

# National pilot audit of intermediate care

Tom Hutchinson, John Young and Duncan Forsyth

**ABSTRACT – The National Service Framework for Older People resulted in the widespread introduction of intermediate care (IC) services. However, although these services have shared common aims, there has been considerable diversity in their staffing, organisation and delivery. Concerns have been raised regarding the clinical governance of IC with a paucity of data to evaluate the effectiveness, quality and safety of these services. This paper presents the results of a national pilot audit of IC services focusing particularly on clinical governance issues. The results confirm these concerns and provide support for a larger scale national audit of IC services to monitor and improve care quality.**

**KEY WORDS:** audit, intermediate care, older people

## Introduction

In 2000, the National Beds Inquiry found that significant numbers of older people stayed in acute hospitals longer than was necessary or desirable.<sup>1</sup> Similarly, older patients were being admitted to hospital for want of community-based services that would better meet their needs.<sup>2</sup> This report led to a new health-care policy for a range of services referred to as intermediate care (IC). The development of IC services was set out in 2001 within the National Service Framework for Older People.<sup>2</sup> The aims of IC were stated as being to:

- promote faster recovery from illness
- support timely discharge from hospital
- prevent unnecessary acute hospital admission
- maximise independent living.

The expectation was of multiagency working, based on comprehensive geriatric assessment, with short-term interventions to enable users to remain or resume living at home. The expansion of IC was carefully monitored against national targets. These targets were met or exceeded by 2004.<sup>3</sup>

This was an encouraging start. The concept of IC appeared to have been embraced, with a diverse range of services designed to meet local need. Services included bed-based IC, such as community hospitals and rehabilitation beds in nursing and residential homes, and home-based IC, such as hospital-at-home and community rapid response teams. Commentators became con-

cerned about the lack of evidence for effectiveness and the lack of a unifying understanding for IC.<sup>4,5</sup> Variation in staffing structures, organisation and delivery of IC services was acknowledged and specific professional and government guidance was developed.<sup>6,7</sup> Despite these initiatives a national survey of IC conducted in 2006 described the services as ‘fragmented’.<sup>8</sup> A particular concern has been that IC services have fallen outside of the statutory inspection agencies (at that time, the Healthcare Commission and the Care Standards Commission and Inspectorate; currently the Care Quality Commission) with no national monitoring of the effectiveness, quality and safety of these services.

For these reasons, it was seen as timely to design and conduct a national audit of IC. In this report a national pilot audit completed in 2009 is described. The pilot audit had a particular focus on clinical governance issues and was primarily conducted to determine if a larger scale audit would be justified.

## Methods

The development of the national pilot audit was overseen by the Older Peoples Specialists Forum (OPSF). This group includes representation from: the Department of Health (DH) (England), British Geriatrics Society (BGS), Royal College of Nursing, Chartered Society of Physiotherapy, College of Occupational Therapists (Specialist Section for Older People), National Association of Primary Care, Royal College of Speech and Language Therapists, Society of Radiographers, Faculty of Old Age Psychiatry and British Association of Art Therapists. The audit was jointly funded by the BGS and AGILE (Chartered Physiotherapists working with Older People). Members of OPSF and BGS were asked to identify colleagues working in IC provider services who would be willing to pilot the audit questionnaires. This is, therefore, a convenience sample, but one which provided a wide geographic spread and range of IC services. The audit standards were derived from good practice guidance from the DH, the Federation of Royal Medical Colleges and the BGS.<sup>2,6,9</sup> These good practice statements were incorporated into audit questions by discussion and consensus agreement under the auspices of the OPSF. In the spring of 2009, audit forms were distributed via OPSF members and through BGS regional networks to participating centres. Completed forms were returned to the BGS by August 2009.

There were two parts to the audit. The first focused on good practice standards in IC – ie what we might agree should happen. All participating centres were asked to complete this part of the audit as a minimum commitment. Data were obtained from a working knowledge of the IC facility and its

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policies. The second was a case note audit, from the clinical records, of 10 consecutive patients discharged (including deaths) from an IC service of the auditor's choosing – ie what actually happens. Participating centres were encouraged to complete audit 2 but were not required to do so. Centres could submit anonymised data on 10 patients from more than one IC facility.

## Results

### Results of audit 1

Responses were received from 40 IC provider organisations in England, Wales and Northern Ireland. Data were provided on 126 separate IC services. Bed-based IC services (71%) were analysed separately from home-based IC services (29%) as they are operationally distinct. Table 1 shows the proportion of IC services that achieved quality standards for effective clinical governance. The expected standard was 100% attainment.

### Results of audit 2

Data were provided on 426 patients discharged from 49 IC facilities in England, Wales and Northern Ireland; 284 (67%) from bed-based IC (average age 80.1 years (range 27–100); 65% female); and 142 (33%) from home-based IC services (average age 78.4 years (range 38–100), 66% female). Figure 1 shows the source of admissions to IC services. The majority of admissions were 'step-down' from acute hospital wards (56% bed-based, 49% home-based IC) or 'step-up' care from patient's homes (32% bed-based, 31% home-based IC).

The most common recorded reasons for admission to IC were rehabilitation after a medical illness such as pneumonia (36% bed-based; 44% home-based IC), and falls, with or without a fracture (44% bed-based; 37% home-based IC). Patients recovering from elective orthopaedic surgery accounted for only 11% of the admissions to home-based IC services. Admissions attrib-

uted solely to 'social' reasons were low (5% bed-based, 3% home-based IC).

Figure 2 shows which professionals assessed the patients during their stay in the IC service. Most, but not all, patients saw a nurse, physiotherapist and occupational therapist. Geriatricians were involved in the majority of bed-based IC admissions (60%) but only infrequently in home-based IC (25%). There was a low involvement of social workers and care managers.

In total, 12% of bed-based IC patients and 10% of home-based IC patients required transfer to acute services, mostly to a medical ward. Delirium and pneumonia were more commonly reported as complications of bed-based IC than of home-based IC (Fig 3).

At the time of discharge from IC services the majority returned or remained living in their own homes (69% bed-based, 77% home-based IC). Greater numbers of bed-based patients were transferred to a care home (14% bed-based, 3% home-based IC). Mortality was low in both bed-based and home-based IC (4% and 3% respectively) but it was not clear

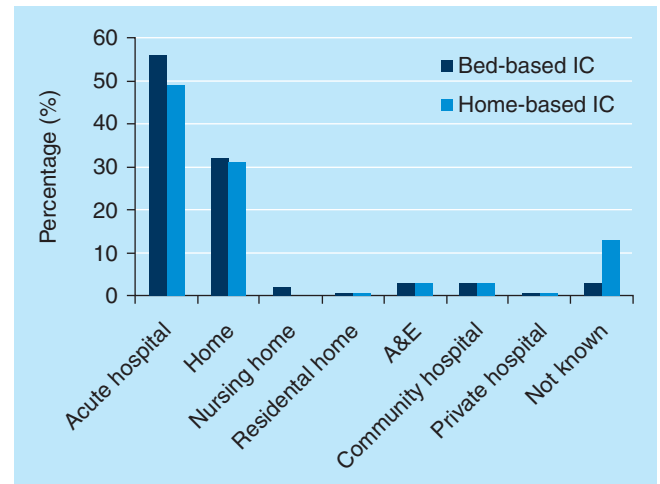


Fig 1. Sources of admissions to intermediate care (IC) services.

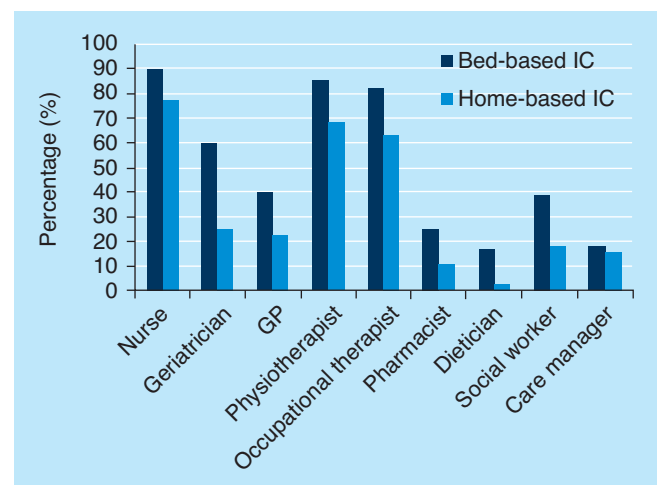


Fig 2. Proportion of patients assessed by each professional group during their intermediate care (IC) admission.

Table 1. Key clinical governance indicators.

	Bed-based IC (%)	Home-based IC (%)
Weekly multidisciplinary team meetings	84	72
Single patient records	60	75
Clinical governance meetings	71	74
Emergency transfer reporting	64	69
Falls reporting	88	83
Healthcare-associated infection reporting	72	44
Medication error reporting	80	72
Patient involvement	72	81
Carer involvement	69	81

IC = intermediate care.

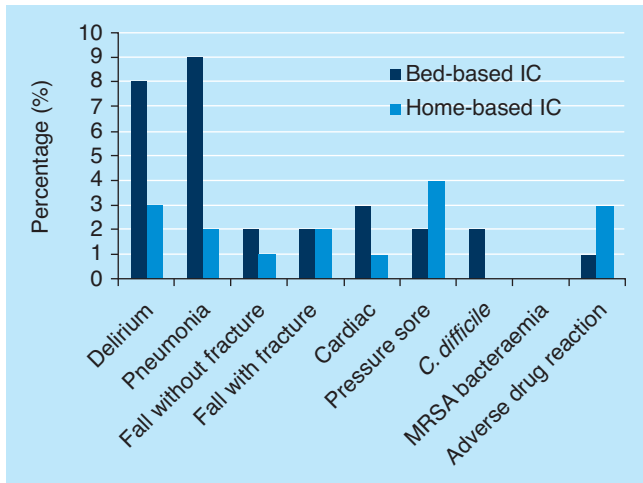


Fig 3. Complications recorded in intermediate care (IC) services.

how many of those who were transferred to the acute hospitals subsequently died.

Delayed discharges were more common from bed-based IC (27% bed-based; 10% home-based IC). Setting up a home care package was the most frequent cause of delayed discharge: 37% of patients received a home care package on discharge compared to 23% on admission. Of those who had a care package on admission, 27% received an increase in their care package.

Delays in provision of equipment also delayed discharge (17% bed-based IC delays, 21% home-based IC delays). The average length of stay was 26.8 days for bed-based IC (range 1–180 days) and 30.6 days in home-based IC (range 1–180 days). A stated national expectation for IC services was that of a short-term intervention defined as ‘typically lasting no longer than six weeks and frequently as little as one to two weeks or less’.<sup>2</sup> In this audit, the six-week target was achieved for 74% of bed-based and 80% of home-based IC admissions, but the two-week target for only 35% of bed-based and 32% of home-based IC admissions.

Finally, for each IC admission audited the respondent was asked to consider whether the admission was appropriate. In both bed-based and home-based IC over 80% of admissions were thought to be appropriate including those with delayed discharges.

## Discussion

IC services have developed rapidly and now comprise an important component of healthcare provision nationally. Demonstrating effectiveness and safety is clearly important. This pilot audit was designed primarily to assess the feasibility and relevance of a future larger national audit and had a particular emphasis on clinical governance. The findings need to be interpreted with caution as the participating centres expressed an interest in participating in the audit and, therefore, do not necessarily comprise representative services.

The response to the audit was encouraging with healthcare professionals working in 126 separate IC services prepared to participate. Thus, healthcare professionals were prepared to engage with a centrally coordinated audit process and it was possible to recruit widely dispersed services. One conclusion, therefore, is that a larger scale audit might be feasible. The number of patients included in audit 2 exceeded expectations and is a reflection of the enthusiasm for an audit of IC. Future audits will need to be designed and planned to handle large quantities of data.

The main function of IC appears to be providing ‘step-down’ care from acute hospital wards (approximately 50% of referrals). However, 30% of referrals were direct admissions or ‘step-up’ care with patients receiving an IC service from their own home. Such ‘admission avoidance’ is consistent with the stated policy aims of IC.<sup>2</sup> Thus, large numbers of patients, comprising mainly older people recovering from acute illness or with non-specific syndrome of falls, are being treated in non-acute care settings. This suggests that medical assessment and review should be an important aspect of IC service provision. The low input from consultant geriatricians in IC (60% bed-based and 25% home-based) is therefore of concern and should be explored in more detail in a future audit.

It is now widely acknowledged that care quality standards, outcomes and safety should be carefully monitored in all healthcare services. This requires a clinical governance framework to be in place. Unfortunately, a significant proportion of the IC services participating in this audit had no clinical governance meetings (29% bed-based; 26% home-based IC). Quarterly clinical governance meetings were most frequent (36% bed-based and home-based IC) and so might be regarded as a minimum standard for a future audit. Another aspect of clinical governance is risk management and critical incident reporting. This has been standard practice in acute trusts. Indeed, from April 2010, it will be mandatory for NHS trusts in England to report all patient safety incidents to the National Patient Safety Agency.<sup>10</sup> There is no reason to suggest that these reporting mechanisms should be any less important in IC. Routine reporting of critical incidents in IC was low and is a concern. Emergency transfer reporting is important to monitor the appropriateness of IC for patients admitted directly from the community, and to identify and record patients transferred too early from the acute sector, but was recorded in only 64% of bed-based IC and 69% of home-based IC services. Reporting of *Clostridium difficile* and methicillin-resistant *Staphylococcus aureus* (MRSA) is mandatory in the acute sector with associated large financial implications but was not the case for IC services. However, although routine safety monitoring systems were suboptimal, the individual patient audit demonstrated a reassuringly low rate of complications in both bed-based and home-based IC services. The higher rates of delirium and pneumonia recorded for patients in bed-based IC is likely to reflect a different case-mix of less ill patients in the home-based services. There were reassuringly low rates of *C. difficile* and no reports of MRSA bacteraemia.

Multidisciplinary meetings, with goal setting and goal review, have long been regarded as good practice to coordinate and optimise rehabilitation team working. This standard practice was lacking in approximately one fifth of IC services. A shared, single patient record is also a recommended practice to improve communication between rehabilitation professionals but was a reported feature in only 60% of bed-based and 75% of home-based IC. These deficiencies in care process might contribute to inefficient services and some evidence of this was found in the audit with lengths of stay exceeding recommended national targets for IC.<sup>7</sup> Patient and carer involvement, in terms of feedback from tools such as patient satisfaction questionnaires, is increasingly being used as a key quality indicator for patient services. IC appears to be doing well in this respect but future audits should explore this issue in greater detail.

A primary goal of IC is to maximise independent living so that the high rates for return to, or continued, living at home are encouraging.<sup>2</sup> It is also reassuring that IC was considered an appropriate service for 87% of the patients audited, including those with delayed discharges. Although this is a subjective view, it implies considered assessments prior to transfer to IC and that the service is seen as beneficial to patient care. The main reason given for IC being inappropriate for the patient was inadequate assessment of their medical needs in the acute and community settings prior to transfer to IC services.

The results indicate that significant improvements can be made in the clinical governance of IC services. Previous national audits, such as the organisation of services for falls and bone health in older people and the sentinel stroke audit, have improved standards and uniformity of care.<sup>11,12</sup> Therefore, a future national audit of IC could form an important role in achieving these improvements.

## Conclusions

The results of this pilot audit have indicated sufficient variations in clinical governance and diversity of practice within IC services to justify a larger scale national audit. The response to the pilot audit was encouraging and suggests that a larger audit would be supported.

## Acknowledgements

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