National Audit of Intermediate Care 2018

Proposal for the National Audit of Intermediate Care 2018

Benchmarking Network

ROYAL COLLEGE OF SPEECH & LANGUAGE THERAPISTS

directors of adass adult social services

AGILE Chartered Physiotherapists working with older people

Royal College of Nursing

BGS British Geriatrics Society Improving healthcare for older people

the patients association

Royal College of Occupational Therapists Specialist Section Older People

Llywodraeth Cymru Welsh Assembly Government

HSC Health and Social Care

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1. Background to the National Audit of Intermediate Care (NAIC)

The audit is a partnership project between the NHS Benchmarking Network, NHS England, the Welsh Government, the Public Health Agency and Health & Social Care Board in Northern Ireland, 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, the Royal College of Speech and Language Therapists and the Royal College of General Practitioners (RCGP).

The audit is now well established, having run for five years, and when it last ran in 2017, record coverage was reached in **England** with 99 CCGs, 55 Local Authorities, 118 providers, 461 services taking part, and NAIC 2017 included over 17,500 service user responses.

In **Wales**, 6 University Health Boards (UHBs) submitted strategic level information and 7 UHBs submitted operational level information. 94 intermediate care services were registered in total, and 1,674 service users contributed to NAIC 2017.

Northern Ireland participated for the first time in NAIC 2017 and provided data for 5 Local Commissioning Groups and 5 Health and Social Care Trusts. The 5 Health and Social Care Trusts registered 62 different intermediate care services between them, and 2,185 service user contributions were received.

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 you to address the following questions:

- Are we achieving good outcomes for service users?
- Do we have the correct balance of provision across the four service categories?
- What is the whole system contribution of our intermediate care services?
- How cost effective and efficient are our services?

The audit allows commissioners / funders 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, the Welsh Government and the Northern Ireland Public Health Agency and Health & Social Care Board are supporting the audit and strongly encourage commissioners / funders and providers of intermediate care to take part in NAIC 2018. NHS England will be providing a letter of support which will be accessible via the NAIC webpages.

HQIP has announced that the National Audit of Intermediate Care has been included on the 2018/19 Quality Accounts list. It is mandatory for NHS Trusts in England to produce a quality account every year which details the Provider's participation in clinical audits. The following link has the background and legislation regarding the HQIP quality accounts and the Statutory and mandatory requirements for Clinical Audit.

NICE have used the NAIC service category definitions in the development of their guidelines NG 74 Intermediate Care including re-ablement and in the new draft Quality Standards, which are currently being consulted upon.

The NAIC Summary Report 2017 is available to download here.

2. Funding

The 2018 audit will be supported by NHS England, the Welsh Government and the Northern Ireland Public Health Agency and Health & Social Care Board. The audit is therefore free of charge for all commissioners / funders and providers of intermediate care services in England, Wales and Northern Ireland.

3. NAIC 2018 aims and objectives

3.1 Purpose

The audit measures intermediate care (IC) service provision and performance against standards derived from government guidance and from evidence based best practice. The audit provides national comparative data for bed and home based intermediate care and re-ablement services provided by a range of health and social care providers including acute trusts, community service providers and Local Authorities. NICE issued new guidance in September 2017 on *Intermediate care including re-ablement* and are currently consulting on the development of Quality Standards.

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 three 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.

Crystal Mark 21029 Clarity approved by Plain English Campaign

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 previous iterations of the audit, four service categories for intermediate care will be used in 2018; crisis response, bed based IC, home based IC and re-ablement. The definitions are unchanged for 2018. Appendix 1 contains the Service Category Definitions which will be supplied to each audit participant to enable them to categorise IC services for the purposes of the audit.

The Department of Health (DH) introduced reference costs for intermediate care in 2013/14. The DH previously, and now NHS Improvement, has referenced extensively the definitions used for the NAIC in *Combined costs collection: reference costs collection guidance 2016-17:*

https://improvement.nhs.uk/uploads/documents/Reference_costs_collection_guidance_201617.pdf

For the Trusts providing intermediate care services in England, 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 2018 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 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, the Welsh Government and the Northern Ireland Public Health Agency.
6. To continue to share good practice in intermediate care services by encouraging networking amongst participants and developing case studies.

4. NAIC 2018 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 hospitals, community service providers and Local Authorities. These services are provided in a range of health and social care settings including service users' own homes, hospitals, community hospitals and residential care homes. All eligible commissioners and providers across the NHS and social care in England, Wales and Northern Ireland will be invited to participate in the audit.

As in previous years, the 2018 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 2018 organisational level audit will have sections for commissioners (strategic level) and providers (operational level). This structure enables a "whole health economy" perspective to be taken by commissioners / funders, in addition to allowing comparisons to be made between services. The data sharing arrangements for each country agreed with the national bodies funding the audit, are explained in section 4.8.

Commissioner (strategic) 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 remain the same for NAIC 2018.

Commissioner (strategic) organisational level audit

The commissioner organisational level survey will be completed for each health and social care economy. In England, where many services are jointly commissioned by the CCG and Local Authority, they are asked to produce a joint submission for their health economy. In Wales, University Health Boards will be requested to provide a commissioner / strategic level submission for each area. In Northern Ireland, the Local Commissioning Groups will be requested to provide a commissioner submission for each area.

The commissioner organisational audit covers:

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

The NICE guidance has extensively referenced the NAIC and the quality standards have already been covered on different aspects of the audit.

Provider (operational) 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). 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 could 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 from previous years allowing year on year comparisons to be made.

4.3 Proposed scope of the service user level audit

From 2012 to 2017, 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 in 2014, a PREM was available for completion by service users. For 2015, the Steering Group extended the use of the home based service user questionnaire (with PREM) to re-ablement services.

Service User Questionnaire

In previous audits, providers of bed based IC services were asked to complete the service user questionnaire for 50 consecutive patients referred to the service. The standardised outcome measure chosen by the Steering Group for bed based services was the Modified Barthel Index. In 2017, 4,874 service user questionnaires were completed in England, 206 in Wales and 655 in Northern Ireland 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 2018, bed based services will again be asked to complete 50 forms for consecutive service users.

In previous years, providers of home based IC services were asked to complete the service user questionnaire for 100 consecutive service users referred to the service. 5,934 forms were returned in 2017 in England, 495 in Wales and 335 in Northern Ireland. The home based services form included two standardised outcome measures; the Sunderland Community Re-ablement Scheme and two domains from the Therapy Outcome Measure (Participation and Wellbeing). The same questionnaire was used for re-ablement services in 2017, who were also asked to complete the forms for 100 consecutive service users; 1,408 were returned from England, 489 from Wales and 544 from Northern Ireland. The NAIC Steering Group have recommended that for NAIC 2018, 80 service users questionnaires are completed.

PREM

In 2013, PREM forms were developed with the assistance of the Academic Unit of Elderly Care and Rehabilitation, Bradford Teaching Hospitals/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. Every year, the PREM questions have been reviewed and validated, to ensure they are measuring the same construct. The PREM questions for 2018 will remain the same as in 2017.

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.

The scope and content of both the organisational level audit and the service user audit has not changed materially from NAIC 2017.

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 15th November 2018.

4.4 Approach to data collection

Registration

Provider and Commissioner registration for NAIC 2018 will be made available through downloading a copy of the NAIC registration form from the NAIC website here. There are different registration forms for Providers and Commissioners. At this stage, providers will be asked to identify the intermediate care services to be included in the audit, against each of the four service categories. A telephone and email helpline will be available to assist providers with this identification and classification task.

Both Commissioner and Provider registration forms should be returned to nhsbn.naicsupport@nhs.net to confirm the registration. Provider registration forms should be returned no later than 20th April 2018. Services registered after this date may not be able to take part in the Service User Audit element of NAIC.

If your organisation took part in 2017, the Project Lead (both Commissioners and Providers) will have received a pre-populated version of the registration template, to check the registration details remain correct for NAIC 2018. Contact nhsbn.naicsupport@nhs.net if you require copy of your organisation's template.

Organisational level audit

As in previous years, the organisational level audit for 2018 will be completed via a web based data entry tool via a secure interface (see Section 4.5 data protection below). Project and service leads completing the audit will be provided with individual login details. A downloadable data specification will be available on the website to assist participants with collating the data ready for input. The helpline will be available to assist users with data definitions and with completing the online data entry tool.

Service user audit

1. At the start of data collection each intermediate care Service Lead (identified at the registration stage of the audit) will receive a pack containing the following: -
    - A booklet containing instructions on how to administer the Service User Questionnaires and PREMs for Project Leads.
    - Copies of the Service User Questionnaire and PREM (50 for bed based services and in the range of 80 for home based services and re-ablement services; to be confirmed by the NAIC Steering Group).
    - Freepost envelopes for handing out to the patient / carer to return the PREM.
    - Instructions on how to return the completed Service User Questionnaires.
    - A parcel to return the completed Service User Questionnaires.
2. The first 6 pages of the Service User Questionnaire should be completed by a member of the intermediate care service with the patient. The first half of the booklet should be completed when the patient is admitted into the service and the remainder of the booklet should be completed when the patient is discharged from the service.

3. The PREM, which is the final page of the Service User Questionnaire booklet, should be handed to the patient with a freepost envelope on discharge from the service (in most cases the PREM will be handed to the patient when the final section of the Service User Questionnaire is completed). Services should encourage the patient (and/or carer) to complete and return the PREM.
4. The completed Service User Questionnaires should be collated within the service and returned to the Project Lead for onward posting back as per the instructions in the pack.
5. The completed PREM forms will be posted back directly by the patient / carer using the free-post envelopes provided, ensuring the independence of the survey.

A telephone helpline and user support email service will be in place throughout the project to support participant enquires in all aspects of the project work. The NAIC support e-mail is nhsbn.naicsupport@nhs.net or telephone 0161 266 1967.

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. A Data Privacy Impact Assessment will be completed and will be available on the NAIC webpages.

Data is transferred via a website, and stored in an SQL database, hosted within the NHS secure network.

4.6 Analysis and validation

Analysis is supported by an SQL database and is undertaken using bespoke software tools. The tools can be used to compare results with previous iterations of the NAIC.

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, with the opportunity to review draft outputs and amendments made where necessary before finalisation of the project outputs.

4.7 Audit outputs and reporting

Summary reports for NAIC 2018 will be produced separately for England, Wales and Northern Ireland giving an overview of the results of the organisational level and service user level audits. These summary reports 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 summary report for England will be publicly available.

Bespoke dashboard reports will be made available to all participants. These will contain summary metrics in dashboard style to give an at-a-glance finding for the commissioner / funder, provider or service.

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. Peer group profiling by country will be available within the tool.

The outputs of the audit will be meaningful to the wide range of audiences who have a stake in the success of intermediate care services including service users, providers, clinicians, policy makers, government agencies and commissioners**.**

4.8 Use of data

The data sharing arrangements are different for England, Wales and Northern Ireland. In summary, these are outlined below: -

England

- High level national report for England – anonymised data, report available publicly
- All England data available to NHS England on named basis (only commissioner data to be shared further e.g. through RightCare)
- Commissioner positions available on named basis to other CCGs and CCGs' own providers (if participating)
- Provider positions on selection of key metrics available to the Provider's own commissioners only (if participating)

Wales

- High level national report for Wales – available to the Welsh Government and Welsh participants only; all Welsh positions identified
- All Welsh commissioners and provider data identifiable to Welsh participants only

Northern Ireland

- High level national report for Northern Ireland – available to the Public Health Agency and Health & Social Care Board in Northern Ireland and Northern Ireland participants only; all Northern Irish positions identified
- All Northern Irish commissioners and provider data identifiable to Northern Ireland participants only

4.9 Engagement with participants

Summary information will be e-mailed to the Boards of all CCGs, NHS Trusts, Health and Wellbeing Boards and Local Authorities in England, University Health Boards in Wales and Local Authorities in Wales to raise awareness of the project. It will also be e-mailed to Health and Social Care Trusts and Local Commissioning Groups in Northern Ireland.

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 has worked with a wider reference group of audit participants on several issues related to the scope, content and process for NAIC 2018. Regular updates on the audit development and next steps will be posted on the NAIC website.

A national event to discuss the findings of NAIC 2018 will be held on the 15th November 2018 at The ICC in Birmingham. The event is free to audit participants.

5. Outline project plan NAIC 2018

Action	When
Registration for NAIC 2018 commences	w/c 12th March 2018
Northern Ireland – pre-engagement event	April 2018
Service user audit data collection commences	June 2018
Organisational level data collection opens	8th May 2018
Organisational level data collection closes	27th July 2018
Service user audit data collection completes	31st August 2018
Data validation with participants	September 2018
Data analysis – organisational level data and service user audit data	August – October 2018
NAIC UK Conference	15th November 2018
NAIC Wales Feedback Conference	December 2018
NAIC Northern Ireland Feedback Conference	February 2019
Summary reports published, bespoke reports for participating organisations published and online benchmarking toolkit issued	December 2018 – February 2019

* Please be aware that these dates are subject to change throughout the process.

6. Standards and guidelines

Guidance for IC services in England 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.

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.

In Wales, the key guidance for the Intermediate Care Fund can be found at https://www.google.co.uk/webhp?sourceid=chrome-instant&ion=1&espv=2&ie=UTF-8#q=wales%20intermediate%20care%20guidance

In Northern Ireland, the relevant guidance for intermediate care can be found at https://www.health-ni.gov.uk/publications/intermediate-care-guidance

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.

NHS England leads the National Health Service in England. They set the priorities and direction of the NHS and encourage and inform the national debate to improve health and care. NHS England commissions health care services in England for GPs, pharmacists and dentists, and support local Clinical Commissioning Groups, who plan and pay for local health services. A key strategy for the NHS in England can be found in the Five Year Forward View.

The Welsh Government provides the publicly funded National Health Service of Wales providing healthcare to some 3 million people who live in the country. The NHS has a key principle which is that good healthcare should be available to all, regardless of wealth. NHS Wales provides services ranging from smoking cessation, antenatal screening, and routine treatments for coughs and colds to open heart surgery, accident and emergency treatment and end-of-life care. Setting health policy for the NHS in Wales and the funding for health services is the responsibility of the Welsh Government.

The **Northern Ireland Public Health Agency** (PHA) was established in April 2009 as part of the reforms to Health and Social Care (HSC) in Northern Ireland. They are the major regional organisation for health protection and health and social wellbeing improvement. Their role also commits them to addressing the causes and associated inequalities of preventable ill-health and lack of wellbeing. They are a multi-disciplinary, multi-professional body with a strong regional and local presence. In fulfilling their mandate to protect public health, improve public health and social wellbeing, and reduce inequalities in health and social wellbeing, the PHA works within an operational framework of three areas: Public Health, Nursing and Allied Health Professionals, and Operations.

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 **Royal College of Occupational Therapists Specialist Section for Older People** (RCOTSS-OP) is passionate about older peoples' 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, the 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, 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.

The **Royal College of General Practitioners** (RCGP) is the professional membership body for family doctors in the UK and overseas. They are committed to improving patient care, clinical standards and GP training.

8. Project 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.

The current NAIC Steering Group membership is as follows:

1. Chair: Dr Duncan R Forsyth Consultant Geriatrician, Addenbrooke's Hospital Cambridge University Hospitals NHS FT Representing: **British Geriatrics Society**	11. Adrian Crook Assistant Director, Health and Adult's Social Care, Integration and Provider Services, Bolton Metropolitan Borough Council Representing: **Association of Directors of Adult Social Services**
2. Cynthia Murphy Chair, Royal College of Occupational Therapists, Specialist Section – Older People Representing: **Royal College of Occupational Therapists**	12. Dawne Garrett Professional Lead – Older People and Dementia Care Representing: **Royal College of Nursing**
3. Vicky Paynter Physiotherapist – Intermediate Care, Bristol Community Health / AGILE National Executive Committee member Representing: **AGILE, Chartered Physiotherapists working with Older People**	13. Dr Fiona Kearney Consultant Geriatrician Nottingham University Hospitals NHS Foundation Trust Representing: **British Geriatrics Society**
4. Claire Holditch Project Director for the National Audit of Intermediate Care Representing: **NHS Benchmarking Network**	14. Professor Martin Vernon National Clinical Director for Older People and Integrated Person-Centred Care Representing: **NHS England**
5. Debbie Hibbert Project Manager for the National Audit of Intermediate Care Representing: **NHS Benchmarking Network**	15. Dr Dawn Moody Associate National Clinical Director for Older People and Integrated Person-Centred care Representing: **NHS England**
6. Joanne Crewe Director of Quality and Governance / Executive Nurse NHS Harrogate and Rural District CCG Representing: **Commissioner organisations**	16. Kathryn Evans Community Nurse Lead / Acting Head of Planning Delivery Programme Lead – Hospital to Home National Directorate of NHS Operations and Delivery Representing: **NHS England**
7. Vacant position Representing: **Royal College of Speech and Language Therapists**	17. Tom Luckraft Assistant Head of Planning Delivery

	Hospital to Home Team - National Directorate of NHS Operations and Delivery Representing: **NHS England**
8. Rachel Power CEO Representing: **The Patients Association**	18. Tracey Williams Assistant Director for The National Unscheduled Care Programme National Collaborative Commissioning Representing: **Welsh Government**
9. Vacant position Representing: **Commissioner organisations**	19. Shane Breen AHP Consultant Representing: **Northern Ireland Public Health Agency and Health & Social Care Board**
10. Lizanne Harland Head of Contracts NHS Gloucestershire Clinical Commissioning Group Representing: **Commissioner organisations**	

9. Further information

9.1 Further information

For further information about the audit please contact the NAIC Support Team on nhsbn.naicsupport@nhs.net or call on 0161 266 1967 or visit the NAIC 2018 webpages at https://www.nhsbenchmarking.nhs.uk/naic

APPENDIX 1- Service category definitions

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 rehabilitation	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
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 ongoing 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