National Audit of Intermediate Care

Summary Report - England

2017

Assessing progress in services aimed at maximising independence and reducing use of hospitals

This report covers organisational level data relating to the period 2016/17. Service user and patient reported experience data was collected between May and August 2017.

Published: November 2017, NHS Benchmarking Network
Document Reference: NAIC2017

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 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 **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 **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, promote better education and training of speech and language therapists and provide information for members and the public about speech and language therapy. Speech and language therapists work with patients of all ages including children with developmental speech and language impairments and the elderly with acquired difficulties requiring rehabilitation.

The Patients Association is a national health and social care campaigning charity which has been in existence for 51 years. Our motto is ‘Listening to Patients, Speaking up for Change’. We strive to ensure that patients’ views and experiences are heard. Themes from our national Helpline, large scale surveys and casework influence our campaigns. We also work with NHS organisations to facilitate service improvement through our national project work and staff training. We advocate for better access to accurate and independent information for patients and the public; equal access to high quality health and social care; and the right for patients to be involved in all aspects of decision making regarding their care and treatment.

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

NHS England leads the National Health Service (NHS) in England. We set the priorities and direction of the NHS and encourage and inform the national debate to improve health and care. We want everyone to have greater control of their health and their wellbeing, and to be supported to live longer, healthier lives by high quality health and care services that are compassionate, inclusive and constantly-improving. We have devised a strategic vision for the NHS, along with our partners in health, called the Five Year Forward View. And now, with our partners, we are delivering that vision. We strongly believe in health and high quality care for all, now and for future generations.

Contents

Appendices

1: Foreward

Professor Martin J Vernon
National Clinical Director for Older People and Integrated Person-Centred Care, NHS England

I am pleased to introduce the National Audit of Intermediate Care (NAIC) Summary Report 2017 for England. The audit represents the largest and most comprehensive assessment to date of this key group of community services. Findings from this iteration of the audit are especially pertinent, given that there was no audit in 2016.

The information published in this Summary Report provides an updated picture of what is happening within intermediate care services, which are delivering care and support largely, but not exclusively, to older people living with complex conditions including frailty, multi-morbidity and with reduced functional ability. These increasingly vital services are a barometer for the care of this cohort of older people as they move through our health and social care system.

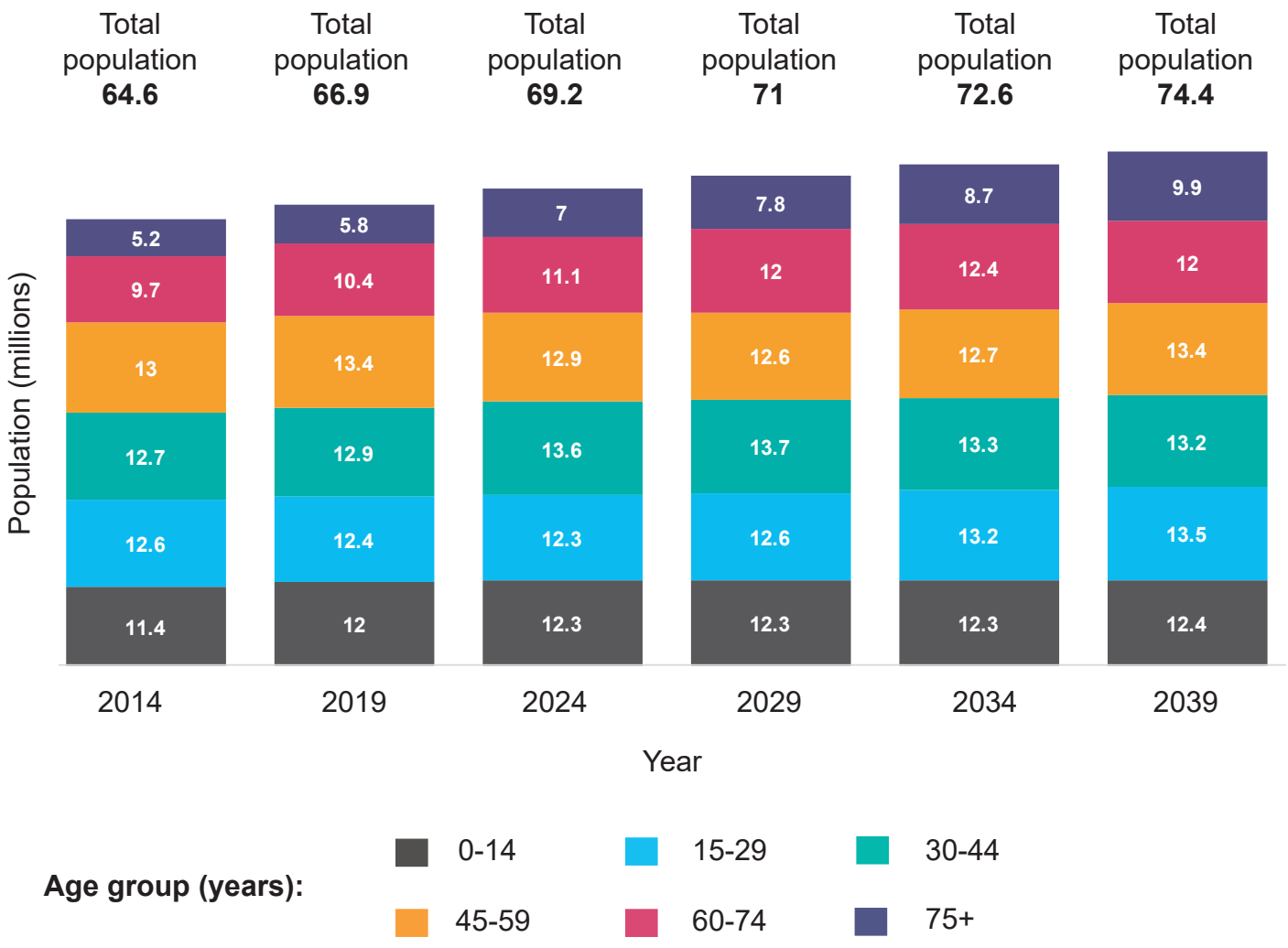
We know from NAIC 2017 that the average age of service users in bed based intermediate care is 83 years, in home based services is 80 and re-ablement services, 79. In bed based services, 25% of service users are over the age of 90. We also know that expansion of the older population will accelerate over the next 20 years. By 2035, the Government Office for Science predicted there will be 14.5 million people who are over the age of 65; within this figure, 1.1 million people will be aged 90 plus. 15 million people currently live with a long-term condition, with 58% of these being over the age of 60.

Intermediate care services are well placed to offer timely and effective interventions when people experience an exacerbation of their long-terms conditions, as well as for rehabilitation and recovery, following a period of acute illness. The definition of intermediate care, can be found on page 17 of the NAIC Summary Report 2017.

England's ageing population and the impact of intermediate care

An ageing population is a challenge to UK society, along with other developed economies of the world. The challenge is to keep this population as healthy and functionally independent as possible, well into old age.

We know intermediate care works. The findings from NAIC 2017 show that the average change in the dependency score of service users in bed based services in NAIC 2017 was 18.8 points (representing a 35% improvement) and that the average score on admission was 54.1 (compared with 57.3 in NAIC 2015), suggesting a more dependent cohort of patients entering bed based intermediate care. This and previous iterations of the audit have demonstrated that across all service categories, good outcomes for service users are delivered. Moreover, the audit has also demonstrated that service users of any age (even the very old) have the propensity to benefit from intermediate care, and become less dependent, following intervention from the service (NHS Benchmarking Network et al., *NAIC Summary Report 2014*).



NHS England's strategy

NHS England's *Five Year Forward View* and *Next Steps for the Five Year Forward View*, published earlier this year, makes specific mention of the national strategy for supporting older people. This is unsurprising given the population changes noted above, and the impacts that ageing and the acquisition of frailty has on health outcomes. There is a strong focus on prevention, a role for stronger provision of community services (which, when closely aligned to acute health care and social care, are crucial in supporting older people to live independently at home), the further integration of care, and a lead role for GPs. Intermediate care remains at the forefront of the integration agenda and progress is explored in the audit.

Driving up quality in intermediate care services

September 2017 saw the timely publication of the new NICE guidelines NG 74 on *Intermediate care including re-ablement.* The NAIC Steering Group was pleased to note that the NICE Guideline Development Committee utilised the four service category definitions (see Appendix 3) developed by the National Audit of Intermediate Care. Worth particular mention within the guidelines is a recommendation that all four elements of intermediate care should be made available locally, delivered in an integrated way, so that service users can move easily between them, with care dependent upon their individual needs, wrapped around them. The NICE Guidelines also outline the key operational components of closer working, which are tested within the audit.

The NICE guidelines recommend that intermediate care teams contain a broad range of disciplines, including nursing, social work and therapy professions. As a geriatrician, I am particularly pleased to see emphasis on *Comprehensive Geriatric Assessment* within the *NICE Guidelines*, an evidence based intervention for older people with complex conditions, proven to produce better outcomes for this patient group. This report covers the workforce aspects of intermediate care services in section 6.7.

The NAIC Steering Group is particularly pleased to see the inclusion of a standard covering the need to refer service users to bed based intermediate care who are in an acute but stable condition, but not fit for a safe transfer home. The guideline also introduces an important aim for bed based services to start within two days of receiving an appropriate referral, in order to reduce the risk of further deterioration. This report highlights how well services are currently adhering to this guideline.

Maintaining flow in the system

The average age of hospital patients has been rising steadily for years. Between 2005/6 and 2015/16 the number of admissions in England for patients aged 44 and under rose by just under 9%, while for those over 45 it rose by almost 44% to nearly 10 million[1]. At the same time the growing population of older people has been accompanied by a disproportionate

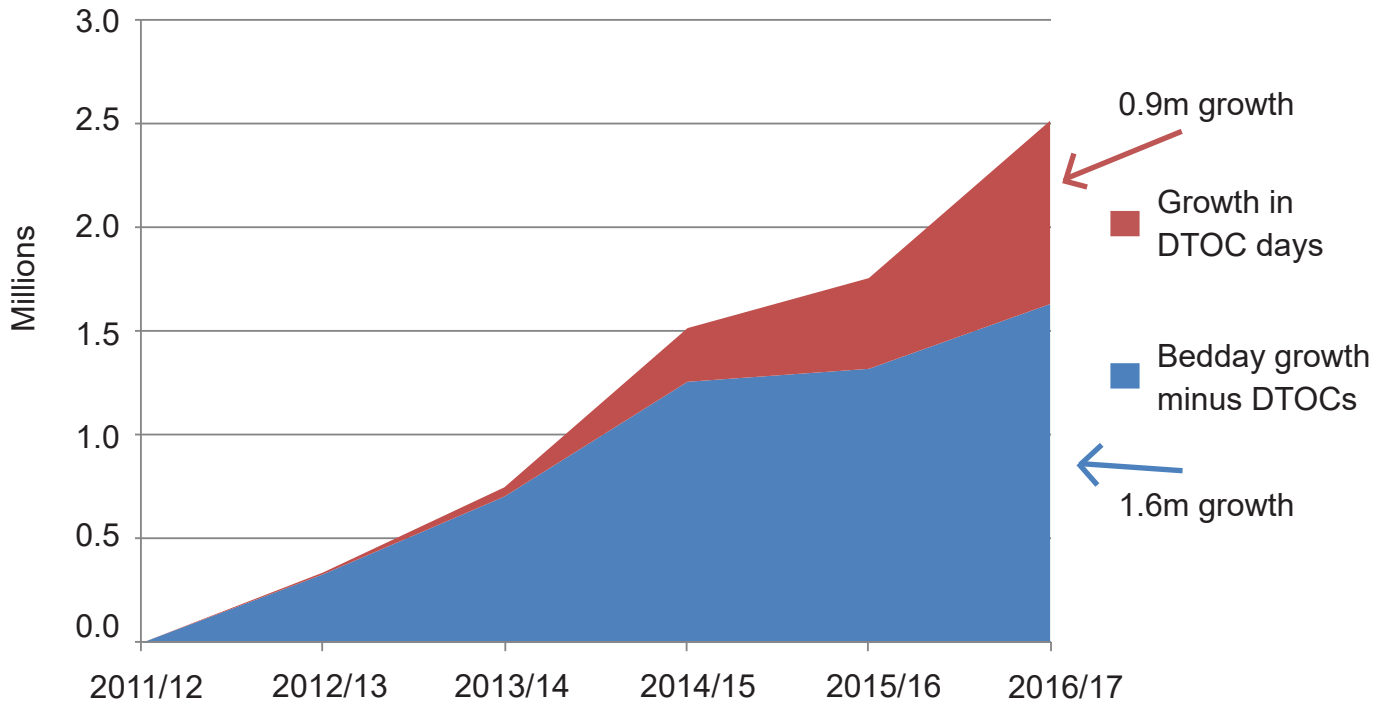
1 http://content.digital.nhs.uk/article/7491/Hospital-admissions-hit-record-high-as-population-ages

growth in older people admitted to hospital. For example, the number of people aged 65 to 69 has grown by 34% in the last 10 years, with corresponding hospital admissions growing by 57%.

Furthermore, there has been a cumulative growth in bed days and Delayed Transfers of Care (DTOC) since 2011/12. The chart below illustrates this growth in bed days associated with DTOC, particularly between 2014/15 and 2016/17. The NHS Benchmarking Network's report on *Older People's Care in Acute Settings*, collecting data on DTOCs at 2015/16 outturn, illustrated that in the 85+ age group, 17% of DTOCS were awaiting intermediate care, whilst 22% were awaiting a care package in their own home. This is set against a steady reduction of general and acute beds since 2010 of 8%.

Delays in health care delivery serve no benefits to anyone, particularly for those most in need. As all parts of the health and care system come under increasing pressure, maintaining flow through the timely and effective delivery of care is becoming one of our biggest public service challenges to date. Intermediate care, as a key part of an integrated whole systems approach, has a crucial role in maintaining flow through the acute sector. In NAIC 2012, it was calculated that intermediate care capacity needed to double to meet demand, and make an impact upon secondary care utilisation. As in previous audits, the findings from the 2017 iteration do

Cumulative growth in bed days and DTOC since 2011/12



If we look at growth in emergency bed days and DTOCs since 2011/12, DTOCs account for about a third* of the cumulative growth since then.

* This assumes that only a negligible proportion of DTOCs are for non-emergency care.
Sources: *NHS England published DTOC data - April 2011-March 2017; SUS bed days data for financial years 2010/11 to 2016/17*

not suggest any step-change in investment has been achieved (section 6.4 of this report).

The jointly developed *High Impact Change Model* highlights a number of tools for health and social care economies to use for managing service user flow and transfers of care. Within the model, intermediate care is an essential component to facilitate early discharge, monitor patient flow in the system, provide MDT assessment and intervention, wrapped around service users' individual needs, assist with early supported discharge schemes and more latterly, with discharge to assess. Discharge to assess models have become increasingly recognised as effective where service users have been deemed "clinically optimised", no longer require an acute hospital bed, but may require some care and support to be provided in the short-term to enable them to regain functional independence at home. This is a key function of intermediate care services.

Service user experience is important

With all this in mind, and as a clinician, I am especially pleased to be associated with a national clinical audit that has delivered one of the largest involvements of service users. As can be seen in the table on page 23, in England, over 12,000 service users contributed to the audit, with over 5,000 service users giving us feedback about their experiences of intermediate care services.

How the data will be used

NHS RightCare is a national NHS England supported programme committed to delivering the best care to patients, making the NHS's money go as far as possible and improving patient outcomes[2]. This innovative programme uses leading edge medical evidence and practical support to help local health economies understand how money is spent to deliver the best care in different parts of the country. The data collected as part of NAIC 2017, will be used as part of this programme for the first time, and will be used to help identify unwarranted variation, assist with designing optimal care pathways to improve patient experience and outcomes, and ultimately to deliver sustainable change across England. We are hopeful that the NAIC data, not available currently elsewhere in the NHS, will help with delivery of this important programme focused on maintaining delivery of quality healthcare for NHS service users.

The future

The demand for high quality care and support for older people with health and care needs will continue to increase. Many of these will be older people living with frailty, have multiple long-term conditions, or lost functional ability risking their maintained wellbeing. Complex and evolving social and economic determinants of adverse health outcomes coupled with changing and diverse family structures place communities, families and individuals under considerable pressure when attempting to maintain wellbeing for themselves and those most important to

2 https://www.england.nhs.uk/rightcare/what-is-nhs-rightcare/

them. Our health and social care system must be adequately equipped to deal with this increasingly complex population and their needs. The *Five Year Forward View* is explicitly committed to strategies focused on prevention which are working towards minimising future health care needs. At the same time our current systems must be optimised sustainably to keep them safe, effective and providing positive experiences of care to service users. Intermediate care is a key component of the community services we provide to achieve this. The National Audit of Intermediate Care provides an essential tool for both commissioners and providers of intermediate care to make decisions about its provision and quality improvement into the future. I commend the audit to you.

Martin J Vernon
National Clinical Director for Older People and Integrated Person-Centred Care, NHS England
Consultant Geriatrician, Manchester University NHS Foundation Trust

2. Executive summary

Intermediate care and re-ablement services are an essential element of national healthcare policy to provide health and care closer to home and avoid hospital admissions. NHS England's *Five Year Forward View* and *Next Steps for the Five Year Forward View* emphasise the need to help frail and older people stay healthy and independent, a key function of intermediate care. Policy documents call for greater integration across all sectors of the health and care system aimed at slowing growth in hospitalisations and improving people's quality and experience of care. Intermediate care remains at the forefront of this agenda.

Intermediate care services improve patient flow through the system. *The High Impact Change Model for Managing Transfers of Care* suggests local systems should provide short-term care and reablement in people's homes or use 'step down' beds to bridge the gap between hospital and home so that people no longer need wait unnecessarily for assessments in hospital. The provision of sufficient intermediate care and re-ablement capacity for people stepping down from hospital reduces delayed discharges and improves patient flow. Additionally, the admission avoidance (step up) function of intermediate care reduces unnecessary hospital and long-term care admissions.

The National Audit of Intermediate Care (NAIC), now in its fifth iteration, provides a unique assessment of progress in community services aimed at maximising independence and reducing use of hospitals and care homes. The audit provides a comprehensive analysis of the models and performance of services that support, typically older, people living with frailty with high levels of need and complex comorbidities, at transition points in the system. The audit looks at four service categories; crisis response, home based intermediate care, bed based intermediate care and re-ablement services. The service user audit and patient reported experience measure included in the NAIC, eliciting over 20,000 responses from England, Wales and Northern Ireland this year, provide unique evidence on the quality, effectiveness and experience of services.

The publication of the new NICE guideline *NG 74 Intermediate Care including reablement,* brings a welcome focus on intermediate care services, highlighting good practice and making recommendations on equity of access and a more integrated approach to provision. The audit provides an early test of compliance with some of the guideline's key recommendations.

The key themes evident from NAIC 2017 are:

Effectiveness of intermediate care

Evidence from the audit demonstrates that intermediate care works with more than 91% of service users either maintaining or improving their level of independence in undertaking activities of daily living, during their episode of care.

In 2017, the mean percentage improvement in dependency levels recorded were 31% for home, 35% for bed and 36% for re-ablement services. The dependency levels of people on admission, and the improvements made during their stay, were similar to the 2015 results for home and re-ablement services. However, people admitted to bed based services were more dependent on admission in the 2017 sample, but made a similar improvement in dependency, when compared to 2015.

Reflecting the increased dependency of people in bed based services in the 2017 sample, a lower proportion returned home and a higher proportion returned to acute hospitals, than in 2015. However, overall the percentages of people returning home for the three categories of intermediate care remained high at 80% for home, 69% for bed and 83% for re-ablement services.

Service user experience

The experience of intermediate care service users was generally positive with all the aspects of services investigated by the Patient Reported Experience Measure (PREM) obtaining high results. Over 91% of people felt they had been treated with dignity and respect. The median PREM summary scores for home, bed and re-ablement services are similar to those recorded in NAIC 2015.

From the open narrative question, the most common source of praise was staff attitudes and 'receiving good service or care'. The most common themes for service improvement were facilities (in bed based services), communication, timing of visits (in re-ablement services) and the need for joined up services.

A full report on the PREM open narrative responses is available on the NAIC webpages.

Integration

Integration at the strategic level between health and social care continues to progress with the incidence of multi-agency boards with a remit over intermediate care and the use of *Section 75* pooling arrangements both increasing in NAIC 2017.

Over half of commissioners are commissioning integrated services but many have yet to develop a single point of access, a single management structure and a single assessment process, as recommended in the *NICE guideline*, suggesting there is still work to be done on these operational components of closer working, to achieve truly integrated services.

Analysis of referral sources suggest crisis response services are well integrated within the health and social care system. However, the links between health and social care in the other service categories appear weak when reviewing national average positions, suggesting the need for closer working between sectors, for example, to ensure referral pathways are optimised.

Investment and capacity

It was calculated in NAIC 2012 that intermediate care capacity needed to approximately double to meet demand. Given the ageing population and the increase in emergency admissions, it is likely that demand has continued to rise over the last five years. However, as in previous iterations of the audit, there is no evidence to suggest the step change in investment and capacity needed to meet demand has been achieved in 2017. Total investment in intermediate care services is around £2.8 million per 100,000 weighted population.

Whilst expenditure on beds has increased slightly, the increase has been absorbed in higher costs for bed based provision, rather than increased capacity. The evidence suggests the number of beds commissioned per 100,000 weighted population has reduced in 2017. Higher costs are being driven by increased staffing levels and, possibly, also by the implementation of the living wage in care home sector. Increased staffing levels may in turn reflect increased service user dependency within bed based services (section 6.1).

A factor in the static investment position may be the difficulty commissioners have in allocating funds to intermediate care within current funding arrangements where separate, competing funding models exist for each part of the health and social care system. There is an opportunity with new structures such as Accountable Care Systems, for new funding models to be explored which would better incentivise a whole system approach, for example, capitated budgets for older people.

In addition to total investment levels, the balance of step up and down provision within intermediate care systems should be considered to ensure there is adequate step up capacity, which may come under pressure from step down demand. This year's results suggest re-ablement services are being increasingly used for step down provision, which may reflect the pressure on social care to assist in reducing delayed transfers of care.

Access to intermediate care services

Waiting times are a key measure of accessibility and are particularly important for older people who may deteriorate rapidly whilst waiting for an intermediate care service in an acute hospital bed. The importance of limiting waiting times has been recognised in the recently published *NICE guideline*, which states that bed based intermediate care should be started within two days of receiving an appropriate referral.

A new metric on the two-day wait quality standard has been introduced into the audit this year for three service categories; home, bed and re-ablement services. Performance is highly variable with results ranging from 100% to 0% of people waiting more than two days for referral to commencement of service. Average waiting times have slightly reduced in home based services to 5.8 days (referral to assessment) and 2.5 days (referral to commencement) in bed based services. Whilst the reduction is welcome, the averages are still higher than the two-day wait standard.

Home services have improved their availability with more services open at weekends and less services limited to a 9 to 5 service.

Workforce

The attitude of staff was the most common source of praise in the PREM open narrative question for bed and re-ablement services, reflecting the dedication and professionalism of the intermediate care workforce.

Staffing levels have increased in bed based services, which may be driving the cost increases noted above.

The audit provides evidence to support multi-disciplinary team working with service user outcomes improving the more types of staff people come into contact with. Analysis of the discipline mix suggests social care remains poorly represented in health based intermediate care services and mental health workers are rarely included in intermediate care service establishments. Therapy input remains limited in bed based services, at around 10% of the workforce, and appears to have declined in re-ablement services to just 3% of the workforce.

Mental health provision within intermediate care services

The inclusion of mental health workers within the establishment of intermediate care services remains unusual (less than 1% of the establishment) (section 6.7). However, around one third of services are able to access mental health services directly and more than a quarter of commissioners are now including mental health specialists in integrated teams (in home and re-ablement services).

The picture for those with cognitive impairment is mixed with almost all home based services stating that their services are open to service users with cognitive impairment (96%); in contrast, a lower proportion of bed based services say they accept people with cognitive impairment (81%).

Intermediate care service user demographics and processes

The demographic profile of intermediate care service users is broadly unchanged since 2015. The average age of intermediate care service users in the NAIC 2017 service user sample was 80 years in home based services, 83 years in bed based services and 79 years in re-ablement services. The proportion of people aged 90 and over in bed based services has plateaued at 25%, after increasing every year between 2013 and 2015.

Evidence from the audit suggests those service users with a documented care plan and a care plan that has been reviewed by the multi-disciplinary team, have better outcomes.

The NAIC 2017 included a new question on screening for frailty. Screening was most likely to occur in bed based services.

NAIC 2017 - key findings at a glance

Workforce

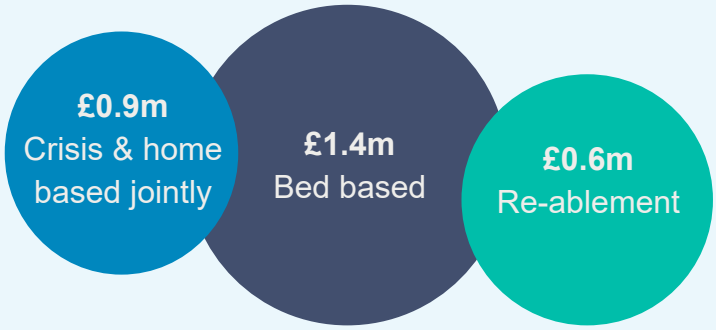
Home based
2.7 clinical WTE
per 100 service users

Bed based
1.5 clinical WTE
per bed

Re-ablement
6.5 clinical WTE
per 100 service users

Investment

per 100,000 population



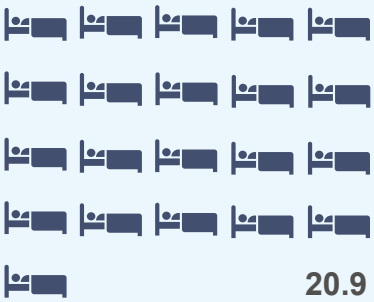
Referrals

per 100,000 population

Home based | Bed based | Re-ablement | Crisis response

Beds commissioned

per 100,000 population

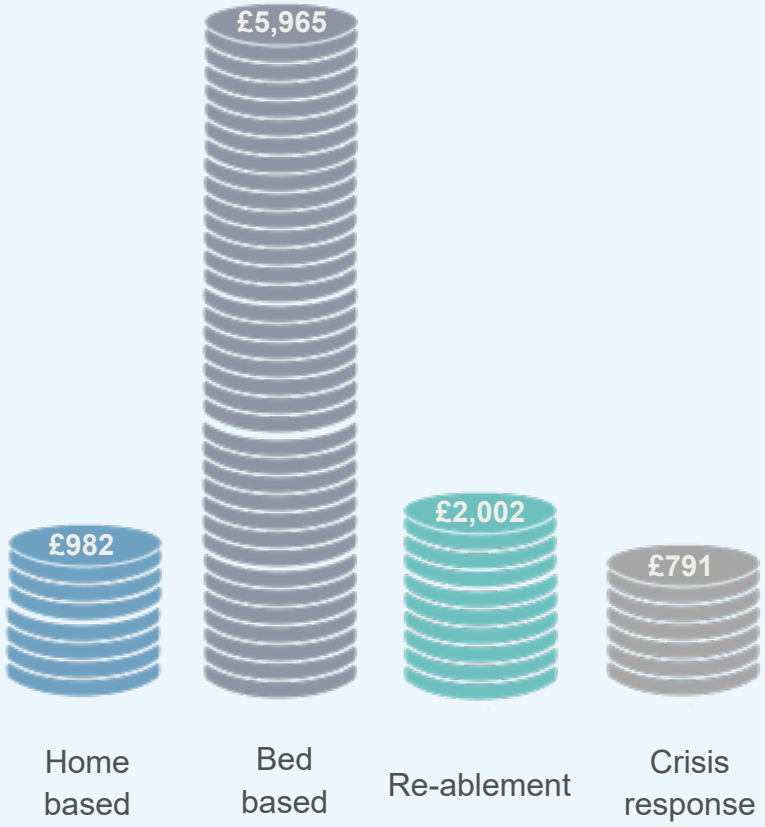


Waiting times

Referral to assessment

Home based | Bed based | Re-ablement | Crisis response

Direct cost per service user accepted

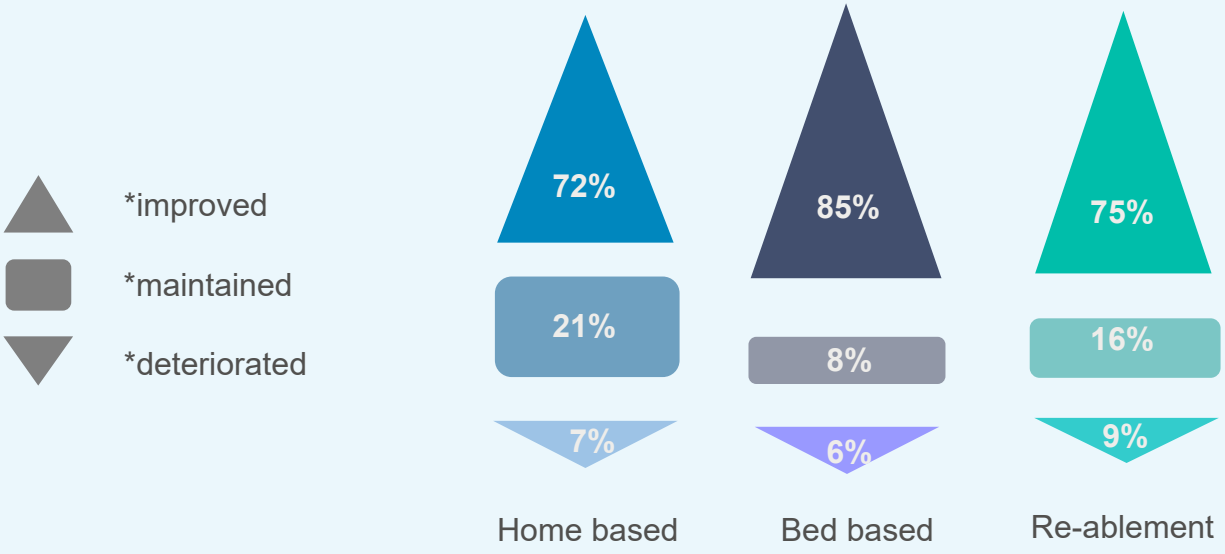


Length of stay

Against 6 week limit recommended in *Halfway Home*

Outcomes

% of patients whose dependency was maintained or improved



3. Introduction

The National Audit of Intermediate Care is now in its fifth iteration. This high-level report gives a summary of the findings from both the commissioner and provider aspects of the audit for 2017 for England only. Additional Summary Reports have also been provided for Wales and Northern Ireland, who also participated in NAIC 2017. The report will provide an analysis of trends using data from previous iterations of the audit. All commissioners and providers who took part in the audit will receive a bespoke report, highlighting their results against the nationally reported position for selected key metrics. In addition, the online benchmarking toolkit is available to participants on the members' area of the Network website, providing comparisons for the full range of metrics calculated from the NAIC dataset.

A commentary is provided in this England Summary Report, on the results of the commissioner level audit and on the four provider service categories within intermediate care as defined by the audit; crisis response, home based intermediate care, bed based intermediate care and re-ablement services (see Appendix 3 for full service category definitions). Results on compliance with commissioner quality standards are included in section 7.

The audit previously ran from 2012 to 2015. There was no audit in 2016, due to funding constraints. The report presents findings from data collected during 2017 in respect of the NHS financial year 2016/17. NAIC 2015 refers to data collected for 2014/15. Reports for previous years of the audit can be found here.

The audit is a partnership project between the British Geriatrics Society, AGILE – Chartered Physiotherapists working with older people, the Royal 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, ADASS – Directors of Adult Social Services, and the NHS Benchmarking Network. A Steering Group (see Appendix 1) comprising representatives from the partner organisations guided the audit. Project management, data collection, analysis and event management were provided by the NHS Benchmarking Network.

For NAIC 2017, NHS England supported the audit and encouraged all CCGs to take part. As in previous years, HQIP included the National Audit of Intermediate Care on the *2017/18 Quality Accounts* list.

In addition, during 2017, NICE published their new guideline, *Intermediate Care including reablement (NG 74)*. A member of the NAIC Steering Group was selected to work with the NICE guideline development committee, and the NAIC Steering Group was pleased to note that the four service category definitions (see Appendix 3) used throughout the lifetime of the audit were used to frame the NICE guidelines.

NAIC 2017

A core aim of the audit continues to be the examination of variation and effective use of resources in intermediate care. The Steering Group also agreed to continue the

emphasis on quality and "what good looks like" in intermediate care commissioning and provision in the 2017 iteration of the audit. However, the NAIC constantly evolves based on feedback from audit participants. As there had been a gap in the NAIC in 2016, the NAIC Steering Group, reviewed all feedback from NAIC 2015, conducted a survey with both commissioners and providers of intermediate care to obtain feedback, and held a workshop with key stakeholders (national bodies were included, as well as commissioner and provider representatives), to review the content on the organisational level, and the service user, audit.

For the 2017 iteration, the NAIC Steering Group agreed the following changes:

- The NAIC Steering Group membership and Terms of Reference was reviewed to involve representatives from NHS England, NHS Wales and the Northern Ireland Public Health Agency, given the support for the audit from the three countries.
- To ensure that the questions asked were applicable to Wales and Northern Ireland, some additional clarification on definitions / updates on terminology was required, but, in the main, metrics were applicable to all three countries.
- To continue to keep home based intermediate care services and re-ablement services separate as in previous years, due to differing activity currencies used in the monitoring of these services. Additional questions were agreed on the provider organisational level audit to further test how well integrated services were on the ground.
- The question posed in the NAIC 2015 Summary Report by the then National Clinical Director for Integration and Frail Older People, Professor John Young, on introducing a new national indicator on a "two-day wait" for access to intermediate care services was agreed as a key metric to collect in the 2017 audit. Section 6.5 contains the findings on this important target. The *NICE Guideline* included a recommendation for bed based intermediate care services that service users should not wait longer than two days.
- Further workforce categories were introduced to the provider audit, and additional clarification questions asked on intermediate care team training and the operation of trans-disciplinary roles in practice.
- An additional section on "Quality" at an organisational level was included for the four provider services.
- All participants would be requested to participate in the service user audit rather than "opt-in" for this element of the audit used in previous years.
- The service user questionnaire would be reviewed to ensure clarity on the pathways into intermediate care services, and additional questions on the assessment of frailty would be introduced, given the cohort of service users in intermediate care services.
- The Steering Group agreed that, as in previous years, the service user audit would not be extended to crisis response services due to the very short-term nature of these services, and their main function being assessment and triage, prior to signposting

to other services.

- The Patient Reported Experience Measure (PREM) questions for both bed and home / re-ablement services were reviewed following the validation of the PREM tool undertaken after NAIC 2015 (see section 4.4).

Objectives

The objectives of the NAIC 2017 are:

1. To assess performance at the national level against key performance indicators and quality standards and provide benchmarked comparisons at the local level to facilitate service improvement.

2. To assess the service user experience of intermediate care through the Patient Reported Experience Measures (PREM) for bed, home and re-ablement services, highlighting areas of improvement that are important to service users.

3. To introduce and collect standardised outcome measures for intermediate care and to use the outcomes data to understand the key features of high performing services.

4. To provide evidence of the whole system impact of intermediate care to assist commissioners in making the case for intermediate care investment.

5. To inform future policy development within the Department of Health (DH), NHS England, NHS Wales and the NHS in Northern Ireland.

6. To continue to share good practice in intermediate care services by encouraging networking amongst participants and developing case studies.

4. Methodology

4.1. Scope

For the purposes of the audit, the definition of intermediate care provided by the Department of Health (*Intermediate Care - Halfway Home*) is used; “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”. An explanation of intermediate care was developed in 2013 with the Plain English Campaign to supplement the Department of Health definition (see box below).

The four categories of service defined for the previous iterations of the audit have been used again in 2017; crisis response, bed based intermediate care, home based intermediate care and re-ablement. The defining features of these categories (setting, aim of service, period of service and nature of workforce) are set out in Appendix 3.

Crisis response is distinguished by having a standard response time of less than four hours and interventions typically lasting up to 48 hours. Bed based services are distinguished by their setting. Home based intermediate

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, 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.

care services are provided to service users in their own homes by a multi-disciplinary team but predominantly health professionals. Re-ablement is provided to service users in their own homes by a multi-disciplinary team but predominantly social care professionals. These categories were developed to ensure comparability when benchmarking and to allow for the different units of currency used in health and social care (for example to record activity).

The definitions for crisis response, home and bed based intermediate care are consistent with reference cost guidance *Combined costs collection: reference costs collection guidance 2016/17.*

4.2. Eligibility, recruitment and registration

All commissioners and providers of intermediate care across the NHS in England were invited to participate. Although the findings from Wales and Northern Ireland are the subject of separate Summary Reports for contextual purposes, all Welsh and Northern Ireland services identified as either commissioning or providing intermediate care services participated. NHS Scotland decided not to participate due to a separate national intermediate care work programme. In England, letters inviting organisations to register were sent to the Boards of all CCGs, Local Authorities, Health & Wellbeing Boards and Trusts in the NHS, together with a detailed proposal for the audit. All previous contacts from the operation of NAIC over the previous iterations were also contacted. The audit in England was supported by NHS England, enabling all commissioners and providers of intermediate care services to participate, however, this was not mandated.

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 categories. Providers were requested to list the commissioners for whom they provided services.

4.3. Audit structure and content

The audit was structured with organisational and service user level components. 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:

- Population covered
- Quality standards (based on *Intermediate Care - Halfway Home*)
- Services commissioned
- Access criteria
- Intermediate care funding
- Crisis response activity
- Home based activity
- Bed based activity
- Re-ablement activity

Providers were asked to give responses for each service identified at registration.

Questions, which varied to some extent for each of the four service categories, covered the following topics:

- Service models
- Funding
- Activity
- Workforce
- Quality (introduced as a new section for the 2017 audit).

Although some audit questions have undergone refinement (as reported in section 3), changes were kept to a minimum to ensure comparability between years.

NAIC 2017 included a service user questionnaire for home based services, bed based services and re-ablement services. A PREM was delivered in home based, bed based and re-ablement services, with the same version of the PREM being used in home based and re-ablement services. The questions were slightly different for home / re-ablement services and bed based services, to reflect the different settings of care.

4.4. Development of the service user questionnaires and PREM for NAIC 2017

Service user questionnaire development for NAIC 2017

Both service user questionnaires for bed based services and home / re-ablement services underwent some changes from the questionnaire administered in NAIC 2015. The NAIC Steering Group chose to keep the outcome measures used in previous years of the audit, as follows:

Intermediate care service	Outcome measure utilised
Bed based	*Modified Barthel Index*
Home based / re-ablement	*Sunderland Community Scheme* Two domains of the *Therapy Outcome Measurement* tool: • Participation • Wellbeing

The *Modified Barthel Index* has been collected for the last four iterations of the audit (NAIC 2013 to NAIC 2015, and again in NAIC 2017), whilst the home / re-ablement outcome measure has been collected for the last three years of the audit (NAIC 2014 and NAIC 2015, and again in NAIC 2017).

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's intention was to promote standardisation around commonly accepted and utilised tools, as a way of moving the agenda on the measurement of effectiveness forward. The high level of responses to the service user audit, making it one of the largest clinical audits in England (section 5.1), suggests this strategy has been successful in building a consensus around the selected tools and enabling meaningful benchmarking to be undertaken.

For NAIC 2017, additional questions were asked in both service user questionnaires on ethnicity, further options on where the service user was admitted from and whether the

service user had been screened for frailty.

The service user questionnaire was designed to be used prospectively to overcome some of the technical limitations of retrospective samples.

As the service user questionnaire had been piloted extensively in previous iterations of the audit, the NAIC Steering Group agreed that further piloting was not necessary.

Bed based services were requested to complete service user questionnaires for 50 consecutive referrals to services, and for home based and re-ablement services, 100 consecutive referrals. In all cases, the PREMs were detached from the questionnaires and given to service users on discharge from the service. Carers were requested to help service users complete the PREM forms where required.

PREM development for NAIC 2017

The PREM was first utilised in NAIC 2013. Since then, in the iterations of the audit that followed, the PREM has been validated every year with the assistance of the Academic Unit of Elderly Care and Rehabilitation, Bradford Institute for Health Research. A full description of this can be found in the *NAIC Summary Report 2015, NHS Benchmarking Network et al.*, and it has also been explained in further detail in *A Patient Reported Experience Measure (PREM) for use by older people in community services.*

The PREM was validated again at the end of the 2015 iteration of the audit. This was in relation to the PREM questions measuring key domains of patient experience, but also to assess again whether the questions asked could be aggregated to form a PREM Summary Score. Feedback from participants in previous years had indicated that although the detailed benchmarked responses on the PREM were useful for services, it would be useful for services to have an overall PREM Summary Score which would assist services with assessing progress with patient experience year on year. In summary, the Bradford Institute for Health Research concluded that each of the PREMs measured a single construct with moderate scaling properties, allowing a summation of scores, for a number of questions, to give a composite measure of patient experience. Therefore, the PREM summary score is measured out of a possible score of 12 for home based and re-ablement (12 being the highest and 0 being the lowest score), and is measured out of 14 for bed based (14 being the highest and 0 being the lowest score). Rather than using the mean to report a national average position, it has been advised that the median be used as a marker of central tendency.

As four questions were identified as not to be included within the PREM Summary Score, the NAIC Steering Group took the decision to conduct a Delphi process to identify whether other questions ought to be included for the 2017 PREMs. The Patients Association assisted the NAIC Steering Group with identifying potential replacement questions. A Delphi process was conducted, which consisted of one round only, as Steering Group members reached an early consensus that the original questions from the 2015 audit

should remain. The PREM questions therefore remained unchanged from 2015 to 2017.

The open narrative question for both versions of the PREM, “Do you feel there is something that could have made your experience of the service better?” has also remained the same for the 2017 audit.

The full PREM results, the PREM open narrative question responses and the PREM summary score are reported in the online benchmarking toolkit, and in the provider bespoke dashboard reports.

4.5. Data collection

The data collection process was managed by the NHS Benchmarking Network with data collection for the organisational level audit taking place between 2nd May 2017 and 18th August 2017. Data was requested for 2016/17 outturn.

Data collection for the organisational level audit was via a bespoke web based data entry audit tool, completed directly by participants, as in previous years. The website and database are hosted within the NHS secure N3 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.

The data collection for the service user level audit was via paper forms completed by intermediate care clinicians (for the bed and home / re-ablement service user questionnaires) and service users for the PREM forms, between 24th April and 18th August 2017. Service users / carers were provided with freepost envelopes to return the PREM forms. All forms were returned to the Document 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.

4.6. Data sharing

The data sharing arrangements for the outputs from NAIC were refined for the 2017 iteration. These were explained in the audit proposal for 2017. For England, these were agreed as follows:

- High level national Summary Report for England – anonymised data reported, report available publicly
- All England data to be made available to NHS England on named basis (however, only commissioner data will be shared further e.g. through RightCare, GIRFT etc.)
- Commissioner positions will be available on named basis to other CCGs and CCGs’ own providers
- Provider positions on a selection of key metrics will be made available to the Provider’s own commissioners only

4.7. Other data sources

Commissioners were requested to supply both registered and weighted population figures for their CCG area. Checking of the population figures was undertaken by using an extract from the NHS England 2016-17 to 2020-21 Allocations – Overall weighted populations for core CCG allocations (Gateway reference number: 05100). These population figures were used in the calculation of benchmarks per 100,000 registered and weighted population within the analysis of the commissioner data.

5. Participation and data quality

5.1. Participation

As in previous years, participation in the audit is voluntary, although supported by NHS England. For NAIC 2017, the participation in NAIC has reached record levels, not only with Wales and Northern Ireland participating, but also in the sign up from both English CCGs / Local Authorities and provider organisations. In England, 154 organisations registered 85 submissions between them (compared to 53 commissioner submissions in 2015). The reason that the number of submissions is lower than the number of organisations is because a large proportion of the commissioner submissions were made on a joint basis, often with their constituent Local Authority, and in some cases, conglomerations of CCGs and Local Authorities, reflecting the changing face of the commissioner landscape in the English NHS. 99 individual CCGs (representing 48% of CCGs in England) and 55 Local Authorities participated in the audit, compared to 61 CCGs and 46 Local Authorities in NAIC 2015.

For the provider level audit, data was provided by 461 services registered by 118 providers in England, representing an increase of 36% in participation levels from the 2015 audit. When these are broken down into the four service category types, there are 56 crisis response services, 134 home based intermediate care services, 227 bed based intermediate care services and 44 re-ablement services. This compares to the 2015 participation of 340 services registered by 95 providers, comprising 48 crisis response services, 109 home based intermediate care services, 139 bed based intermediate care services and 44 re-ablement services.

As the audit is voluntary, there has been some change in the commissioner and provider participants between 2015 and 2017 (approximately 40% of the participants provided data in both years). Conclusions on trends in the data drawn in this report are made after careful review of the trends in both the full and overlapping samples.

Table 5.1.1 outlines the number of service user questionnaires and PREMs returned from participating services in England:

Table 5.1.1 Intermediate care service	Service user questionnaires returned	From number of services	Return rate (%)	PREMs returned	From number of services	Return rate (%)
Home based	5,934	106	56%	2,514	109	23%
Bed based	4,874	144	68%	2,090	147	28%
Re-ablement	1,408	28	50%	709	34	21%
TOTAL	12,216	278		5,313	290	

5.2. Completeness of data

The level of completeness of data from both commissioners and providers is shown in Appendix 4.

For the service user questionnaires, the 2017 iteration had a return rate in England of 56% in home based, 68% in bed based and 50% in re-ablement services. The PREMs always have a lower completion rate, as this depends on the number of service user questionnaires completed. The clinical teams are also dependent upon the service user / carer to complete and return the PREM form. The return rates for the PREMs are 23% in home based, 28% in bed based and 21% in re-ablement services.

5.3. Data validation

Validation controls were implemented on several levels within the data collection tool. A number of information buttons containing data definitions to assist with completion of the data fields were supplied throughout the tool. These were refined where previous years' audits had indicated some difficulty with participants' understanding of exactly what data was required, to ensure the consistency of data supplied. New metrics collected in the 2017 audit had data definitions agreed by the NAIC Steering Group. In addition, system validation was implemented to protect the integrity of the information being recorded, including allowable ranges within fields, expected magnitude of data fields, appropriate decimal placing and text formatting.

During both the registration and data collection period, a helpline was available, manned by the NHS Benchmarking Network, to advise on service and data definitions to ensure consistency of approach. Previous years' helpline logs were reviewed to ensure data definitions in information buttons were refined where required.

An extensive data validation exercise was undertaken with all participants during August and September 2017. Charts generated from the data analysis were reviewed and outlying positions were queried with NAIC participants. NAIC participants had an early sight of the draft benchmarking toolkit to assist with contextualising the validation queries. Due to the increased overall participation, validation queries increased also with 239 queries being raised with providers and 135 queries with commissioners in England.

6. Key themes from NAIC 2017

This section discusses the key themes evident from the results of NAIC 2017. Further detail can be found in the online benchmarking toolkit on the members' area of the Network website, and in the bespoke reports for both commissioners and providers (for participants only). Comparison of the results for the four service categories included in the audit are considered, in addition to the new material for NAIC 2017.

Comments from service users recorded as responses to the PREM open question 'Do you feel that there is something that could have made your experience of the service better?' are shown in text boxes throughout this section.

6.1. Effectiveness of intermediate care

Section summary: Effectiveness of intermediate care

Evidence from the audit demonstrates that intermediate care works with more than 91% of service users either maintaining or improving their level of independence in undertaking activities of daily living during their episode of care.

In 2017, the mean percentage improvement in dependency levels recorded were 31% for home-based, 35% for bed-based and 36% for re-ablement services. The dependency levels of people on admission, and the improvements made during their stay, were similar to the 2015 results for home and re-ablement services. However, people admitted to bed based services were more dependent on admission in the 2017 sample, but made a similar improvement in dependency, when compared to 2015.

Reflecting the increased dependency of people in bed based services in the 2017 sample, a lower proportion returned home and a higher proportion returned to acute hospitals, than in 2015. However, overall the percentages of people returning home for the three categories of intermediate care remained high at 80% for home, 69% for bed and 83% for re-ablement services.

The NAIC supplements the findings from the organisational level data collection with a service user audit, comprising a service user questionnaire (SUQ) and a Patient Reported Experience Measure (PREM). The SUQ assesses the effectiveness of intermediate care through the adoption of standardised outcome measures, and the PREM evaluates the experience of the service users. Further information on the development of the service user audit is available in section 4.4.

Dependency levels

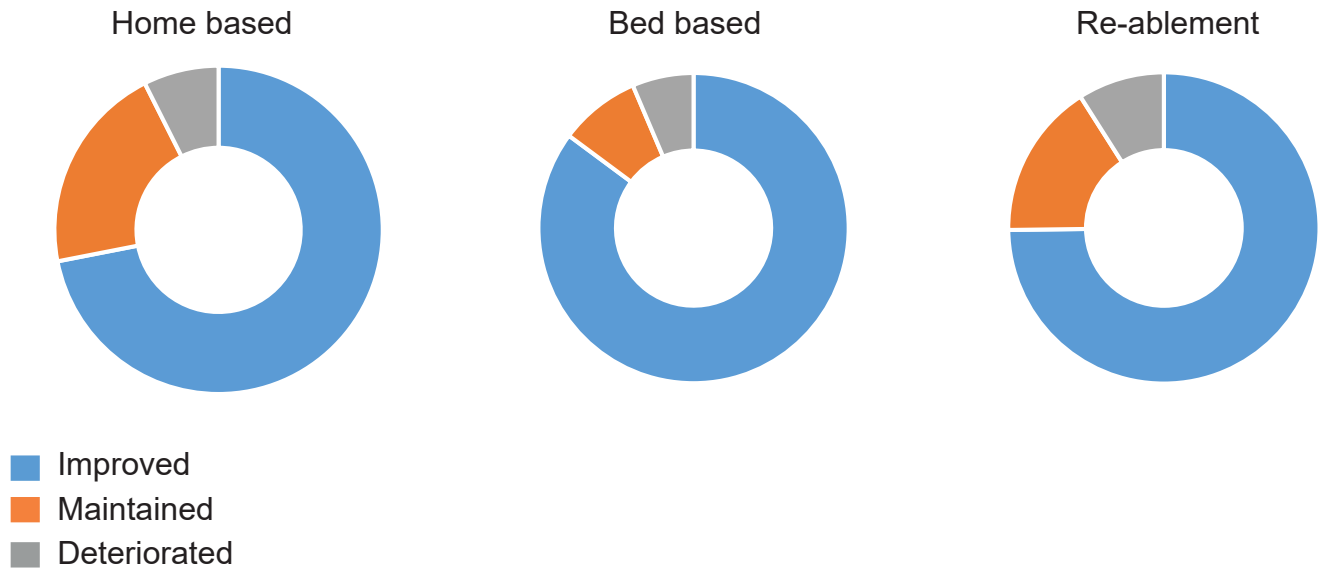
The use of standardised outcome measures allows the success of intermediate care interventions to be assessed in terms of maintaining and improving dependency, and enables comparisons of

service user cohorts to be made between services and between audit iterations.

As noted in section 4.4, the NAIC Steering Group selected the *Modified Barthel Index* (MBI) as the outcome measure for bed based services and the *Sunderland Community Scheme* as the outcome measure for home based and re-ablement services. Services were asked to collect (for all outcome measures) the score for individual service users on admission and again on discharge. The change in score, i.e. the movement in dependency, was calculated for each person and a mean score calculated for each service to compare against the national average position. The results for the participating services are available in the NAIC online toolkit.

The results for NAIC 2017 show that intermediate care works with 93% of service users maintaining or improving their dependency score in home based services, 94% in bed based services and 91% in re-ablement services. The proportion of service users who improved, maintained and deteriorated in dependency level across the three service categories is shown in figure 6.1.1.

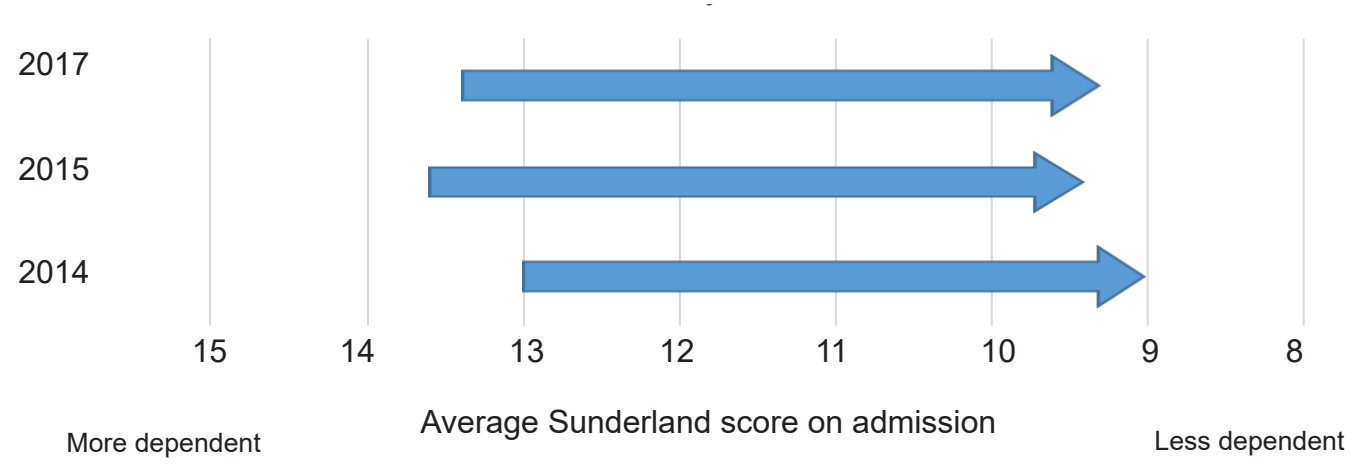
Figure 6.1.1: Service user outcomes NAIC 2017



Home based service outcomes

The average *Sunderland Community Scheme* score on admission, discharge and the change in score are reported in figure 6.1.2 and table 6.1.3. There is a high degree of consistency between the results for 2014, 2015 and 2017.

Figure 6.1.2: Sunderland Community Scheme results - Home based NAIC 2017



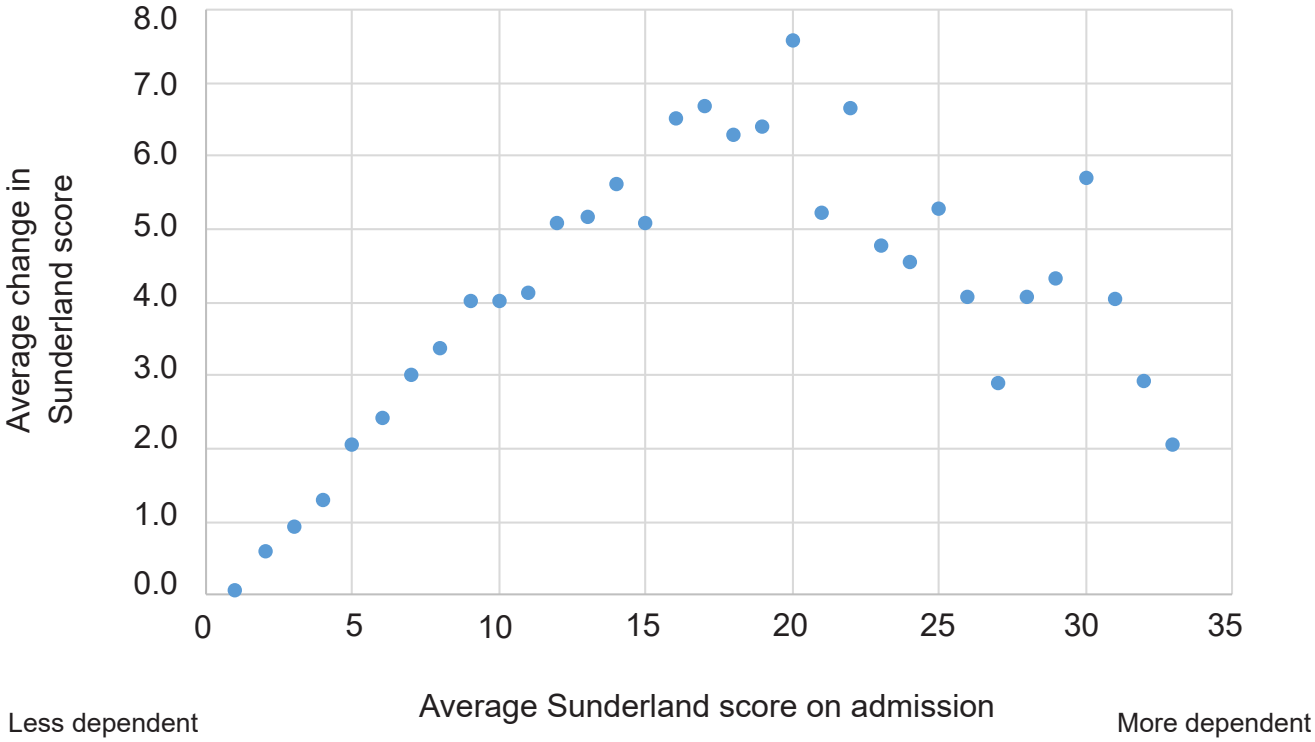
The arrows in figure 6.1.2 show the average Sunderland score on admission moving to the average score on discharge for the whole service user sample from NAIC 2017. Note that, for the Sunderland score, a lower number is better (i.e. the person is less dependent).

Table 6.1.3: Sunderland Community Scheme results - Home based

Year	Average score on admission	Average score on discharge	Average change	Average percentage change
2017	13.4	9.3	4.1	31%
2015	13.6	9.4	4.2	31%
2014	13.0	9.0	4.0	31%

Further analysis was undertaken to consider the scope for improvement of people at different starting levels of dependency. Figure 6.1.4 shows that as people's dependency level increases, initially they have more scope to make improvement, but the average improvement achieved peaks at a starting score of around 17 and 22 points; beyond that, as dependency continues to increase, the gains achieved start to reduce.

Figure 6.1.4: Average Sunderland score on admission against average change in Sunderland score - Home based services NAIC 2017

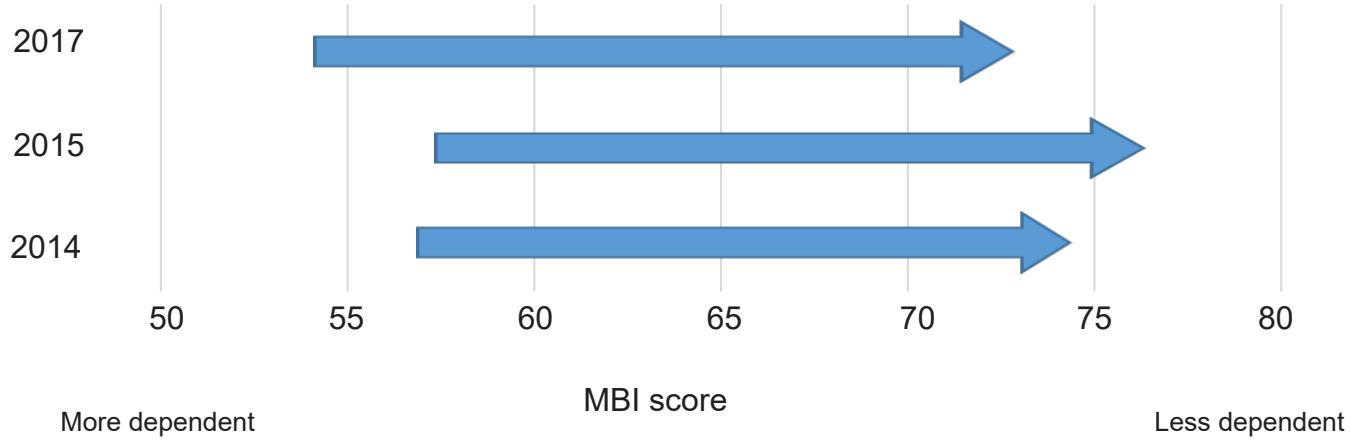


To supplement the information available from the Sunderland score outcome measure, two elements of the *Therapy Outcome Measure (TOMS)*, participation and wellbeing, were included within the home and re-ablement SUQs. For home based services, the average change in the TOMS participation score was 0.3 (the average score on admission was 2.8 and the average score on discharge was 3.1). The average change in the TOMS wellbeing score was also 0.3 (the average score on admission was 3.4 and the average score on discharge was 3.7).

Bed based service outcomes

People admitted to bed based services were more dependent on admission in the 2017 sample in comparison to the 2015 sample; however, a similar improvement in dependency was made (figure 6.1.5 and table 6.1.6). For bed based services, peak gains were made by service users with an average score on admission of around 40 points on the MBI, beyond which average improvement in scores start to reduce.

Figure 6.1.5: Modified Barthel Index - Bed based NAIC 2017



The arrows in figure 6.1.5 show the average MBI score on admission moving to the average score on discharge for the whole service user sample from NAIC 2017. Note that, for the MBI, a lower number is worse (i.e. the person is more dependent).

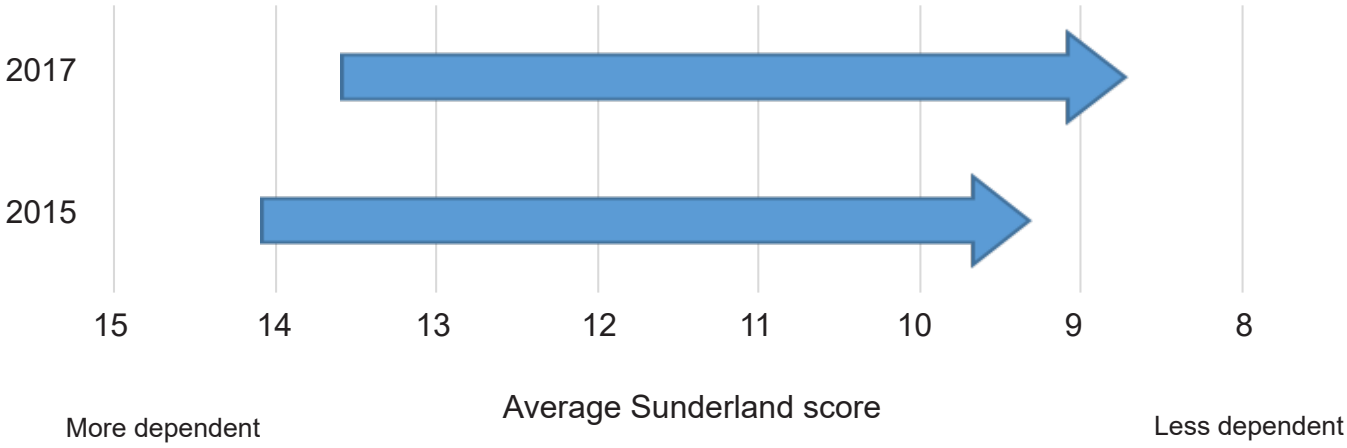
Table 6.1.6: Modified Barthel Index - Bed based NAIC 2017

Year	Average score on admission	Average score on discharge	Average change	Average percentage change
2017	54.1	72.9	18.8	35%
2015	57.3	76.4	19.1	33%
2014	56.8	74.4	17.6	31%

Re-ablement service outcomes

Both the average dependency on admission and the change in mean score were very similar in 2017 to 2015 for re-ablement services (see figure 6.1.7 and table 6.1.8). The relationship between the starting dependency and the gains made showed a very similar pattern to the result for home based services illustrated in figure 6.1.4.

Figure 6.1.7: Sunderland Community Scheme results - Re-ablement NAIC 2017



The arrows in figure 6.1.7 show the average Sunderland score on admission moving to the average score on discharge for the whole service user sample from NAIC 2017. Note that, for the Sunderland score, a lower number is better (i.e. the person is less dependent).

Table 6.1.8: Sunderland Community Scheme results - Re-ablement

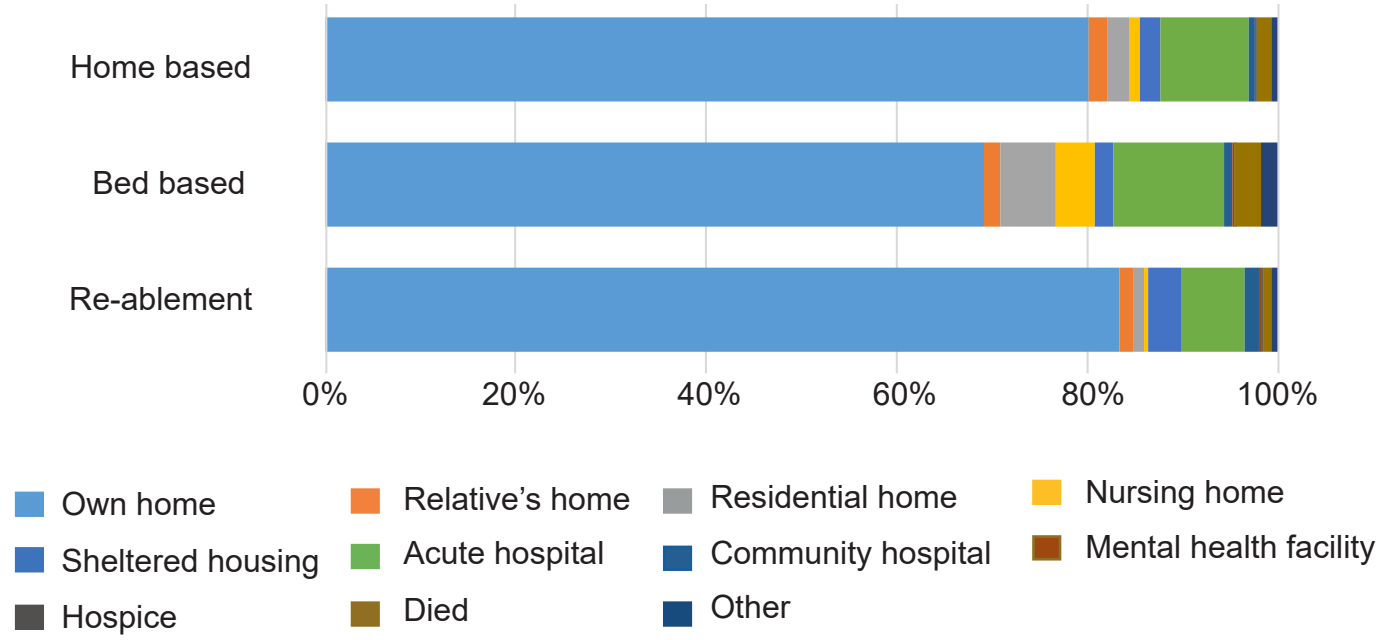
Year	Average score on admission	Average score on discharge	Average change	Average percentage change
2017	13.6	8.7	4.9	36%
2015	14.1	9.3	4.8	34%

The average change in the TOMS participation score for re-ablement service is 0.4 (the average score on admission is 2.9 and the average score on discharge is 3.3). For the TOMS wellbeing score, the average change is 0.3 (the average score on admission is 3.3 and the average score on discharge is 3.6).

Destination on discharge

Destination on discharge is considered as a proxy outcome measure within the NAIC. The data shown in figure 6.1.9 is taken from the service user level audit. Most people seen within intermediate care services are discharged home (80% from home based, 69% from bed based and 83% from re-ablement services), however, a proportion are discharged to an acute hospital reflecting the age and frailty of the service user cohort. In bed based services, the proportion returning to acute care has increased from 10% to 12%, consistent with the increased dependency level of the service user cohort noted above.

Figure 6.1.9: Destination on discharge NAIC 2017

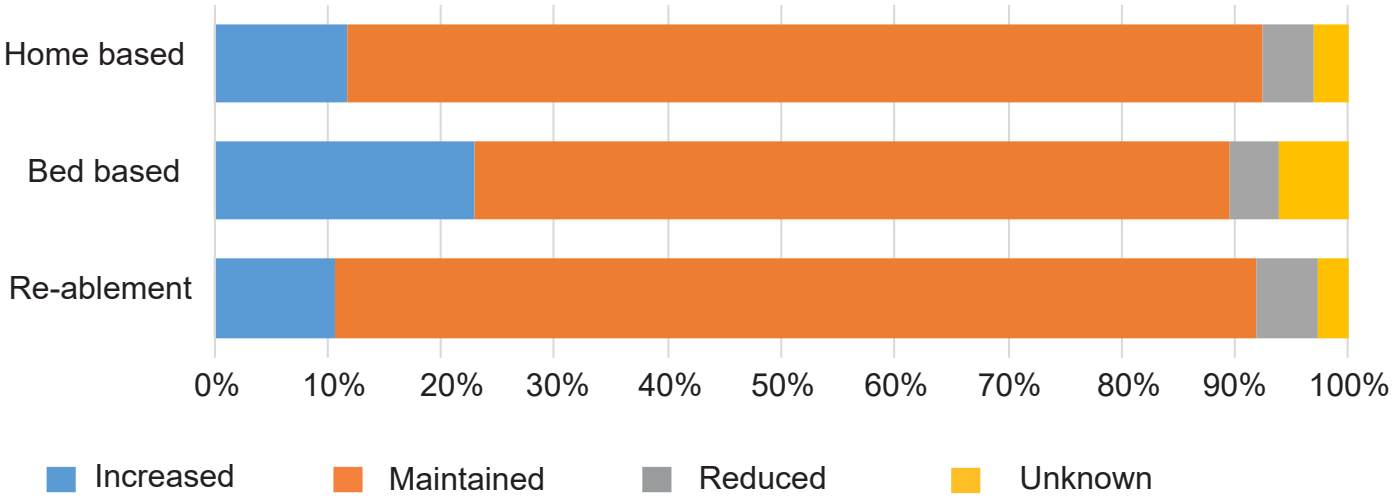


Change in dependency of care setting

Alongside destination on discharge, the service users' location before the intermediate care episode (i.e. their normal living arrangements) was compared with their final location (destination on discharge). A high proportion of patients were able to maintain their care setting after their intermediate care service; 81% for home based services (82% in 2015), 81% in re-ablement (75% in 2015) and 67% in bed based services (72%), again consistent with the more dependent cohort in these services.

Figure 6.1.10 illustrates the change in the dependency of care setting in 2017.

Figure 6.1.10: Change in dependency of care setting NAIC 2017



6.2. Service user experience of intermediate care services

Section summary: service user experience of intermediate care services

The experience of intermediate care service users was generally positive with all the aspects of services investigated by the Patient Reported Experience Measure (PREM) obtaining high results. Over 91% of people felt they had been treated with dignity and respect. The median PREM summary scores for home, bed and re-ablement services were similar to those recorded in NAIC 2015.

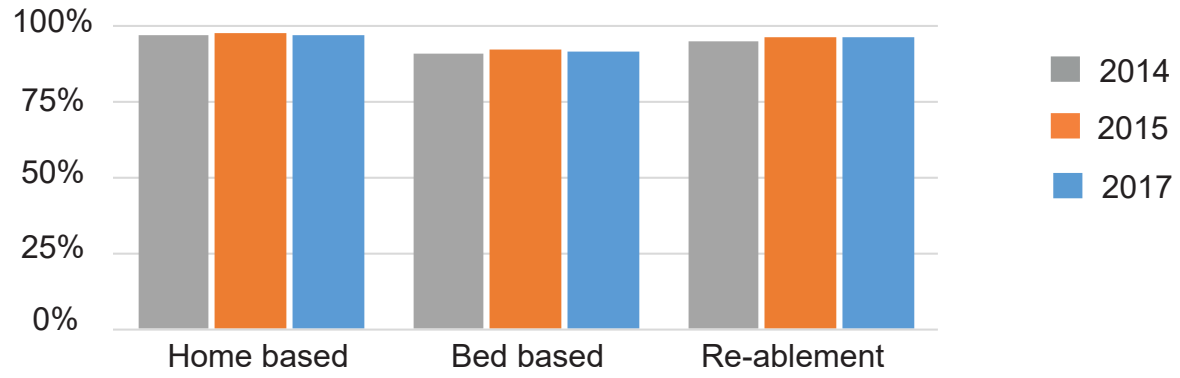
From the open narrative question, the most common source of praise was staff attitudes and 'receiving good service or care'. The most common themes for service improvement were facilities (in bed based services), communication, timing of visits (in re-ablement services) and the need for joined up services.

A full report on the PREM open narrative responses is available on the NAIC webpages.

As explained in sections 4.4 and 4.5, the PREM is a subsection of the NAIC 2017 service user audit. The PREM produces quantitative and qualitative data on the people's experience of home based, bed based and re-ablement services. A separate version of the PREM is available for home and re-ablement services, and for bed based services. The full survey results for both versions of the PREM can be reviewed on the NAIC online toolkit. This section provides examples of the questions included within the PREM, as well as providing the results of the PREM summary score.

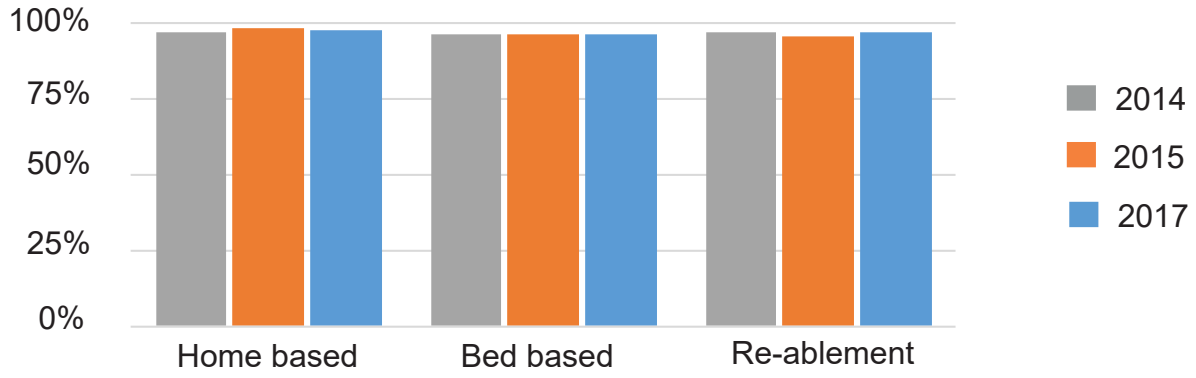
Figure 6.2.1, shows that over 91% of service users responded ‘yes – always’ to the question ‘I felt I was treated with dignity and respect from this service’. As illustrated in the chart, the results are consistent with reported findings from previous years, with re-ablement showing a slight year on year improvement.

Figure 6.2.1: PREM question: Overall, I felt I was treated with respect and dignity whilst I was receiving my care from this service - % of patients responding ‘Yes - always’



Good communication with service users is essential and the NICE guideline recommends services should ‘tell the person what will be involved’ and ‘discuss and agree intermediate care goals with the person’. Across all service categories, over 96% of service users replied ‘yes – definitely’ to the question ‘I was aware of what we were trying to achieve’ (figure 6.2.2).

Figure 6.2.2: PREM question: I was aware of what we were aiming to achieve - % of patients responding ‘Yes’



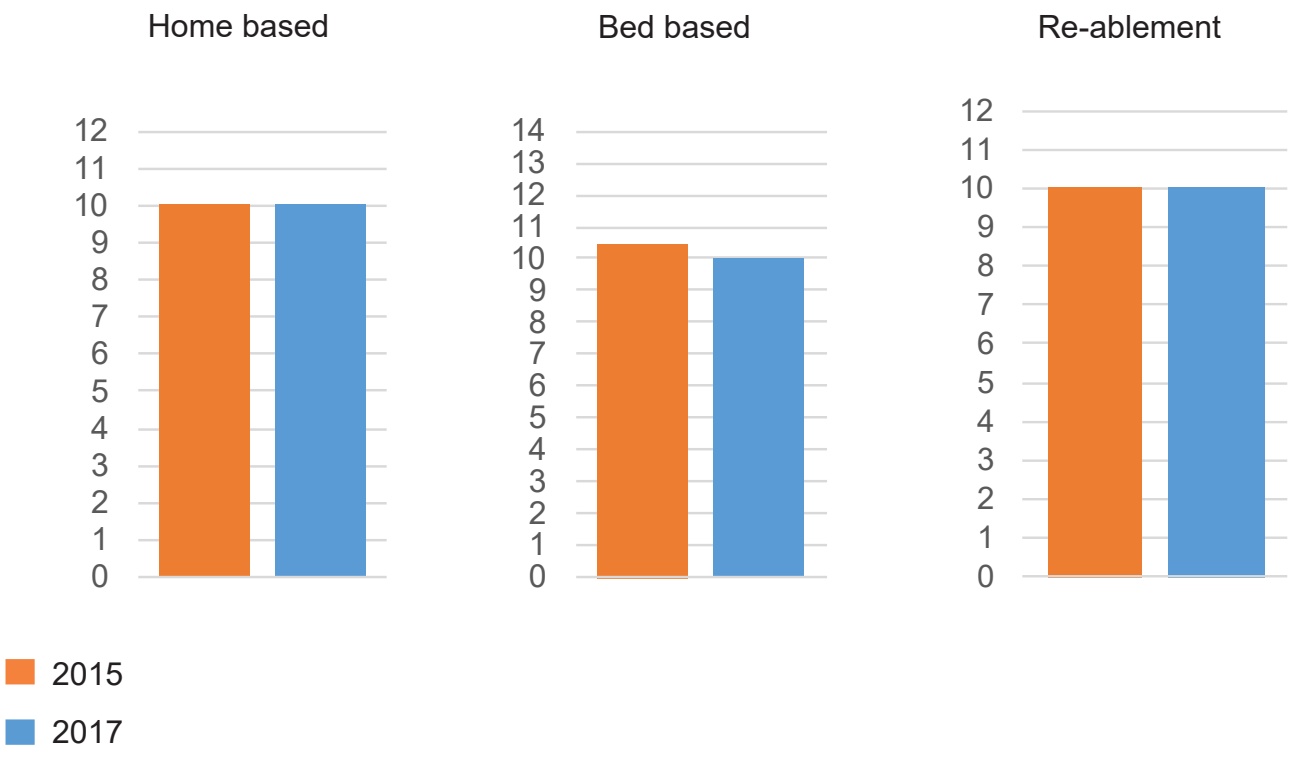
PREM summary score

The PREM responses have been collated to obtain a PREM summary score which sums the results of the PREM questions where they were determined to be measuring the same construct of patient experience. Section 4.4 explains how the summary score was developed. The PREM summary score for each participating service is available within the online toolkit in the members' area of the Network website.

For the home / re-ablement PREM, 12 questions (out of 15 asked) were determined to be measuring the same underlying construct and could be summed. The maximum possible summary score for the home/re-ablement PREM is therefore 12. The median summary score for participating services was 10 for both home based and re-ablement services (no change from 2015) (figure 6.2.3).

For the bed based PREM, 14 questions (out of 15 asked) were determined to be measuring the same underlying construct and could be summed. The maximum possible summary score is therefore 14 for bed based services. The median summary score for participating bed based services was 10, compared to 10.5 in NAIC 2015 (figure 6.2.3).

Figure 6.2.3: PREM summary score



Open narrative question results

The phrasing of the PREM open narrative question, 'Do you feel there is something that could have made your experience of the service better?' is more likely to elicit negative rather than positive comments, however 44%, 27% and 49% of responses for home, bed and re-ablement respectively, were positive. For bed based services, by far the most common source of praise was the attitude of staff. The most common area for possible improvements was facilities, specifically 'food and fluids', 'toilet' and 'washing and bathing', followed by communication, particularly comments on the theme of 'lack of appropriate or consistent information about services'.

For home based services, the most common source of praise was receiving a good service or care, with the majority of comments expressing extreme satisfaction, for example, "This is the most excellent treatment I have had. Thank you". The most common theme for improvement in home based services was joined up and appropriate services; 'timeliness and information about how long to wait' was the most commonly cited issue, closely followed by 'communication, co-ordination and organisation within and between services'.

As in bed based services, for re-ablement services the most common source of positive comments was the attitude of staff. The timing of visits was the most common improvement point noted by users of re-ablement, followed by the lack of 'joined up, appropriate, timely and informed services'. The emphasis on 'joined up' services by both home based and re-ablement service users highlights the importance of progressing integration as discussed in the next section, 6.3.

6.3. Progress with integration

Section summary: Progress with integration

The incidence of multi-agency boards with a remit over intermediate care and the use of Section 75 pooling arrangements have both increased in NAIC 2017, suggesting further progress with integration at the strategic level.

Over half of commissioners are commissioning integrated services but many have yet to develop a single point of access, a single management structure and a single assessment process, as recommended by NICE, suggesting there is still work to be done at an operational level to achieve truly integrated services.

Supporting the view that integration is a work in progress, service users continue to highlight co-ordination and communication issues.

In October 2014, NHS England published *The Five Year Forward View* emphasising the need to integrate services around the patient. The report called for better integration of GP, community health, mental health and hospital services, as well as more joined up working with home care and care homes. *Next steps on the NHS Five Year Forward View*, March 2017, reported results from the vanguard sites taking this approach, seeing slower growth in emergency hospitalisations and less time spent in hospital compared to the rest of the country. The results were particularly

noticeable for people over 75.

Intermediate care has been at the vanguard of health and social care integration for more than 15 years and is an important barometer of progress with the integration agenda. The commissioner quality standards within the NAIC include questions on closer working at the strategic level between CCGs and Local Authorities. In 2017, multi-agency boards whose remit covers intermediate care were in place in 86% of participating commissioners, a notable increase on previous years (68% in NAIC 2015). The use of Section 75 pooled budgets continues to increase, with 60% of commissioners reporting they were in place in 2017 (52% in NAIC 2015). Strategic planning is undertaken jointly by health and local government in 95% of commissioners (92% in NAIC 2015), showing continued good compliance with this standard. The proportion of respondents stating that they had a joint lead commissioner responsible for commissioning all intermediate care services (including re-ablement) in the health and social care economy, was 42% in NAIC 2017 (44% in 2015).

Providers are also asked about integration in the organisational level audit. In NAIC 2017, 52% of providers stated that re-ablement services were integral to the provision of intermediate care services, a lower proportion than was reported in 2015 (71% in NAIC 2015). In NAIC 2017, a new question was included on whether the service was part of the community integrated locality teams that deliver wider community services; 65% of home based intermediate care and 48% of re-ablement services stated ‘yes’.

To unpick what is meant by ‘integration’, a more detailed set of questions on the operational components of closer working was introduced in the commissioner level audit in NAIC 2015. A number of these components have been included in the *NICE Guideline* as necessary to ensure that intermediate care is provided in an integrated way; a single point of access for those referring to the service, a management structure across all services that includes a single accountable person and a single assessment process.

The degree of integration between home based and re-ablement services and between home and bed based intermediate care services is explored in the audit. In NAIC 2017, 51% of commissioners stated that they commission an integrated service that covers home and re-ablement services (56%, NAIC 2015), and 51% commission an integrated service that covers home and bed intermediate care services (65%, NAIC 2015). Where services are integrated, compliance with the components of closer working was tested, and findings are reported in table 6.3.1.

Table 6.3.1: Integration of services NAIC 2017

	Home based & re-ablement	Home based & bed based
Do you commission an integrated service?	51%	51%
Do integrated services have:		
A single point of access for these services?	53%	45%
A single assessment process for these services?	36%	41%
A single patient record, shared by these services?	29%	39%
A single management structure for these services?	29%	32%
Staff working across services?	56%	46%
Trans-disciplinary roles within the service?	43%	37%
Joint training and induction programme for health and social care staff in these services?	31%	30%
Weekly MDT meetings attended by health and social care staff?	71%	59%
Mental health specialist included in the establishment of the service?	28%	19%
A single performance management framework for these services?	39%	32%

In line with the picture established in 2015, over half of commissioners are commissioning integrated services. However, the scores for the elements of service models that indicate closer working were generally still at low percentages in 2017, suggesting integration is still work in progress. For example, in 2017, only 29% of integrated home and re-ablement services, and 32% of integrated bed and home services, have a single management structure.

Within integrated home based and re-ablement services, 71% of services reported weekly MDT meetings attended by both health and social care staff and 31% reported joint induction and training for staff. The percentage of services able to access a single shared patient record is still low in both areas; 29% in home and re-ablement services, and 39% in home and bed based services.

As identified in earlier iterations of the audit, mental health specialists are rarely part of the

establishment of integrated teams. Mental health provision in intermediate care is discussed further in section 6.8.

As noted in section 6.2, responses from the PREM open narrative question also indicated that there is still work to be undertaken in improving co-ordination and communication between services and with the service user. See below for some examples of what service users felt about their experience of co-ordination and organisation between services:

The PREM open question 'Do you feel that there is something that could have made your experience of the service better?'

The hospital did not properly advise about my treatment on discharge and failed to say that I had to stay with leg raised full time for 6 weeks.

There was poor co-ordination between the hospital and care home.

Only the timing of the discharge could be better coordinated. Apparently, there is no control over the timing of transport to take people home.

Main area of concern that we feel could be rectified is the change over from the enablement team to the carers. In fact, there is none. The family had to begin all over again explaining where things were, what dad needed, his medication, the food etc. Could there not be a primary session involving the enablement team, the carers and the family?

Information between carers and social services lacking so incorrect set up in follow on care.

6.4. Investment and capacity

Section summary: Investment and capacity

It was calculated in NAIC 2012 that intermediate care capacity needs to approximately double to meet demand. Given the ageing population and the increase in emergency admissions, it is likely that demand has continued to rise over the last five years. However, as in previous iterations of the audit, there is no evidence to suggest the step change in investment and capacity needed to meet demand has been achieved in 2017. Total investment in intermediate care services is around £2.8 million per 100,000 weighted population.

Whilst expenditure on beds has increased slightly, the increase has been absorbed in higher costs for bed based provision, rather than increased capacity. The evidence suggests the number of beds commissioned per 100,000 weighted population has reduced in 2017. Higher costs are being driven by increased staffing levels and, possibly, also by the implementation of the living wage in the care home sector.

In addition to total investment levels, the balance of step up and down provision within intermediate care systems should be considered to ensure there is adequate step up capacity, which may come under pressure from step down demand. This year's results suggest re-ablement services are being increasingly used for step down provision, which may reflect the pressure on social care to assist in reducing delayed transfers of care.

Demand for intermediate care

In NAIC 2012, it was calculated that intermediate care capacity needed to approximately double to meet the potential demand. Potential step up demand was calculated by using the assumption that 20% of emergency admissions of older people to secondary care may be inappropriate. Potential step down demand was calculated using research evidence that suggested up to 25% of elderly patients admitted to hospital may have post-acute care needs. On this basis, both average step up and step down capacity nationally, identified through the audit, were about half the level of estimated average demand. Given the age profile of intermediate care service users, the ageing population and significant increase in the number of emergency admissions of older people noted in the foreword of this report, it appears likely that need for intermediate care has also grown over the period.

Capacity of intermediate care

One of the key measures monitored by NAIC to assess changes in capacity has been the level of investment in the four types of intermediate care service provision. There continues to be very wide variation in investment levels across England. Local positions can be viewed by audit participants in the NAIC online benchmarking toolkit.

The mean investment levels by service category, as measured by the commissioning spend on intermediate care per 100,000 weighted population, are summarised in table 6.4.1. In NAIC 2017, commissioners were asked to provide data for both 2015/16 and 2016/17, due to the audit not running in 2016.

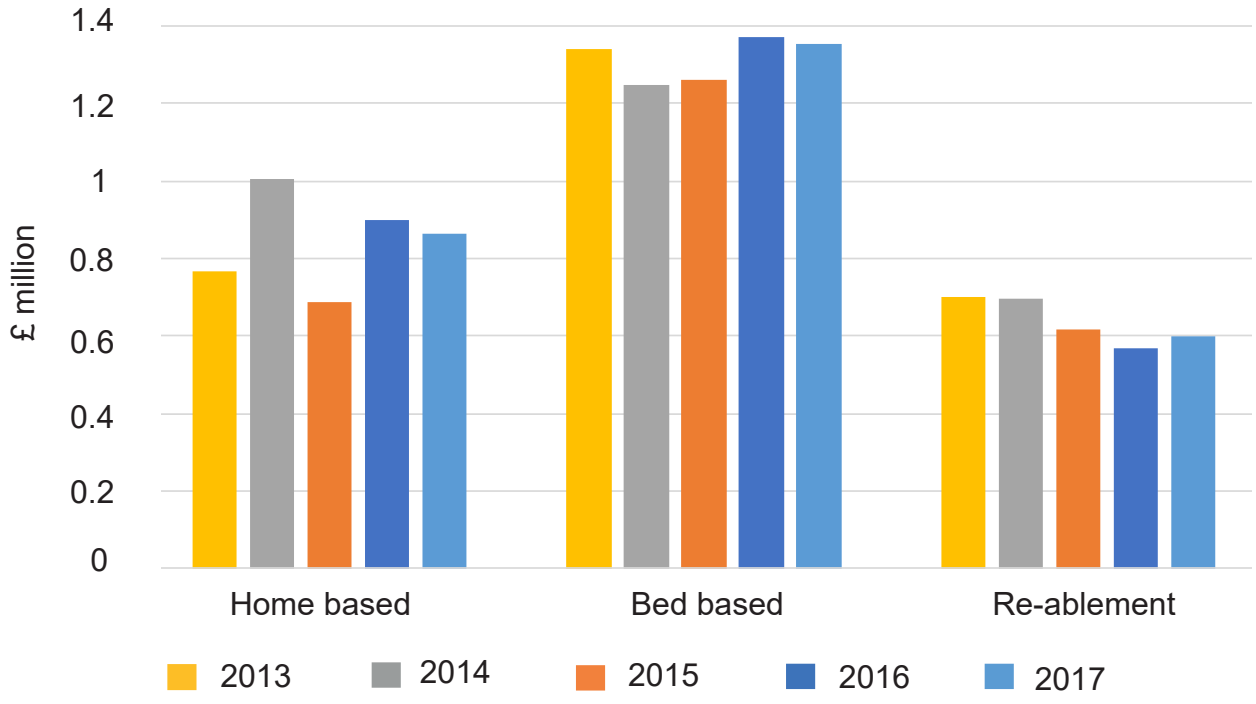
Table 6.4.1: Commissioner spend on intermediate care per 100,000 weighted population

Intermediate care service	NAIC 2016 Financial year 2015/16 Mean value	NAIC 2017 Financial year 2016/17 Mean value
Home based (including crisis response)	£0.90 million	£0.87 million
Bed based	£1.37 million	£1.35 million
Re-ablement	£0.60 million	£0.60 million

It should be noted that the sample of commissioners taking part is different each year, since the audit is voluntary. However, the graph at figure 6.4.2 illustrates that there is no evidence of a material, step change in the level of investment in England over the last five years.

Analysis of data from commissioners who participated in both 2017 and 2015, suggests a small increase in overall investment in the two-year period, driven by an increase in spending on bed based provision. However, the number of beds commissioned has decreased (see below), suggesting investment has been utilised to cover increasing costs rather than to create additional capacity.

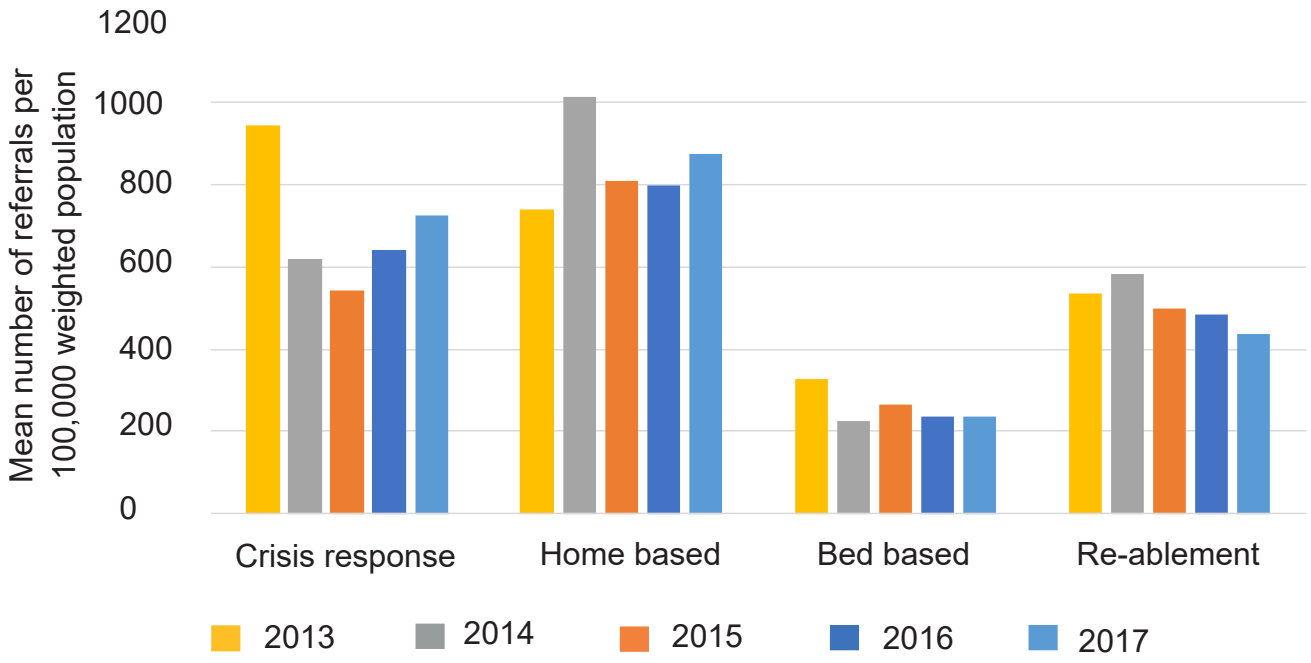
Figure 6.4.2: Commissioner budgets for intermediate care per 100,000 weighted population (mean)



Commissioners reported an average number of beds commissioned (including spot purchased beds) per 100,000 weighted population in NAIC 2017 of 20.9 beds, compared to 25.6 reported in NAIC 2015. Analysis of those that provided data in both NAIC 2017 and NAIC 2015 confirms a reduction in the number of beds commissioned.

The audit also uses referrals, benchmarked per 100,000 weighted population, as an estimate of capacity in the system and as a way of comparing the capacity available in different CCG areas. Figure 6.4.3 shows the referrals per annum per 100,000 weighted population (mean) for the four categories of intermediate care. Analysis of the overlapping samples for NAIC 2017 and NAIC 2015 confirms a slight upward trend in home based intermediate care referrals. In re-ablement services, the overlapping sample confirms a downward trend in both referrals and assessments per 100,000 weighted population.

Figure 6.4.3: Referrals to intermediate care services per annum per 100,000 weighted population (mean)



Although we cannot make definitive statements about trends over time because of the changing sample of commissioners contributing to the project, there appears to be no evidence, from either commissioner expenditure or activity data, of the step change in investment in intermediate care services needed to meet demand.

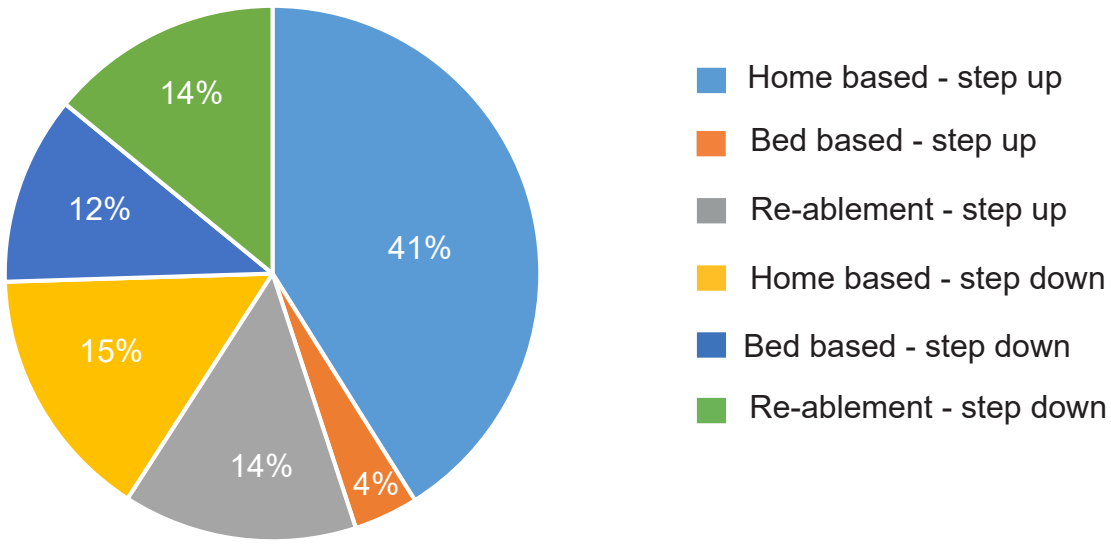
Balance of provision

In addition to the total capacity of intermediate care services, the balance of step up and step down provision is also important if services are to facilitate patient flow effectively across the whole system. Step up capacity is essential to support admission avoidance but can come under pressure as places are filled with people stepping down from hospital. Figure 6.4.4 provides an estimate of how capacity is currently utilised in the intermediate care system. Overall, 59% of capacity is being used for step up, the majority of this within home based and re-ablement services, with the remaining 41% of total capacity being used for step down.

Approximately one quarter of home based capacity is used for step down and three quarters for step up. For bed based services, the opposite is true, with the proportion of capacity used for step down being 75% this year.

In re-ablement services, the profile is 50% utilised on step down, an increase from 35% in 2015, and the balance on step up. This change may reflect pressure on social care to support the health system in reducing delayed transfers of care.

Figure 6.4.4: Balance of step up and down intermediate care provision (estimated) NAIC 2017



6.5. Accessibility of intermediate care services

Section summary: Accessibility of intermediate care

Whilst referral sources suggest crisis response services are well integrated, the links between health and social care in the other service categories appear weak when reviewing national average positions.

A new metric on the two-day wait quality standard (introduced by NICE for bed based services) has been introduced this year. Performance is highly variable across home, bed and re-ablement services, with results ranging from 100% to 0% of people, waiting more than two days.

Average waiting times have slightly reduced in home based services to 5.8 days (referral to assessment) and 2.5 days (referral to commencement) in bed based services. Whilst the reduction is welcome, the average is still higher than the two-day standard.

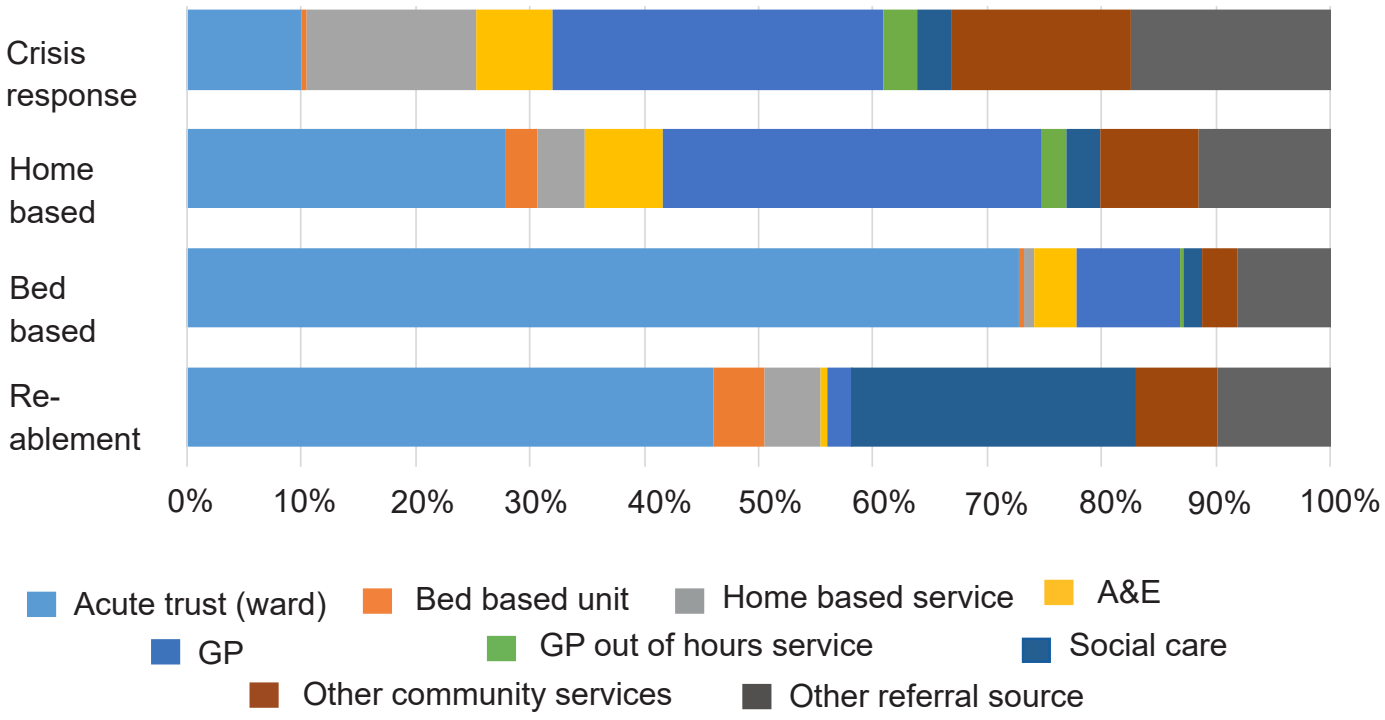
Home based services have improved their availability with more services open at weekends and less services limited to a 9 to 5 service.

Services that can respond quickly, particularly in a crisis, play a major role in reducing admissions to secondary care and maintaining people at home. Admission avoidance (step up provision) is a key function of all four intermediate care service categories. Bed, home and re-ablement services also need to be quickly accessible by service users to maintain patient flows out of hospital (step down provision).

Referral sources

Referral source information can provide an indication of how well integrated intermediate care services are within the local health and social care economy and how easily they can be accessed from other parts of the health and social care system. The referral source data for NAIC 2017 shows that crisis response services have a wide range of referral sources including A&E, GPs and other community services. There continues to be scope to increase the links between wider social care services and health based intermediate care services; currently only 3% of referrals to crisis response services, 3% of referrals to home based services, and 2% to bed based services, come from social care.

Figure 6.5.1: Referral sources for intermediate care services NAIC 2017



Response times in crisis response services

The *NICE guideline* recommends that crisis response should be started within 2 hours of receipt of a referral where necessary. The median standard response time target set by crisis response services reported in NAIC 2017 was consistent with this recommendation, at 2 hours. The actual performance reported by services showed a mean time from referral to assessment of 4.8 hours and, median time, 2 hours. Around 16% of services are taking, on average, more than 8 hours to respond.

Waiting times – two-day wait target

Waiting times are a key measure of accessibility and are particularly important for older people who may deteriorate rapidly whilst waiting for an intermediate care service in an acute hospital bed. Research evidence suggests that delay to starting rehabilitation may impact on the effectiveness of the intervention (*An estimate of post-acute intermediate care need in an elderly department for older people*).

The importance of limiting waiting times has been recognised in the *NICE guideline*. The guideline states that for bed based intermediate care, providers should ‘start the service within 2 days of

receiving the appropriate referral'. A two-day wait metric was introduced into the NAIC for the first time in 2017 to provide a baseline for compliance with the new NICE guideline. Home, bed and re-ablement services were asked to report the percentage of service users waiting over two days from referral to commencement of service. There was wide variation in all three service categories from 0% to 100% of service users waiting more than two days. The results can be summarised as follows:

Table 6.5.2: Percentage of patients waiting two days or more NAIC 2017

Intermediate care service NAIC 2017	% of services reporting more than half of people are waiting more than 2 days	% of services reporting that no-one is waiting more than two days
Home based	33%	16%
Bed based	13%	26%
Re-ablement	28%	25%

Service users picked up some issues on waiting times reported via the PREM open narrative questions:

> Quicker referral would have been better and would have helped my discharge planning.

> After being out of action for 5 weeks, I still have no care and my family are having to look after me - disappointing but I understand not the staff at X fault.

> I was rung up and told that someone might come the next morning; in two days' time - no-one.

Average waiting times

For home based intermediate care services, the average waiting time from referral to assessment (in days) reported by the NAIC 2017 sample of services was 5.8 days, close to the 6.3 days reported by the NAIC 2015 sample. The overlapping sample for home based services (where data was available for both years) was consistent in showing a reduction in waiting times.

For bed based intermediate care services, the total wait from referral to commencement of service was 2.5 days in NAIC 2017 (3.0 days in NAIC 2015). The overlapping sample for bed based services also showed a reduction in waiting times.

The average waiting time for re-ablement services in NAIC 2017 was 3.5 days. Due to changes in the sample, evidence on the movement between years is inconclusive for re-ablement services.

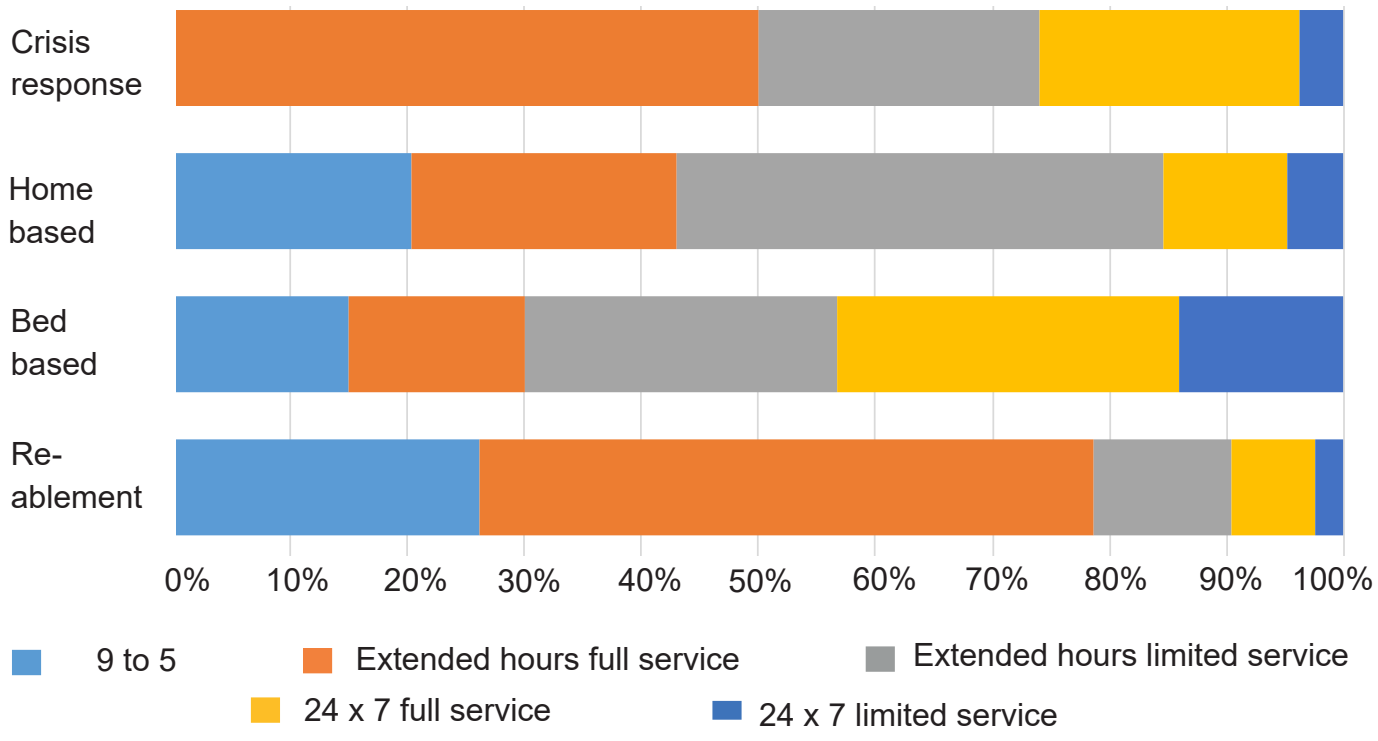
Opening hours

Days and hours of service availability are crucial factors if intermediate care services are to act as an alternative to A&E attendance and hospital admission.

100% of crisis response, 81% of home based, 89% of bed based and 62% of re-ablement services are open to admissions 365 days a year, with an increase in weekend working in home based services reported this year.

Re-ablement services are most likely to be open to new admissions for extended hours (full service) (52% reported in NAIC 2017), followed by crisis response services (49%). For home based and bed based services, this model of operation is less evident (23% and 15% respectively). The proportion of home based services operating 9 to 5 has reduced from 31% (NAIC 2015) to 20% (NAIC 2017). For re-ablement services, this is reported at 26% in NAIC 2017, up from the 24% reported in NAIC 2015. The opening hours profiles are shown in figure 6.5.3.

Figure 6.5.3: Opening hours profile for intermediate care services NAIC 2017



6.6. Use of resources

Section summary: Use of resources

Participants can use the online benchmarking toolkit to review the efficiency of their own service compared to others.

The mean values for average length of stay for home, bed and re-ablement services have remained at around one month, consistent with the recommendation in *Halfway Home* that services are normally time limited to six weeks. The service user data suggests the number of people with very long stays has reduced, particularly in bed based services.

A balance must be struck on length of stay between the needs of individual service users and the need to maintain throughput so that everyone who could potentially benefit can access the service in a timely fashion.

Participants in the audit can review their performance on key efficiency metrics using the online benchmarking toolkit available to participants on the members' area of the Network website. The direct cost per service user is calculated as an overall measure of the use of resources for each service category. Unit costs are influenced by a number of factors that can be assessed using the audit tools; length of stay, intensity of input for each service user and staff productivity. The national picture for these efficiency metrics is considered in this section. Unit costs will also be impacted by staffing levels and skill mix, which are considered in section 6.7.

Direct cost per service user

The total direct cost per service user is calculated by dividing the total pay and non-pay costs by the individual numbers of service users assessed / accepted during the period. The mean values reported in NAIC 2017 are set out in table 6.6.1. Note these are not fully costed figures since indirect costs and overheads are excluded. Bed based provision is the most expensive, on average, six times costlier than home based provision. Re-ablement is also more expensive than home based intermediate care due to the higher intensity of input (see table 6.6.4). The direct costs for bed provision have increased in the overlapping sample by 11%, consistent with the increasing cost of bed provision evident from the commissioner level audit.

Table 6.6.1: Direct cost per service user of intermediate care services (excludes indirect costs and overheads)

Intermediate care service	Metric	NAIC 2017 Mean value
Crisis response	Direct cost per service user assessed	£791
Home based	Direct cost per service user accepted	£982
Bed based	Direct cost per service user admitted	£5,965
Re-ablement	Direct cost per service user accepted	£2,002

Average length of stay for home, bed and re-ablement

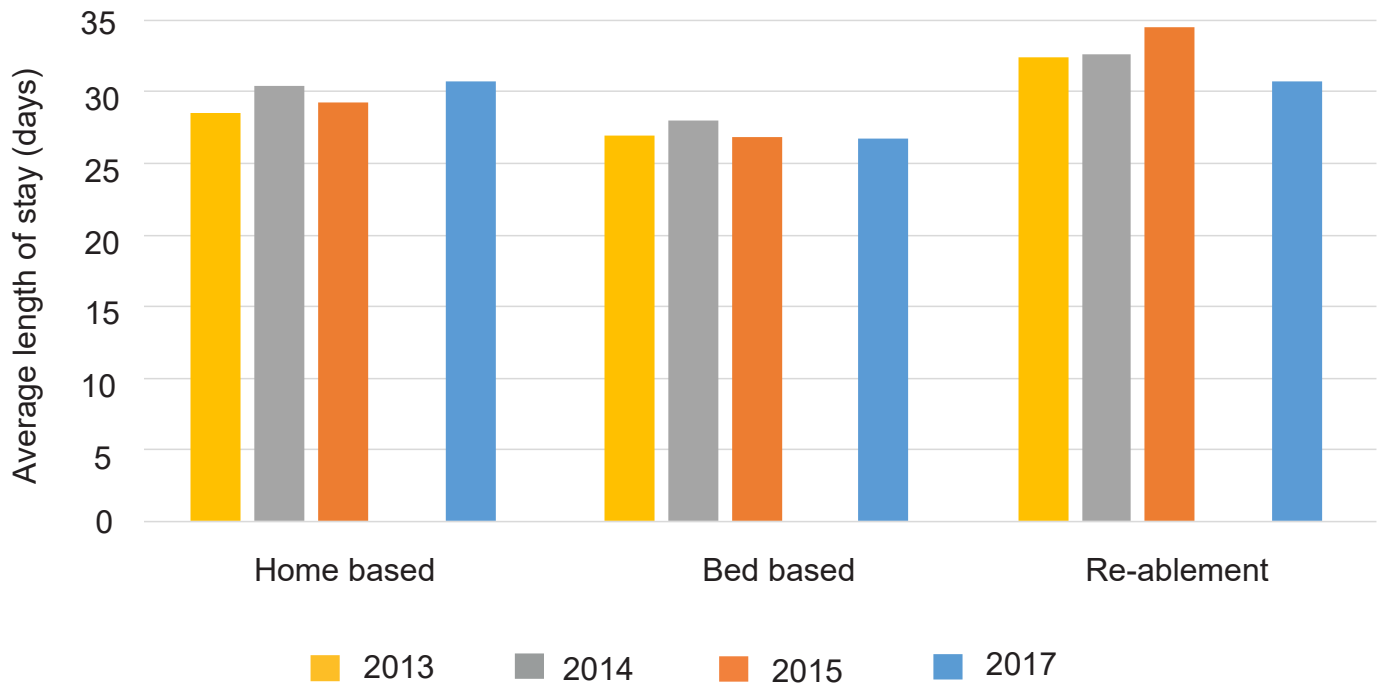
It was concluded in NAIC 2014 (NHS Benchmarking Network et al., *NAIC Summary Report 2014*, November 2014) that some people make gains in their independence score faster than others and it is not possible to infer a 'correct' average length of stay that will optimise outcomes. However, longer lengths of stay will decrease the throughput of service users and hence increase the cost per person of the service.

Table 6.6.2 gives the mean values for average length of stay for home, bed and re-ablement services in 2017. The chart at figure 6.6.3, illustrating the mean values reported in each year of the audit, suggests average lengths of stay have remained at around one month, with slightly lower stays in bed and slightly higher in re-ablement. The mean values are consistent with the recommendation in *Halfway Home* are normally time limited to six weeks, but frequently as little as one to two weeks.

Table 6.6.2: Average length of stay

Intermediate care service	NAIC 2017 Average length of stay in days
Home based	30.7
Bed based	26.8
Re-ablement	30.8

Figure 6.6.3: Average length of stay in intermediate services



In addition to average length of stay reported in the organisational level audit, the service user audit also collates data at individual service user level on length of stay. A length of stay profile for each service compared to the whole sample is available in the online benchmarking toolkit. Approximately 80% of people using all service categories had stays within the six-week period recommended in *Halfway Home*. The proportion of service users with very long stays (over 90 days) has reduced in bed based intermediate care to 0.6% in NAIC 2017 from 1.7% in NAIC 2015 and, for home based services, to 1.1% in NAIC 2017 from 1.2%.

The PREM open narrative responses had a number of service users' comments about length of stay.

> We were surprised at the discharge being so soon as there was definite improvement in her condition although rather slow. Only wish it could have continued.

> I need care and Physiotherapist service longer. I am not fully mobile. I am not truly independent.

> I feel 21 days in not long enough in my case to become mobile

Intensity of input

The intensity of input for each person receiving services will also impact on unit costs and was considered in the audit for both home based intermediate care and re-ablement services. The currencies used were ‘contacts’ in home based services, and number of ‘contact hours’ delivered in re-ablement services. Contacts are an accepted currency in community services used by the Department of Health to calculate Reference Costs. Contact hours are the accepted currency in social care.

Table 6.6.4 shows the intensity of input in home based and re-ablement services reported in NAIC 2017.

Table 6.6.4: Intensity of input

Intermediate care service	Metric	NAIC 2017 Mean value
Home based	Contacts per service user	13.0
Re-ablement	Contact hours per service user	45.8

Productivity

Staff productivity is another key measure of service efficiency. Levels of productivity may be affected by many factors including the urban or rural nature of the community served which will affect travel times. Due to the different currencies noted, different productivity metrics were calculated for crisis response, home based, bed based and re-ablement services.

The productivity metrics used and mean values reported in NAIC 2017 are summarised in table 6.6.5. Productivity has improved in both home and re-ablement services in 2017.

Table 6.6.5: Productivity

Intermediate care service	Metric	NAIC 2017 Mean value
Crisis response	Assessments per clinical whole time equivalent (WTE) per annum	94
Home based	Contacts per clinical WTE per annum	646
Re-ablement	Contact hours per WTE per annum	840

6.7. Workforce

Section summary: Workforce

The attitude of staff was the most common source of praise in the PREM open narrative question for bed and re-ablement services, reflecting the dedication and professionalism of the intermediate care workforce.

Staffing levels have increased in bed based services, which may be driving the cost increases noted in both the commissioner and provider audits for this service category. Higher staffing levels may reflect the increased dependency level of service users admitted to bed based intermediate care (section 6.1).

The audit provides evidence to support multi-disciplinary team working with service user outcomes improving the more types of staff people come into contact with. Analysis of the discipline mix suggests social care remains poorly represented in health based intermediate care services and mental health workers are rarely included in intermediate care service establishments. Therapy input remains limited in bed based services, at around 10% of the workforce, and appears to have declined in re-ablement services to just 3% of the workforce.

Staffing levels

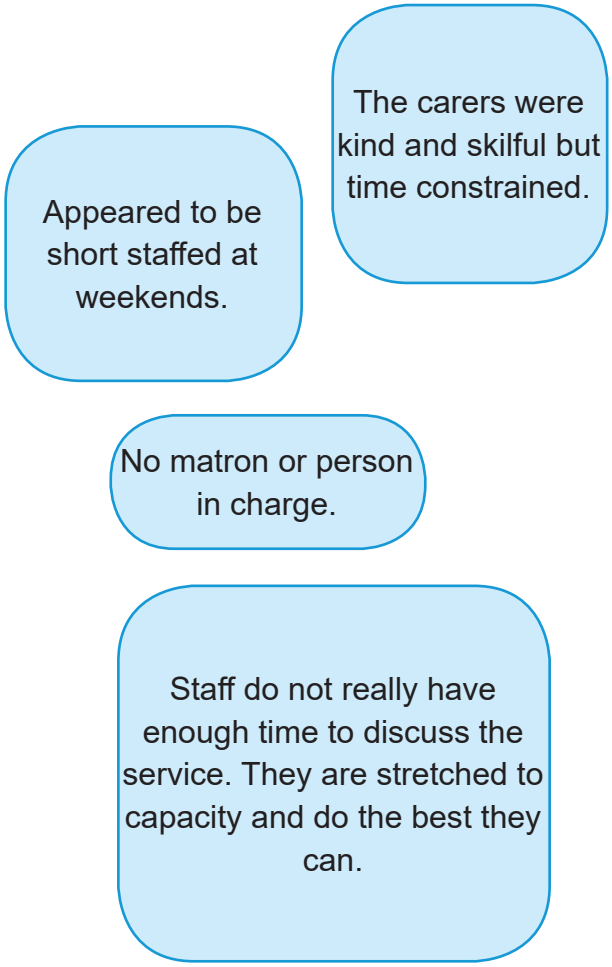
To gauge staffing levels and enable comparisons to be made, the number of whole time equivalents (WTEs) per 100 service users for home based intermediate care and re-ablement services were calculated. For bed based services, the metric of mean clinical WTEs per bed was used. Table 6.7.1 shows the benchmarked staffing levels of intermediate care services.

The number of clinical WTEs per bed has increased by around 7% in NAIC 2017 in both the full and overlapping samples, suggesting staffing levels are increasing in bed based provision, which may be driving the cost increases noted in both the commissioner and provider audits. Higher staffing levels may reflect the increased dependency level of service users admitted to bed based intermediate care (section 6.1).

Table 6.7.1: Staffing levels of intermediate care services

Intermediate care service	Metric	NAIC 2017 Mean value
Home based	Clinical WTEs per 100 service users accepted	2.7
Bed based	Clinical WTEs per bed	1.5
Re-ablement	WTEs per 100 service users accepted	6.5

The attitude of staff was the most common source of praise in the PREM open narrative question. Attitudes that were particularly valued were dedication, friendliness, being professional, displaying kindness, helpfulness, being caring, compassionate, patience and respecting dignity. However, inadequate staffing levels were highlighted in some instances, with lack of therapy input a particular concern.



Discipline mix

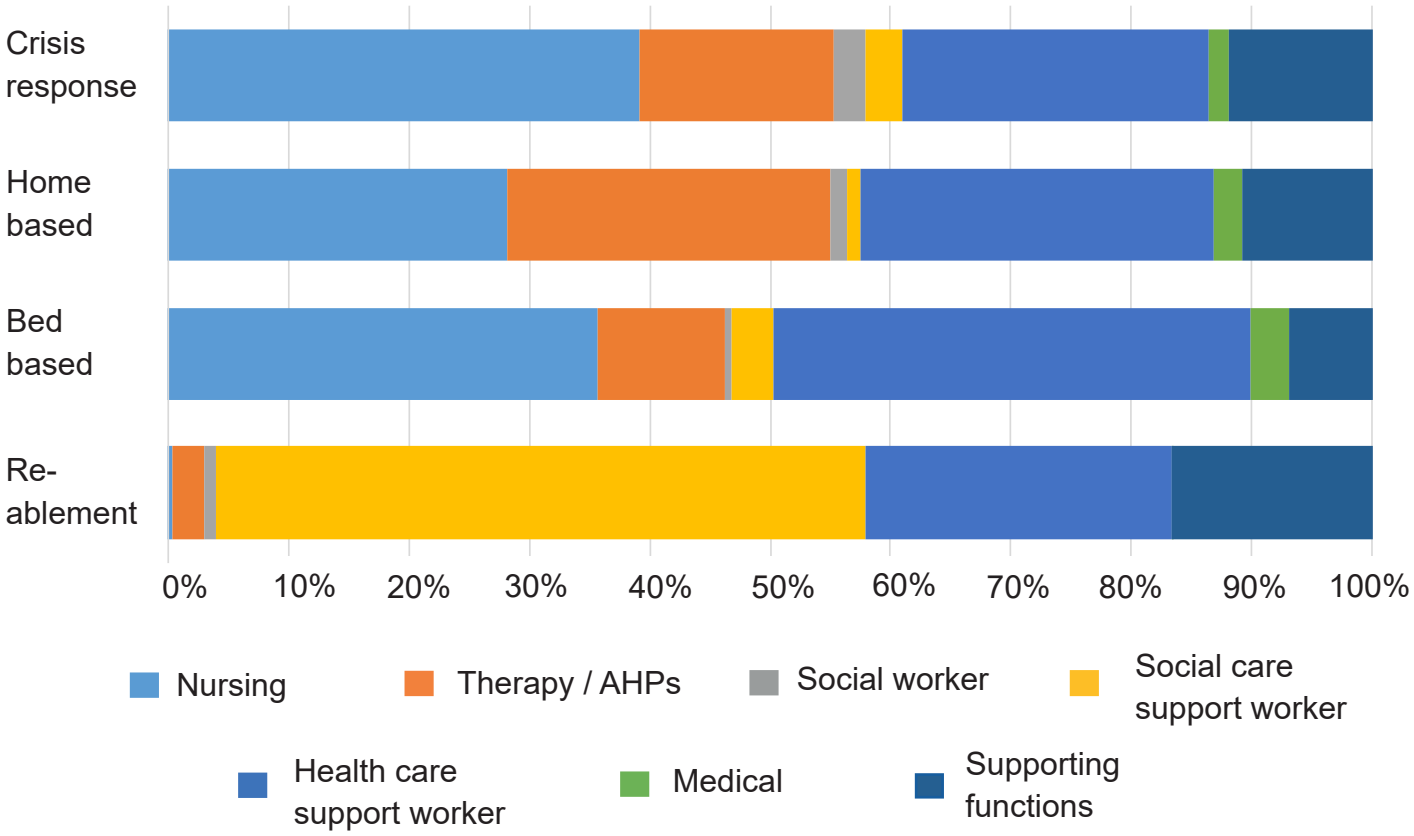
Data on discipline mix in intermediate care services based on traditional disciplines is collected as part of the audit. In addition, this year, audit participants were asked for further detail on the development of trans-disciplinary roles (discussed below).

As in previous years, the NAIC 2017 results showed that the skill mix within crisis response services, home based and bed based intermediate care is dominated by registered nurses and health care support workers whilst the skill mix within re-ablement services is predominantly social care support workers. The percentage of social care workers in crisis, bed and home based services remains low. Therapy input in bed based services (10%) appears limited and, in re-ablement services appears to have declined to just 3% of the workforce. Mental health workers represent less than 1% of the workforce in all four intermediate care service categories.

The ratio of “nursing” to “unregistered health staff” for intermediate care units in community hospitals and acute settings was 51:49 for NAIC 2017. The ratio is still below the RCN recommended ratio of 65:35 for ideal, good quality care in these settings, although is close to the ratio for basic, safe care, 50:50 (*Safe Staffing for older people’s wards: RCN Summary guidance and recommendations*).

Figure 6.7.2 shows the discipline mix of the four intermediate care service categories reported in NAIC 2017.

Figure 6.7.2: Mix of disciplines within intermediate care services NAIC 2017



In addition to the discipline mix from the organisational level audit considered above, data was reviewed from the service user audit that allowed outcomes to be compared to the number of staff disciplines the service user came into contact with as part of their care during their intermediate care stay. For bed and home based services, 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 the bed and home results showing a clear positive relationship (figures 6.7.3 and 6.7.4).

Figure 6.7.3: Change in Modified Barthel score against number of staff types involved in providing care (bed based) NAIC 2017

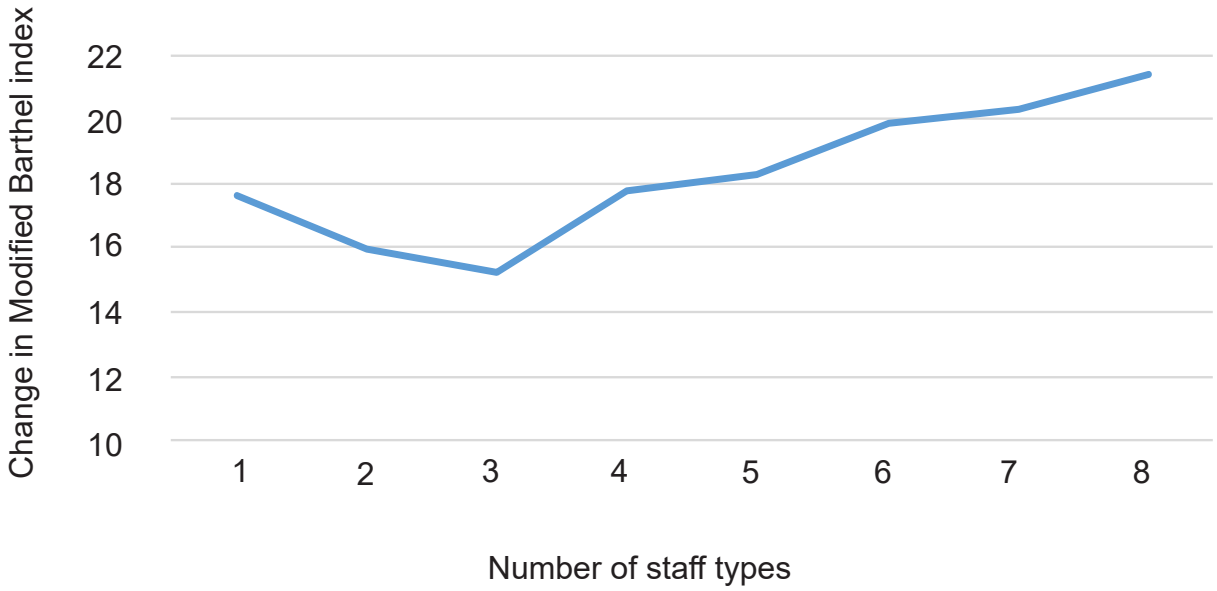
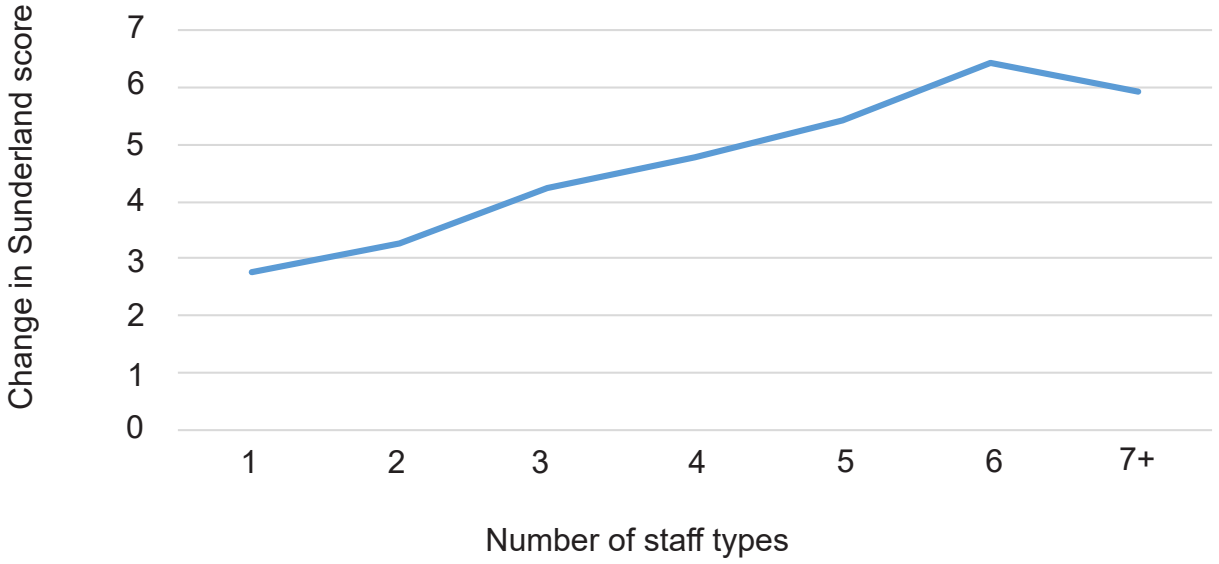


Figure 6.7.4: Change in Sunderland score against number of staff types involved in providing care (home based) NAIC 2017



Trans-disciplinary roles

As integration progresses, more services are looking at innovative ways of breaking down traditional distinctions between disciplines and developing new ways of working. In NAIC 2017, services were asked additional questions about the development of trans-disciplinary roles. The results are set out in table 6.7.5 and suggest these new ways of working are being considered for both registered and unregistered staff, in a significant proportion of services. The definition of trans-disciplinary roles used for the purposes of the audit is given in the glossary of terms in section 10.

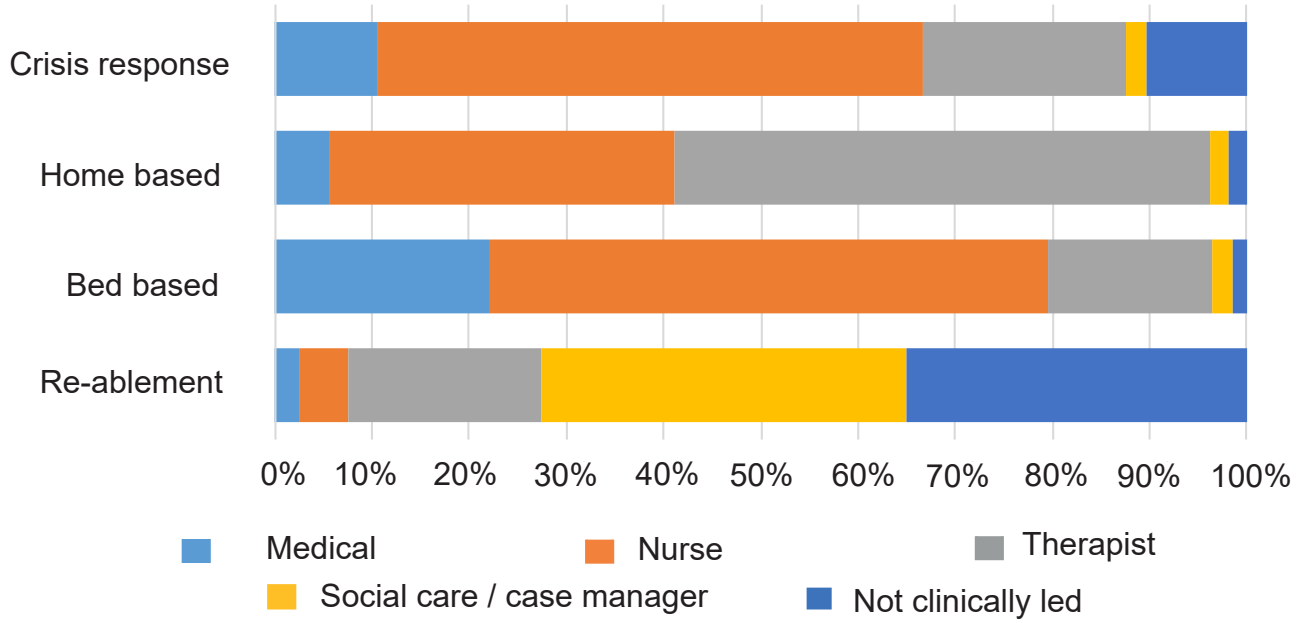
Table 6.7.5: Trans-disciplinary roles NAIC 2017

Trans-disciplinary roles in intermediate care services	Crisis response	Home	Bed	Re-ablement
Are you using or developing trans-disciplinary roles for staff?	58%	71%	34%	41%
If yes, do the roles apply to registered staff?	85%	71%	36%	33%
If yes, do the roles apply to unregistered staff?	67%	74%	66%	67%
If yes, is the nursing discipline affected?	85%	65%	45%	10%
If yes, is the therapies discipline affected?	93%	84%	62%	43%
If yes, is the social care affected?	33%	42%	8%	67%

Clinical leadership

Clinical leadership of the different intermediate care services is shown in figure 6.7.6. Therapists lead more than half of home based services. As might be expected, medical leadership is more common in bed based services and social care/ case manager for re-ablement.

Figure 6.7.6: Clinical leadership in intermediate care services NAIC 2017



Dedicated medical cover

New questions were asked in NAIC 2017 about dedicated medical cover on both weekdays and weekends. The findings are reported in table 6.7.7. All services show a substantial drop in dedicated cover at weekends.

Table 6.7.7: Hours of dedicated medical cover

Intermediate care service NAIC 2017	Average number of hours of dedicated medical cover during the week (out of 120 hours available)	Average number of hours of dedicated medical cover during the weekend (out of 48 hours available)
Crisis response	20 (17% of hours available	5 (10% of hours available)
Home based	13 (11% of hours available)	3 (6% of hours available)
Bed based	34 (28% of hours available)	3.5 (7% of hours available)

6.8. Mental health provision within intermediate care services

Section summary: Mental health provision

The inclusion of mental health workers within the establishment of intermediate care services remains unusual. However, around one third of services are able to access mental health services directly and more than a quarter of commissioners are now including mental health specialists in integrated teams (in home and re-ablement services).

The picture for those with cognitive impairment is mixed with almost all home based services stating that their services are open to service users with cognitive impairment (96%); in contrast a lower proportion of bed based services say they accept people with cognitive impairment (81%).

Given the prevalence of dementia in the service user cohort, a key area of interest from participants has been how well specialist mental health input and advice is embedded within intermediate care services. Commissioners were asked whether mental health specialist roles were commissioned specifically within integrated services. The results for the 2017 iteration showed these specialist roles were commissioned in 28% of integrated home and re-ablement services and 19% of integrated home and bed based intermediate care services.

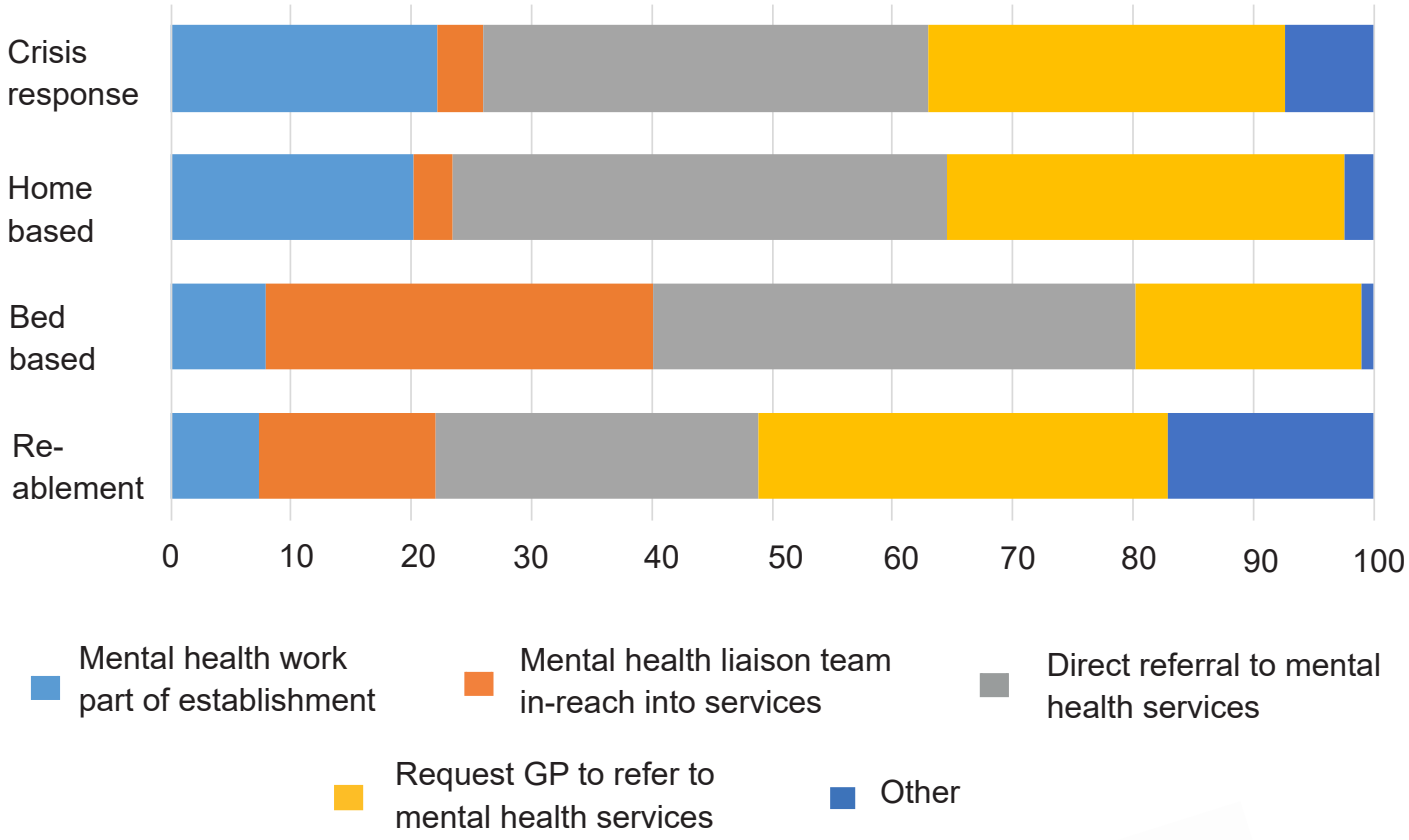
Providers were asked whether their service accepts people who, in addition to a rehabilitation need, also had a cognitive impairment and / or, challenging behavioural disturbance. Crisis response and home based intermediate care services were more likely to accept those with cognitive impairment than bed based services and re-ablement (table 6.8.1).

Table 6.8.1: Cognitive impairment

Intermediate care services able to accept people who, in addition to a rehabilitation need, also had a cognitive impairment and / or challenging behavioural disturbance	% of providers stating 'Yes' in NAIC 2017
Crisis response	92%
Home based	96%
Bed based	81%
Re-ablement	88%

Providers were also requested to note how access to mental health input was managed. For crisis response, home and bed based intermediate care services, the most common method was direct referral to mental health services (more than 35%) (figure 6.8.2). In re-ablement services, however, 34% of services reported having to request a GP to make the referral.

Figure 6.8.2: Access to mental health input from intermediate care NAIC 2017



Screening for cognitive impairment

Service users were screened for cognitive impairment whilst in intermediate care in 42% of home based services, 65% of bed based services and 39% of re-ablement services.

The PREM open narrative question responses highlighted a number of areas where service users have commented on mental health provision within intermediate care services.

> Regular faces instead of new people all the time. Anxiety is a very bad illness made easier by getting used to someone.

> X spoke to patient's daughter who stated that her mother is in early stages of dementia and she doesn't feel that the time was taken to let her mother understand what to expect of the service. She felt her mother was not involved in decisions and that her daughter would have liked more involvement.

6.9. Intermediate care service user demographics and processes

Section summary: Intermediate care service user demographics and processes

The demographic profile of intermediate care service users is broadly unchanged since 2015. The average age of intermediate care service users in the NAIC 2017 service user sample was 80 years in home based services, 83 years in bed based services and 79 years in re-ablement services. The proportion of people aged 90 and over in bed based services has plateaued at 25%, after increasing every year between 2013 and 2015.

Evidence from the audit suggests those service users with a documented care plan and a care plan that has been reviewed by the multi-disciplinary team, have better outcomes.

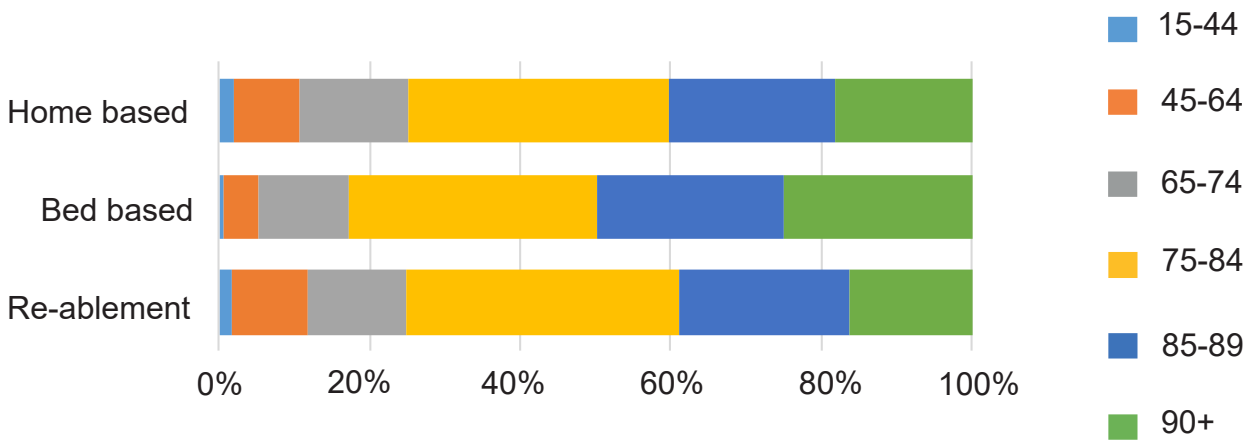
The NAIC 2017 included a new question on screening for frailty. Screening was most likely to occur in bed based services.

The demographics of intermediate care service users and information on key processes such as care planning are available from data collected using the service user questionnaire. This section details the profile of users' age, gender and ethnicity, as well as their appropriateness for the intermediate care service. Information on screening for frailty is available for those service users who were accepted into the service.

Age and gender profile of service users

The average age of intermediate care service users is 80 in home based services, 83 in bed based services and 79 in re-ablement services. There has been little movement in the average age of intermediate care service users since 2015. In particular, the proportion of people aged 90 and over in bed based services has plateaued at 25%, after increasing every year between 2013 and 2015. The split between age categories is available in figure 6.9.1.

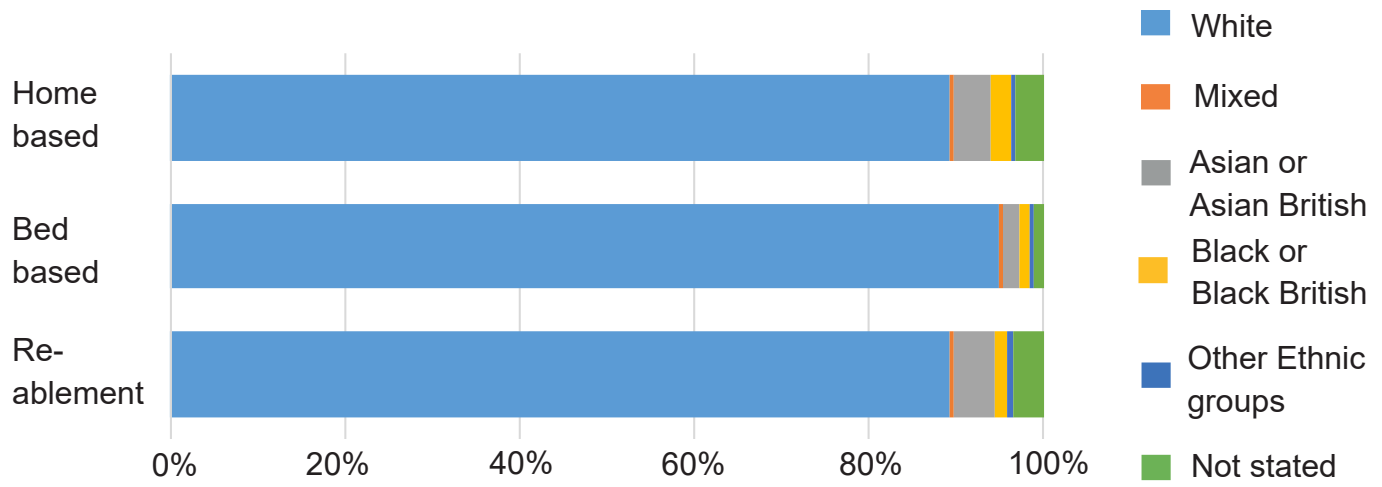
Figure 6.9.1: Age profile of intermediate care service users NAIC 2017



As in previous years of the audit, approximately two thirds of intermediate care service users are female, across the three service categories.

The majority of service users in intermediate care, across all service categories, are white (89% in home based and re-ablement services, and 95% in bed based services). The service users' ethnicity was not stated in 3% of cases in home based services, 1% in bed based services and 4% in re-ablement services.

Figure 6.9.2: Ethnicity profile of intermediate care service users NAIC 2017



Appropriateness of user for intermediate care service

The first question included within the service user questionnaire is, 'Will this patient be receiving your service?' This question allows the percentage of referrals accepted within the data collection period to be calculated. Respondents who stated that the patient would not be receiving the intermediate care service were directed to a question that asked whether they would be referred to an alternative service. Overall acceptance rates are high (see table 6.9.3).

Table 6.9.3: Percentage of referrals accepted into intermediate care services NAIC 2017

Service type	% of referrals accepted into IC service	% of unaccepted referrals signposted onto another service
Home based	87%	46%
Bed based	89%	50%
Re-ablement	91%	49%

Care planning

The service user audit includes questions on whether the service user had a care plan documented and whether the plan had been reviewed at least once per week by the multi-disciplinary team. The results have been plotted against service user outcomes for home and bed services (figures 6.9.4 and 6.9.5 respectively), suggesting those service users with a documented care plan and a care plan that has been reviewed, have better outcomes.

Figure 6.9.4: Care planning - Home based NAIC 2017

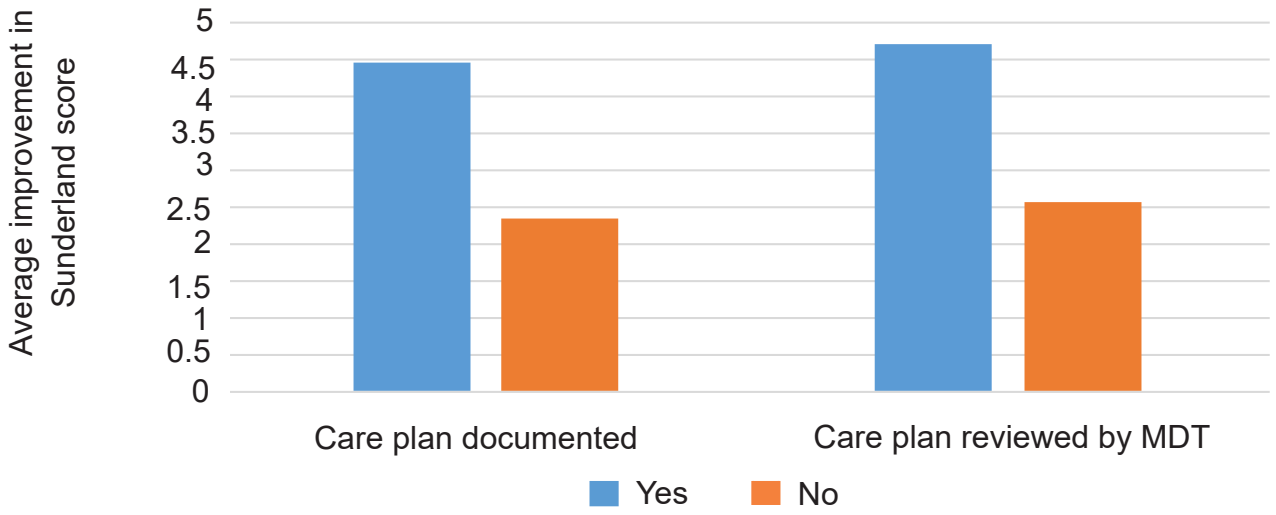
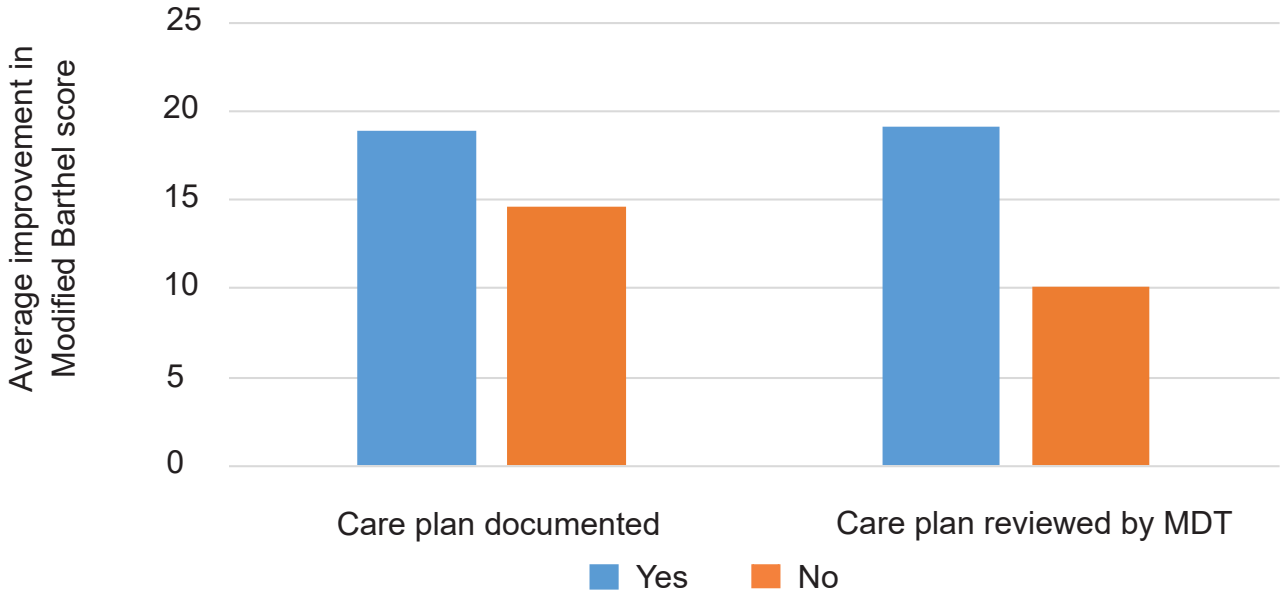


Figure 6.9.5: Care planning - Bed based NAIC 2017



Screening for frailty

A new question was added to the service user audit in 2017 on screening for frailty. The highest use of screening was in bed based services (42%). In home based services, the rate of screening was 28%, and in re-ablement, 30%.

7. Quality standards

7.1. Introduction

Guidance for intermediate care services was set out by the Department of Health in the *National Service Framework for Older People* (DH 2001), identifying the following principles for the provision of services:

- Person-centred care
- Whole system working
- Timely access to specialist care, and
- Promoting a healthy and active life.

Further guidance, reinforcing these principles was published by the Department of Health in *Intermediate Care - Halfway Home*, 2009. The quality standards in the audit have been developed from the standards set out in *Halfway Home*.

Section 7.2 sets out the results for the commissioner quality standards audit for 2017.

7.2 Results: Quality standards for commissioners

Section summary: Quality standards

Whilst compliance with some of the key governance and strategy standards remains high, the existence of joint strategic needs assessments and local intermediate care strategic plans is relatively low, with just over half of commissioners complying. Access to shared patient records (electronic or paper) remains an issue in a high proportion of areas.

As explained in section 5.1, in comparing the 2017 results for quality standards to the 2015 audit, it should be noted that the sample of commissioners completing the audit in 2015 and 2017 was different.

Commissioner governance and strategy standards

The responses for governance and strategy standards are set out in table 7.2.1.

Table 7.2.1: Governance and strategy standards results

Governance and strategy standards	NAIC 2015 % stating 'Yes'	NAIC 2017 % stating 'Yes'
Is there a multi-agency board whose remit covers intermediate care?	68%	86%
Has clinical governance or quality assurance been incorporated into intermediate care service specifications?	83%	95%
Is strategic planning for intermediate care undertaken jointly by health and local government?	92%	95%
Has a joint strategic needs assessment that addresses the need for intermediate care been carried out?	60%	53%
Is there a local intermediate care strategic plan?	63%	59%
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?	43%	32%
Is there a shared, electronic patient record accessed and updated by all intermediate care services?	20%	25%
Is there a comprehensive, shared paper patient record accessed and updated by all intermediate care services?	29%	29%

There is a step change in the compliance with the existence of a multi-agency board whose remit covers intermediate care. One reason for this may be that intermediate care services have become subsumed in the wider strategic planning undertaken by local Unscheduled Care Boards / Networks.

The proportion of commissioners stating that clinical governance and quality assurance has been incorporated into intermediate care specifications and that strategic planning is undertaken jointly, remain high (both at 95%). However, the proportion of commissioners who have completed a joint strategic needs assessment and a local intermediate care strategic plan remain relatively low, at just over half of respondents.

Access to shared patient records (electronic or paper) remains an issue in a high proportion of areas.

Commissioner participation standards

The views of patients and carers on current services and future plans have been actively sought by 79% of commissioners in NAIC 2017, consistent with NAIC 2015.

Commissioner pathway standards

NICE have recommended the provision of a single point of access for those referring to the service. In NAIC 2017, the number of commissioners with a single point of access for their whole intermediate care system, was 41% (35% in NAIC 2015).

In the 2017 audit, commissioners were requested to answer whether they actively commissioned / funded the four different service category elements of intermediate care. For crisis response services, 89% of commissioners actively commissioned these services. Bed based, home based and re-ablement services, were commissioned by 96%, 88% and 89% of commissioners for the respective services. 42% of health and social care economies said they had a joint lead commissioner responsible for commissioning all intermediate care services locally.

Commissioners were asked to indicate the type of shared assessment framework incorporated into commissioning contracts. The most common response was “No shared assessment framework specified in contracts” at 50%, followed by “locally developed assessment framework” (37%).

Commissioner performance management standards

Performance monitoring by commissioners at both a strategic level (the impact of intermediate care upon the whole health and social care system), and at a local operational level (through regular review of service performance) is emphasised in *Halfway Home*. Table 7.2.2 shows progress against the performance management standards included in NAIC.

Table 7.2.2: Performance management standards

Performance management standards	NAIC 2015 % stating ‘Yes’	NAIC 2017 % stating ‘Yes’
Have performance goals been set and measured for the whole of the health and social care system?	64%	49%
Have goals that reflect the quality of the service and the users’ experience been set?	77%	80%
Have indicators to monitor the delivery of service performance been developed and reviewed at least annually for each intermediate care service you commission?	83%	86%

8. Audit developments

In 2017, the online benchmarking toolkit contains additional refinements from previous years:

- The commissioner toolkit allows profiling by STP footprint (note that not all CCGs in the footprint may have provided data).
- The commissioner and provider toolkits have an additional function to profile by England, Wales, Northern Ireland or 'all organisations'.
- Some provider metrics allow toggling between denominators.
- The toolkit permits toggling between weighted and registered populations (England only) on any benchmarks which have the population as a denominator.
- The provider toolkit allows users to profile the bed based provision by the location of beds.

Subject to agreement of funding arrangements, it is intended that the National Audit of Intermediate Care will run again in 2018. Developments for next year's audit will also be considered by the NAIC Steering Group, following feedback received at this year's NAIC National Conference on 15th November 2017 and a survey to be completed by participants after the National Conference.

If the NAIC runs again in 2018, it is suggested that the audit content is reviewed in the light of the new *NICE Guidelines* issued in 2017.

9. Acknowledgements

The National Audit of Intermediate Care is supported by NHS England and is 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 Royal 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 the North of England CSU who provided Finance and IT support to the audit on behalf of the Network.

We would like to thank Dr Elizabeth Teale, Clinical Senior Lecturer and Consultant in Elderly Care Medicine, Academic Unit of Elderly Care and Rehabilitation, Bradford Institute for Health Research, for help with validation of the PREM questions with the NAIC Steering Group, for both the bed and home based intermediate care / re-ablement services.

Thanks to Dr Steven Ariss and Kinga Lowrie from the School for Health and Related Research, University of Sheffield, for their help in analysing the PREM open narrative question for England.

We would also like to thank Professor Pam Enderby for representing the NAIC Steering Group on the NICE guideline standards committee for the new NICE guideline, *NG74 Intermediate care including reablement*. We look forward to providing input to the new quality standards on the same topic as a key stakeholder.

The Document 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 for NAIC 2017. This was particularly important with an increased uptake of this element of the audit from providers.

Finally, many thanks to all the participants in the audit, including management, clinical, informatics, clinical audit, HR 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 service users.

10. Glossary of terms

Term	Definitions
Clinical Commissioning Group (CCG)	Clinical Commissioning Groups (CCGs) commission most of the hospital and community NHS services in the local areas for which they are responsible.
Commissioner	Commissioners decide what services are needed for diverse local populations, and ensure that they are provided. Services that commissioners may commission include: • most planned hospital care • rehabilitative care • urgent and emergency care (including out-of-hours) • most community health services • mental health and learning disability services
Delphi technique	The Delphi technique is structured communication technique or method, originally developed as a systematic, interactive forecasting method which relies on a panel of experts. The experts answer questionnaires in two or more rounds. After each round, a facilitator or change agent provides an anonymised summary of the experts' forecasts from the previous round as well as the reasons they provided for their judgments. Thus, experts are encouraged to revise their earlier answers considering the replies of other members of their panel. It is believed that during this process the range of the answers will decrease, and the group will converge towards the 'correct' answer. Finally, the process is stopped after a predefined stop criterion (e.g. number of rounds, achievement of consensus, stability of results) and the mean or median scores of the final rounds determine the results. Delphi is based on the principle that forecasts (or decisions) from a structured group of individuals are more accurate than those from unstructured groups.
Getting it Right First Time (GIRFT) Programme	Getting It Right First Time (GIRFT) is a national programme designed to improve medical care within the NHS by reducing unwarranted variation. By tackling variation in the way services are delivered across the NHS, and by sharing best practice between trusts, GIRFT identifies changes that will help improve care and patient outcomes, as well as delivering efficiencies such as the reduction of unnecessary procedures and cost savings.

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, with an expected standard response time of less than 4 hours. Crisis response services will typically 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, 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 professionals and carers (in care homes).

Term	Definitions
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.
Local Authority	A local authority is an organisation that is officially responsible for all the public services and facilities in an area.
Provider	A health care provider is an organisation acting as a direct provider of health care services. A health care provider is a legal entity, or a sub-set of a legal entity, which may provide health care under NHS service agreements or contracts; it may operate on one or more sites within and outside hospitals, in the community and in primary care.
RightCare	NHS RightCare is a national NHS England supported programme committed to delivering the best care to patients, making the NHS's money go as far as possible and improving patient outcomes. NHS RightCare advises local health economies to make the best use of their resources – by tackling over use and underuse of resources. • Understand their performance – by identifying variation between demographically similar populations so they can adopt and implement optimal care pathways more efficiently and effectively. • Talk together about the same things – about population healthcare rather than organisations and encouraging joint decision-making. • Focus on areas of greatest opportunity by identifying priority programmes which offer the best opportunities to improve healthcare for people and ensuring taxpayer money goes as far as possible. • Use tried and tested evidence based processes to make sustainable improvement to reduce unwarranted variation.

Term	Definitions
Section 75 Agreement	An agreement made under Section 75 of the 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.
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.
Step down	Intermediate care function to receive patients from acute care for rehabilitation and to support timely discharge from hospital.

Term	Definitions
Trans-disciplinary roles	"Trans-disciplinary working means that one discipline may take on the traditional role of another by agreement, where the barriers between different disciplines break down and roles within the team are redesigned to make optimum use of team skills and knowledge. Assessments may be carried out by different disciplines working together with insights from one discipline informing the assessments of another; 'the whole will be greater than the sum of the parts'. Patient plans will benefit from interdisciplinary insights, and a learning culture within the team will value all insights, especially those of the patient themselves. This is particularly true of care co-ordination and some teams have created specific roles to carry this out. This sort of working requires team members to sink part of their individual professional role into the team effort, and teams are non-hierarchical and often self-governing"
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

11. References

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

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

Department of Health / Department for Communities and Local Government *2017-19 Integration and Better Care Fund Policy Framework*. March, 2017

Enderby P, John A *Therapy Outcome Measures for Rehabilitation Professionals.* Third Edition, J & R Press, Guildford

Healthcare Quality Improvement Partnership NHS England Quality Accounts List 2017/18. January 2017

Local Government Association et al. High Impact Change Model: Managing Transfers of Care.

NHS Benchmarking Network, et al. *National Audit of Intermediate Care - Summary Report 2014.* November 2014

NHS Benchmarking Network, et al. *National Audit of Intermediate Care - Summary Report 2015.* November 2015

NHS Benchmarking Network, et al. *Older people's care in acute settings - National Report.* March 2016

NHS Derby City *Adapted from the Sunderland Community Re-ablement Scheme: Using the Derby Outcome Measure.* 2009

NHS England *2014-15 and 2015-16 CCG Allocations – Overall CCG weighted populations* (Gateway reference number: 01356)

NHS England *The Five Year Forward View*. October 2014

NHS England *MDT Development Guide*. January 2015

NHS England *Next steps on the NHS Five Year Forward View*. March 2017

NHS Improvement *Combined costs collection: reference costs collection guidance 2016/17*. February 2017

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

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

Teale, E.A and Young, J. B. *A Patient Reported Experience Measure (PREM) for use by older people in acute services*. Academic Unit of Elderly Care and Rehabilitation, Bradford Institute for Health Research. Published in "Age and Ageing" on February 21, 2015.

The National Institute for Health and Care Excellence *Nice Guideline – Intermediate care including reablement (NG74).* September 2017

The Care Act 2014

Young J, Forster A and Green J. *An estimate of post-acute intermediate care need in an elderly care department for older people*. 2003(1998)

Appendix 1. National Audit of Intermediate Care Steering Group 2017

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

David Bramley
Deputy Head and Programme Lead - Long-Term Conditions, Older People and End of Life Care Team
Medical Directorate
NHS England

Shane Breen
AHP Consultant
Public Health Agency, Northern Ireland

Joanne Crewe
Director of Quality and Governance / Executive Nurse
NHS Harrogate and Rural District CCG

Adrian Crook
Assistant Director - Health and Adult's Social Care, Integration and Provider Services
Bolton Metropolitan Borough Council

Professor Pam Enderby
Emeritus Professor of Community Rehabilitation
University of Sheffield

Dawne Garrett
Professional Lead - Older People and Dementia Care
Royal College of Nursing

Lizanne Harland
Head of Contracts
NHS Gloucestershire Clinical Commissioning Group

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

Dr Fiona Kearney
Consultant Geriatrician
Nottingham University Hospitals NHS Trust

Lucinda Keenan
Helpline Manager
The Patients Association

Dr Dawn Moody
Associate National Clinical Director for Older People and Integrated Person-Centred Care
NHS England

Cynthia Murphy
Chair, Royal College of Occupational Therapists, Specialist Section Older People

Vicky Paynter
Physiotherapist, Bristol Community Health
AGILE National Executive Committee
Chartered Physiotherapists working with Older People

Iola Shaw
Project Delivery Manager, Long Term Conditions, Older People & EOLC
Medical Directorate
NHS England

Helen Speed
Programme Director Urgent Care and Collaborative Commissioning
North Manchester Clinical Commissioning Group

Professor Martin Vernon
National Clinical Director for Older People and Integrated Person-Centred Care
NHS England

Tracey Williams
Assistant Director for The National Unscheduled Care Programme
National Collaborative Commissioning Unit, NHS Wales

Appendix 2. National Audit of Intermediate Care Advisory Group Members 2017

Professor David Oliver
Consultant Geriatrician, Hampshire Hospitals NHS Foundation Trust
Clinical Vice President, Royal College of Physicians of London

Dr Imran Rafi
Chair, Clinical Innovation and Research Centre
Royal College of General Practitioners

Dr Elizabeth Teale
Clinical Senior Lecturer and Consultant in Elderly Care Medicine
Academic Unit of Elderly Care and Rehabilitation
Bradford Institute for Health Research

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	Services with an expected, standard response time of less than four hours. Interventions for the majority of service users will typically be short (less than 48 hours) but may last up to a week (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	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

IC Function	Setting	Aim	Period	Workforce	Includes	Excludes
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. Data completeness

Data completeness for the commissioner level audit was as follows:

	Number of commissioner groups contributing to each section	Section % completion
Baseline	85	95%
Governance	81	100%
Strategy	81	99%
Participation	78	99%
Pathways	81	98%
Performance management	82	98%
Services commissioned / funded	81	89%
Funding	79	83%
Crisis response activity	51	49%
Home based activity	55	46%
Bed based activity	58	55%
Re-ablement activity	53	51%

Data completeness for the provider level audit was as follows:

	Service type	Number of services contributing to section	Section % completion
Service model	Crisis	56	90%
	Home	134	87%
	Bed	227	86%
	Re-ablement	44	81%
Referrals	Crisis	56	70%
	Home	134	65%
	Bed	227	48%
	Re-ablement	44	49%
Activity	Crisis	56	58%
	Home	134	56%
	Bed	227	62%
	Re-ablement	44	78%
Finance	Crisis	56	64%
	Home	134	66%
	Bed	227	70%
	Re-ablement	44	67%
Workforce	Crisis	56	71%
	Home	134	69%
	Bed	227	71%
	Re-ablement	44	73%
Quality	Home	134	54%
	Bed	227	73%
Quality / outcomes	Re-ablement	44	72%

Appendix 5. Audit participants - England

Commisioners

Grouping represents CCGs and Local Authorities who have jointly submitted to NAIC 2017.

Aylesbury Vale CCG	Brent CCG
Buckinghamshire County Council	London Borough of Brent
Chiltern CCG	Bromley CCG
Bath and North East Somerset CCG	Bury CCG
Bath and North East Somerset Council	Bury Metropolitan Borough Council
Barnet CCG	Blackburn with Darwen Borough Council
London Borough of Barnet	Blackburn with Darwen CCG
Barnsley CCG	Cambridgeshire and Peterborough CCG
Bassetlaw CCG	Cambridgeshire County Council
Birmingham City Council	Peterborough City Council
Birmingham Cross City CCG	Central Manchester CCG
Birmingham South and Central CCG	Chorley and South Ribble CCG
Bolton CCG	Greater Preston CCG
Bolton Metropolitan Borough Council	City and Hackney CCG
Bradford City CCG	London Borough of Hackney
Bradford Districts CCG	Croydon CCG
Bradford Metropolitan District Council	Dudley CCG

Dudley Metropolitan Borough Council	London Borough of Haringey
Ealing CCG	Harrogate and Rural District CCG
London Borough of Ealing	North Yorkshire County Council
East and North Hertfordshire CCG	Harrow CCG
Hertfordshire County Council	Heywood, Middleton and Rochdale CCG
East Lancashire CCG	Hillingdon CCG
Lancashire County Council	Hounslow CCG
Enfield CCG	London Borough of Hounslow
London Borough of Enfield	Ipswich and East Suffolk CCG
Fylde and Wyre CCG	Cornwall Council
Gloucestershire CCG	Kernow CCG
Gloucestershire County Council	Lambeth CCG
Great Yarmouth and Waveney CCG	Lancashire County Council
Norfolk County Council	Leeds City Council
Greater Huddersfield CCG	Leeds North CCG
Halton Borough Council	Leeds South and East CCG
Halton CCG	Leeds West CCG
Haringey CCG	East Leicestershire and Rutland CCG

Leicester City CCG	North Lincolnshire CCG
Leicester City Council	North Lincolnshire Council
Leicestershire County Council	Manchester City Council
Rutland County Council	North Manchester CCG
West Leicestershire CCG	North Warwickshire CCG
Luton CCG	Warwickshire CCG
Mansfield and Ashfield CCG	Central London (Westminster) CCG
Newark and Sherwood CCG	Hammersmith and Fulham CCG
Newcastle Gateshead CCG (Newcastle)	London Borough Council of Hammersmith & Fulham
Newcastle Gateshead CCG (Gateshead)	Royal Borough of Kensington and Chelsea
Newham CCG	West London (K & C and Qpp) CCG
Corby CCG	Westminster City Council
Nene CCG	Norfolk County Council
Doncaster CCG	North Norfolk CCG
Doncaster Metropolitan Borough	Norwich CCG
North East Essex CCG	South Norfolk CCG
North East Lincolnshire CCG	Nottingham City CCG
North Kirklees CCG	Oldham CCG

Oxfordshire CCG	Staffordshire County Council
Oxfordshire County Council	Stockport CCG
Portsmouth CCG	Stockport Metropolitan Borough Council
Portsmouth City Council	Stoke CCG
Richmond CCG	Stoke on Trent City Council
London Borough of Richmond upon Thames	Surrey County Council
Rotherham CCG	Surrey Heath CCG
Rotherham Metropolitan Borough Council	Derbyshire County Council
Salford CCG	Tameside and Glossop CCG
Sandwell and West Birmingham CCG	Tameside Metropolitan Borough Council
Sandwell Metropolitan Borough Council	Telford and Wrekin CCG
Sheffield CCG	Thurrock CCG
Sheffield City Council	Trafford CCG
Fareham and Gosport CCG	Walsall CCG
South Eastern Hampshire CCG	Walsall Metropolitan Borough Council
South Manchester CCG	Wandsworth Borough Council
Southampton CCG	Wandsworth CCG
North Staffordshire CCG	Great Yarmouth and Waveney CCG

Suffolk County Council
West Cheshire CCG
Essex County Council
West Essex CCG
Norfolk County Council
West Norfolk CCG
West Suffolk CCG
Coastal West Sussex CCG
Crawley CCG
Horsham and Mid Sussex CCG
West Sussex County Council
Wigan Borough CCG
Wigan Metropolitan Borough Council
Wiltshire CCG
Wiltshire Council
Wolverhampton CCG
Wolverhampton City Council

Providers

Anglian Community Enterprise CIC	Central Manchester University Hospitals NHS Foundation Trust
Barnet, Enfield and Haringey Mental Health Trust	City Healthcare Partnership
Berkshire Healthcare NHS Foundation Trust	Cornwall Partnership NHS Foundation Trust
Birmingham Community Healthcare NHS Trust	Countess of Chester NHS Foundation Trust
Blackpool Teaching Hospitals NHS Foundation Trust	County Durham & Darlington NHS Foundation Trust
Bolton Metropolitan Borough Council	Coventry & Warwickshire Partnership NHS Trust
Bradford Metropolitan District Council	Croydon Health Services NHS Trust
Bradford Teaching Hospitals NHS Foundation Trust	Derby Teaching Hospitals NHS Foundation Trust
Bridgewater Community Healthcare NHS Foundation Trust	Doncaster & Bassetlaw Hospitals NHS Foundation Trust
Bromley Healthcare CIC Ltd	Doncaster Metropolitan Borough Council
Buckinghamshire Healthcare NHS Trust	Dorset Healthcare University NHS Foundation Trust
Bupa (Dudley)	East London NHS Foundation Trust
Burton Hospitals NHS Foundation Trust	East Sussex Healthcare NHS Trust
Bury Metropolitan Borough Council	First Community Health and Care
Cambridgeshire & Peterborough NHS Foundation Trust	Gateshead Health NHS Foundation Trust
Camden and Islington NHS Foundation Trust	Gloucestershire Care Services NHS Trust
Central & North West London NHS Foundation Trust	Guys' & St Thomas' NHS Foundation Trust
Central London Community Healthcare NHS Trust	Halton Borough Council

Hertfordshire Community NHS Trust	Medway Community Healthcare CIC
Hollybush House Nursing Home	Mid Cheshire Hospitals NHS Foundation Trust
Homerton University Hospital NHS Trust	Mid Yorkshire Hospitals NHS Trust
Hounslow and Richmond Community Healthcare	Norfolk Community Health and Care NHS Trust
Humber NHS Foundation Trust	Norfolk County Council
Kent Community Health NHS Foundation Trust	North East London NHS Foundation Trust
Lancashire Care NHS Foundation Trust	North Lincolnshire Council
Lancashire County Council	North Somerset Community Partnership
Leeds Community Healthcare NHS Trust	North Tees and Hartlepool NHS Foundation Trust
Leicester City Council	North West Boroughs Healthcare NHS Foundation Trust
Leicestershire County Council	Northamptonshire Healthcare NHS Foundation Trust
Leicestershire Partnership Trust	Nottinghamshire Healthcare NHS Foundation Trust
Lewisham & Greenwich NHS Trust	Oxford Health NHS Foundation Trust
Lincolnshire Community Health Services	Oxford University Hospitals NHS Trust
Liverpool Community Health NHS Trust	Pennine Acute Hospitals NHS Trust
Livewell Southwest	Pennine Care NHS Foundation Trust
Locala Community Social Enterprise	Rotherham, Doncaster & South Humber NHS Foundation Trust
London North West Healthcare NHS Trust	Rotherham NHS Foundation Trust

Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust	St George's University Hospitals NHS Foundation Trust
Rutland County Council	St Helens and Knowsley Teaching Hospitals NHS Trust
Salford Royal NHS Foundation Trust	Staffordshire & Stoke on Trent Partnership NHS Trust
Sandwell & West Birmingham Hospitals NHS Trust	Stockport NHS Foundation Trust
Sandwell Community Caring Trust	Stoke on Trent City Council
Sandwell Metropolitan Borough Council	Sussex Community NHS Foundation Trust
Sheffield Teaching Hospitals NHS Foundation Trust	Tameside and Glossop Integrated care NHS Foundation Trust
Sherwood Forest Hospitals NHS Foundation Trust	Tameside Metropolitan Borough Council
Shropshire Community Health NHS Trust	Telford and Wrekin Borough Council
Sirona Health & Care CIC	The Ipswich Hospital NHS Trust
Solent NHS Trust	The Newcastle upon Tyne Hospitals NHS Foundation Trust
Somerset Partnership NHS Foundation Trust	The Royal Marsden NHS Foundation Trust
South Essex Partnership NHS Foundation Trust	Tiled House Care Centre
South Warwickshire NHS Foundation Trust	Torbay and South Devon NHS Foundation Trust
South West Yorkshire Partnership NHS Foundation Trust	University College Hospitals NHS Foundation Trust
Southern Health NHS Foundation Trust	University Hospital of South Manchester NHS Foundation Trust
Southport & Ormskirk Hospital NHS Trust	Virgin Care
Spiral Health CIC	Walsall Healthcare NHS Trust

West London Mental Health NHS Trust	Wiltshire Health and Care
West Suffolk NHS Foundation Trust	Windsor and Maidenhead Royal Borough Council
West Sussex County Council	Worcestershire Health and Care NHS Trust
Whittington Health NHS Trust	Wye Valley NHS Trust
Wiltshire Council	York Teaching Hospitals NHS Foundation Trust

Prepared in partnership with:

NHS Benchmarking Network
www.nhsbenchmarking.nhs.uk

British Geriatrics Society
www.bgs.org.uk

Association of Directors of Adult Social Services (ADASS)
www.adass.org.uk

Royal College of Nursing
www.rcn.org.uk

Royal College of Speech & Language Therapists
www.rcslt.org

The Patients Association
www.patients-association.org.uk

Royal College of Physicians
www.rcplondon.ac.uk

Royal College of Occupational Therapists Specialist Section for Older People
www.cot.co.uk

AGILE; Chartered Physiotherapists working with older people
agile.csp.org.uk

NHS England
https://www.england.nhs.uk/