Proposal for the National Audit of Intermediate Care 2015

Implementation plan for the fourth round of the audit
1. Background to the National Audit of Intermediate Care (NAIC)

The audit is a partnership project between the British Geriatrics Society, the NHS Benchmarking Network, the Association of Directors of Adult Social Services, AGILE - Chartered Physiotherapists working with older people, the 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.

The audit is now well established, having run for three years, and is a large audit, covering 75 CCGs, 124 providers, 472 services and included over 12,000 service user responses in 2014.

The NAIC focuses on services which support, usually frail, elderly people, at times of transition when stepping down from hospital or preventing them being admitted to secondary or long term care. These services are a crucial part of the solution to managing increasing demand in the health and social care system. The audit shines a light on intermediate care and provides a stocktake of current service provision. The unique combination of organisational data and outcomes data collected in the audit enables us to address the following questions:

- Does intermediate care work?
- Is it cost effective?
- Do we have enough capacity to make a difference?
- What are the features of a “good” service?
- How do we make the case for investment?

The audit allows commissioners and providers to consider both the national answers to these questions but also, importantly, how their local health and social care economy is performing on these key issues. Audit participants can access their local results via an online toolkit.

NHS England has recently endorsed the audit and is encouraging CCGs and providers of intermediate care to take part in NAIC 2015.

HQIP has announced that the National Audit of Intermediate Care has been included on the 2015/16 Quality Accounts list. It is mandatory for NHS Trusts to produce a quality account every year which details the Provider’s participation in clinical audits. The following link has the background and legislation with reference to the HQIP quality accounts and the Statutory and mandatory requirements for Clinical Audit.


Audit participants were invited to the National Conference at the ICC in Birmingham on 12th November 2014 to discuss the findings of the 2014 audit. This event was an opportunity for audit participants to consider the results, provide feedback on the audit content and process and share good practice.

2. Funding model

As in previous years, the audit will be financed using a subscription model. Health economies (based on Clinical Commissioning Group (CCG) boundaries) will be charged a fee maintained at £3,500 each to take part in the audit in 2015.

Given the integrated nature of intermediate care services and the need to engage both providers and commissioners across health and social care, both commissioners and providers of intermediate care services will be approached to register their interest in participating in 2015. As in previous years, if commissioners sign up to participate in the audit, the fee of £3,500 will also cover the participation of all
their local providers of intermediate care services. However, if commissioners do not wish to pursue this approach; providers will be given the opportunity to join the project independently at a cost maintained at £1,000 each.

The outputs of the audit may be flexed depending on the funding pool raised via the subscription fees.

3. **NAIC 2015 aims and objectives**

3.1 **Purpose**

The audit measures intermediate care (IC) service provision and performance against standards derived from DH guidance and from evidence based best practice. The audit provides national comparative data for bed and home based intermediate care services provided by a range of health and social care providers including acute trusts, community service providers and local authorities.

The audit takes a whole system view of the effectiveness of intermediate care services and the contribution made to demand management across health and social care systems in the four UK countries.

3.2 **Definition of intermediate care**

For the purposes of the audit, the following definition of IC has been developed with the help of the Plain English Campaign:

- **What is intermediate care?**
  Intermediate care services are provided to patients, usually older people, after leaving hospital or when they are at risk of being sent to hospital. The services offer a link between hospitals and where people normally live, and between different areas of the health and social care system – community services, hospitals, 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.

As in 2013 and 2014, four service categories for intermediate care (IC) will be used in 2015; crisis response, bed based IC, home based IC and re-ablement. The definition of crisis response has been reviewed for 2015 with these services being distinguished by having a standard response time of less than four hours rather than the definition being limited to those with very short (less than 48 hours) interventions. The definitions of the three other service categories are unchanged for 2015. Appendix 1 contains the revised Service Category Definitions which will be supplied to each audit participant to enable them to categorise IC services for the purposes of the audit.

For Trusts, this should mean that they are applying the same principles for the reference costs as for NAIC, for the health funded elements of intermediate care.

3.3 Objectives
The objectives of the NAIC 2015 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) and NHS England.

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

4. NAIC 2015 methodology
In this section the proposed scope, approach to data collection, analysis and reporting are considered.

4.1 Scope
The audit will include crisis response, bed based IC, home based IC and re-ablement services provided by a range of health and social care providers including acute trusts, community service providers and Local Authorities. These services are provided in a range of health and social care settings including service user’s own homes, hospitals, community hospitals and residential care homes. All eligible commissioners and providers across the NHS and social care in England, Wales, Scotland and Northern Ireland will be invited to participate in the audit.

As in previous years, the 2015 audit will have both organisational and service user level components. The organisational level is a necessary element because this is an audit of a service rather than a condition. An understanding of the organisational and service framework within which patient care is being provided is key to reaching conclusions on how patient outcomes can be optimised.

4.2 Proposed structure and scope of the organisational level audit
As in previous years, the 2015 organisational level audit will have sections for commissioners and providers. This structure allows providers to participate independently should they choose to do so and also enables a “whole health economy” perspective to be taken by commissioners. Commissioners and providers will be able to opt at the outset to view each other’s outputs so that the whole picture for their locality can be viewed in the online tool.
Commissioner and provider quality standards for IC services

The quality standards were originally developed from DH guidance and other evidence based best practice and cover governance, strategy, participation, pathways and performance management. The NAIC quality standards utilised in previous years have been updated for 2015. In order to make the provider organisational level audit more succinct, the provider quality standards have been removed; questions which mirror what is asked in the commissioner quality standards section have been deleted and questions which would be better placed in the service user section have been moved. The commissioner quality standards have been updated by reducing some of the questions that ask for more detail.

Commissioner organisational level audit

The commissioner organisational level survey will be completed for each health and social care economy. Where services are jointly commissioned by the CCG and Local Authority, they are asked to produce a joint submission for their health economy.

The commissioner organisational audit covers:

- Scope of intermediate care services commissioned
- Commissioning arrangements
- Access criteria
- Funding and costs
- Activity

New questions will be added this year on the impact of the Better Care Fund on intermediate care, progress with integration and links with the non-statutory sector.

Commissioner finance questions will be updated to reflect closer working between health and social care. Questions will be removed where it is judged that provider data produces more robust results (e.g. unit costs of activity).

Provider organisational level audit

Providers are asked to identify separate IC services provided in their locality and categorise them as either crisis response services, bed based IC, home based IC or re-ablement services (based upon an agreed set of definitions, see Appendix 1). As noted above, the definition of crisis response will be clarified for 2015. Different questionnaires are provided for these service categories reflecting the different currencies used in these services (for example, bed days, community service “contacts”, re-ablement “contact hours” etc.). Feedback has suggested that most providers were able to describe the variety of the IC services provided using this structure. Guidance will be provided on how services which are very integrated, for example across bed and home provision, should complete the audit.

The provider audit covers:

- Service models
- Activity
- Finance
- Workforce

The provider questions will remain largely unchanged allowing year on year comparisons to be made. However, new questions will be included on the management of people with cognitive impairment.
### 4.3 Proposed scope of the service user level audit

In both 2013 and 2014, standardised outcome measures were collected for bed based IC services via a service user questionnaire completed by clinicians. The bed based service user questionnaire included a detachable Patient Reported Experience Measure (PREM) for completion by service users. In 2014, this approach was extended to home based IC services with standardised outcome measures developed and collected using a service user questionnaire suitably revised for use in home based services, again with a detachable PREM. For re-ablement, a PREM was available for completion by service users.

For 2015, the Steering Group has decided to extend the use of the home based service user questionnaire (with PREM) to re-ablement services.

**Service User Questionnaire**

In the 2014 audit, providers of bed based IC services were asked to complete the service user questionnaire for 50 consecutive patients referred to the service. In 2014, 3,548 service user questionnaires were completed enabling conclusions, collated at both national and local level, to be reached on areas such as the demographic of the patient cohort nationally, waiting times, length of stay and patient pathways through the system. In 2015, bed based services will again be asked to complete 50 forms for consecutive service users. The bed based service user questionnaire in 2014 included two outcome measures the “Levels of care” tool and the Modified Barthel Index. For 2015, the Steering Group has decided to remove the “Levels of care tool” and replace it with additional questions on care planning and dementia.

In 2014, providers of home based IC services were asked to complete the service user questionnaire for 100 consecutive service users referred to the service and this will be repeated in 2015. 3,830 forms were returned in 2014. The home based services form included two standardised outcome measures; the Sunderland Outcome Measure and an excerpt from the Therapy Outcome Measure. These measures will remain for 2015 but additional questions on care planning and dementia will be added. The same, revised questionnaire will be used for re-ablement services, who will also be asked to complete the forms for 100 consecutive service users.

**PREM**

In 2013, PREM forms were developed with the assistance of the University of Leeds and the Patients Association. Two slightly different versions were produced for bed and for home/re-ablement services. The forms included 15 questions, plus an open text question asking for suggestions for improvement. The questions were reviewed in 2014. Work was undertaken to describe the feasibility and acceptability of the measures and examine the questionnaire scaling properties, *A Patient Reported Experience Measure (PREM) for use by older people in community services*, E. A Teale, J. B. Young on behalf of the NAIC steering committee (Age and Ageing, in press).

In 2015, the wording of the question which aims to measure social isolation (“I feel less anxious/less worried since having this service”) will be reviewed. Otherwise the questions will remain unchanged.

For all three services, the PREM will be a detachable form at the back of the service user questionnaire to be handed to the service user with a pre-paid envelope on discharge.

There will be no service user questionnaire/PREM for crisis response because of the short term nature of these services.

**Good practice case studies**

The inclusion of the PREM and outcome measures, alongside existing efficiency metrics, will enable high performing IC services to be identified from the audit results. Discussions will be held with these services to enable more detailed case studies to be developed. The services will also be invited to present on their service models at the national conference to be held on 11th November 2015.
4.4 Approach to data collection

As in previous years, the organisational level audit for 2015 will be completed via a web based data entry tool via a secure interface (see Section 4.5 data protection below). Registration for NAIC 2015 will also be online. This will enable the links between providers and commissioners to be held within the database and allow participants to indicate whether they wish to allow their partner organisations to view their data. Logins, as in 2014, will be individual to enable access to the online data collection tool to be controlled.

Audit participants will be requested to “opt-in” to the service user questionnaire/PREM audit at the registration stage. As for 2014, the service user questionnaires will comprise coded, paper forms for completion by clinicians. These are collated by the organisation’s project lead and returned for scanning. The PREM forms are paper forms handed to the service user by the clinician with a freepost envelope. The PREM form is then completed and posted by the service user. All paper forms are scanned and the data uploaded into the NAIC database.

A telephone helpline and user support email service will be in place throughout the project to support participant enquiries in all aspects of the project work.

4.5 Data protection

Given that the audit will include sample data collection from patient/service user records the study will comply with the information governance standards for the NHS and social care. No patient/service user identifying information will be collected.

Data is transferred via a website hosted within the NHS secure N3 network. Participant organisations will be able to access this service via existing nhsnet email and server connections hosted via the N3 network.

4.6 Use of data

By taking part in the audit, participants will agree to their data being used for other research projects currently being undertaken by the NHS Benchmarking Network in conjunction with the National Institute for Health Research and academic bodies. All data used will be anonymous and there will be no organisation identifiable information in any outputs.

Where participants are also members of the NHS Benchmarking Network, they are also agreeing to their NAIC data being used in the Integrated Care, Older people in acute settings benchmarking projects and other Network projects. All data used will be anonymous and there will be no organisation identifiable information in any outputs.

4.7 Analysis

Analysis is supported by an SQL Server database. Further development of the database is being undertaken to improve the efficiency of the analysis stage. This work will support the ability to identify the key characteristics common to high performing services. The analysis will include trends over time as the audit progresses.

4.8 Validation

Validation controls are implemented on several levels within the data collection tool. Information buttons containing data definitions to ensure the consistency of data supplied are available throughout the tool. System validation is implemented to protect the integrity of the information being recorded (e.g. allowable ranges, expected magnitude, appropriate decimal places and text formatting). Integrity checks were also incorporated into the underlying database structure, for example, the use of uniqueness constraints to prevent the creation of duplicate records.

Following the first phase of the analysis, outlying positions will be validated with participants and amendments made where necessary before finalisation of the project outputs.
4.9 Audit outputs and reporting

A Summary Report for NAIC 2015 will be produced giving an overview of the results of the organisational level and service user level audits. This will include an introduction to the national audit, methodology and participants, key findings from the audits including compliance with agreed quality standards, progress in developing outcome measures, key discussion points and references. The annual report will be publicly available.

Participants will also have access to an online benchmarking analysis tool that will allow them to view their own performance in detail on the audit metrics against national comparators.

The outputs of the audit will be meaningful to the wide ranges of audiences who have a stake in the success of IC services including service users, providers, clinicians, policy makers/DH, and commissioners.

4.10 Engagement with participants

A summary brochure with the key findings from NAIC 2014 has been e-mailed to the Boards of all CCGs, NHS Trusts, Health and Wellbeing Boards and Local Authorities in England, Local Health Boards in Wales, NHS Scotland Boards and Health and Social Care Board/Trusts in Northern Ireland to raise awareness of the project.

A communications plan has been agreed with the NAIC Steering Group to ensure regular communication with audit participants throughout the process.

The NAIC Steering Group is working with a wider reference group of audit participants on a number of issues related to the scope, content and process for NAIC 2015. Regular updates on the audit development and next steps will be posted on the website and circulated in a new NAIC monthly newsletter.

A national event to discuss the findings of NAIC 2014 will be held on 11th November 2015 at the ICC, Birmingham. The event will include seminars focussing on the high performing services identified in the audit as described in Section 4.3 above and provides the opportunity for audit participants to provide feedback. The event is free to audit participants.

5. Outline project plan

<table>
<thead>
<tr>
<th>Date 2015</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>w/c 2 February</td>
<td>Launch NAIC 2015 and commence registration</td>
</tr>
<tr>
<td>11 March</td>
<td>Amendments to audit content agreed by NAIC Steering Group</td>
</tr>
<tr>
<td>19 March</td>
<td>Registration complete</td>
</tr>
<tr>
<td>w/c 20 April</td>
<td>Participants receive service user questionnaires/PREMs ready to commence service user audits</td>
</tr>
<tr>
<td>4 May</td>
<td>Organisational level data collection commences online and service user audit commences</td>
</tr>
<tr>
<td>24 July</td>
<td>Deadline for both service user and organisational level data collections</td>
</tr>
<tr>
<td>August</td>
<td>Data validation with participants</td>
</tr>
<tr>
<td>September/October</td>
<td>Analysis, drafting of reports and development of online tool</td>
</tr>
<tr>
<td>11 November</td>
<td>Launch of 2015 findings at NAIC 2015 conference</td>
</tr>
</tbody>
</table>
6. Standards and guidelines

Guidance for IC services was set out by the DH in the National Service Framework for Older People in 2001 (2). Further guidance, entitled Intermediate Care - Halfway Home was published by DH in 2009 (9).

The National Service Framework for Older People set out some key guiding principles for the provision of IC services:

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

Halfway Home updates the original guidance and sets out the definitions, service models, responsibilities for provision, charges and planning. The guidance recommends that health and local government organisations, with a shared vision, should undertake strategic planning for intermediate care jointly. The guidance recommends a core multidisciplinary intermediate care team, which is led by a senior clinician, ideally with one overall manager, and closely linked to re-ablement services in social care. The key target groups for Intermediate care, people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute inpatient care, long term residential care or continuing NHS in-patient care, remain the priority.

The specific points included in the DH guidance regarding, for example, access criteria, the preference for a single point of access and multidisciplinary team working are used in the national audit to develop quality standards for service provision. However, the guidance in relation to patient outcome measures is limited.

7. Project partners

The partners who have come together to develop and deliver the National Audit of Intermediate Care are:

The NHS Benchmarking Network is the in house benchmarking service of the NHS promoting service improvement through benchmarking and sharing good practice. The NHS Benchmarking Network provides project management, data collection, analysis, reporting and events management to the NAIC.

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 a 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 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 College of Occupational Therapists Specialist Section for Older People (COTSS-OP) is passionate about older peoples' independence, well-being and choice. COTSS-OP provides professional and clinical information on all aspects of occupational therapy practice related to older people. Through Clinical Forums, the COTSS-OP aims to encourage evidence based practice and provide guidance on
occupational therapy intervention in the areas of: acute and emergency care, intermediate care, dementia, falls, mental health and care homes.

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 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 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 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 therapist work with patients of all ages including children with developmental speech and language impairments and the elderly with acquired difficulties requiring rehabilitation.

8. Project risks and governance

8.1 Development of outcome measures

The audit has developed standardised outcome measures for IC services; beginning with bed based services in 2013 and adding an instrument for home based services in 2014. As described in Section 4.3 above, although this has been challenging, participation has been strong and the new instruments well received. In 2015, this work will be extended to re-ablement services. There is a risk that the service user questionnaire may prove to be difficult to administer in re-ablement services particularly where provision is sub-contracted resulting in receiving insufficient data to draw conclusions.

8.2 Data quality

For the organisational audit there are risks of poor data quality due to difficulties in defining services given, for example, the many different names given to similar services and variation in service models. Commissioners may have difficulties in obtaining information in some instances. These risks are
mitigated by continued careful consideration of service category and data definitions by the NAIC Steering Group. The use of the NAIC definitions for intermediate care reference costs purposes assists with defining the NHS funded elements of intermediate care services.

8.3 Governance

A Steering Group with formal terms of reference oversees the National Audit of Intermediate Care. The NAIC Steering Group membership includes representatives from the stakeholder groups listed in Section 7. The Steering Group will meet approximately monthly.

Current Steering Group membership is as follows:

<table>
<thead>
<tr>
<th>Chair:</th>
<th>Debbie Hibbert</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Duncan Forsyth</td>
<td></td>
</tr>
<tr>
<td>Consultant Geriatrician</td>
<td></td>
</tr>
<tr>
<td>Addenbrooke’s Hospital</td>
<td></td>
</tr>
<tr>
<td>Cambridge University Hospitals NHS FT</td>
<td></td>
</tr>
<tr>
<td>Joanne Crewe</td>
<td></td>
</tr>
<tr>
<td>Operational Director – Acute and Cancer Care</td>
<td></td>
</tr>
<tr>
<td>Harrogate and District NHS FT</td>
<td></td>
</tr>
<tr>
<td>Claire Holditch</td>
<td></td>
</tr>
<tr>
<td>Project Director NAIC</td>
<td></td>
</tr>
<tr>
<td>NHS Benchmarking Network</td>
<td></td>
</tr>
<tr>
<td>Adrian Crook</td>
<td></td>
</tr>
<tr>
<td>Association of Directors of Adult Social Services</td>
<td></td>
</tr>
<tr>
<td>Assistant Director</td>
<td></td>
</tr>
<tr>
<td>Bolton Council</td>
<td></td>
</tr>
<tr>
<td>Cynthia Murphy</td>
<td></td>
</tr>
<tr>
<td>Intermediate Care Co-Lead and Vice Chair</td>
<td></td>
</tr>
<tr>
<td>College of Occupational Therapists, Specialist Section Older People</td>
<td></td>
</tr>
<tr>
<td>Heather Eardley</td>
<td></td>
</tr>
<tr>
<td>Director of Development</td>
<td></td>
</tr>
<tr>
<td>The Patients Association</td>
<td></td>
</tr>
<tr>
<td>Damon Palmer</td>
<td></td>
</tr>
<tr>
<td>Lead for Health and Social Care Integration</td>
<td></td>
</tr>
<tr>
<td>Department of Health</td>
<td></td>
</tr>
<tr>
<td>Professor Pam Enderby</td>
<td></td>
</tr>
<tr>
<td>Professor of Community Rehabilitation</td>
<td></td>
</tr>
<tr>
<td>University of Sheffield</td>
<td></td>
</tr>
<tr>
<td>Royal College of Speech &amp; Language Therapists</td>
<td></td>
</tr>
<tr>
<td>Vicky Paynter</td>
<td></td>
</tr>
<tr>
<td>Chair of AGILE, Chartered Physiotherapists working with Older People</td>
<td></td>
</tr>
<tr>
<td>Dawne Garrett</td>
<td></td>
</tr>
<tr>
<td>Professional Lead – Care of Older people</td>
<td></td>
</tr>
<tr>
<td>Royal College of Nursing</td>
<td></td>
</tr>
<tr>
<td>Helen Speed</td>
<td></td>
</tr>
<tr>
<td>Programme Director Urgent Care and Collaborative Commissioning</td>
<td></td>
</tr>
<tr>
<td>North Manchester CCG</td>
<td></td>
</tr>
<tr>
<td>Lizanne Harland</td>
<td></td>
</tr>
<tr>
<td>Head of Community Commissioning</td>
<td></td>
</tr>
<tr>
<td>Bristol CCG</td>
<td></td>
</tr>
<tr>
<td>Professor John Young</td>
<td></td>
</tr>
<tr>
<td>National Clinical Director for Integration and the Frail Elderly, NHS England and Head, Academic Unit of Elderly Care and Rehabilitation</td>
<td></td>
</tr>
<tr>
<td>Bradford Hospitals NHS Trust</td>
<td></td>
</tr>
</tbody>
</table>
9. Further information

9.1 Further information

For further information about the audit please contact Katherine McAloon, Project Support at katherine.mcaloon@nhs.net or visit http://www.nhsbenchmarking.nhs.uk/projects/partnership-projects/National-Audit-of-Intermediate-Care.php.
### APPENDIX 1- Service category definitions

<table>
<thead>
<tr>
<th>IC function</th>
<th>Setting</th>
<th>Aim</th>
<th>Period</th>
<th>Workforce</th>
<th>Includes</th>
<th>Excludes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Crisis response</strong></td>
<td>Community based services provided to service users in their own home/care home</td>
<td>Assessment and short term interventions to avoid hospital admission</td>
<td>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)</td>
<td>MDT but predominantly health professionals</td>
<td>Intermediate care assessment teams, rapid response and crisis resolution</td>
<td>Mental health crisis resolution services, community matrons/active case management teams</td>
</tr>
<tr>
<td><strong>Home based rehabilitation</strong></td>
<td>Community based services provided to service users in their own home / care home</td>
<td>Intermediate care assessment and interventions supporting admission avoidance, faster recovery from illness, timely discharge from hospital and maximising independent living</td>
<td>Interventions for the majority of service users will last up to six weeks (though there will be individual exceptions)</td>
<td>MDT but predominantly health professionals and carers (in care homes)</td>
<td>Intermediate care rehabilitation</td>
<td>Single condition rehabilitation (e.g. stroke), early supported discharge, general district nursing services, mental health rehabilitation/ intermediate care</td>
</tr>
<tr>
<td><strong>Bed based</strong></td>
<td>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</td>
<td>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</td>
<td>Interventions for the majority of service users will last up to six weeks (though there will be individual exceptions)</td>
<td>MDT but predominantly health professionals and carers (in care homes)</td>
<td>Intermediate care bed based services</td>
<td>Single condition rehabilitation (e.g. stroke) units, general community hospital beds not designated as intermediate care/rehabilitation, mental health rehabilitation beds</td>
</tr>
<tr>
<td><strong>Re-ablement</strong></td>
<td>Community based services provided to service users in their own home / care home</td>
<td>Helping people recover skills and confidence to live at home, maximising their level of independence so that their need for ongoing homecare support can be appropriately minimised</td>
<td>Interventions for the majority of service users will last up to six weeks (though there will be individual exceptions)</td>
<td>MDT but predominantly social care professionals</td>
<td>Home care re-ablement services</td>
<td>Social care services providing long term care packages</td>
</tr>
</tbody>
</table>