

## COMMENTARIES

# The second national audit of intermediate care

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## Abstract

Intermediate care services have developed internationally to expedite discharge from hospital and to provide an alternative to an emergency hospital admission. Inconsistencies in the evidence base and under-developed governance structures led to concerns about the care quality, outcomes and provision of intermediate care in the NHS. The National Audit of Intermediate Care was therefore established by an interdisciplinary group. The second national audit reported in 2013 and included crisis response teams, home-based and bed-based services in approximately a half of the NHS. The main findings were evidence of weak local strategic planning, considerable under-provision, delays in accessing the services and lack of mental health involvement in care. There was a very high level of positive patient experience reported across all types of intermediate care, though reported involvement with care decisions was less satisfactory.

**Keywords:** *intermediate care, national audit, older people*

The modern general hospital is complex, expensive and has proved harmful to many people, and so simpler, cheaper and safer care alternatives have been sought, particularly for older people who are now the predominant users of hospital care. There has been international interest, therefore, in the development of a new tier of services that occupy the 'virtual' space between primary and secondary care. Collectively referred to as intermediate care services, they became a prominent part of the English NHS following the National Service Framework for Older People [1].

The core evidence base for intermediate care relates to its functions in providing alternatives to hospital care, either by preventing hospital admission or expediting discharge from hospital, using a rehabilitation-type intervention typically lasting <6 weeks [2]. The randomised controlled trial evidence reveals an inconsistent picture across the different functions and models of intermediate care. Admission avoidance by a hospital-at-home service is associated with a reduction in mortality, increased patient satisfaction and can reduce hospital use by 14 days [3]. Early discharge for older patients with a mix of medical

conditions using a hospital-at-home service is associated with a wide range of statistically plausible mortality rates that include a 31% reduction, or a 61% increase; an increase in hospital admissions; increased patient satisfaction; an average reduction of 7 days and a reduction in institutional care [4]. Early discharge by transfer to a community hospital is associated with improved clinical outcomes [5], whereas nurses-led units have a trend to increased mortality; an additional 5 days length of stay; reduced readmission rates and reduction in need for institutional care [6]. The health economics of service models for intermediate care are similarly inconsistent. Admission avoidance through hospital at-home appears less expensive when informal carer costs are excluded [3]. A recent (non-randomised) study of three sites reported that the cost savings come, paradoxically, not from acute care bed days saved but through savings in elective in-patient care and out-patient attendances [7]. It is unclear whether early discharge supported by hospital-at-home is less expensive than usual hospital care [4], but community hospitals are cost-effective (better outcomes at similar cost) compared with general hospital care [8].

### Box 1: The definition of intermediate care used in the audit as developed with the help of the Plain English Campaign

#### 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 hospitals and where people normally live, and between different areas of the health and social care system—community services, hospitals, general practitioners and social 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.

These inconsistencies in the evidence base, in combination with varying local provision and the structural location of intermediate care between primary and secondary care, led to concerns over its governance in the NHS. It was for these reasons that a national audit of intermediate care was established. The audit is funded by subscription and includes organizational- and patient-level components for both bed- and home-based intermediate care services. The objectives of the audit are (i) to develop quality standards for key metrics based on published Department of Health (England) best practice guidance, (ii) to incorporate patient outcome and patient reported experience measures (PREMs), (iii) to assess performance against the quality standards and outcomes, (iv) to summarise national data and provide local benchmarked results on key performance indicators and (v) to inform policy and service development.

This first audit reported in 2012 and revealed a more complex pattern of service provision understood to be in the intermediate care sector that included rapid response services (responding within hours but offering provision for 48 h or so), and reablement services funded, staffed and run by local authorities. The second audit reported in 2013 and included these other services and had a focus on outcome measurement that included a specifically developed intermediate care PREM [9]. To ensure consistency in

the audit, a definition of intermediate care (Box 1), and for the specific types of intermediate care included in the audit, was developed [9].

### Uptake of audit

Although involvement in the audit is voluntary, there was a high level of engagement such that the audit encompasses approximately half the NHS in England (107 of the 211 Clinical Commissioning Groups). Data were submitted from 202 provider organisations for 410 intermediate services (55 crisis response, 130 home-based, 176 bed-based and 49 reablement intermediate care services) and from 8,342 service users. The data quality was high: 7 of 11 quality sections had over 97% completeness.

### Commissioning issues

There was evidence of weak local strategic planning processes for intermediate care as demonstrated by under provision of multi-agency commissioning boards (70%), Joint Strategic Needs Assessment of intermediate care (46%) and a local intermediate care plans (34%). It is therefore unsurprising that the provision of intermediate care nationally varied hugely as indicated by the number of bed-based and home-based services (<25 to >1,200 and <50 to 3,500 per 100,000 weighted population, respectively). The local commissioning spend on intermediate care underpinned this service provision variation with a large range between less than £500,000 to over £4 million per 100,000 weighted population. The average spend was £1.95 million per 100,000 population, up only slightly from 2012 (£1.91 million), suggesting that investment in intermediate care had stalled nationally. Assuming a conservative 25% of older people in hospital would be candidate for an early discharge service [10], and that ~30% might be suitable for admission avoidance [11], the intermediate care capacity nationally was still only less than half of that required to respond to need. This is a serious concern and is an important factor in increasingly pressed acute sector. The average local authority spends £0.7 million per 100,000 weighted population which represents a significant contribution (26%) of the total intermediate care funding.

### Service integration

Older people with frailty frequently need to move between services and organisations and are therefore particularly susceptible to the effects of multiple assessments, delays or the simple abandonment that are the characteristics of poorly integrated services. Intermediate care was always conceived as a platform for multi-agency working and better integrated care [1]. However, a mixed picture of integration is presented in the audit. The crisis response teams and the home-based services appeared to be well integrated into the wider health

and social care systems with referrals received from primary, secondary, community and social care sources. On the other hand, the staffing structures were highly polarised with the 'health' services predicated on health staff and vice versa for the social care reablement services. And there was evidence that the services were running in parallel with the 'health' intermediate care receiving 'health' referrals and a trivial number from the social care sector, whereas social sector referrals comprised the dominant source of work for the reablement services. Perhaps this parallel service provision is unsurprising given that formal arrangements for combined health and social care funding ('Section 75' funding) had been taken up by only 33% commissioners (albeit up from 21% in the 2012 audit). One consequence of poor integration from the patient perspective was in delays to access intermediate care (3.4 days for bed-based services, 4.8 days for home-based and 4.2 days for enabling services). A further finding of concern relating to integration was the lack of involvement of mental health services. The proportion of mental health trained staff in any of the service models audited was miniscule, and training in dementia care had only been provided to about half the staff.

### Patient experience of care

The PREM was completed by 6,449 service users. Importantly, over 95% of users reported that they had 'always' been treated with respect and dignity. This provides considerable confidence in the quality of service delivery nationally and is in contrast to patient experience reported with hospital care (the 'Friends and Family' test) and the findings in the General Practice Patient Survey. On the other hand, the PREM was sensitive to aspects of less than adequate experience, particularly in the experience of being involved with goal planning, decision-making and involvement of carers. This was further supported in the 'open' response section of the audit in which some common themes emerged including patients feeling threatened or unsafe when in bed-based intermediate care, feeling that discharge was not discussed and occurred without warning, and that people were left without adequate aftercare.

### Conclusion

Within 2 years, the intermediate care audit has become comparable in size to the other, more established national audits and is now included in the NHS Quality Accounts as a mandated audit for provider organisations. This reflects both the quality of the audit and its importance in describing services that are not captured in other data sets. The findings of the 2013 audit indicate that intermediate care capacity, integration and aspects of patient experience are important areas to be addressed.

### Key points

- The National Audit of Intermediate Care covers about half of the NHS in England.
- There is considerable local variation in provision of intermediate care, and the national capacity is estimated to be about half of that required.
- There is evidence that intermediate care services could be better integrated with other health and social care services.
- The reported patient experience is very positive, but involvement in goals and care decisions are areas for improvement.

### Conflicts of interest

None declared.

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