

The Networked Data Lab

Topic 4: Intermediate Care Highlights

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Glossary

- **Neighbourhood teams** – neighbourhood teams bring together a range of professionals, including district nurses, therapists, GPs, and social care staff into the teams providing care and treatment to patients in their own homes.
- **Step down** – care following discharge from an acute, or urgent unplanned, hospital admission, which is less expensive than hospital inpatient care.
- **Reablement** – supporting patients when getting dressed, showering, preparing meals and moving around the house. Practicing these tasks builds confidence and abilities.
- **Intermediate Care (IC)** – care services provided to patients that may help in recovering after a fall, acute illness, or operation. Can avoid, going to hospital unnecessarily and returning home more quickly after hospital stay.
- **Community Care Beds (CCB)** – provide rehabilitation in a homely environment for people who do not need to go into or remain in hospital but cannot be cared for safely at home.
- **Community (Home) Based Services (CBS)** – working with people in their own homes but also within community settings such as residential care and nursing homes and within supported living.
- **Adult Social Care Community (Reablement) ASCCOM** – type of care that helps you relearn how to do daily activities like cooking meals, washing, and carrying out day to day activities.

Data sources

- Leeds GP registered cohort
- Secondary Uses Service (SUS) Dataset - we selected only inpatients, planned, unplanned, excluding day care and regular day night attendance.
- Leeds Community Health (LCH) – home based services
- Community Care Beds - beds
- Client Information System (CIS) – Leeds City Council adult social care, reablement
- Yorkshire Ambulance Service – 999
- Local Care Direct – NHS 111, GP out of hours (GPOOH)
- Local Care Direct – EMIS / TPP

Introduction

Intermediate care (IC) services are provided to patients, usually older people, after leaving hospital (step down) or when they are at risk of being sent to hospital, (step up). Intermediate care helps people avoid going into hospital or residential care unnecessarily and helps people to be as independent as possible after a stay in hospital. This data report is focusing on step down IC care only.

In England over half of the growth of emergency admissions is related to older people: 80% stay in hospital for less than 24 hours.

Networked Data Lab (NDL) analysis has expanded on previous analysis done in Leeds to build a complete picture of IC following hospital admission.

The aim of this study is to understand who is using step down IC and to explore the role of IC in reducing hospital re-admission.

What we found

The team looked at patients who were discharged from hospital between April 2022 and April 2023. The study examined 53,323 admissions involving 38,970 patients. 80% of patients were discharged directly to their own homes with no support while 17% were followed by some form of community care or reablement. 1% were admitted to rehabilitation centres / bed care facilities and 2% to long term bed settings, for example hospices or care homes.

Examining the hospital admissions followed by step down IC, we found 90% were non-elective (unplanned conditions) with only 10% being elective (planned conditions) mostly home-based support.

Patients admitted for planned care experienced shorter hospital stays (seven days on average) compared to non-planned admissions (15 days).

Readmission

On examining hospital readmission (excluding Emergency Department (ED) contacts) among step down IC patients, we found that 25% of patients were readmitted within 30 days. 6% of patients were admitted more than once.

Who receives IC?

Results show that:

- There are more females and white patients that use step down IC.
- Patients from Asian backgrounds received majority home-based services: a very small number of Asian patients were discharged to rehab centres (this may be because of community and family support).
- 33% of patients receiving IC are from deprived areas.
- On average, older patients (above 80 years old) receive reablement at home or stay in rehabilitation centres: this group of patients is also frail.
- Younger patients (average age 75) received community home-based services (neighbourhood teams, stroke, respiratory management, virtual ward, antibiotics)
- Receiving IC at home is much shorter than in the rehabilitation centre (20-30 days compared with 50 days on average)
- Patients who are referred to the IC then have a stay in hospital and then return to IC are known as receiving “continuity of care” this means they receive long-term step-down IC resulting with 40 days of the stay between hospital stay.
- Home-based services take the longest time for first contact (six days on average)
- Patients who already receive ongoing care are contacted faster than new referrals (two days on average)
- People with dementia who need IC are more likely to receive support at home after hospital discharge (caveat: there was limited access to bed case data).
- Men are more likely to be readmitted within 30 days after being discharged from step down IC.
- Patients with multiple admissions tend to be frailer and more likely to have a long-term condition. However, their stay within IC is shorter compared to those with single hospital admissions.
- We found that patients in community-based services have a higher rate of readmission within 30 days.
- People who used IC also used 999 calls, GP, and Emergency Department (ED) more, compared to patients who do not use IC. The main contact prior to hospital admission for IC patients was GP followed by 999.

How did we embed Patient and Public Involvement and Experience (PPIE) in the project and what did people say?

Healthwatch was involved in facilitating the participation of local Leeds residents in focus groups, aimed at improving the Intermediate Care Service.

1. Intermediate Care Patients and Carers' Panel

The panel members were a good mix of both male and female participants and people from British, Indian, Chinese, and African backgrounds. Panel members spoke about what would improve their experience with the themes of:

- Improving communication between hospital staff and patients and their family.
- Considering family and friends views during the discharge process.
- Providing options for intermediate care after hospital discharge.

2. Enter and View visits

Healthwatch carried out Enter and View visits to three Intermediate Care settings and received additional feedback from 49 service users and their families & friends.

- Most respondents said they or their relatives felt safe at the recovery hub and were treated with respect by staff.
- Many people and their carers did not feel adequately informed about the next steps.
- Many people reported insufficient access to physiotherapy sessions and stimulating activities.
- A few people noted that their special care needs, such as those related to dementia or sensory impairment required more personalised care and should be communicated amongst all staff members.

3. Care at home panel

Healthwatch also organised a one-off focus group to gather insights about receiving Intermediate Care at home.

- The three cases discussed highlighted the importance of clear communication and better coordination during the discharge and post discharge process.
- Additionally, the heavy reliance on family and friends can put considerable pressure on them, potentially leading to a negative impact on their wellbeing.

Discussion from the data

Overall research indicates that prolonged stays in IC settings are associated with reduced hospital readmission. Data suggests the importance of comprehensive care provision during IC. Non-elective care patients were more likely to be readmitted to hospital.

Patients waiting a shorter time for a first contact with IC services also had a positive impact on readmission: more research is needed to target intervention.

To summarise, the information from our PPIE work with three separate groups of patients and families revealed one important cross cutting theme: communication. Improved communication is needed between staff, patients, and their families. Clear communication and coordination of the discharge and post discharge is needed.

What's next?

Leeds analysts will meet with the Intermediate Care Patients and Carers' Panel to talk through the findings, and together, recommendations from the study will be agreed. The findings and recommendations will then be discussed with local decision makers. The final report will be shared with the Health Foundation as part of the national study. The Health Foundation will then publish the national report which will then be discussed with national decision makers. A "you said we did" template will be created to hold decision makers to account.