

Appendix E Expert testimony papers

Section A: NCCSC to complete	
Name:	Nipa Shah
Job title:	Clinical Manager, STARRS
Address:	London North West Healthcare NHS Trust
Guidance title:	Intermediate care (incl reablement)
Committee:	Meeting 6
Subject of expert testimony:	Crisis response intermediate care
Evidence gaps or uncertainties:	[Please list the research questions or evidence uncertainties that the testimony should address]
<p>Our review question about crisis response intermediate care is:</p> <p>a) What is the effectiveness and cost-effectiveness of crisis response intermediate care?</p> <p>b) What are the views and experiences of people using services, their families and carers in relation to home based intermediate care?</p> <p>c) What are the views are experiences of health, social care and other practitioners about crisis response intermediate care?</p> <p>To answer these questions, we conducted a search of bibliographic databases (as outlined in our review protocol). The systematic reviewers screened the results of the search and then extracted data from the included papers and assessed the quality of the methodology in the reported studies. The result of this review work was that 3 papers were identified as meeting the inclusion criteria for the crisis response question. These were synthesised and reported to the Guideline Committee to use as a basis for developing recommendations for the guideline.</p> <p>The 3 included papers all reported data that helped to answer parts ‘b’ and ‘c’ of the review question. They provided some insight into the views and experiences of people using services and their carers as well as the views and experiences of practitioners. However, the three papers were based on only 2 studies and they were all judged to be of low quality (quality ratings are low [-], moderate [+] and good [++]). The studies did indicate that there may be a lack of understanding and knowledge among practitioners about crisis response intermediate care, which leads to inappropriate referrals to the service. There was also a small amount of evidence that people using crisis response and practitioners are dissatisfied with the time limited nature of the service. Although the Guideline Committee agreed recommendations based on this information, the quality and quantity is clearly lacking so further data about the views and experiences of people using crisis response and practitioners would strengthen the evidence already identified through the review process.</p> <p>The main gap in evidence however is around the effectiveness of crisis response intermediate care. No evidence was located that could answer this aspect of the review question. Many studies were located that evaluated ‘crisis response teams’</p>	

but they all described services that are considered outside the scope of this guideline, for example community palliative care, ambulance services and ward based rapid response teams. These studies were therefore excluded during the review process.

In light of these limitations the Guideline Committee agreed to seek to fill the gaps in research evidence through testimony provided by an expert witness. Members are looking for the witness to present evidence about the outcomes of crisis or rapid response services, as defined by the National Audit of Intermediate Care (NAIC). According to the NAIC definition, crisis response includes community based multi-disciplinary services provided to people in their own homes for a period of up to 48 hours. The aim is to avoid hospital admission by conducting assessments and short term interventions. In this sense, London North West NHS Trusts' STARRS team, providing rapid response, appears to fit the definition and the Guideline Committee would therefore welcome testimony about the service, especially any evaluation or service monitoring data derived using before and after or comparison group methods.

In summary, evidence on the following aspects of crisis or rapid response intermediate care would enable the Guideline Committee to develop additional recommendations or add weight to those already drafted:

- The effectiveness and cost effectiveness of crisis or rapid response services designed to avoid hospital admissions. In the absence of cost effectiveness analyses, cost data and cost savings evidence as a result of rapid response.
- Practitioner views (health, social care and others) about crisis or rapid response services including what works and what does not work well in this context.
- Feedback from people using crisis or rapid response services or their carers about whether the support provided is personalised and well-coordinated and about what works and what does not work well.

Section B: Expert to complete

Summary testimony:

[Please use the space below to summarise your testimony in 250–1000 words – continue over page if necessary]

The Short Term Rehabilitation and Reablement Service (STARRS) was established in 2010 to focus on Admission avoidance, Early supported discharge and Community rehabilitation. This would enable patients to retain more independence and receive coordinated support by continuing the care required at home.

STARRS has a multi- disciplinary team of nurses, physiotherapists, occupational therapists, consultant physicians (geriatricians), speech and language therapist (SALT), dietician, paramedics, pharmacist and health care support workers. The team is supported by an administrative team to provide a single point of access (SPA).

The service is commissioned by Brent CCG and managed by the London North West hospitals NHS trust. Hours are:

8am- 8.30 pm 7 days a week

8am- 10.30 pm 7 days a week in A/E

Referrals are accepted from GPs, LAS, outpatient clinics, District nurses.

Conditions seen by Rapid response include:

- exacerbations of Chronic Obstructive Pulmonary Disease (COPD)

- chest infections,
- urinary tract infections
- cellulitis
- intravenous antibiotics and Furosemide
- exacerbations of heart failure
- falls
- reduced mobility
- suspected deep vein thrombosis (DVT)
- urine retention
- pain management
- gastroenteritis
- interim management of unstable diabetes,
- poorly controlled hypertension
- any crisis that may result in inappropriate hospital admission.

The service provides:

- comprehensive assessment in patients own home within 2 hours of referral or A/E
- rapid access to diagnostics (pathology and imaging)
- rapid treatment by provision of pre pack medication, PGDs, e prescribing
- consultant led virtual ward rounds daily and on-call cover
- review in HOT clinic by geriatricians or domiciliary visits if required
- medications review and optimisation
- provision of any equipment needed
- established guidelines/protocols developed in conjunction with specialists
- close working relationships with GPs
- ongoing clinical and social care for up to 3-5 days, until clinically stable
- referral to onward care once patient deemed stable for discharge i.e. heart failure nurse

Achievements:

- Average number of patients seen for Rapid response per month is 331
- Average number of admissions avoided per month is 243
- Average patient satisfaction 97%
- Readmissions 1 month post RR 8.4%
- Readmissions 3 months post RR 14.7%

According to an in-depth review conducted by Brent CCG in May 2015, average saving per patient was £893, which gives an overall savings of £2.7m annually

References (if applicable):

N/A

Section A: NCCSC to complete	
Name:	Dick Dickinson
Job title:	Enhanced Reablement Nurse London Borough of Islington, Reablement and Home Support Service
Address:	4th Floor, 222 Upper Street, London N1 1XR
Guidance title:	Intermediate care (incl reablement)
Committee:	Meeting 7
Subject of expert testimony:	Intermediate care and reablement for people living with dementia
Evidence gaps or uncertainties:	[Please list the research questions or evidence uncertainties that the testimony should address]
<p>Our review question about intermediate care and reablement for people living with dementia:</p> <p>a) What is the effectiveness and cost-effectiveness of intermediate care and reablement for people living dementia?</p> <p>b) What are the views and experiences of people living with dementia, their families and carers in relation to intermediate care and reablement?</p> <p>c) What are the views are experiences of health, social care and other practitioners about intermediate care and reablement for people living dementia?</p> <p>To answer these questions, we conducted a search of bibliographic databases (as outlined in our review protocol). The systematic reviewers screened the results of the search and only one single paper met the inclusion criteria. Data were extracted from the paper and the quality of the methodology was assessed. This single paper will be presented to the Guideline Committee to use as a basis for developing recommendations for the guideline.</p> <p>The one included paper reported data that helped to answer part 'a' of the review question. It reported the results of an evaluation of a time limited specialist home treatment service for people living with dementia. Although the findings were broadly positive the quality of the study was rated as low (-), not least because there was no comparison group. The confidence that the Committee can have in the findings is therefore limited.</p> <p>Coupled with the poor quality data on effectiveness in the included study, there were no reported findings about the views and experiences of people living with dementia, their families or practitioners and this represents another major gap in the evidence. Guideline Committee members have no research evidence to help them form a view about the acceptability of intermediate care and reablement from the perspective of people living with dementia and their families. Nor is there any research evidence about practitioners' views, in particular what works and what does not work well in supporting people living with dementia through intermediate care and reablement. Along with the low quality effectiveness data, this will make it very difficult for members to develop recommendations about whether or how intermediate care and reablement should be adopted as a means of enabling this particular population.</p>	

In light of these limitations the Chair, on behalf of the Guideline Committee, agreed to seek to fill the gaps in research evidence through testimony provided by an expert witness. Members are looking for the witness to present evidence about the outcomes of intermediate care and reablement, specifically for people living with dementia. Islington's Reablement and Home Support Service provides such support through enhanced reablement and the Committee would therefore welcome testimony about the service, especially any evaluation or service monitoring data derived using before and after or comparison group methods.

In summary, evidence on the following aspects of the enhanced reablement element of the Reablement and Home Support Service would support the Guideline Committee in developing recommendations in this area:

- The effectiveness and cost effectiveness of reablement for people living with dementia. In the absence of cost effectiveness analyses, cost data and cost savings evidence as a result of providing enhanced reablement.
- Outcomes data, which may include service monitoring, for example hours of care required before and after the reablement service.
- Practitioner views (health, social care and others) about the use of reablement to support people living with dementia including works and what does not work well in this context.
- Feedback from people using the enhanced reablement element of the Reablement and Home Support Service or their carers about whether the support provided is personalised and well-coordinated and about what works and what does not work well.

Section B: Expert to complete

Summary testimony:

[Please use the space below to summarise your testimony in 250–1000 words – continue over page if necessary]

Description

The enhanced reablement service is a function of Islington's mainstream reablement service and has been in operation since August 2011. It is currently led by Dick Dickinson, Registered Mental Health Nurse, whose contact details are given below. Referrals are welcome from Islington Social Care Staff/ REACH Therapists/ St Pancras Hospital Social Workers/ Mental Health and ILDP Care Coordinators. Enhanced reablement provides a time limited intervention (typically 1 to 2 weeks) of assessment, monitoring and reablement and can exceed the upper attendance limit for mainstream reablement by providing up to six calls a day (1 or 2 enablers) and /or up to 3 nights of constant attendance by a carer within the service user's home (dependent on availability). At the end of a period of enhanced reablement people requiring further rehabilitation may be eligible for transfer to mainstream reablement, or may require on-going care services over a longer term. If the service user is transferred from enhanced to mainstream reablement then the time spent on enhanced reablement is included in the overall reablement service limit of up to 6 weeks. There is no charge to the service user for either enhanced or mainstream reablement.

Enhanced Reablement Criteria

If a person is experiencing a temporary decline in their normal level of functioning due to a current or recent illness or injury, then they may be eligible for referral to

Islington's mainstream reablement service to support their recovery. The patient must be considered to have the potential to make progress towards regaining their previous level of functioning within 6 weeks, and must have stated that they are willing to cooperate fully in reablement activities.

Some service users however may be more appropriately referred to enhanced reablement which is primarily aimed at providing help to service users who are suffering from memory problems or other mental health issues. If it is thought that mental health issues may impact on the delivery of reablement then the person should be referred for enhanced reablement. The person must still meet the criteria for reablement as stated in the paragraph above. They may be ready for discharge from hospital or an intermediate care facility, or may require the service whilst at home to prevent admission to a hospital or care home.

Enhanced reablement uses the same enabling workforce as mainstream reablement and is an integral part of Islington's reablement service. The enablers can encourage, supervise or assist the person in the performance of their daily activities such as washing, dressing, personal care, meal and drink preparation, assistance and supervision with transfers and mobilising, prompting medication from blister packs, laundry, housework and shopping as required.

Outcome Data

Data such as age, gender, ethnicity, source of referral and reason for acceptance or rejection of referral of enhanced reablement is collected routinely. The destination of each case following a period of enhanced reablement is also captured. Destinations include standard reablement, standard package of care and further medical care or therapy. Total hours accrued by each case of enhanced reablement is also collected on a weekly basis.

Feedback from service users and their families is not collected separately for the enhanced reablement element of the reablement service. Practitioner views of enhanced reablement are anecdotal but generally the service appears to be very much appreciated.

Some enhanced reablement cases studies are compiled.

References (if applicable):

N/A

Section A: NCCSC to complete	
Name:	Alyson Davies
Job title:	Assistant Director of Therapies & Health Science/ Head of Occupational Therapy SSIA Dementia Reablement Service
Address:	Cwm Taf Local Health Board / Bwrdd Iechyd Lleol Cwm Taf Prince Charles Hospital Merthyr Tydfil CF47 9DT
Guidance title:	Intermediate care (incl reablement)
Committee:	Meeting 8
Subject of expert testimony:	Intermediate care and reablement for people living with dementia
Evidence gaps or uncertainties:	[Please list the research questions or evidence uncertainties that the testimony should address]
<p>Our review question about intermediate care and reablement for people living with dementia:</p> <p>a) What is the effectiveness and cost-effectiveness of intermediate care and reablement for people living dementia?</p> <p>b) What are the views and experiences of people living with dementia, their families and carers in relation to intermediate care and reablement?</p> <p>c) What are the views are experiences of health, social care and other practitioners about intermediate care and reablement for people living dementia?</p> <p>To answer these questions, we conducted a search of bibliographic databases (as outlined in our review protocol). The systematic reviewers screened the results of the search and only one single paper met the inclusion criteria. Data were extracted from the paper and the quality of the methodology was assessed. This single paper was presented to the Guideline Committee to use as a basis for developing recommendations for the guideline.</p> <p>The one included paper reported data that helped to answer part 'a' of the review question. It reported the results of an evaluation of a time limited specialist home treatment service for people living with dementia. Although the findings were broadly positive the quality of the study was rated as low (-), not least because there was no comparison group. The confidence that the Committee can have in the findings is therefore limited.</p> <p>Coupled with the poor quality data on effectiveness in the included study, there were no reported findings about the views and experiences of people living with dementia, their families or practitioners and this represents another major gap in the evidence. Guideline Committee members have no research evidence to help them form a view about the acceptability of intermediate care and reablement from the perspective of people living with dementia and their families. Nor is there any research evidence about practitioners' views, in particular what works and what does not work well in</p>	

supporting people living with dementia through intermediate care and reablement. Along with the low quality effectiveness data, this will make it very difficult for members to develop recommendations about whether or how intermediate care and reablement should be adopted as a means of enabling this particular population.

In light of these limitations the Chair, on behalf of the Guideline Committee, agreed to seek to fill the gaps in research evidence through testimony provided by an expert witness. Members are looking for the witness to present evidence about the outcomes of intermediate care and reablement, specifically for people living with dementia. The SSIA Dementia Reablement Service provides such support and the Committee would therefore welcome testimony about the service, especially any evaluation or service monitoring data derived using before and after or comparison group methods.

In summary, evidence on the following aspects of the Dementia Reablement Service would support the Guideline Committee in developing recommendations in this area:

- The effectiveness and cost effectiveness of reablement for people living with dementia. In the absence of cost effectiveness analyses, cost data and cost savings evidence as a result of providing enhanced reablement.
- Outcomes data, which may include service monitoring, for example hours of care required before and after the reablement service.
- Practitioner views (health, social care and others) about the use of reablement to support people living with dementia including works and what does not work well in this context.
- Feedback from people using the service or their carers about whether the support provided is personalised and well-coordinated and about what works and what does not work well.

Section B: Expert to complete

Summary testimony:

[Please use the space below to summarise your testimony in 250–1000 words – continue over page if necessary]

The Reablement teams for Cwm Taf University Health Board (CTUHB) were established as integrated services together with both Local Authorities situated within the Health Board footprint. The initial reablement service, established in 2003 with limited resources, delivered short-term intervention for up to six week and focussed on people with physical health conditions or disabilities. The positive impact of reablement services in reducing demand on rehabilitation beds for this population was recognised but occupational therapists (OT’s) highlighted particular concern in being able to discharge patients with a cognitive impairment in a timely manner, with a resultant impact on the individual’s function and length of hospital stay.

It was decided from this practice based evidence, to second a specialist OT into the both reablement teams to determine whether it was possible to reduce the length of hospital stay and improve the patient pathway. As a short-term service offering support for up to six weeks, clinical experience suggested that targeting those with mild to moderate memory impairment affecting their daily function would be most effective: it was decided that a diagnosis of dementia was not essential as many people who might benefit from this service may not have a formal diagnosis. The role of the OT was to provide robust assessment, maintenance of roles, routines and skills, to educate and support carers, to optimise cognitive and physical function, to

facilitate timely discharge and early intervention for people living in the community to prevent avoidable admission.

Evidence from data collected suggested that just under half of those referred during 2015/16 left the service independent of statutory services, that support hours required on programme commencement were reduced by approximately two thirds by the end of the programme and that there was a significant improvement in functional independence using the Morrision Occupational Therapy Outcome Measure (MOTOM). Accurately determining a reduction in length of hospital stay has proved more challenging as the primary reason for admission to an acute DGH would be a physical illness and the clinical coding would reflect that, rather than a cognitive impairment. However, it was possible to determine with some confidence that from the 64 hospital referrals, 103.8 bed days were saved.

From the perspective of clinical practice, it has become increasingly clear that referral at an appropriate stage into the service is key to the success of the programme. Enabling approaches that encourage and allow the individual to maintain their function can be used at most stages of the disease process. Cognitive impairment and dementia has an individualised impact and the process of decline requires a different response at different stages. As NICE guidance for dementia suggests, early intervention is key: education of the individual and carer is important to ensure positive risk taking, together with use of compensatory strategies to enable individuals to maintain their roles, routines, skills, employment and whatever else is important to them. Repetition, advice and support for brief and intense periods, when required, can be effective.

As the disease progresses and individuals struggle with impairment affecting their daily function, brief and intense interventions become too stressful. Enabling approaches with increased focus on compensatory strategies at a less intensive and frequent pace allow the individual to assimilate at their own pace, with more likelihood of success. This approach is modified in response to the changing home environment, resources and the needs of the individual.

Personalised services are integral to the reablement approach and feedback received from the whole population of people referred for reablement and their carers in 2015/16 is generally very positive, however, data specific to this population of patients with memory impairment has not been gathered separately. Case studies and digital stories have been captured to describe the impact on service users but these are all positive examples. Informal engagement through the local Alzheimer's Society with carers and service users who had received occupational therapy was conducted in 2015. This indicated that some individuals who had received reablement did not wish to receive the intensive approach provided. Additionally, this highlighted that the distinction between traditional care and an enabling approach may not be fully understood by individuals seeking services, with expectations for the former impacting upon patient experience when receiving the latter. An on-going UKCRN study at Cwm Taf UHB, exploring experiences of occupational therapy captured data on a range of services, including reablement. Whilst the majority of data pertained to other services, one occupational therapist working in an older person's community mental health team reflected upon people's experiences of reablement. As advocated by service users and carers, it was noted that some carers and services users do not want an intensive approach, which can impact upon their engagement with subsequent services provided by traditional community mental

health teams
References (if applicable):
Social Services Improvement Agency (2015): Developing a reablement Service for people with memory problems or a dementia living at home in Wales

Section A: NCCSC to complete	
Name:	Claire Holditch
Job title:	Director, NHS Benchmarking Network
Address:	C/o 3000 Aviator Way Manchester Business Park Manchester M22 5TG
Guidance title:	Intermediate care (incl reablement)
Committee:	Meeting 10
Subject of expert testimony:	National Audit of Intermediate Care
Evidence gaps or uncertainties:	[Please list the research questions or evidence uncertainties that the testimony should address]
<p>Our review of evidence on intermediate care and reablement was based on the 6 following questions.</p> <p>Home based intermediate care</p> <p>a) What is the effectiveness and cost-effectiveness of home based intermediate care?</p> <p>b) What are the views and experiences of people using services, their families and carers in relation to home based intermediate care?</p> <p>c) What are the views are experiences of health, social care and other practitioners about home based intermediate care?</p> <p>Bed based intermediate care</p> <p>a) What is the effectiveness and cost-effectiveness of bed based intermediate care?</p> <p>b) What are the views and experiences of people using services, their families and carers in relation to bed based intermediate care?</p> <p>c) What are the views are experiences of health, social care and other practitioners about bed based intermediate care?</p> <p>Crisis response</p> <p>a) What is the effectiveness and cost-effectiveness of crisis response intermediate care?</p> <p>b) What are the views and experiences of people using services, their families and carers in relation to home based intermediate care?</p> <p>c) What are the views are experiences of health, social care and other practitioners about crisis response intermediate care?</p>	

Reablement

- a) What is the effectiveness and cost-effectiveness of reablement?
- b) What are the views and experiences of people using services, their families and carers in relation to reablement?
- c) What are the views and experiences of health, social care and other practitioners about reablement?

People living with dementia

- a) What is the effectiveness and cost-effectiveness of intermediate care and reablement for people living with dementia?
- b) What are the views and experiences of people living with dementia, their families and carers in relation to intermediate care and reablement?
- c) What are the views and experiences of health, social care and other practitioners about intermediate care and reablement for people living with dementia?

Information, advice, training, advocacy and support

- a) What is the effectiveness and cost-effectiveness of information, advice, advocacy, training and support for people using intermediate care and reablement?
- b) What are the views and experiences of people using intermediate care and reablement, their families and carers in relation to information, advice, advocacy, training and support?
- c) What are the views and experiences of health, social care and other practitioners about information, advice, advocacy, training and support for people using intermediate care and reablement?

Note that the definitions of the 4 service models of intermediate care are matched with the descriptions used in the annual National Audit of Intermediate Care.

To answer these questions, we conducted a search of bibliographic databases (as outlined in our review protocols). The systematic reviewers screened the results of the search and then extracted data from the included papers and assessed the quality of the methodology in the reported studies.

The following information provides an overview of the volume and nature of the evidence reported to the GC:

- Home based IC: 12 RCTs, 5 studies reporting user/ carer views and experiences and 2 studies reporting practitioner views and experiences.
- Bed based IC: 6 RCTs (in 7 papers), 2 studies reporting user/ carer views and experiences and 3 studies reporting practitioner views/ experiences.
- Crisis response: 3 studies reporting views and experiences data. Note that in light of the gap in effectiveness evidence on crisis response services, the GC invited an expert witness to provide testimony and attempt to plug the gap in research evidence.
- Reablement: 7 effectiveness studies, 5 user/ carer views and experiences studies and 1 practitioner views and experiences study.
- Intermediate care and reablement for people living dementia: 1 (low quality) study providing evidence of effectiveness. Note that in light of this gap in evidence, the GC invited 2 expert witnesses to provide testimony specifically in relation to supporting people living with dementia via intermediate care and reablement.

- Information, advice, advocacy and support for people using intermediate care and reablement. 2 studies providing data about the views and experiences of people using intermediate care and reablement.

The GC felt they needed a clearer picture of the advantages of different models of intermediate care, including home-based versus bed-based and a more precise understanding of the elements of the different service models which contribute to the effectiveness and cost-effectiveness of each approach. GC members agreed to invite an expert witness from the NHS Benchmarking Network to provide insight and findings from the NAIC. In particular, they are seeking evidence from the NAIC that would help them address the following gaps:

Identifying & referring to most appropriate service

- who should get which intervention, when (including different levels of need/dependency; people’s preferences)
- what info do users and staff need to make referral decisions
- how should referral processes work

Crisis response

- timing of response and access to specialist services & diagnostics

Intervention effectiveness

- overview of IC service types and key components
- what interventions should include
- what specific components make the difference
- how long interventions should be delivered for and how long impacts last (long-term effectiveness)

Optimum team composition

Remit of interventions re: wider wellbeing

- extent to which services can/should address this

Involvement and support for families

- involvement of carers in rehab goal-setting
- support for carers and families to play role in reablement

Specific support to BME communities

- How IC services should address cultural and language barriers to access (incl in relation to information and advice)

There were particular gaps in evidence in relation to, crisis response, dementia and information, advice and advocacy (for people using IC&R and their families/ carers).

Section B: Expert to complete

Summary testimony:	[Please use the space below to summarise your testimony in 250–1000 words – continue
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Identifying & referring to most appropriate service

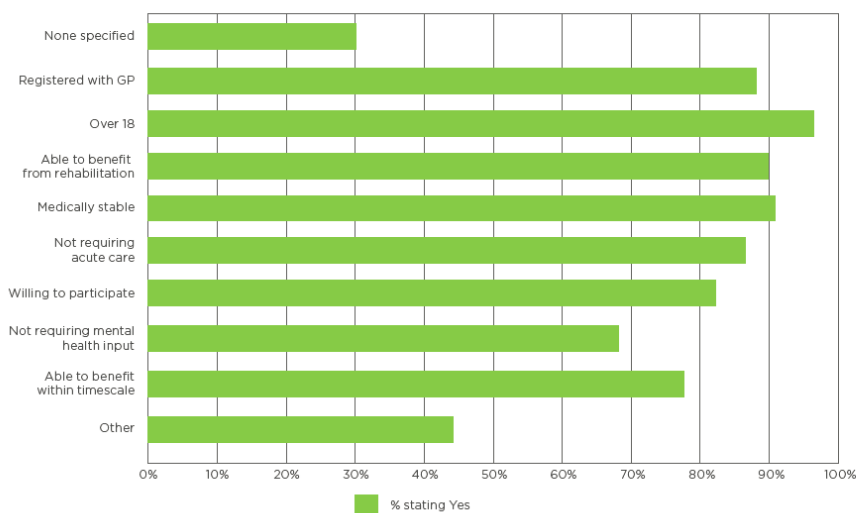
- who should get which intervention, when (including different levels of need/dependency; people's preferences)

Intermediate care provides a variety of services to a heterogeneous group of service users. Service users are typically elderly (average age over 80) and may be frail and have multiple long term conditions, in addition to having suffered a particular incident, such as a fall, which has brought them into contact with services. The NAIC Steering Group decided not to go down the route of collecting data on interventions because it would not be possible to undertake case mix adjustment to produce a meaningful analysis of the results.

- what info do users and staff need to make referral decisions

The NAIC 2014 collected data on referral criteria, giving an indication of the areas considered in referral decision making. The utilisation of typical access criteria (% of commissioners stating these criteria are applied) was as follows (NAIC 2014):

Figure 3.2.3: Access criteria for intermediate care services



- how should referral processes work

In many areas, services are fragmented and difficult to navigate by users and staff making referrals. The NAIC Steering Group would advocate the use of a single point of access for all referrals to intermediate care, at which point the decision about the appropriate type of service (home, bed, re-ablement) can be made. The number of receiving IC services should be reduced as much as possible, with integration between home and re-ablement where possible. A single management structure over all intermediate care services helps to bring coherence to the service provision. There should be a single assessment process that brings together the input of a multi-disciplinary team, without the need for duplication. Ideally, a single patient record should be shared across health and social care. Assessments carried out at the referral stage (e.g. by a supported discharge in hospital) should be accepted by the receiving services without the need for duplication.

Crisis response

- timing of response and access to specialist services & diagnostics

80% of crisis response services report a standard response time of 2 hours (NAIC 2015). Most crisis response teams have direct admitting rights to other IC services; home (79%), bed (77%), re-ablement (69%).

NAIC also asked about access to mental health services. For crisis response services,

- 16% had a mental health worker as part of the establishment
- 1% had MH liaison in-reach into the service
- 46% could refer directly to MH services
- 34% needed to request the GP
- 3% other

The NAIC doesn't include data on use of diagnostics by crisis response teams.

Intervention effectiveness

- overview of IC service types and key components

The NICE committee has received the service category definitions that are used for the NAIC. These can be found on page 68/69 of the NAIC Summary Report 2015

<http://www.nhsbenchmarking.nhs.uk/CubeCore/.uploads/NAIC/Reports/NAICReport2015FINALA4printableversion.pdf>.

The common features of intermediate care across these categories are the short term nature of the services and the use of multi-disciplinary teams. DH guidance on IC suggests that intensive packages of care should be delivered which are no longer than six weeks in length, and often much less (on average around a month).

- what interventions should include

As noted above, the NAIC does not collect data on interventions.

- what specific components make the difference

The Steering Group believes care planning is important to ensuring service user goals are met. Care plans are consistently documented and reviewed in bed based IC services (see table below), but only around three quarters of service users in home and re-ablement services have a care plan which has been both documented and reviewed.

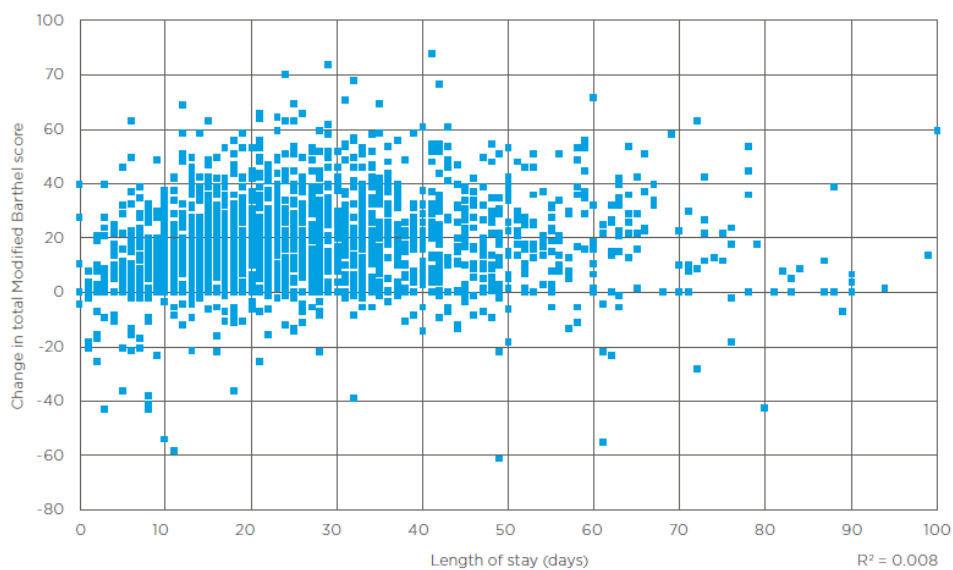
		Care plan documented	Care plan reviewed	Both
				
Home		86%	73%	71%
Bed		98%	95%	94%
Re-ablement		93%	76%	75%

National Audit
of Intermediate Care
2015

- how long interventions should be delivered for and how long impacts last (long-term effectiveness)

In NAIC 2014, the service user level data was used to explore whether there was a correlation between length of stay and outcomes. For bed based services, the change in total Modified Barthel score (the clinical outcome measure used in the service user audit) was plotted against length of stay. No correlation was found (see below). The results showed that the range of gains in functioning made are similar for most people but some people achieve the gains faster than others. A similar result was found for home base services (in this case using the change in Sunderland score as the outcome measure). The results highlighted the difficulty of defining “optimal” interventions or length of interventions for the IC service user cohort.

Figure 6.6.3: Service user data: Change in total Modified Barthel score against length of stay (bed based)



The NAIC does not collect any data on how long impacts last.

Optimum team composition

Also in NAIC 2014, service user outcomes were compared to the number of staff disciplines that the service user came into contact with during their intermediate care stay. For bed and home, the changes in Modified Barthel and Sunderland scores respectively were plotted against the number of staff types involved in the service user’s care, with both showing a clear positive relationship (below), suggesting outcomes improve as more disciplines are involved.

Figure 6.7.4: Change in Modified Barthel score against number of staff types involved in providing care (bed based IC)

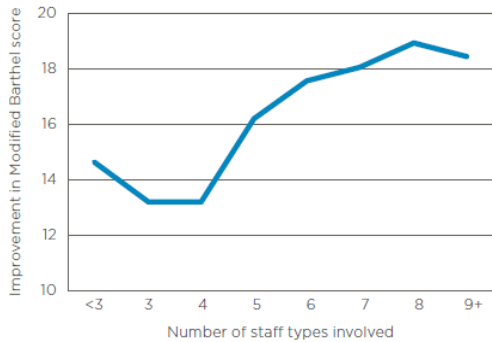
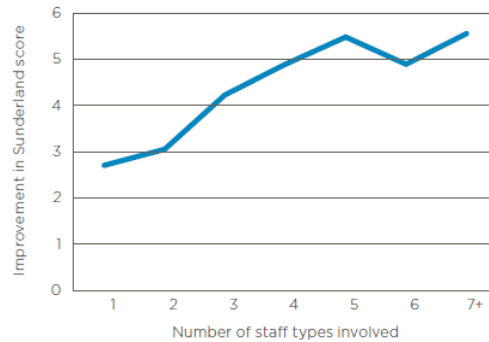
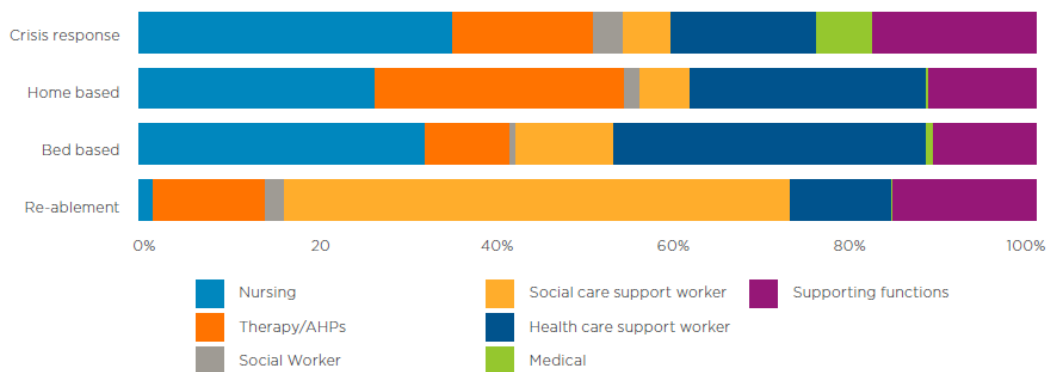


Figure 6.7.5: Change in Sunderland score against number of staff types involved in providing care (home based IC)



The average composition of the intermediate care teams for each service category by discipline (NAIC 2015) is shown below:

Figure 6.6.2: Mix of disciplines within intermediate care services NAIC 2015



Remit of interventions re: wider wellbeing

- extent to which services can/should address this

The NAIC collects Patient Reported Experience Measure (PREM) data for bed, home and re-ablement services. The NAIC Steering Group believes the wider wellbeing of service users should be addressed and included the question "Since having care from this service, my ability to maintain social contact has improved". Results were as follows:

Response	Bed	Home	Re-ablement
Yes-definitely	48%	50%	47%
Yes-to some extent	30%	26%	27%
No	7%	4%	8%
I am not concerned about this	15%	20%	19%

Involvement and support for families

- involvement of carers in rehab goal-setting
- support for carers and families to play role in reablement

The PREM includes the question “Staff gave my family or someone close to me all the information they needed to help care for me”. The results were as follows:

Response	Bed	Home	Re-ablement
Yes-definitely	72%	70%	70%
Yes-to some extent	19%	11%	13%
No	4%	4%	4%
I did not want or need them to	5%	15%	13%

The question asked on goal setting was “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”. Results were as follows:

Response	Bed	Home	Re-ablement
Yes	97%	98%	95%
No	3%	2%	5%

Specific support to BME communities

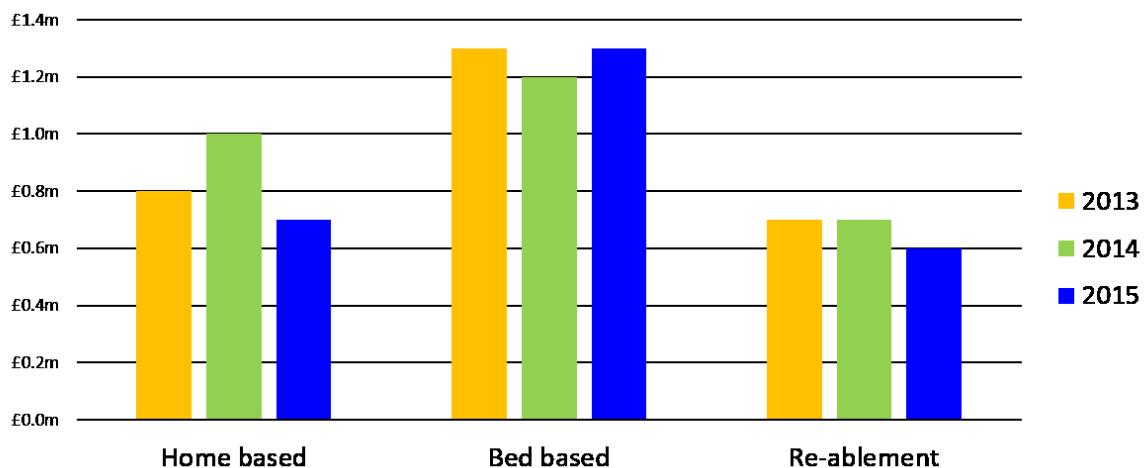
- How IC services should address cultural and language barriers to access (incl in relation to information and advice)

The NAIC doesn't currently address this issue.

Investment levels

In NAIC 2012, it was calculated that capacity in IC needs to approximately double to meet demand (as an average position nationally). However, subsequent iterations of the audit showed no material increase in investment, as illustrated below.

Commissioner budgets for IC per 100,000 weighted population (£m)

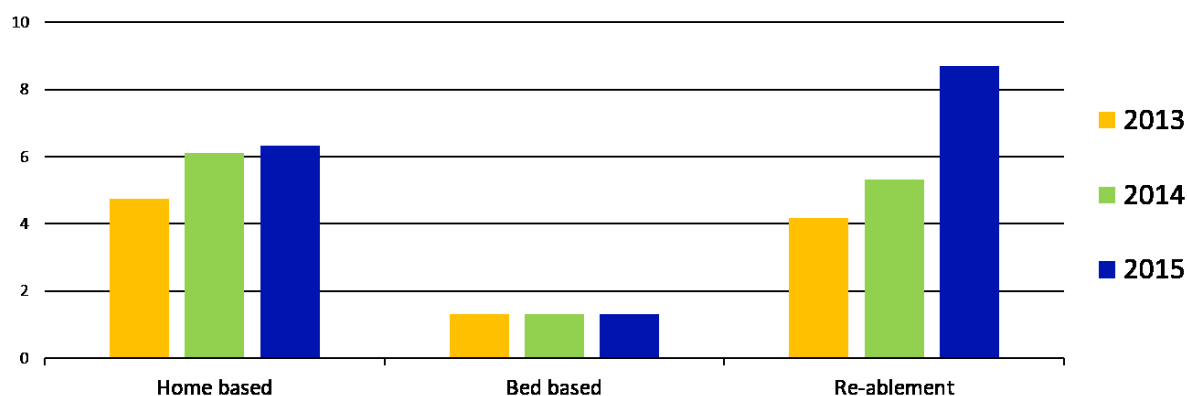


Waiting times

The position on waiting times supports the argument the demand for IC is continuing to outstrip capacity (see chart below). Waiting times from referral to assessment worsened again in 2015, and are now over 6 days for home and 8.7 days for reablement. For bed based IC, there was a wait of 1.3 days referral to assessment (shown in the chart) in 2015, then a further 1.7 days, from assessment to commencement of service.

These waits are obviously a concern in terms of adding to secondary care pressures, as evidence from NAIC shows that around a third of people from home/re-able are waiting in an acute bed. Evidence from research carried out by Prof John Young (1) demonstrates that these waits are highly damaging for older people, as their optimum rehabilitation window may be missed.

Average waiting times from referral to assessment (days)

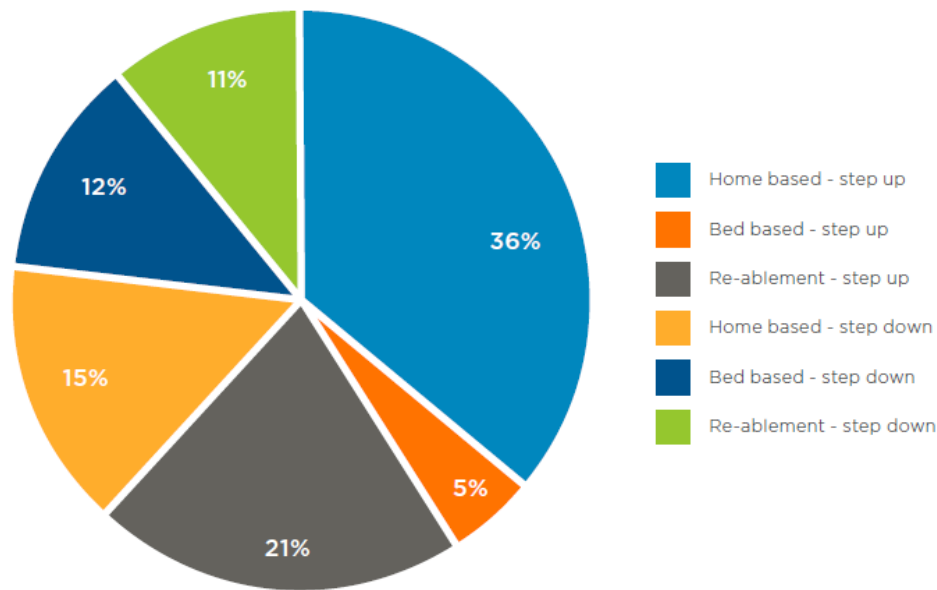


Waits in days	2013	2014	2015
Home based	4.76	6.12	6.33
Bed based	1.32	1.32	1.32
Re-ablement	4.18	5.31	8.7

John Young, then NCD for Integration and Frail Elderly, in his forward to NAIC 2015 Summary Report, recommended a target maximum two day waiting time for IC services. His suggestion is that the percentage of people waiting more than two days for IC access, should be regularly reported.

Use of capacity: balance of step up/down and balance of bed /home

The balance of capacity reported in NAIC 2015, was a follows:



Measures of participation and wellbeing

In NAIC 2014, two domains of the Adapted Therapy Outcome Measure (2) were included in the home based IC service user questionnaire. The domains utilised were participation (social engagement) and wellbeing. The results were as follows:

	Participation	(n)	Wellbeing	(n)
Average score on admission	2.91	3101	3.46	3096
Average score on discharge	3.31	2598	3.77	2595
Average change	0.36	2577	0.28	2573

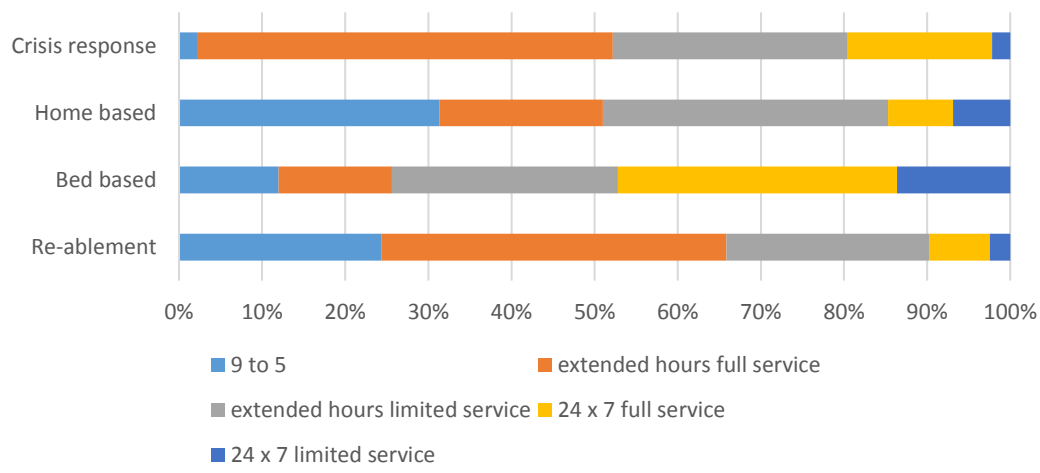
Accessibility of services: days open to admissions

96% of crisis response, 90% of bed based, 72% of home based and 78% of re-ablement services are open to admissions 365 days a year.

Accessibility of services: days open to admissions

The opening hours profile (% of services stating yes to each option) for the four service categories is as follows (figures are given in table below). Extended hours means earlier than 9am and/or later than 5pm.

Figure 6.4.4: Opening hours



	Crisis response	Home based	Bed based	Re-ablement
Hours open to new admissions				
9 to 5	2.2%	31.4%	12.0%	24.4%
extended hours full service	50.0%	19.6%	13.6%	41.5%
extended hours limited service	28.3%	34.3%	27.2%	24.4%
24 x 7 full service	17.4%	7.8%	33.6%	7.3%
24 x 7 limited service	2.2%	6.9%	13.6%	2.4%

References (if applicable):

- (1) An estimate of post-acute intermediate care need in an elderly care department for older people, Young J, Forster A, Green J (2003)
- (2) Enderby P, John A & Petherham B (2006) Therapy Outcome Measures for speech and language therapists, physiotherapists, occupational therapist and rehabilitation nursing (2nd edition). Wileys,UK