

- 'Not to come at 7pm for bedtime'
- 'Lunch visits, not at lunch time'

Lack of continuity of carers, and no name badges:

- '13 different carers over the six weeks'

Having to wait for the service to start (poor coordination with other services):

- 'It would have been helpful if their visits had began sooner after I had been discharged from hospital'

Poor communication:

- 'there should be some contact between carers/GP on future treatments and care'

Service stopping too early, often without prior warning:

- 'Care was stopped without any notice'.
- 'Don't put a time limit on peoples recovery everyone is different!! I still need help!!'

Gender of care staff inappropriate:

- 'Because I refused a male carer, I was without help 7 days of the 6 weeks. I think this is quite wrong to expect an elderly/ old lady like me to get naked in front of a strange man'

Lack of support in accessing continuing care for on-going needs, and lack of follow-up to assess need for readmission:

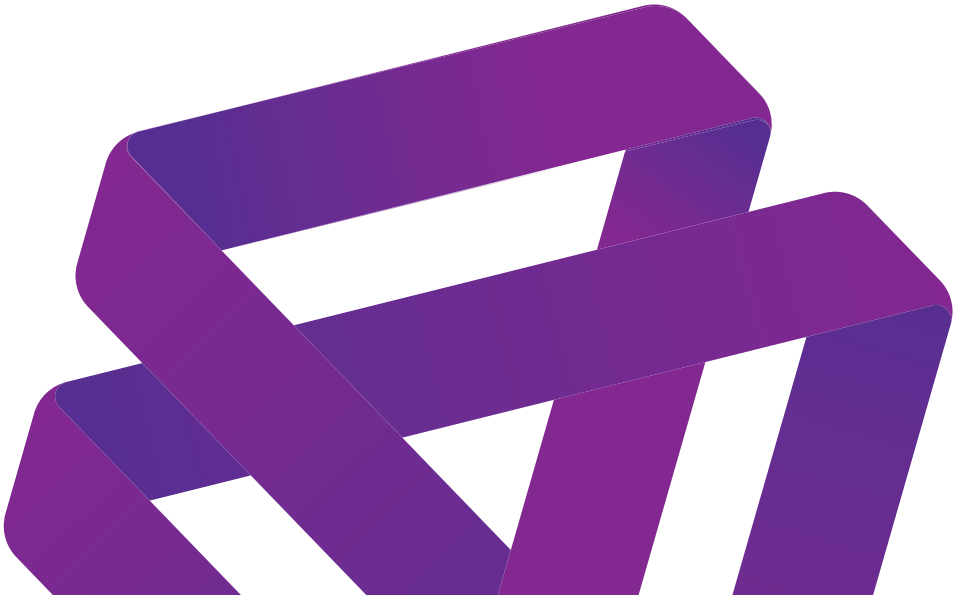
- 'I am left helpless I need help please'
- 'Before stopping their six weeks care service for me, they should have reviewed the service and refer permanent carer for an amputated man like me'

Lack of support in accessing help for unmet needs e.g. shopping (no food in the house on discharge from acute/residential care), cleaning, laundry etc.

- Some respondents wanted help with bathing, which was not forthcoming

Being treated without dignity or respect:

- 'provide more courses for your staff as they lack experience. I.e. communication skills, good manners. How to be helpful'



12.6: Commentary: Re-ablement services

Quality of service provision

Patient experience

In terms of being involved in setting aims for re-ablement interventions, only 75.4% responded "yes – always", suggesting that re-ablement teams ought to be more proactively engaging service users in setting goals for their re-ablement interventions. Only 69.3% said they were given enough notice about when care from the team would be ceasing, which suggests that service user expectations from re-ablement services may not concur with the 6 week time limit for services. As service users may well be expected to pay for on-going social care at home after this date, services should be giving service users adequate notice of cessation. Services will be able to review the individual responses received from their own service users using the online tool which may highlight particular issues that require addressing locally.

Waiting times

Despite the fact that 95.6% of service users stated that the length of time they waited for the service to start was reasonable, the mean waiting time from referral to assessment appears high, with half of services in the sample, reporting a waiting times of 3 days or more. As noted above, evidence suggests there is a short window for rehabilitation to be effective and, given that around one third of these service users are coming from acute wards, the delays represents a potentially significant waste of secondary care capacity.

Medical cover

The data suggests medical cover is not included within establishments in re-ablement services. Further, under quality standards section 6.3, only 34% of re-ablement services stated that they have quick and easy access to specialist elderly care/geriatric assessment. However, 55% of re-ablement services have reported that they provide services for service users with Level 8, "Client needs rehabilitation for complex disabling condition", needs on the Levels of Care scale (section 12.5). This raises a concern as to whether the medical needs of service users within re-ablement services are being adequately addressed.

Appropriateness of staff mix to clinical needs

Disciplines other than social care appear poorly represented in re-ablement services, although this may reflect the way participants were asked to complete the audit. For the teams that are integral to wider intermediate care (57%), other disciplines may be accessed through the wider multi-disciplinary team. However, for the 43% of re-ablement teams that operate separately, this data may indicate a lack of access to health disciplines such as therapies.

Efficient use of resources

Intensity of input

The analysis suggests re-ablement services work more intensively with service users averaging 42 "contact hours" compared to 12 "contacts" in home based intermediate care. It would be useful to collect data on the average length of a "contact" in order to test this hypothesis more accurately. The higher number of wtes per 100 service users in re-ablement (5.5 wtes compared to 2.8 in home based services - section 12.4) also supports this analysis, assuming productivity levels are similar.

Unit costs

The higher costs per service user for re-ablement (£1,850 compared to £1,134 per service user for home based services, section 10.3) are consistent with the greater intensity of input and higher number of staff per service user discussed above. However, the impact of higher staff numbers on unit costs is mitigated by the lower cost of the staff, who are typically social care support workers.

Progress with integration

Performance reporting

Less than half (44%) of respondents are providing performance reports to CCG commissioners, which seems low given that 57% of services are working within a wider intermediate care service.

13: Audit developments

13.1: Future iterations

It is intended that there be a further iteration of the National Audit of Intermediate Care in 2014.

The focus of next year's audit will be considered by the Steering Group following feedback received at the National Conference on 13th November 2013, in addition to feedback received from the helplines and from participant feedback forms. Key themes for consideration now emerging include:

- Whether the separation of Crisis Response services has been successful or whether this is capturing too disparate a group of services
- How best to manage the increasing integration between home based intermediate care and re-ablement services
- The content of the service user questionnaire, in particular the choice of clinical outcome measures
- How engagement in the use of the home based PREM could be increased
- How involvement of Local Authorities in the audit could be increased
- How the involvement of Wales, Scotland and Northern Ireland in the audit could be increased.

13.2: Literature review

A literature review was undertaken to explore the relationship between different team characteristics and patient outcomes in intermediate care (Smith, Harrop, Enderby and Fowler-Davies. *Exploring Differences between Different Intermediate Care Configurations. A Review of the Literature, 2013).*

The literature review (see section 4.5 for explanation of the methodology) identified very few empirical studies that examined specific team level factors associated with better patient care. However, there is substantial literature related to specific chronic conditions, or detailing developments of services and reporting patient experience. Whilst this literature is lower on the scale of evidence, it has been incorporated into the review to assist in a synthesis to extend our understanding of what ingredients contribute to best care in the intermediate care setting.

Studies using a quantitative methodology found a positive impact of the delivery of care by inter-professional (IP) or interdisciplinary teams (IDT); increased shared working which involved higher proportions of support staff, the use of integrated care facilitators, comprehensive assessment and disciplines working effectively in teams were all factors associated with a reduction in length of stay, costs of care and emergency admissions.

Studies using qualitative methodologies supported these findings, reporting that an interdisciplinary team approach to intermediate care was perceived as producing better outcomes for patients and improving staff satisfaction. Team factors contributing to improved outcomes included: team composition, team tenure, regular team meetings, task allocation, cohesiveness, open communication, collaborative team working, multidisciplinary rounds, supervision, education and training, leadership, a holistic approach to care, and strong interpersonal relationships. Rotation, separate location of team members, constant change to services and risk aversion of staff were identified as potential confounding factors.

The findings of the literature review suggest there may be value in looking at team characteristics such as the balance between support and qualified staff in more detail in future iterations of the audit.

The full literature review can be downloaded from *www.nhsbenchmarking.nhs.uk/National-Audit-of-Intermediate-Care/year-two.php*.

14: Acknowledgements

The National Audit of Intermediate Care is a subscription audit managed by the NHS Benchmarking Network working in partnership with 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, the Patients Association and the Royal College of Speech and Language Therapists.

We would like to express our thanks to East London NHS Foundation Trust who host the NHS Benchmarking Network and Cheshire & Merseyside CSU who provided Finance and IT support to the audit on behalf of the Network. Also thanks to Webweavers Design Solutions for work on the web based data entry tool (contact: jackie@webweaversdesigns.co.uk).

We would like to thank Gary Slegg, Research Programme Manager, Academic Unit of Elderly Care and Rehabilitation, Bradford Institute for Health Research, for developing the PREM questionnaires with the NAIC Steering Group, for both the bed and the home based intermediate care services. Also thanks to the Patient Ambassadors from the Patients Association who gave us valuable comments on the PREM questions as they were being developed.

Thanks also to the Picker Institute which provided examples of their patient questionnaires which are widely in use in the NHS, to assist with the development of the intermediate care PREMs.

Thank you to Professor Pam Enderby and Dr Steven Ariss of the University of Sheffield for instigating the PREM open question and undertaking the analysis of the text responses.

Many thanks are extended to the three Service User questionnaire Pilot sites – Manchester Intermediate Care Services, Central Manchester NHS Foundation Trust, Bolton Intermediate Care Services, Bolton NHS Foundation Trust and Halton's Rapid Access and Rehabilitation Service (RARS), Halton Borough Council – who piloted the service user questionnaire with their patients, and gave the NAIC Steering Group valuable feedback on the design and content of the questionnaire.

The Data Capture Company has helped us greatly with their expertise and experience in administering and capturing the data from the Service User questionnaires and the PREM forms surveys, the first ever attempted on such a large scale in intermediate care services.

Thanks must go to the The Plain English Campaign for assisting us with ensuring the term "intermediate care" is more widely understandable.

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 and particularly in administering the service user questionnaires and PREM forms with patients/service users.

15: Glossary of terms

Term	Definitions
Intermediate care	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. Intermediate care services are time-limited, normally no longer than six weeks and frequently as little as one to two weeks or less. Intermediate care should be available to adults age 18 or over.
Crisis Response Services	Community based services provided to service users in their own home/care home. Crisis response services will usually provide an assessment and some may provide short-term interventions (usually up to 48 hours) with the aim of avoiding hospital admission. Services are usually delivered by the multi-disciplinary team, but predominantly by health professionals.
Bed based services	Bed based intermediate care services are provided within an acute hospital, community hospital, residential care home, nursing home, standalone intermediate care facility, independent sector facility, Local Authority facility or other bed based setting with the aim of preventing unnecessary acute hospital admissions and premature admissions to long term care and/or to receive patients from acute hospital settings for rehabilitation and to support timely discharge from hospital. Services are usually delivered by the multi-disciplinary team, but predominantly by health professionals and carers (in care homes).
Home based services	Community based services provided to service users in their own home/ care home. These services will usually offer assessment and interventions supporting admission avoidance, faster recovery from illness, timely discharge from hospital and maximising independent living. Services are usually delivered by the multi-disciplinary team, but predominantly by health care professionals and carers (in care homes).
Re-ablement services	Community based services provided to service users in their own home/ care home. These services help people recover skills and confidence to live at home and maximise their independence. Services are usually delivered by the multi-disciplinary team, but predominantly by social care professionals.
Step up	Intermediate care function to receive patients from home/community settings to prevent unnecessary acute hospital admissions or premature admissions to long term care.

Term	Definitions
Step down	Intermediate care function to receive patients from acute care for rehabilitation and to support timely discharge from hospital.
Weighted population	The population of a defined geographic area (in this report usually a CCG) adjusted to take account of the need for health services of that population, reflecting age distribution and levels of deprivation in the area.
wtes	Whole time equivalents – a whole time equivalent member of staff works 37.5 hours per week.
National Voices	Registered charity which works with their large and varied membership to influence government ministers and departments, professional bodies, and the key players in the new health and social care landscape, to ensure that policy remains focused on issues which will deliver the greatest impact for those with needs.
Section 75 Agreement	An agreement made under section 75 of National Health Services Act 2006 between a Local Authority and an NHS body in England. Many section 75 agreements were made between Local Authorities and PCT(s), which were abolished at the end of March 2013 and their functions have now been largely assumed by clinical commissioning groups (CCGs). Section 75 agreements can include arrangements for pooling resources and delegating certain NHS and Local Authority health-related functions to the other partner(s) if it would lead to an improvement in the way those functions are exercised. Equivalent provisions for Welsh authorities are contained in section 33 of National Health Service (Wales) Act 2006.
Delphi process	The Delphi process is a forecasting method based on the results of questionnaires sent to a panel of experts. Several rounds of questionnaires are sent out, and the anonymous responses are aggregated and shared with the group after each round. The experts are allowed to adjust their answers in subsequent rounds. Because multiple rounds of questions are asked and because each member of the panel is told what the group thinks as a whole, the Delphi process seeks to reach the "correct" response through consensus.

16: References

Department of Health. *National Service Framework for Older People.* DH, 2001

Department of Health. *National service framework for older people: supporting implementation- intermediate care: moving forward.* DH, 2001

Department of Health. *Intermediate Care: Halfway Home: Updated Guidance for the NHS and Local Authorities.* DH, 2009

Department of Health. *Guidance on the routine collection of Patient Reported Outcome Measures (PROMs).* DH, 2008

Department of Health, *Care Services Efficiency Delivery (CSED) Homecare Re-ablement; Prospective Longitudinal Study Final Report,* DH 2010

Department of Health, *2011-12 PCT Recurrent Revenue Allocations Expositions Book.* DH

Royal College of Nursing. *Safe staffing for older people's wards: RCN summary guidance and recommendations.* RCN, 2012

Federation of Medical Royal Colleges. *Medical aspects of intermediate care: Report of a Working Party,* Federation of Medical Royal Colleges, 2002

Young J, Forster A, Green J, 2003
An estimate of post-acute intermediate care need in an elderly care department for older people

British Geriatrics Society. *Quest for Quality: Inquiry into the quality of healthcare support for older people in care homes: A call for leadership, partnership and quality improvement.* BGS, 2011

National Collaboration for Integrated Care and Support. *Integrated Care and Support: Our Shared Commitment.* May 2013

NHS Benchmarking Network, British Geriatrics Society, The Association of Directors of Adult Social Services, The College of Occupational Therapists Specialist Section for Older People (COTTSS – OP), The Royal College of Physicians, The Royal College of Nursing and AGILE, 2012. *National Audit of Intermediate Care Report* 2012

British Geriatrics Society. *Standards of Medical Care for Older People,* BGS 2007

British Geriatrics Society. *Intermediate Care: Guidance to Commissioners of Health and Social Care.* BGS, 2008

British Geriatrics Society. *Rehabilitation of Older People.* BGS, 2009

British Geriatrics Society. *Comprehensive Assessment of the Frail Older Patient.* BGS, 2010

Enderby P & Stevenson J. *What is Intermediate Care? Looking at Needs. Managing Community Care,* (2000)

Shah, S. *Modified Barthel Index or Barthel Index (Expanded).* In S. Salek. (Ed). *Compendium of quality of life instruments, Part II,* (1998)

Xyrichis, A, Ream, E. (adapted by John, Enderby, Judge and Creer) *Teamwork: A concept analysis. Journal of Advanced Nursing 2008,* 61, 232–241

Enderby, P.M., Ariss, S.M., Smith, S.A., Nancarrow, S.A., Bradburn, M.J., Harrop, D., et al. *Enhancing the Efficiency and Effectiveness of Community Based Services for Older People: a Secondary Analysis to Inform Service Delivery.* NIHR Health Services and Delivery Research Programme; 2012.

Patient Satisfaction Questionnaire (V 1) from the EEEICC study (as referenced above)

Smith, Harrop, Enderby and Fowler-Davies. *Exploring Differences between Different Intermediate Care Configurations. A review of the Literature.*

House of Commons. The Mid Staffordshire NHS Foundation Trust Public Inquiry chaired by Robert Francis QC, HC 947, 2013

Appendix 1: NAIC Steering Group

National Audit of Intermediate Care Steering Group membership:

Chair:
Dr Duncan Forsyth
Consultant Geriatrician
Addenbrooke's Hospital
Cambridge University Hospitals NHS FT

Olive Carroll
Association of Directors of Adult Social Services
Director of Personal Social Care
Lancashire County Council

Joanne Crewe
Operational Director - Acute and Cancer Care
Harrogate and District NHS Foundation Trust

Tim Curry
Older People's Advisor
Royal College of Nursing

Heather Eardley
National Projects Director
The Patients Association

Professor Pam Enderby
Professor of Community Rehabilitation
University of Sheffield

Professor John Gladman
Professor of Medicine of Older People
Queen's Medical Centre
Nottingham

Debbie Hibbert
Project Manager for National Audit of Intermediate Care
NHS Benchmarking Network

Claire Holditch
Project Director for National Audit of Intermediate Care
NHS Benchmarking Network

Stephen John
Association of Directors of Adult Social Services
Assistant Director, Adult Social Care
Education, Care & Health Services
Bromley Council

Vicky Johnston
Clinical Lead for Admission Prevention Services
East Coast Community Healthcare CIC
Chair of AGILE, Chartered Physiotherapists working with Older People

Joanna Gough
Scientific Officer, British Geriatrics Society

Cynthia Murphy
Intermediate Care Co-Lead and Vice Chair COTSS-OP
College of Occupational Therapists, Specialist Section Older People

Damon Palmer
Department of Health Policy Lead for Health & Social Care Integration (currently on secondment to Greater Manchester Integrated Care Programme)

Dr Louise Robinson
Professor of Primary Care and Ageing, Newcastle University
RCGP clinical champion for dementia

Dr Kevin Stewart
Geriatrician, Hampshire Hospitals Foundation Trust
Clinical Director, Clinical Effectiveness & Evaluation, Royal College of Physicians of London

Michael Thomas-Sam
Association of Directors of Adult Social Services
Strategic Business Adviser (Families and Social Care), Policy & Strategic Relationships - Business Strategy, Kent County Council

Professor John Young
Clinical Director for the Frail Elderly and Integration
NHS England

Appendix 2: NAIC Participant Reference Group

NAIC Participant Reference Group membership:

Elizabeth Teale
Consultant Geriatrician &
Clinical Senior Lecturer
Bradford Institute for Health Research

Sarah Saych
Commissioner
West Sussex County Council

Anita Porter
Commissioning, Policy & Planning Officer
Durham County Council

Kayleigh Buckley,
Intermediate Care Lead,
Salford Royal Hospitals NHSFT

Natasha Arnold
Consultant Geriatrician & Intermediate Care Lead
Homerton University Hospital NHSFT

Damian Nolan
Divisional Manager – Intermediate Care
Halton Borough Council

Adrian Crook
Head of Service, Central Manchester Intermediate Care, Discharge Services, Falls and Funded Care Service
Central Manchester NHS Foundation Trust

Appendix 3: Service category definitions

The following table was supplied to audit participants to enable them to categorise services in the audit.

IC function	Setting	Aim	Period	Workforce	Includes	Excludes
Crisis response	Community based services provided to service users in their own home/ care home	Assessment and short term interventions to avoid hospital admission	Interventions for the majority of service users will last up to 48 hours or two working days (if longer interventions are provided the service should be included under home based IC)	MDT but predominantly health professionals	Intermediate care assessment teams, rapid response and crisis resolution	Mental health crisis resolution services, community matrons/active case management teams
Home based rehabilitation	Community based services provided to service users in their own home/ care home	Intermediate care assessment and interventions supporting admission avoidance, faster recovery from illness, timely discharge from hospital and maximising independent living	Interventions for the majority of service users will last up to six weeks (though there will be individual exceptions)	MDT but predominantly health professionals and carers (in care homes)	Intermediate care rehabilitation	Single condition rehabilitation (e.g. stroke), early supported discharge, general district nursing services, mental health rehabilitation/ intermediate care
Bed based	Service is provided within an acute hospital, community hospital, residential care home, nursing home, standalone intermediate care facility, independent sector facility, Local Authority facility or other bed based setting	Prevention of unnecessary acute hospital admissions and premature admissions to long term care and/or to receive patients from acute hospital settings for rehabilitation and to support timely discharge from hospital	Interventions for the majority of service users will last up to six weeks (though there will be individual exceptions)	MDT but predominantly health professionals and carers (in care homes)	Intermediate care bed based services	Single condition rehabilitation (e.g. stroke) units, general community hospital beds not designated as intermediate care/rehabilitation, mental health rehabilitation beds
Re-ablement	Community based services provided to service users in their own home/ care home	Helping people recover skills and confidence to live at home, maximising their level of independence so that their need for on-going homecare support can be appropriately minimised	Interventions for the majority of service users will last up to six weeks (though there will be individual exceptions)	MDT but predominantly social care professionals	Home care re-ablement services	Social care services providing long term care packages

Appendix 4: Levels of Care

The following definitions for Levels of Care were provided to participants.

0	**Client does not need any intervention**
1	**Client needs prevention / maintenance programme** Needs monitoring and advice not active rehabilitation
2	**Client needs convalescence** Needs time to recuperate with encouragement and advice not active rehabilitation
3	**Client needs slow stream rehabilitation** Needs watchful waiting, assessment or non-intensive rehabilitation/mobilisation
4	**Client needs regular rehabilitation programme** Needs rehabilitation once or twice a week to maintain steady progress
5	**Client needs intensive rehabilitation** Needs, and can benefit from, rehabilitation every day
6	**Client needs a specific treatment for individual acute disabling condition** Needs specific treatment, for example wound care or PEG feeding
7	**Client needs medical care and rehabilitation** Needs medical care to stabilise one condition such as diabetes or Parkinson's Disease alongside/in order to benefit from rehabilitation
8	**Client needs rehabilitation for complex disabling condition** Needs medical care for two or more conditions (may be combination of long term conditions such as COPD, diabetes, chronic heart disease and acute conditions such as fracture) and rehabilitation
9	**Client needs palliative care**

Reference: Enderby P & Stevenson J (2000). What is Intermediate Care? Looking at Needs. Managing Community Care 8(6): 35-40

Appendix 5: Data completeness

Data completeness for the commissioner level audit was as follows:

Section	Number of commissioners contributing to section	Section % completion
Quality Standards: Governance	79	100.0%
Quality Standards: Participation	79	100.0%
Quality Standards: Pathways	79	100.0%
Quality Standards: Performance	79	95.8%
Quality Standards: Strategy	79	100.0%
Services commissioned	81	91.1%
Access criteria	80	100.0%
Funding	75	68.1%
Bed activity	73	63.0%
Home activity	76	54.9%
Re-ablement activity	68	60.1%

Data completeness for the provider level audit was as follows:

Section	Service type	Number of services contributing to section	section % completion
Quality standards: Governance	Bed	165	100%
	Home	122	100%
	Crisis Response	52	100%
	Re-ablement	46	100%
Quality standards: Participation	Bed	165	100%
	Home	122	100%
	Crisis Response	52	100%
	Re-ablement	46	100%
Quality standards: Pathways	Bed	165	100%
	Home	122	100%
	Crisis Response	52	100%
	Re-ablement	46	100%
Quality standards: Performance	Bed	165	100%
	Home	122	100%
	Crisis Response	52	100%
	Re-ablement	46	100%
Quality standards: Resources	Bed	167	100%
	Home	122	100%
	Crisis Response	52	100%
	Re-ablement	46	100%
Quality standards: Workforce	Bed	165	100%
	Home	122	100%
	Crisis Response	52	100%
	Re-ablement	46	100%
Services provided	Bed	169	97.3%
	Home	125	100.0%
	Crisis Response	55	97.3%
	Re-ablement	47	100.0%
Workforce	Bed	164	87.9%
	Home	123	89.7%
	Crisis Response	50	86.4%
	Re-ablement	45	90.3%
Funding	Bed	167	76.9%
	Home	122	81.4%
	Crisis Response	48	75.5%
	Re-ablement	46	76.6%
Activity	Bed	164	85.0%
	Home	126	81.0%
	Crisis Response	49	76.8%
	Re-ablement	46	86.0%
Outcomes	Re-ablement	46	70.3%

Appendix 6: Audit participants

Commissioners

The following commissioners participated in the audit. Where commissioners participated as part of a cluster or group of commissioners, the name of the cluster is shown in brackets.

- Airedale, Wharfedale and Craven CCG
- Ashford CCG (Ashford CCG/Canterbury and Coastal CCG)
- Canterbury and Coastal CCG (Ashford CCG/Canterbury and Coastal CCG)
- Barking & Dagenham CCG
- Barnet CCG
- Bath and North East Somerset CCG
- Bedfordshire CCG
- Sandwell and West Birmingham CCG (Birmingham CCGs)
- Birmingham South Central CCG (Birmingham CCGs)
- Birmingham Cross City CCG (Birmingham CCGs)
- Blackpool CCG
- Bolton CCG
- Bracknell and Ascot CCG/Bracknell Forest Borough Council
- Bradford City CCG (Bradford CCGs)
- Bradford Districts CCG (Bradford CCGs)
- Brighton & Hove CCG
- Bristol CCG
- Bromley CCG
- Bury CCG
- Calderdale CCG
- Central Bedfordshire Council
- Central Manchester CCG
- Coventry & Rugby CCG/Rugby
- South Norfolk CCG (Central Norfolk CCGs)
- North Norfolk CCG (Central Norfolk CCGs)
- Norwich CCGs (Central Norfolk CCGs)
- City and Hackney CCG/ London Borough of Hackney
- Coventry & Rugby CCG
- Dartford, Gravesham and Swanley CCG (Dartford, Gravesham and Swanley CCG/Swale CCG)
- Swale CCG (Dartford, Gravesham and Swanley CCG/Swale CCG)
- Dorset CCG
- East Lancashire CCG
- East Riding of Yorkshire CCG
- Eastern Cheshire CCG
- Enfield CCG/Enfield London Borough Council
- Fylde and Wyre CCG
- Gateshead CCG/Gateshead Council
- Greenwich CCG
- Halton CCG/Halton Borough Council
- Havering CCG
- Hertfordshire CCGs
- Heywood, Middleton & Rochdale CCG
- Hillingdon CCG
- Islington CCG/Islington London Borough Council
- Kernow CCG
- Knowsley Metropolitan Borough Council
- Lambeth CCG
- Lancashire County Council
- Lewisham CCG
- Lincolnshire East CCG (Lincolnshire CCGs)
- South West Lincolnshire CCG (Lincolnshire CCGs)
- South Lincolnshire CCG (Lincolnshire CCGs)
- Lincolnshire West CCG (Lincolnshire CCGs)
- Liverpool CCG
- Medway CCG
- Mid Essex CCG
- Milton Keynes CCG

- Newark & Sherwood CCG (Newark & Sherwood CCG/Mansfield & Ashfield CCG)
- Mansfield & Ashfield CCG (Newark & Sherwood CCG/Mansfield & Ashfield CCG)
- North East Lincolnshire CCG
- Northern, Eastern, Western Devon CCG
- North Lincolnshire Council
- North Manchester CCG
- North Staffordshire CCG
- North Tyneside CCG/North Tyneside Metropolitan Borough Council
- Northumberland CCG
- Nottingham City CCG
- Redbridge CCG
- Salford CCG
- Slough CCG
- Solihull CCG
- Somerset CCG
- South Cheshire CCG
- South East Staffordshire Health Economy Forum
- South Kent Coast CCG
- South Manchester CCG
- South Sefton CCG
- NHS Nottingham North & East CCG (South Nottinghamshire CCGs)
- NHS Nottingham West CCG (South Nottinghamshire CCGs)
- NHS Rushcliffe CCG (South Nottinghamshire CCGs)
- Southampton CCG/Southampton City Council
- Southwark CCG
- St Helens CCG/St Helens Metropolitan Borough Council
- Stockport Integrated Intermediate Care
- Stoke on Trent CCG
- Sunderland CCG
- Tameside and Glossop CCG
- Tower Hamlets CCG
- Central London CCG (Tri borough cluster)
- Hammersmith and Fulham CCG (Tri borough cluster)
- West London CCG (Tri borough cluster)
- Vale of York CCG
- Vale Royal CCG
- Wakefield CCG
- Walsall CCG
- Waltham Forest CCG
- Warrington CCG/Warrington Borough Council
- West Cheshire CCG
- West Hampshire CCG
- West Kent CCG
- West Sussex Joint Commissioning Unit
- Windsor Ascot and Maidenhead CCG
- Wirral CCG
- Wolverhampton CCG
- South Worcestershire CCG (Worcestershire CCGs)
- Redditch & Bromsgrove CCG (Worcestershire CCGs)
- Wyre Forest CCG (Worcestershire CCGs)

Providers participating in the audit

- 5 Boroughs Partnership NHS Foundation Trust
- Abbey Court Nursing Home
- Age UK Hospital Discharge Team
- Age UK Medway
- Airedale NHS Foundation Trust
- Akari Care
- All Hallows Healthcare Trust
- Allied Health Care group
- Appleby Court Nursing Home
- Barts Health NHS Trust
- Bedford Metropolitan District Council
- Berkshire Healthcare NHS Foundation Trust (BHFT)
- Birmingham City Council
- Birmingham community health care NHS trust
- Blackpool Borough Council
- Bolton Council
- Bolton NHS Foundation Trust
- Bracknell Forest Council
- Bradford Teaching Hospitals NHS Foundation Trust
- Brendoncare Knightwood
- Bridgewater Community Health Care NHS Trust
- Bristol Community Health Services/Bristol City Council
- Bromley Healthcare
- Bupa
- Bupa Care Services
- Bupa Community Beds
- Bury Metropolitan Borough Council
- Calderdale & Huddersfield NHS Foundation Trust
- Cambridgeshire Community Services NHS Trust
- Care Plus Group
- Central Essex Community Services
- Central London Community Health Care NHS Trust
- Central Manchester University Hospitals Foundation Trust
- Cheshire & Wirral Partnership NHS Foundation Trust
- City Hospitals Sunderland NHS Foundation Trust
- Community Careline Services (Gillingham)
- Cornwall Council
- Countess of Chester NHS Foundation Trust
- County Health Partnership
- Coventry and Warwickshire Partnership NHS Trust
- Coventry City Council
- Croydon Health Services NHS Trust
- Cumbria Partnership NHS Foundation Trust
- Derbyshire Community Health Services NHS Trust
- Diamond House
- Docking House Care Home
- Dorset Healthcare
- Ealing Hospital NHS Trust
- East Cheshire NHS Trust
- East Coast Community Healthcare
- East Lancashire Hospitals NHS Trust
- EHG UK
- Elizabeth Homecare Ltd
- Enfield Community Services – Barnet Enfield and Haringey Mental Health Trust
- Family Mosaic
- Ford Place Care Home
- Four Seasons Healthcare
- Frindsbury Hall Nursing Home
- Gateshead Council
- Gateshead Health NHS Foundation Trust
- Guys and St Thomas' NHS Foundation Trust
- Hale Place Care Homes ltd T/A Hale Place Care Solutions
- Hallmark Carehomes
- Halton Borough Council / Bridgewater Community Health Care NHS Trust
- Halvergate House Care Home
- London Borough of Hammersmith and Fulham
- Hampshire County Council
- HEFT Community Services
- Helen McArdle Care
- Hertfordshire Community NHS Trust
- Hillingdon Community Health
- Hilltop Manor Care Home
- Homerton University Hospital NHS Foundation Trust

- Hoylake Cottage Hospital
- Humber NHS Foundation Trust
- Iceni House
- Kent Community Health NHS Trust
- Kent County Council
- Knowsley Metropolitan Borough Council
- Lancashire County Commercial Group
- Larchwood House Care Home
- Liverpool Community Healthcare NHS Trust
- Lewisham Healthcare NHS Trust
- Lincolnshire Community Health Services NHS Trust
- Liverpool City Council
- London Borough of Lewisham
- London Borough of Redbridge
- Lower Farm
- Medway Community Healthcare
- Mid Yorkshire Hospitals NHS Trust
- Milton Keynes Council/Community Health Services
- Central and North West London NHS Foundation Trust
- Central London Community Health Care NHS Trust
- Norfolk Community Health & Care NHS Trust
- Norfolk County Council, Norfolk First Support
- North East London NHS Foundation Trust
- North Tyneside Council
- North West London Hospitals NHS Trust
- Northamptonshire Healthcare NHS Foundation Trust
- Nottingham CityCare Partnership
- Nottingham University Hospitals NHS Trust
- Optalis
- Oxford Health NHS Foundation Trust
- Oxleas NHS Foundation Trust
- Pennine Acute Hospitals NHS Trust
- Pennine Care NHS Foundation Trust
- Plymouth Community Healthcare
- Quantum Care
- Rotherham Doncaster & South Humber NHS Foundation Trust
- The Royal Borough Kensington and Chelsea
- The Royal Borough of Windsor & Maidenhead
- Royal Wolverhampton NHS Trust
- Salford Royal NHS Foundation Trust
- Sandwell and West Birmingham Hospitals NHS Trust
- Sandwell Council
- Sheffield Teaching Hospitals NHS Foundation Trust
- Sirona Care and Health
- Solent NHS Trust
- Somerset Partnership NHS Foundation Trust
- South East Health Ltd
- South Essex Partnership University Foundation NHS Trust
- South Gloucestershire Community Health Services, North Bristol NHS Trust
- South Tees Hospitals NHS Foundation Trust
- South Tyneside NHS Foundation Trust
- St Helens and Knowsley NHS Trust
- St Helens Council
- Staffordshire & Stoke on Trent Partnership Trust
- Strode Park NHS Foundation Trust
- Sunderland City Council
- Sussex Community NHS Trust
- Tameside and Glossop Business Group – Stockport NHS Foundation Trust
- Tarporley War Memorial Hospital
- Tower Hamlets Council
- University Hospital of South Manchester NHS Foundation Trust
- Walsall Healthcare NHS Trust
- Warrington and Halton Hospitals NHS Foundation Trust
- West Sussex County Council ICT Service – Coastal
- Westminster City Council
- Whittington Health
- Wirral University Teaching Hospital NHS Foundation Trust
- Worcestershire Health and Care NHS Trust
- Yeovil District Hospital NHS Foundation Trust
- York Teaching Hospital NHS Foundation Trust

Prepared in partnership with:

NHS Benchmarking Network
www.nhsbenchmarking.nhs.uk
3000 Aviator Way, Manchester, M22 5TG
Tel: 0161 266 1997

British Geriatrics Society (BGS)
www.bgs.org.uk
Marjory Warren House, 31 St John's Square, London, EC1M 4DN
Tel: 020 7608 1369

Association of Directors of Adult Social Services (ADASS)
www.adass.org.uk
Local Government House, Smith Square, London, SW1P 3HZ
Tel: 020 7072 7433

College of Occupational Therapists Specialist Section – Older People
www.cot.co.uk
106-114 Borough High Street, London, SE1 1LB
Tel: 020 7357 6480

The Royal College of Physicians
www.rcplondon.ac.uk
11 St Andrews Place, Regent's Park, London, W1 4LE
Tel: 020 3075 1539

The Royal College of Nursing Older People's Forum
www.rcn.org.uk
Copse Walk, Cardiff Gate Business Park, Cardiff, CF23 8XG
Tel:0345 772 6100

Chartered Physiotherapists working with older people
agile.csp.org.uk
14 Bedford Row, London, WC1R 4ED
Tel: 020 7306 6666

The Patients Association
www.patients-association.com
PO Box 935, Harrow, Middlesex, HA1 3YJ
Tel: 020 84239111

The Royal College of Speech & Language Therapists
www.rcslt.org
2 White Hart Yard, London, SE1 1NX
Tel: 020 7378 1200

NHS England
www.england.nhs.uk
PO Box 16738
Redditch, B97 9PT