Intermediate care

January 2026

NHS Benchmarking Network

Harnessing the power of data to drive meaningful change

Housekeeping

Mute

- Please ensure you remain on mute, unless you are asking a question.

Interact

- We encourage you to interact in the chat, ask questions to our speakers or to other attendees – please introduce yourself!

Recording

- We will be recording this session and it will be available on the Members' Area after the event.

Wellbeing

- Please take opportunities to stand, stretch, move about, and keep hydrated.

Agenda

13:30	**Welcome and Introductions**
13:40	**Benchmarking Findings - Urgent Community Response**
13.55	**Hospital Avoidance Response Team** **Louise Jackson** and **Sadie Kidd**, Age UK
14:05	**Benchmarking Findings - Intermediate Care Provided at Home**
14:20	**The role of a pharmacist in intermediate care (Home Based services)** **Shauna Brady**, Belfast Health and Social Care Trust
14:30	**Benchmarking Findings - Bed Based Intermediate Care**
14:45	**How we use benchmarking** **Kevin Fisher,** Norfolk Community Health and Care NHS Trust
14:55	**Concluding remarks**

Network Vision and Values

Our vision

To enable members to **improve patient outcomes**, **raise health standards**, and deliver **sustainable**, **quality** health and care services through **data excellence**, **benchmarking**, and the **sharing of innovation**.

Our values

Excellence

Respect

Integrity

NHS Benchmarking Network: What do we do?

Source Data

- Extract
- Collect
- Store

Curate Data

- Cleanse
- Pseudonymise
- Validate

Analyse Data

- Benchmark
- Describe
- Model

Visualise Data

- Dashboards
- Charts
- Reports

Collaborative Insights

- Engagement
- Improvement
- ‘So what?’

NHS Benchmarking Network: What do we do?

Membership Programme

Why the Network originally formed, offering a programme of benchmarking opportunities and insights to inform decision making within NHS and healthcare organisations.

Healthcare organisations are welcome to join.

Products and Services

We specialise in unlocking the value of data to support driving improvements across services. With over 25 years of experience, our expert team delivers bespoke analytical solutions, helping organisations translate data into meaningful insights that inform strategic and operational decision-making.

Workforce Programme

Ensuring a workforce of the right size, in the right place, with the right skills is essential to meeting current population need and underpins the ambitious transformation plans set out in key healthcare policy documents.

Currently benchmarking for the mental health workforce nationally across NHS, VCSE, LAs and offering a benchmark of workforce data in tailored solutions for NHSE WT&E.

National Clinical Audits

National Clinical Audits currently delivered by the NHS Benchmarking Network:

CVDPREVENT

National Audit of Care at the End of Life
Auditing last days of life in hospitals

Learning Disability Improvement Standards

NHS Benchmarking Network
30 years of trusted, meaningful insight

NHS Benchmarking Network

Harnessing the power of data to drive meaningful change

What datasets do we benchmark?

Indicators

- National Indicators
- Acute Indicators
- Community Indicators
- MHLDA Indicators

Cross-sector

- Emergency Care
- Managing Frailty in a Bed-based Setting
- Virtual Wards

Acute

- Pharmacy & Medicines Optimisation
- Outpatients
- National Cost Collection

Mental Health

- Adult and Older People's Mental Health
- Children and Young People's Mental Health
- Learning Disability Specialist Services
- MH Pharmacy Pilot

Community

- District Nursing
- Children's Community Services
- Adult's Community Services
- Intermediate Care

Publicly available data
Clinical case review
Staff survey
PREM survey
Friends and Family Survey

KEY LINKS TO 10-YEAR HEALTH PLAN OBJECTIVES

1

Community Care Shift

Move care from hospitals to community settings where appropriate, preventing admissions and promoting patient independence.

2

Workforce Development

Building resilient and sustainable healthcare teams is essential to intermediate care services success and aligns with the health plan objectives.

3

Digital Integration

The use of digital tools enhances efficiency, quality, and supports strategic healthcare improvements.

4

Strategic Healthcare Goals

Investing in intermediate care helps reduce hospital pressures, improves patient experience, and delivers cost-effective care.

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Urgent Community Response

Kaitlyn Biggs
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Demand

Referrals

UCR services received a median of **4,165** referrals annually, averaging **79** weekly referrals.

Assessment Conversion Rate

66.7% of referrals were converted into assessments, averaging **59.4** new assessments per week.

Referral Source Diversity

General Practitioners accounted for **23.2%** and community sources **22.4%** of referrals, indicating diversified referral origins.

Step-Up and Step-Down Referrals

85.8% of referrals were step-up cases preventing hospital admission, while **14.2%** were step-down referral.

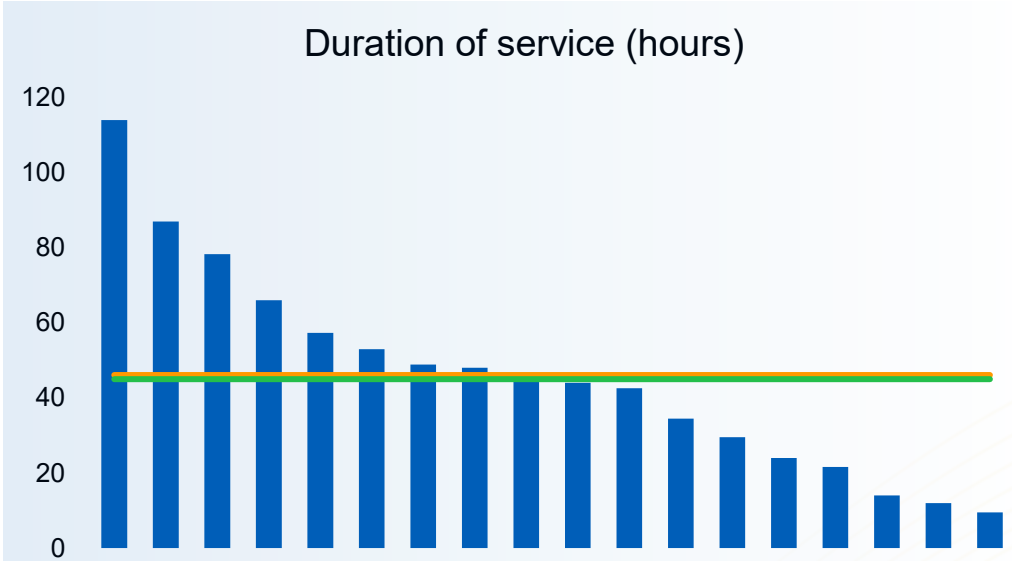
Response time and discharges

81.6% of patients agreed that staff discussed their need for any further health/social care services after this service stopped.

PREM survey

2 Hour Referral to Assessment Target

88.8% of referrals to UCR services were seen within the 2-hour target.



Destination on discharge

- **More patients returning home**
  - Usual place of residence increased from **55.7%** in 2023/24 to **62.7%** in 2024/25, reflecting improved support for safe home discharge.
- **Increase in residential/nursing home discharges**
  - Rose from **1.54%** to **8.83%**, suggests greater use of longer-term care.
- **Reduced hospital and virtual ward use**
  - Acute hospital **6.77%** to **5.44%**, virtual ward **5.19%** to **3.36%**, indicating fewer patients require high-intensity care post-discharge.
- **Better data quality**
  - 'Not known/not recorded' decreased from **29%** to **18%**, providing clearer insight into patient destinations.

89.2% of patients agreed that they were involved in decisions about when care was going to stop.

PREM survey

Patient Reported Experience Measures (PREM)

100%

of users agreed that the **appointment / visit times** by staff were **convenient**.

100%

of users agreed that they always felt **treated with respect** and **dignity** whilst receiving care.

97.3%

of users agreed that when they had important **questions** to ask the staff, they were always **answered well enough**.

97.4%

of users agreed that they were as **involved with decisions** about their care as they wanted to be.

Workforce

Workforce Composition

79% of staff agreed that they felt fully/adequately supported and equipped to handle emergencies

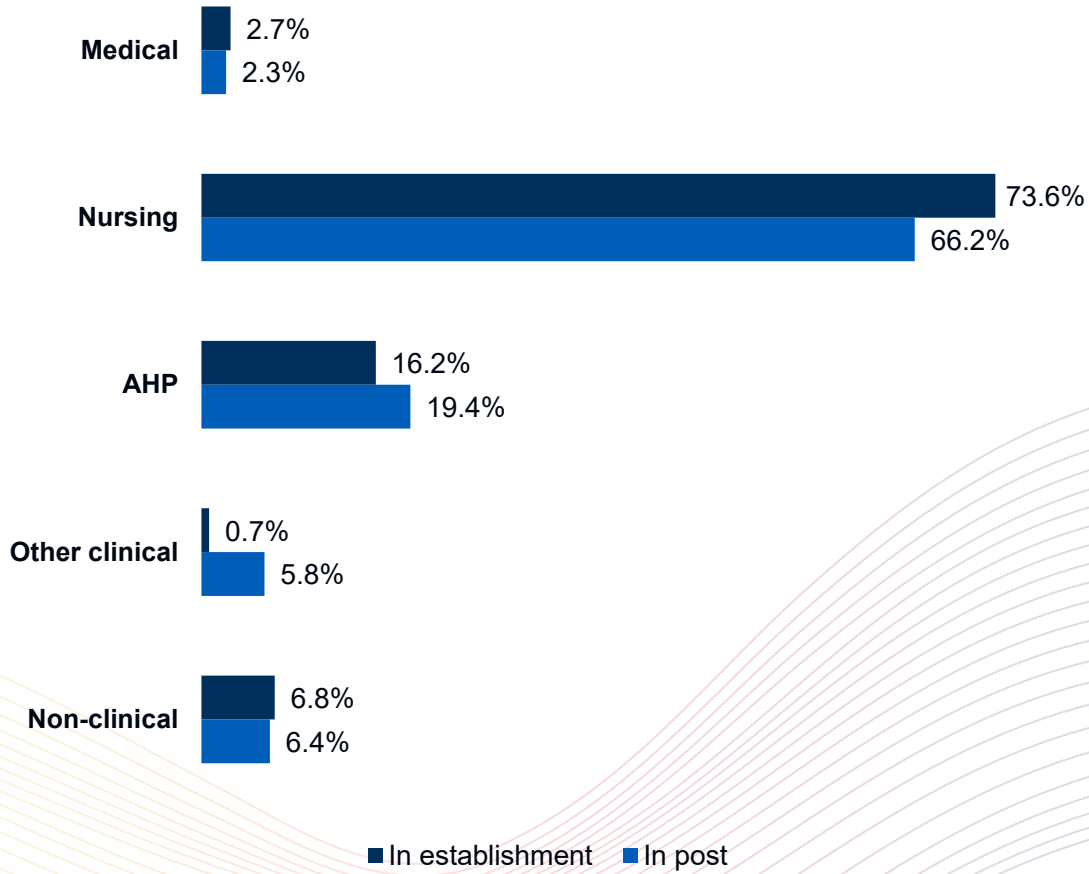
Staff survey

0.92 staff in establishment per 100 new assessments

0.58 nursing roles in establishment per 100 new assessments

Physiotherapists, occupational therapists and paramedics are the main AHP roles seen in UCR services

Discipline mix (%)



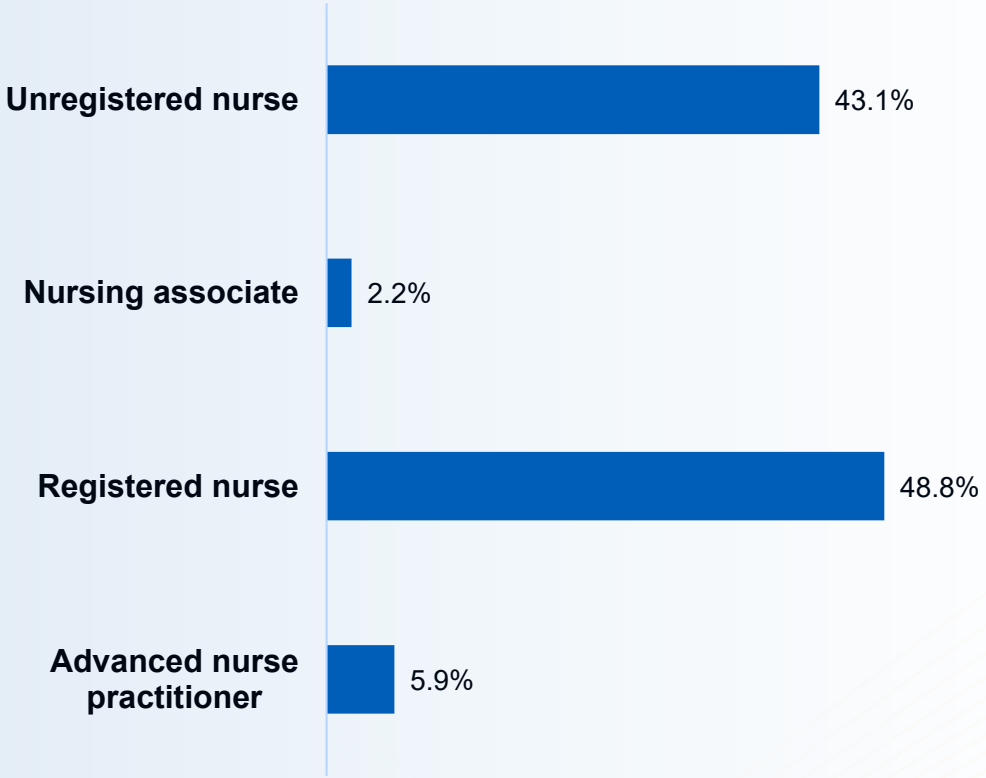
Workforce

Nursing Composition

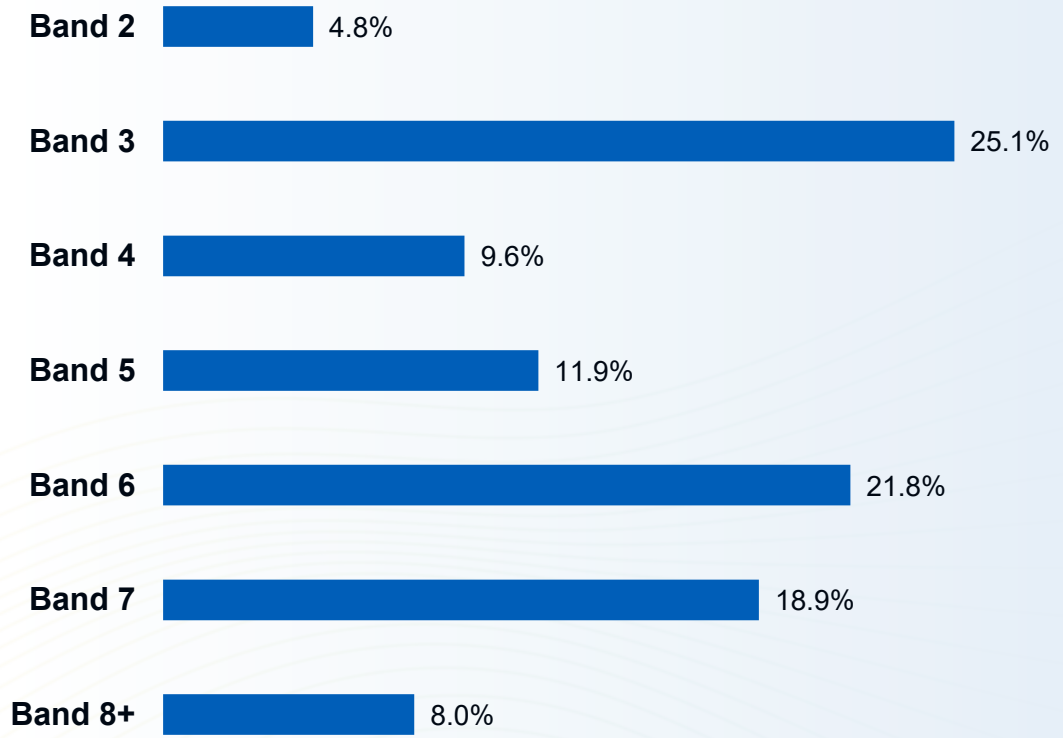
97.1% of staff agreed that their role makes a difference to patients / service users.

Staff survey

Nursing staff discipline mix (%) – in establishment



Nursing staff AFC band mix (%) – in establishment



Workforce

Workforce Challenges

76% of staff reported that working in an IC service has positively impacted their work-life balance.

Staff survey

	Urgent Community Response		NHS	
Vacancy Rate		7.84%		6.70%
Sickness Absence Rate		6.52%		4.90%

= 2%

95.8% of staff agreed they felt able to meet all requirements of their responsibilities.

Staff survey

Finance

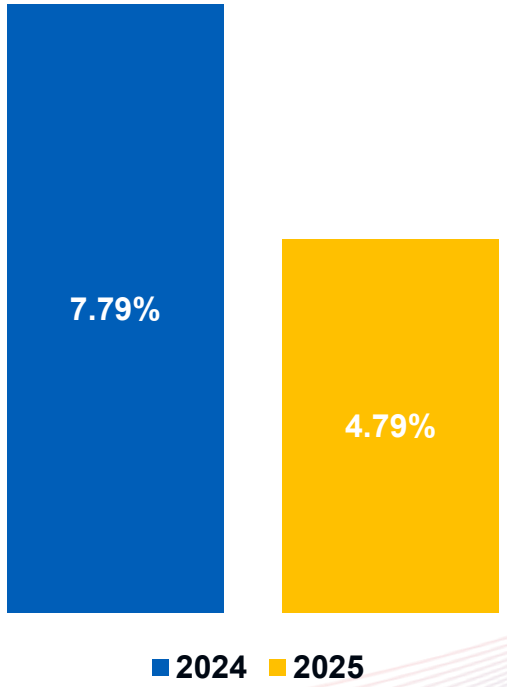
Total staff pay spend per 100 new assessments **£43,391**.

Data shows an **underspend** of –3.4% in **total pay variance** with a range of 17.9% to –65%.

Total direct costs per 100 new assessments, **£52,979**.

Total non-pay spend per 100 new assessments **£2,874**.

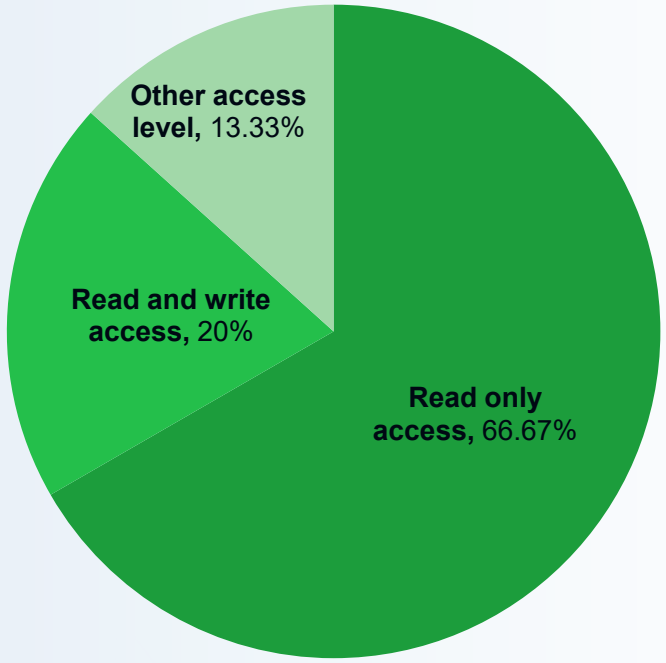
Total bank and agency pay cost as a proportion of total pay costs (%)



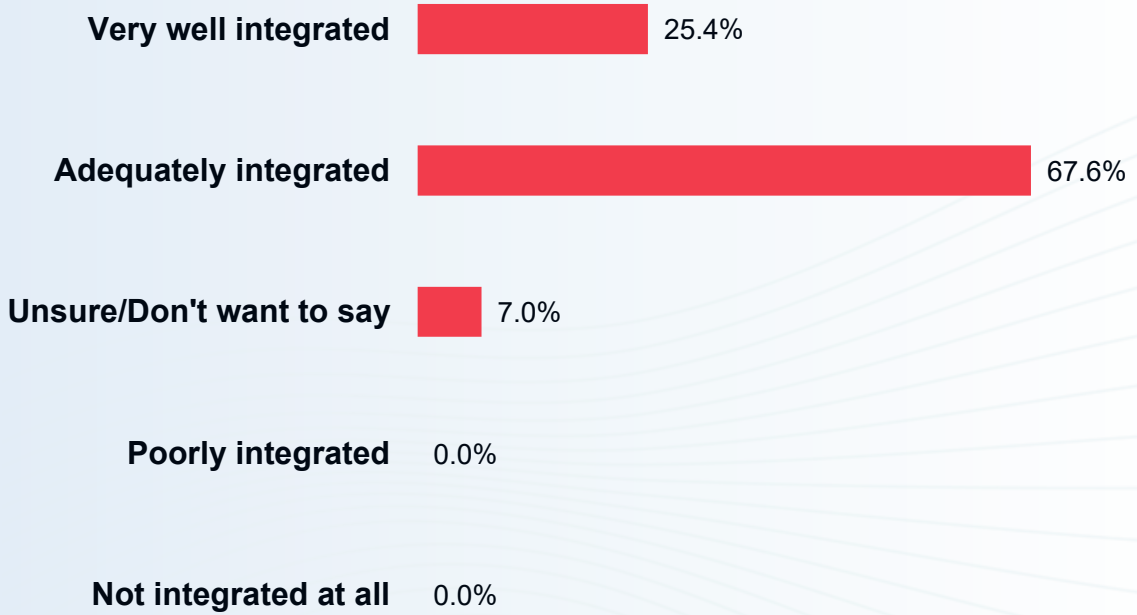
Digital Integration

"There is a lack of knowledge and understanding externally about UCR. We are seen as an urgent assessment service, rather than stopping admissions to hospital."

Shared care record access



Integration with other healthcare services *(staff survey)*



HART

Hospital Avoidance Response Team

Who are HART?

- Hospital Avoidance Response Team
- Established in 2015 by Age UK Lincoln & South Lincolnshire
- Commissioned by Lincolnshire Community Health Services NHS Trust (LCHS)
- Staffing
- Locations

What do HART do?

The Hospital Avoidance Response Team (HART) ultimately provide a flexible approach to delivering short term care and support.

- Hospital discharges
- Admission avoidance
- Urgent care (via the UCR team)

What is our aim?

To assist Lincolnshire County Hospitals in avoiding unnecessary hospital admissions and delayed hospital discharges.
For example, helping to reduce attendance at A&E, emergency admissions, protracted hospital stays and other delayed transfers of care, whilst enabling people to regain and retain their independence.

HART Service

HART provides up to 72 hours support at home where hospital admission is deemed inappropriate or avoidable.
Support is also provided following hospital discharge, when responsive or planned care can either bridge a gap until longer-term arrangements are established, or provide short-term support to sustain independence.

Who can refer into our service?

- Members of hospital discharge teams.
- Community health team members, including GP’s, ASC, EMAS etc.

What support can HART provide?

- Empowering & enabling
- Help to maintain a safe living environment
- Ensuring the home is comfortable
- Ensuring daily essentials for living are available
- Signposting to other services
- Changing linen
- Meal preparation
- Bathing and showering
- Supporting continence care, including catheter and stoma care
- Medication support
- Support with mobilising
- Temporary telecare and Response service – Mangar Elk
- Contacting emergency services

Personalisation – How do we do it?

- Information provided by referrer
- Our first visit
- Care and Support Plans
- Shared decision making
- Complaints
- Choices
- Social prescribing
- Supported self management
- Collaboration with external professionals
- Internal and external referrals

How can you refer to HART?

- Call the HART team on 01522 467200 to make an enquiry. (24 hours a day)
- Provide required details of the individual requiring our support.
- HART will call you back with details of support we can offer.
- If accepted, we will complete the full referral information and confirm our start date and time.

2024/2025 Data – Hospital Discharge

- 646 people supported
- 2,658 visits carried out
- 8778 hospital bed days saved
- £1,694,881 financial saving for the NHS

2024/2025 Data – Admission Avoidance

- 638 people supported
- 8559 visits carried out
- 3466 hospital bed days saved
- £1,681,754 financial saving for the NHS

2024 Data – UCR

- 329 people supported
- 856 visits carried out
- 1787 hospital bed days saved
- £863,181 financial saving for the NHS

Overall Data for 2024

- 1,658 people supported
- 12,073 visits carried out
- 14,031 hospital bed days saved
- £4,239,816 financial saving to the NHS

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Intermediate Care Services Provided at Home

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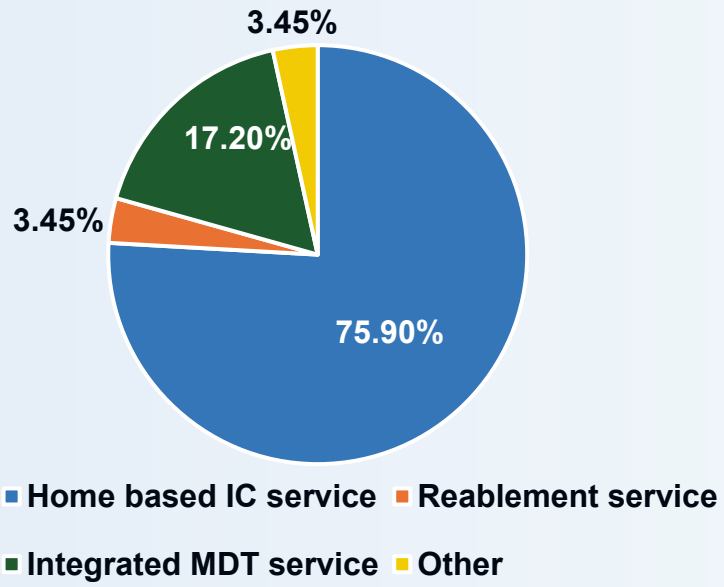
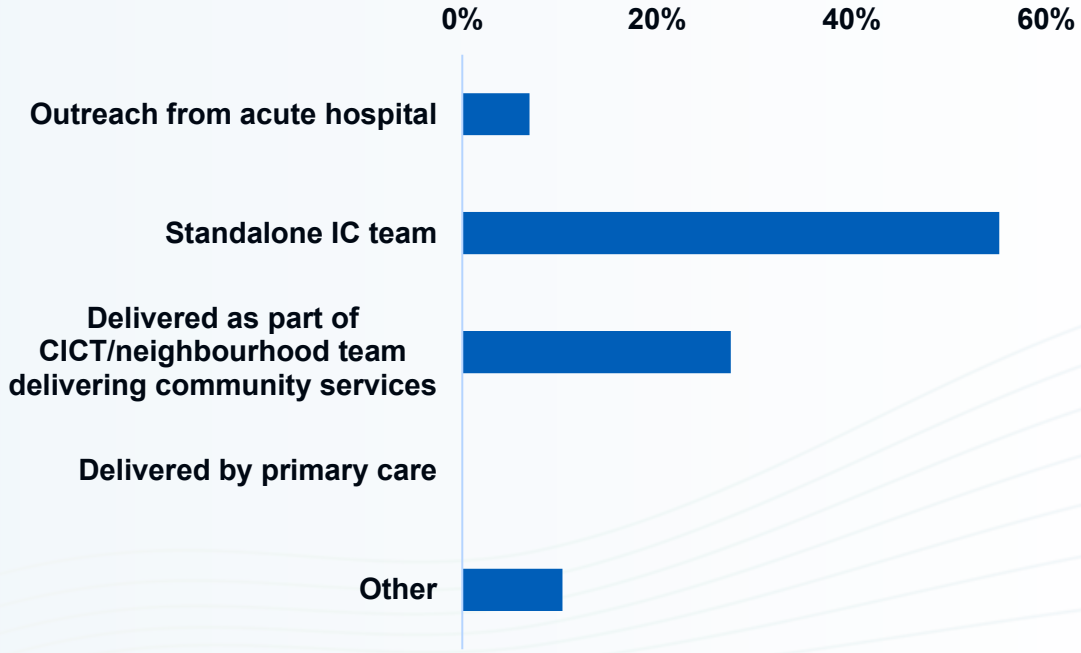
Service overview

Types of IC Provided At Home



Local service provision



Service locations were predominantly **urban 51.9%**, followed by **mixed settings 44.4%**, with a small proportion operating in **rural areas 3.7%**.

Activity and Demand

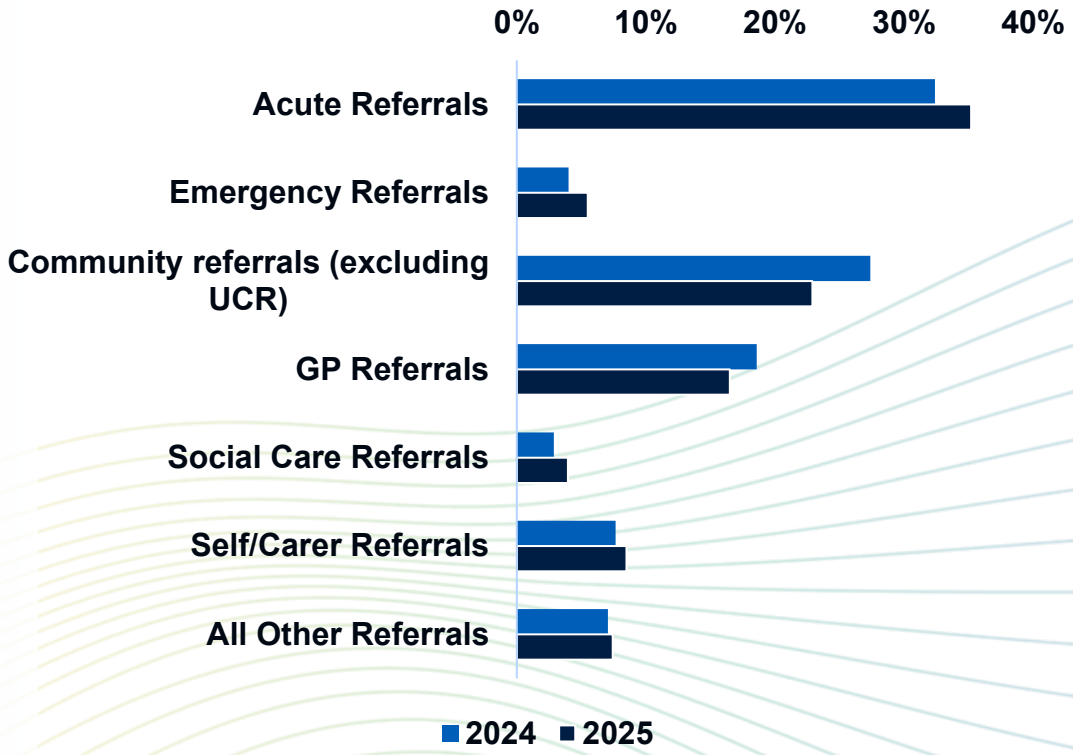
- The median intermediate care provided at home service received 4,100 referrals over the past year, approximately 77.9 per week, representing an increase of 4.9 weekly referrals compared to the previous year.

4,100 referrals = **77.9 per week**

Up from 2023/24 — **4.9 weekly referrals**

- The majority of referrals originated from acute referrals (35.2%) Community (22.9%) and GP referrals (16.5%).
- Referrals are increasingly coming through acute and emergency routes, while GP and community referrals have declined. Self/carer and social care referrals are rising, indicating opportunities to strengthen earlier access and support a future left shift.

Referrals by source



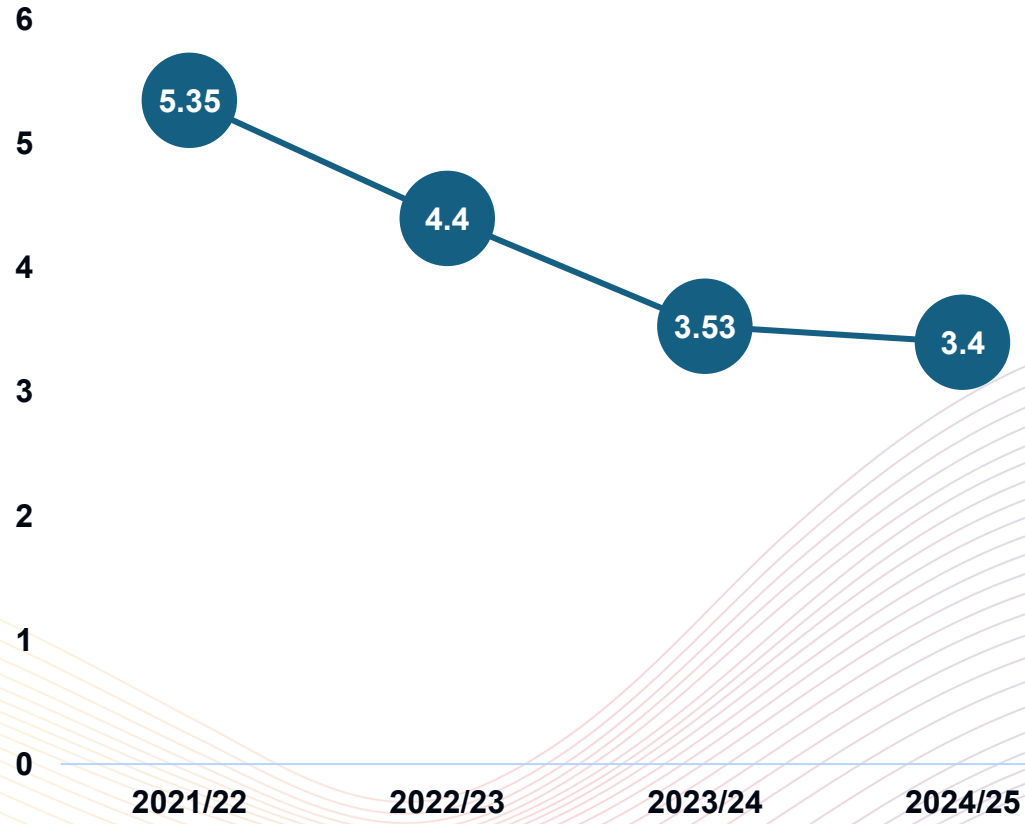
Access and Timeliness

79.5% of referrals were converted to assessments.

This equates to an average of **59.4** new assessments per week.

This indicates strong referral appropriateness and effective triage processes despite increasing demand for the service.

Average time from referral to assessment



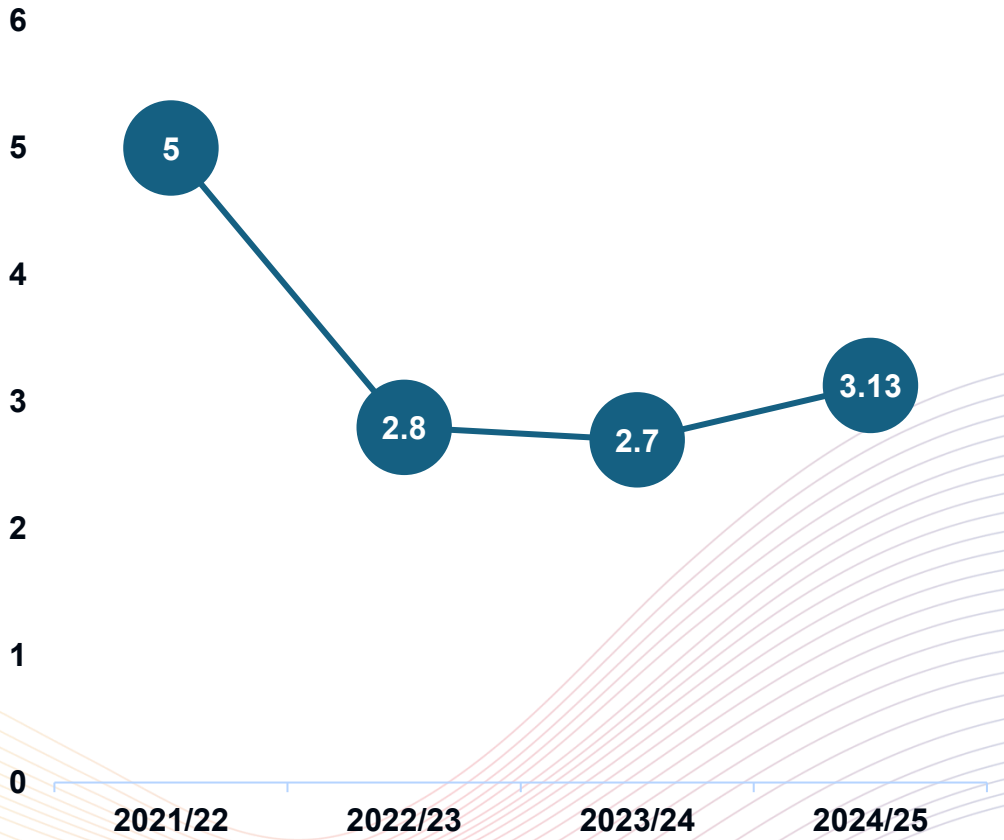
Access and Timeliness

40% of services report a post assessment gap prior to service commencement

56% of patients waiting over 2 days for the service (from referral to commencement of service).

The proportion of patients waiting over 2 days from referral to service commencement has risen from **43%** last year to 56% this year, highlighting increasing pressure on timely access.

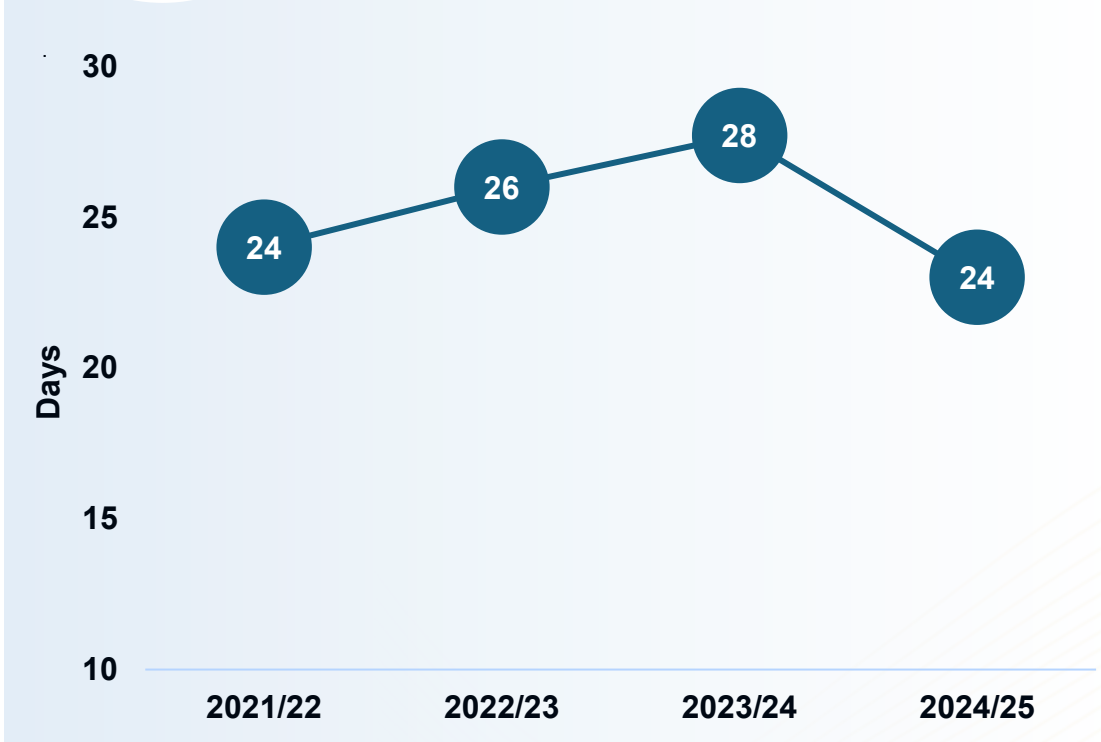
Time from referral to commencement



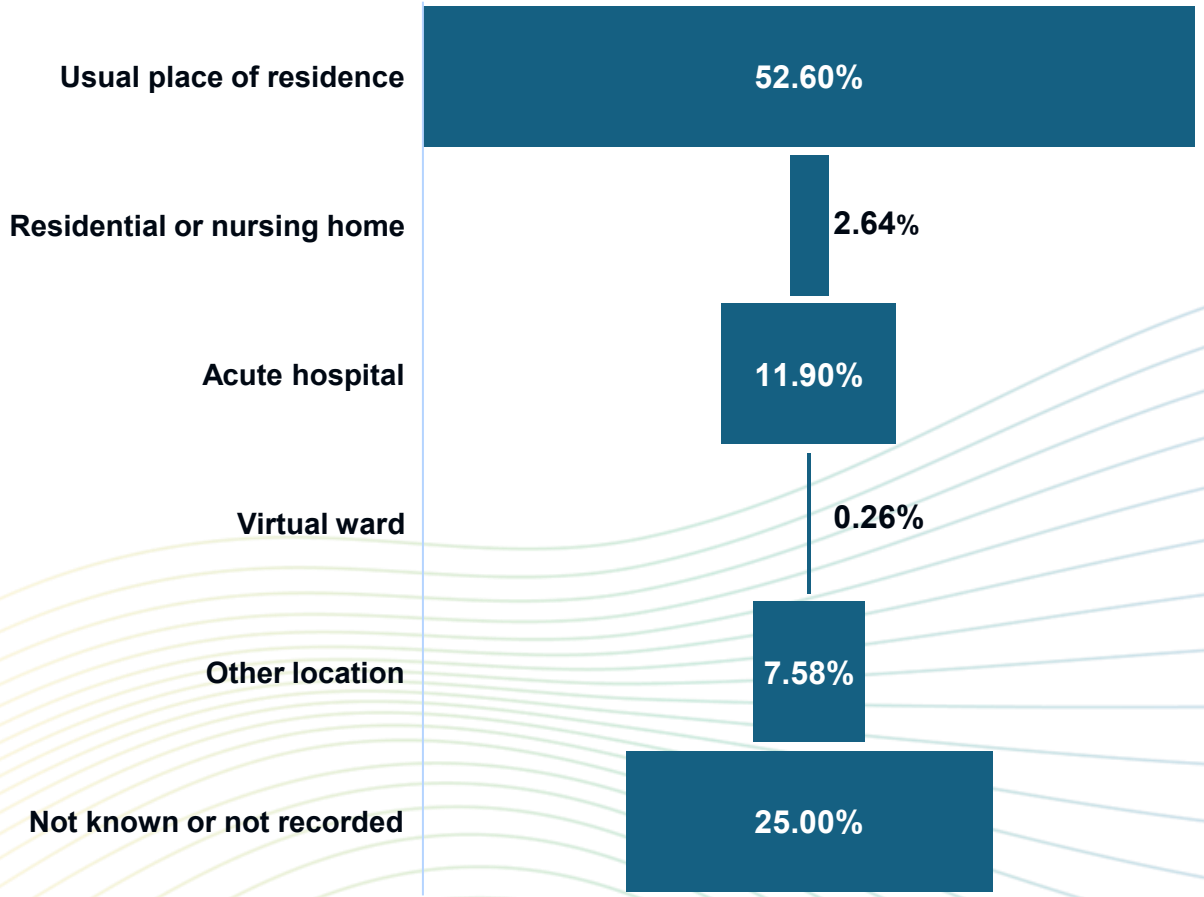
Outcomes

Duration of Service

The average median duration of service for 2024/25 is **23.9 days**, with yearly figures over the past four years ranging from 18 to 35.1 days.

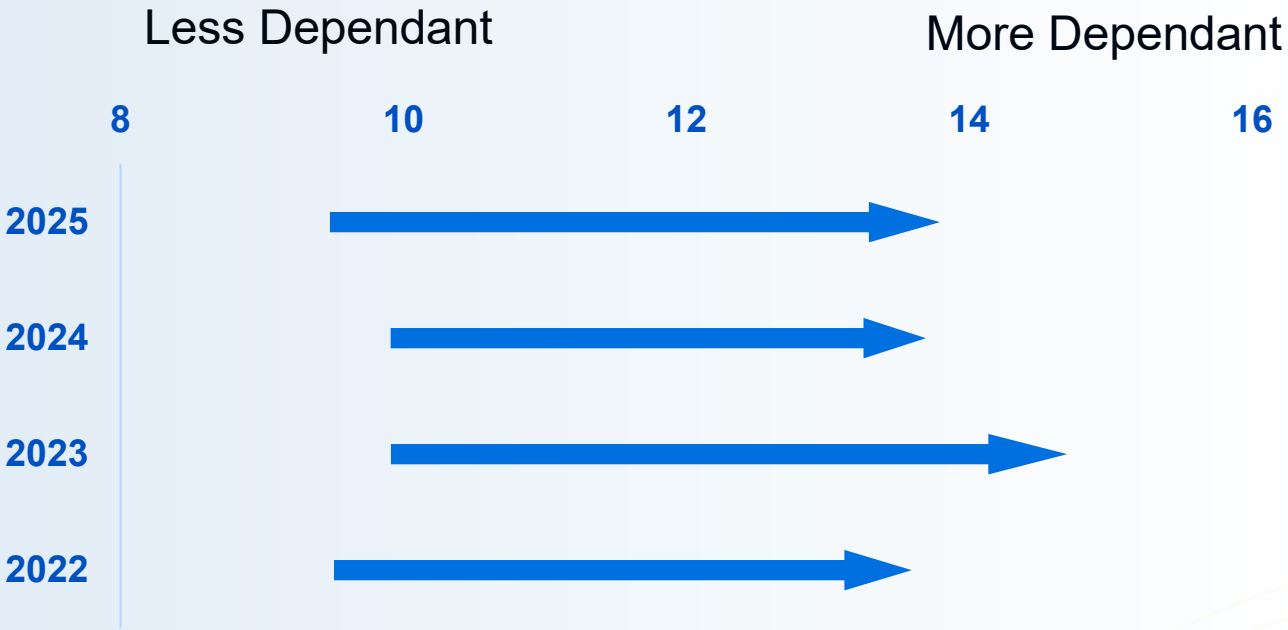


Destination on discharge



Outcomes

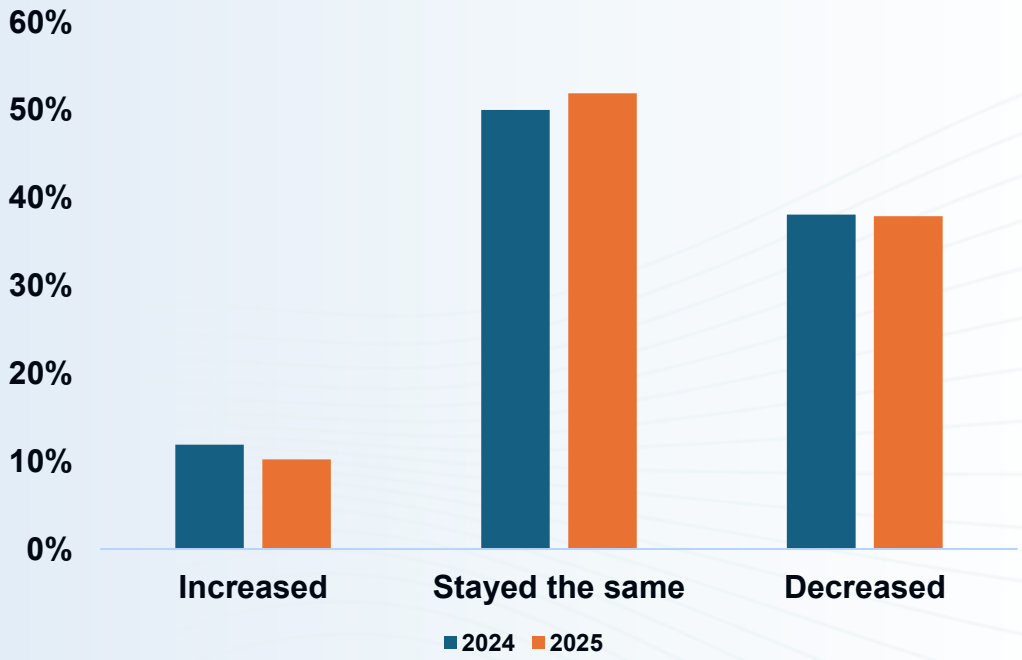
Sunderland Results



The Sunderland score measure is a tool to demonstrate an improvement in a person's functioning. A lower score indicates greater independence and, a higher score indicates greater dependency overall or in a particular function area.

Change in Care Requirements

51.9% of service user captured in the CCRs were discharged with no change/decreased care package.



Patient Reported Experience Measures (PREM)

97.1% users agreed that the length of time they had to wait for their service to commence was reasonable.

95.4% users agreed that they always felt treated with respect and dignity whilst receiving care.

77.9% users agreed that they were definitely involved in decisions about when their care was going to stop.

68.4% users agreed that staff discussed whether they needed any further health or social care services after this service stopped.

98.2% users were involved in the setting of care aims.

82.9% users agreed that when they had important questions to ask the staff, they were always answered well enough.

85.7% users agreed they definitely had confidence in the staff that were treating/supporting them.

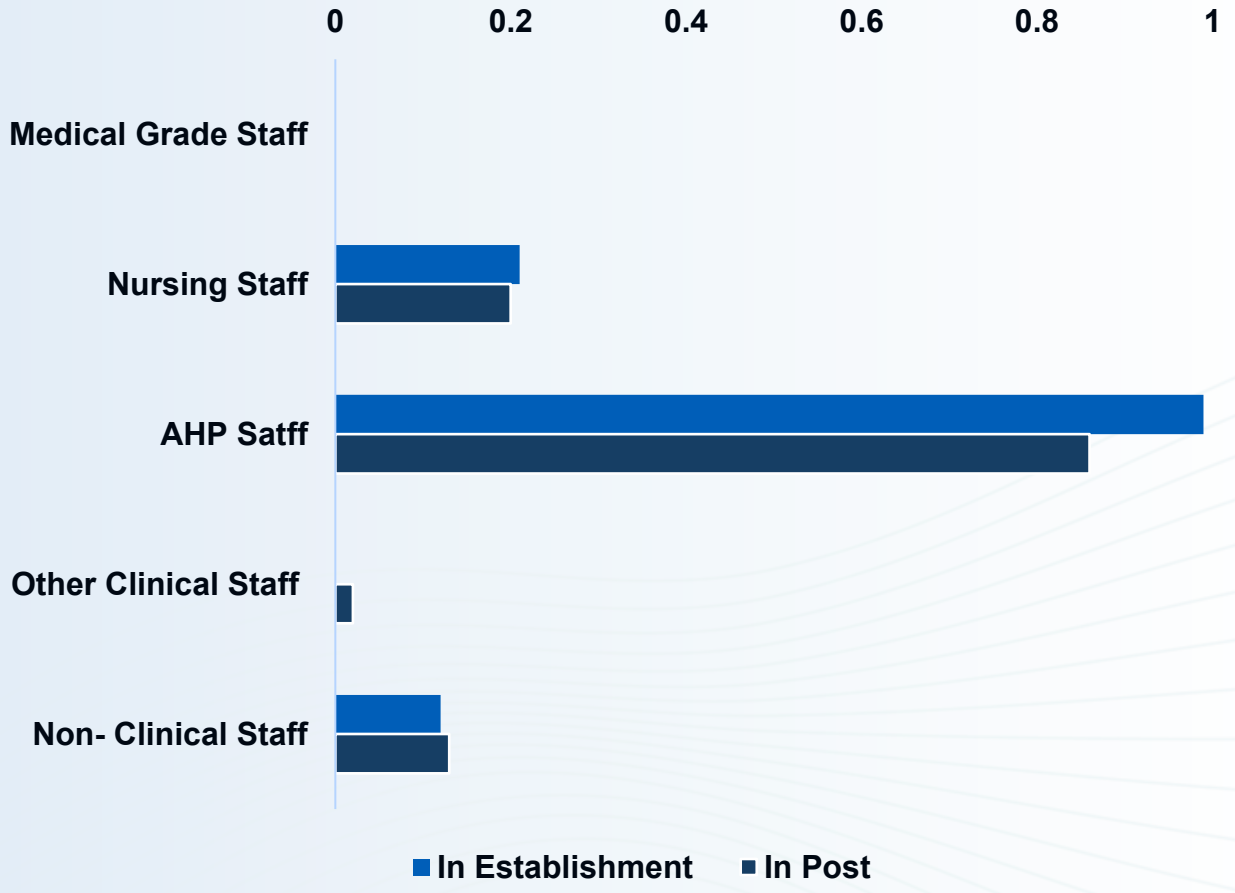
96.5% users agreed that the appointment/ visit times by staff were convenient.

Workforce

AHPs are the dominant group, account for **over half of the median workforce (0.9 of 1.4WTE per 100 new assessments)**; nursing staff contribute **0.2WTE**

Staffing levels show an increased representation of AHPs compared to last year **4.88 to 7.74** in post per 100k population, while nursing **1.13 to 1.21**, non-clinical **0.13 to 0.86** and other clinical staff **0.15 to 0.32** remain comparatively low, with no medical staff in post.

WTE in post and in establishment per 100 new assessments



Workforce

Vacancy Rate

The average service vacancy rate was **12.0%**, an increase compared to last year.

The sickness absence rate among participating services was 5.6% in 2024/25, above the average across all NHS staff at 4.9% (NHS Digital, 2025). The median **staff turnover rate** among participating services was 9.6%, mostly inline with the average amongst all NHS staff at 9.9% (NHS Digital, 2025).

	Intermediate Care		NHS	
Sickness Absence Rate		5.58%		4.9%
Staff Turnover Rate		9.62%		9.9%

= 2%

Staff Surveys Findings

100% respondents agreed that role makes a difference to patients/service users.

90.9% respondents agreed that their organisation has done enough to ensure their safety at work.

50.0% respondents agreed that they feel fully supported and equipped to handle emergencies or unexpected situations.

92.8% respondents agreed that they feel able to meet all requirements of their responsibilities.

84.3% of respondents agreed that working in Intermediate Care has positively affected their work–life balance and emotional wellbeing.

87.7% of respondents agreed that their service integrates well with other healthcare services and departments.

Costing and Efficiency

Direct budget vs spend per service user accepted

Direct costs spend per service user accepted	£818.77
Direct costs budget per service user accepted	£858.74

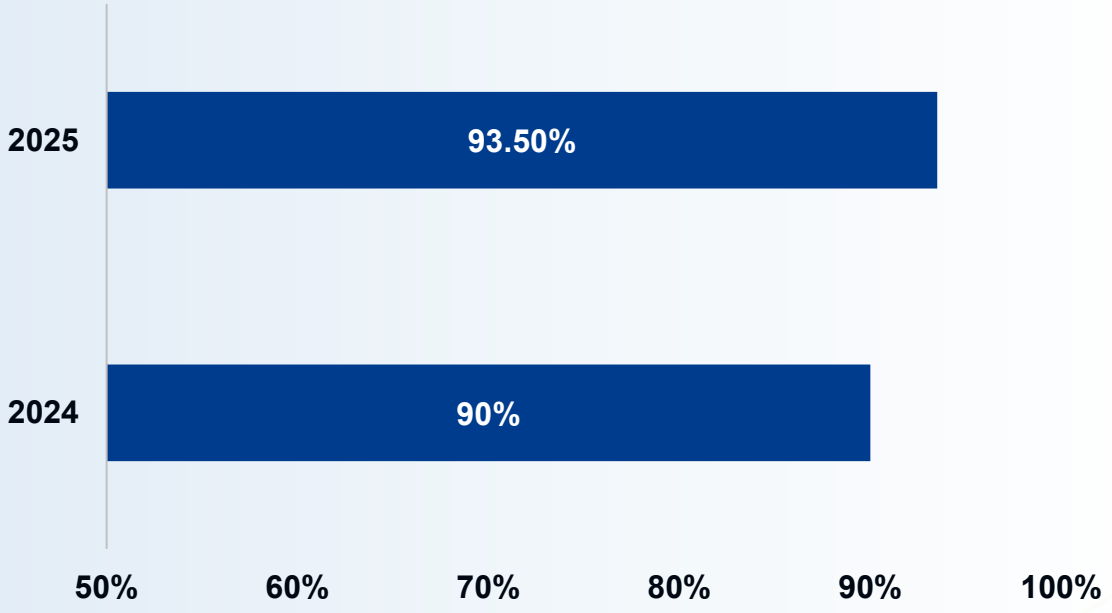
% of direct spend on pay vs non-pay costs

95.86% on pay costs

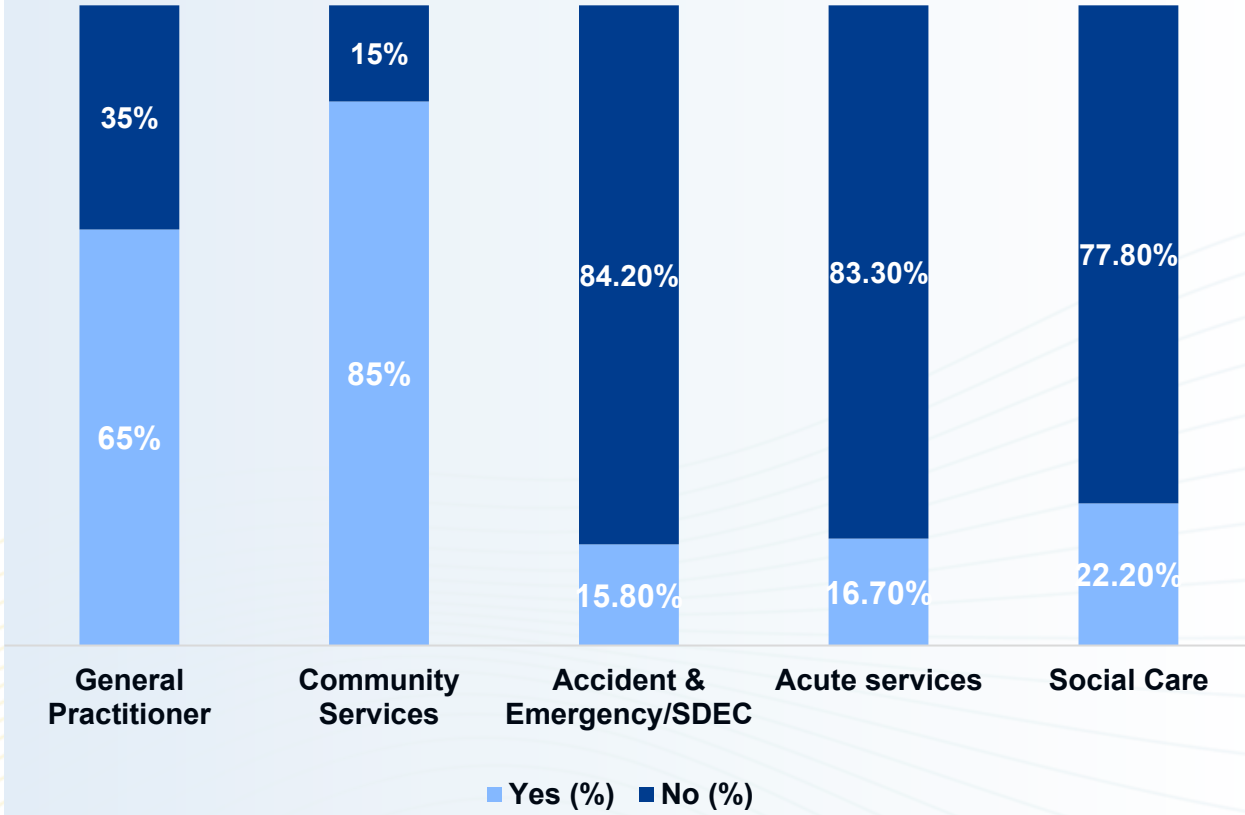
4.54% on non-pay costs

Integration and Equity

% of staff completing Oliver McGowan LD & Autism training.



Is frailty diagnostic data shared with the following:

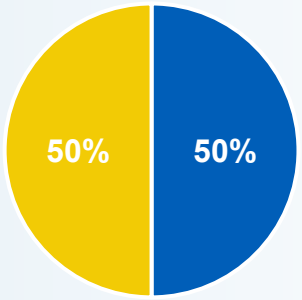


Frailty Screening Status

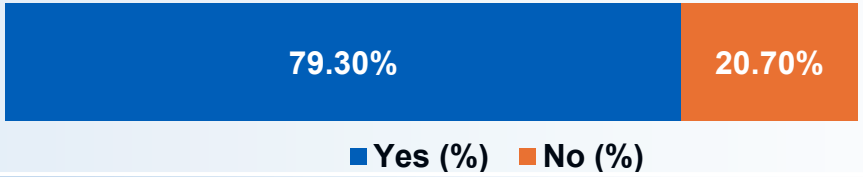
58.7% of service users were screened for frailty at assessment.

Integration and Equity

Do patients and carers receive the results of frailty assessments?

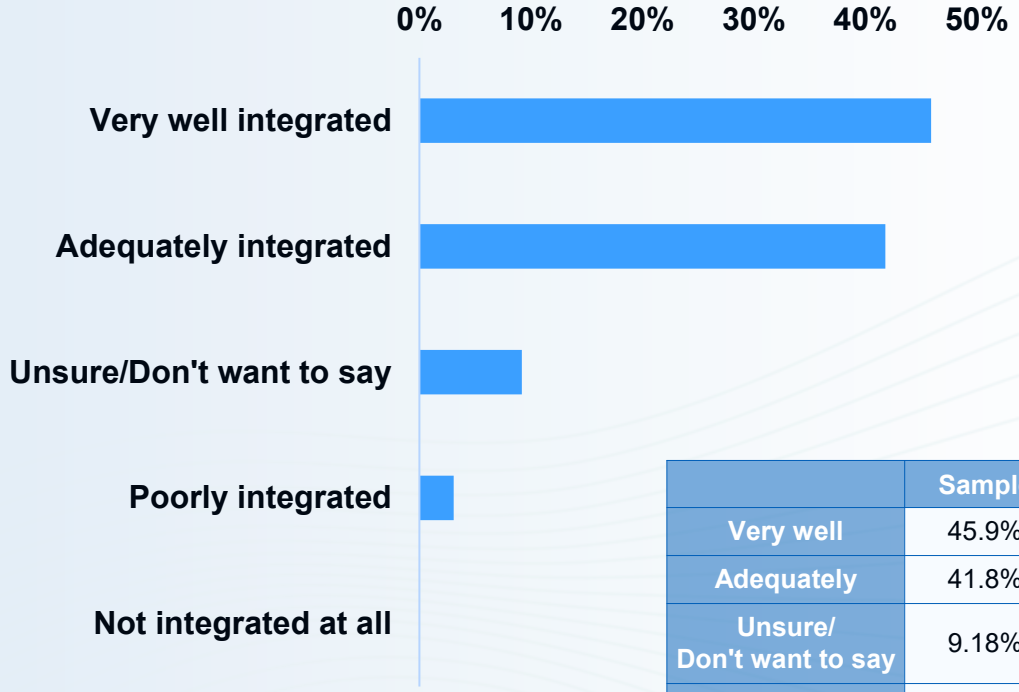


Shared Care Record



Shared care record access levels show that **45.8%** of users have read and write access, **54.2%** have read-only access, and no users reported other access levels.

How well does your service integrate with other healthcare services and departments?



	Sample
Very well	45.9%
Adequately	41.8%
Unsure/ Don't want to say	9.18%
Poorly	3.06%
Not at all	0.0%

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The Role of a Pharmacist in Intermediate Care (Home Based Services)

Shauna Brady Lead Pharmacist Intermediate Care (Home Based Services)

Working together Excellence Openness & Honesty Compassion

Introduction

- Pharmacist introduced to the intermediate care home based services in BHSCT on 1/11/23
- Works with multidisciplinary teams (CRS, reablement and CDS)
- Also works closely with MOOP (medicines optimisation in older people) pharmacy team for peer support
- Role includes completing home visits for medicines adherence reviews, delivering medication management training and reviewing medication policies

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Background

- Medicines are the most commonly used medical intervention in NI and at any one time around 70% of the population take prescribed or over the counter medicines to treat of prevent ill health
- An ageing population and increased prevalence of chronic disease increases the need for medicines
- A pharmacist is able to provide patient centred medication optimisation to ensure better health outcomes through the appropriate use of medicines, taken as directed

Intermediate Care Pharmacist Home Visits

- A referral for a pharmacist home visit is made if a member of the team have concerns about a client's medication adherence. This can be for many different reasons. Some examples including (not exhaustive):

➢ Client struggling to remember to take their medication

➢Client stopped taking a medication due to side effects

➢Client unsure what medication is for/importance of medication

➢Rationalising medication to fit in with other care calls e.g. if client also needing help with personal care, meals etc.

- A medication review will be completed by the pharmacist at the same time as the adherence review

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Interventions

Data was gathered on interventions between 1/11/23 to 31/10/24 and showed:

- 291 clinically significant interventions (Eadon Scale)
- 14% reduction in polypharmacy
- 31% reduction in anticholinergic burden
- Annual cost avoidance and drug savings £33379-£72436 (Scharr and NI Drug Tariff)

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Case Study

- Client with a new diagnosis of dementia. She was not aware of her diagnosis and did not want to know as her brother had previously been diagnosed with early onset dementia
- Medication prescribed 4 times a day. Client had poor adherence with this as client did not like taking medication, she felt she no longer needed to take medication for her diabetes anymore as she thought her diet had improved since retiring and she would forget to take medication. Medication was supplied in a pharmacy filled compliance aid (blister pack)
- Client was very independent and initially refused support with her medication from staff. She did agree to trial a Memorable clock from her OT but was still struggling to take her medication therefore her OT sent a referral to the intermediate care pharmacist

Medication list

- Metformin 500mg three times a day with meals (morning, lunch and teatime
- Gliclazide 40mg three times a day with meals (morning, lunch and teatime
- Amlodipine 5mg in the morning
- Dapagliflozin 10mg in the morning
- Atorvastatin 20mg at night
- Rivastigmine patches once a day (family are able to change these)

Interventions

- Metformin changed to the modified release preparation and prescribed once a day in the morning
- Gliclazide discontinued (potential side effect hypoglycaemia and client eating erratically).
- Atorvastatin changed from night to morning

Results

- Medication now all to be given once a day rather than four times a day. Client agreed to let OT request a care call once a day in the morning for medication.
- HbA1c (marker for diabetes control) fell from 80 to 55. Better diabetes control reduces the risk of long-term complications
- Cholesterol fell from 6.5 to 4.1 therefore was within normal range following intervention reducing the risk of cardiovascular and cerebrovascular disease
- Relieved worry for client's family knowing she was taking her medication correctly as they were unable to oversee this due to work commitments

Care Opinion Feedback from Relative

“My mum-in-law was diagnosed with Alzheimer's very recently.

Immediately after diagnosis a lady was in touch from the reablement team.

Her name is Naiosa, and she is a wonderful example of the NHS. She is kind, thoughtful and puts my mum-in-law at ease.

Naiosa really does her job well, and I hope she is around for a while longer whilst we navigate these early days of Alzheimer's.

Naiosa put us in touch with the team's pharmacist, Shauna, who has been incredibly helpful too.

Looking at the whole picture, not just looking at an effect, but seeing what can be done medication wise overall to help my mum-in-law effectively, wonderful service.”

Belfast Health and Social Care Trust
caring supporting improving together

Other Duties

- The intermediate care pharmacist has taken over medication management training for staff in the home based services
- Development and review of SOPs relating to medication management within intermediate care
- Answering queries relating to medication from members of the intermediate care team

Staff Feedback

Training was excellent. Learning outcomes of the training were strictly up to CRS needs and completed within 2hrs. Previous trainings were too much and beyond our learning needs. There were case studies and separate guidance for patches, inhalers, creams and eye drops. The part I was interested in most was the staff responsibilities during medication errors or incidents.

Belfast Health and Social Care Trust
caring supporting improving together

References

- Northern Ireland Medicines Optimisation Quality Framework, DHSSPS March 2016
- Eadon, H. **International Journal of Pharmacy Practice** Volume 1, Issue 3, pages 145–147, March 1992
- Anticholinergic Burden Calculator web app (ACBcalc®) created by Dr Rebecca King and Steve Rabino (last accessed 30th October 2024)
- Karnon J, Mcintosh A, Dean J et al. 2008. Modelling the expected net benefits of interventions to reduce the burden of medication errors. *J Health Serv Res Policy* 2008; **13:** 85-91.
- Health & Personal Social Services Northern Ireland, December 2024 Drug Tariff (www.hscni.net) (last accessed 9th December 2024)

NHS
Benchmarking Network

Bed based intermediate care

Lillie Phillips

Project Manager

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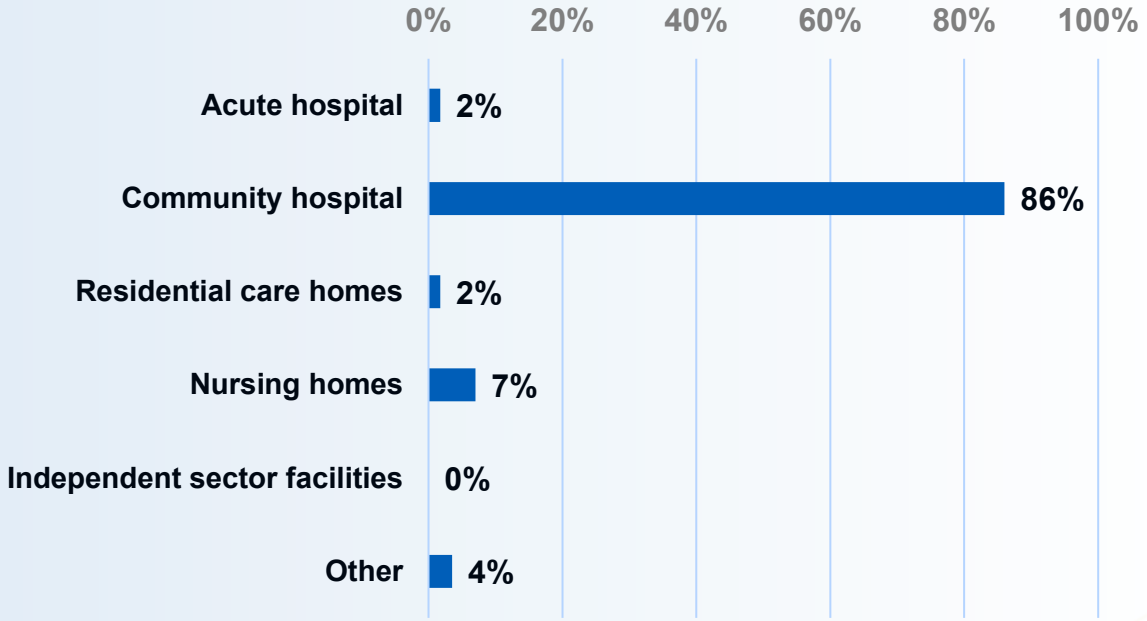
Service model

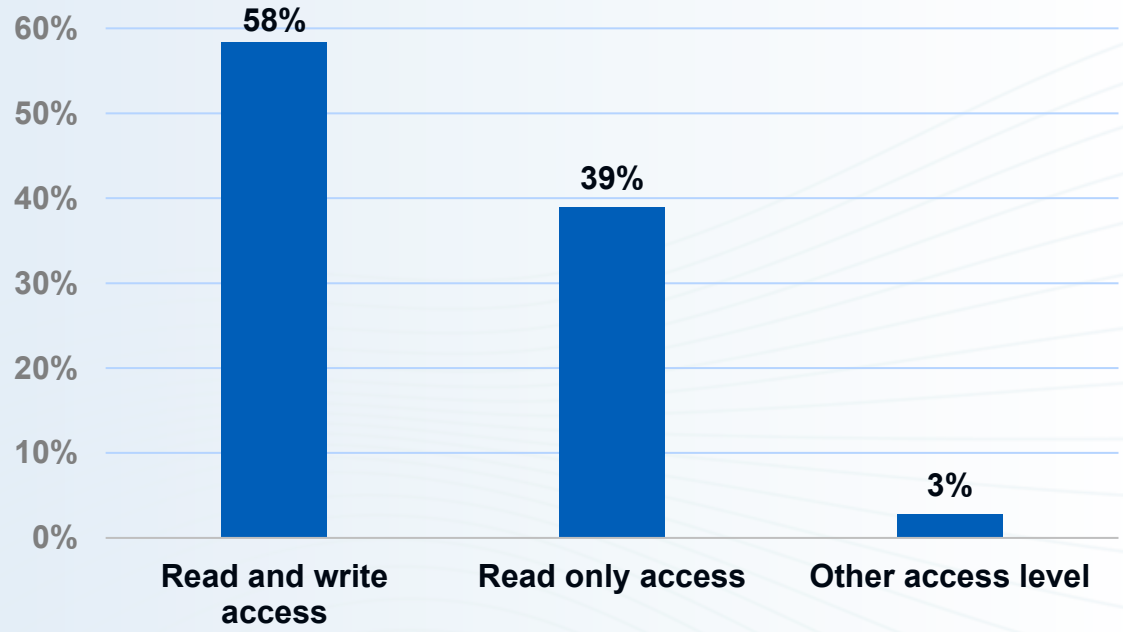
Where is this service located?



The median number of **Intermediate care beds** per 100,000 population increased slightly to **5.35** in 2025, up from **5.30** in the previous year.

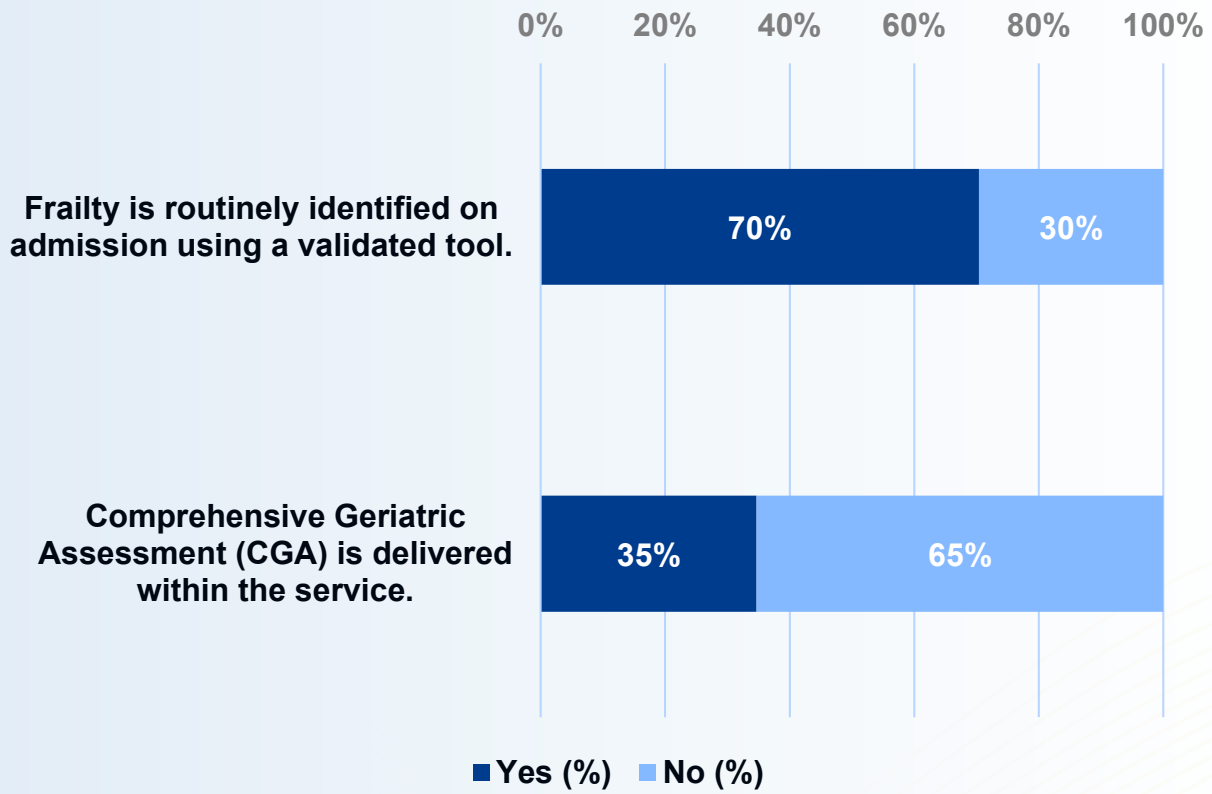
63% of services reported having access to a Shared Care Record collaborative.

Shared Care Record Access Level



Frailty

Management of Frailty



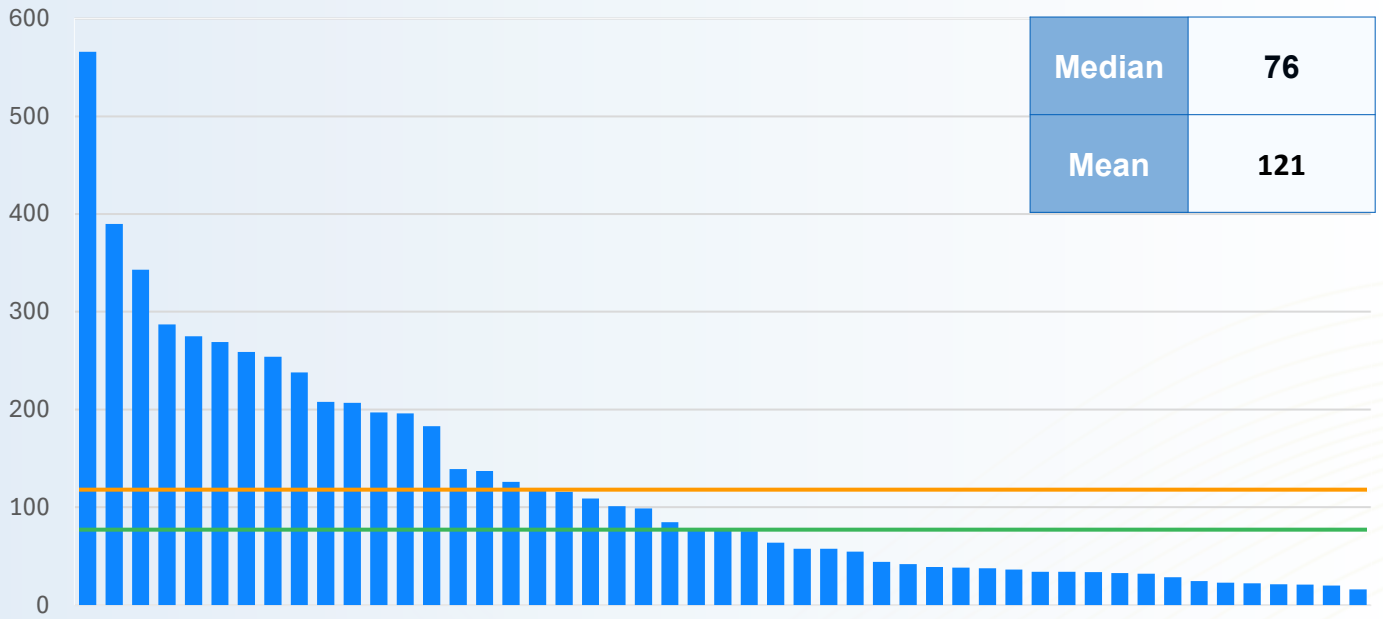
40% of service user were screened for frailty in this service.
Clinical Case Review

65% of service users screened were identified as living with frailty
Clinical Case Review

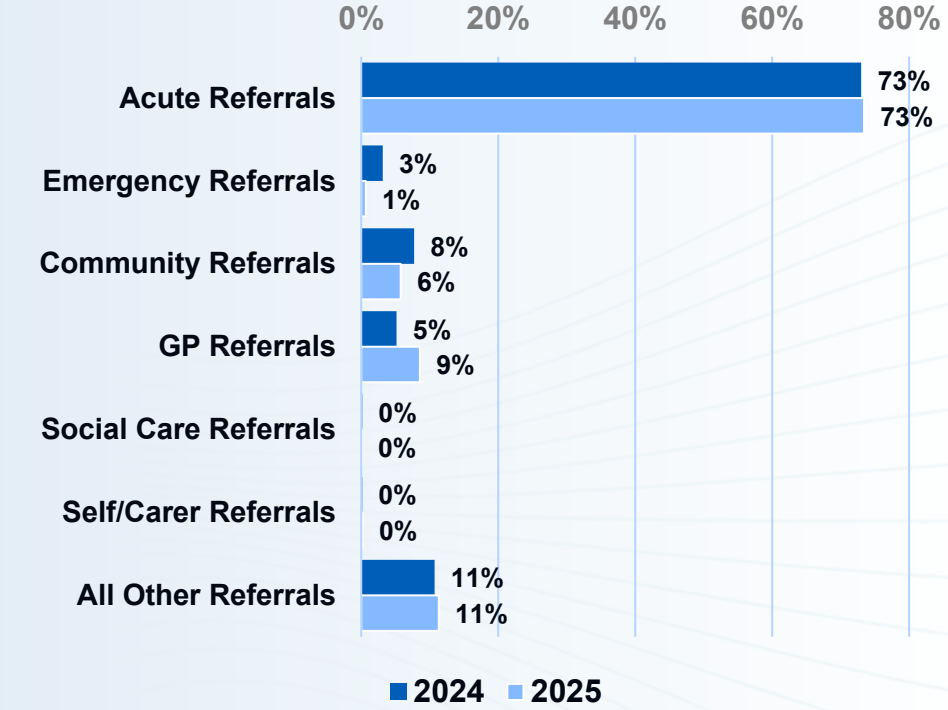
Access

The bed-based intermediate care received a total of **414** referrals over the past year, averaging approximately **7.87 referrals per week**, representing a decrease from **6.73 weekly referrals** compared with the previous year.

Total referrals received per 100,000 population

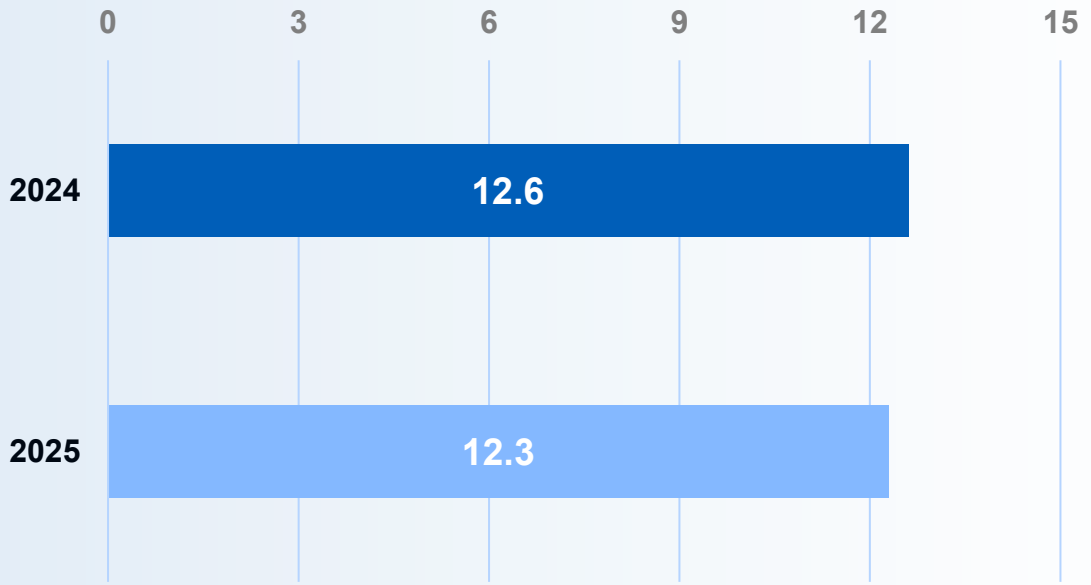


Referrals by source



Activity

Service users accepted per bed



Service users accepted per bed have remained relatively consistent year on year, with a slight reduction in 2025

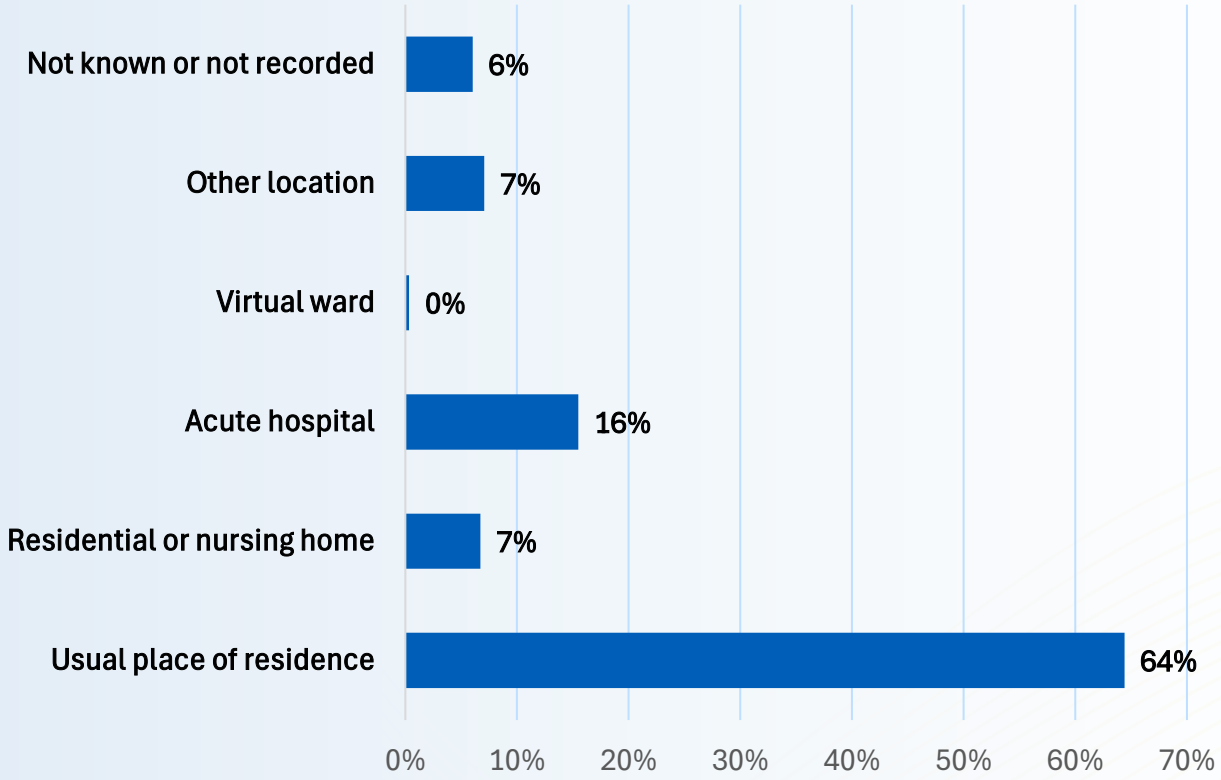
Service users accepted per WTE in post

2024 → 7.1

2025 → 6.4

Discharge

Destination on discharge



Delayed Discharged

The median delayed discharge rate was **26%**, with services falling within the interquartile range of 17%–36%.

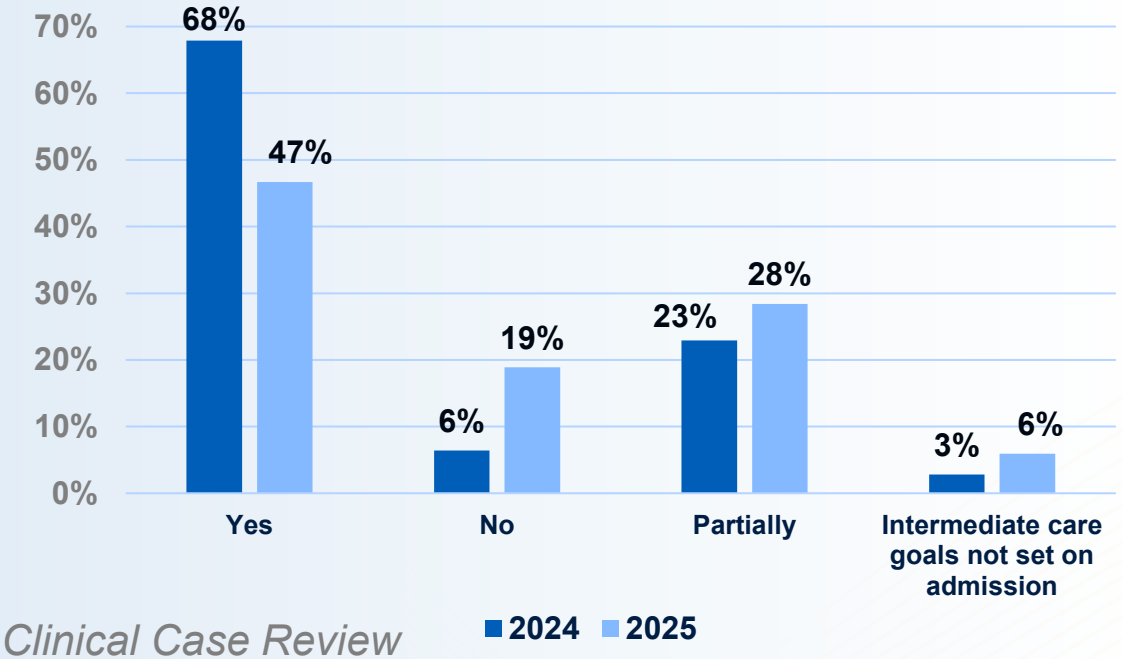
Discharge Destination

64% of patients returned to their usual residence upon discharge, a notable increase from 2024 where this accounted for **55%** of discharges.

Discharge

Goals Achieved

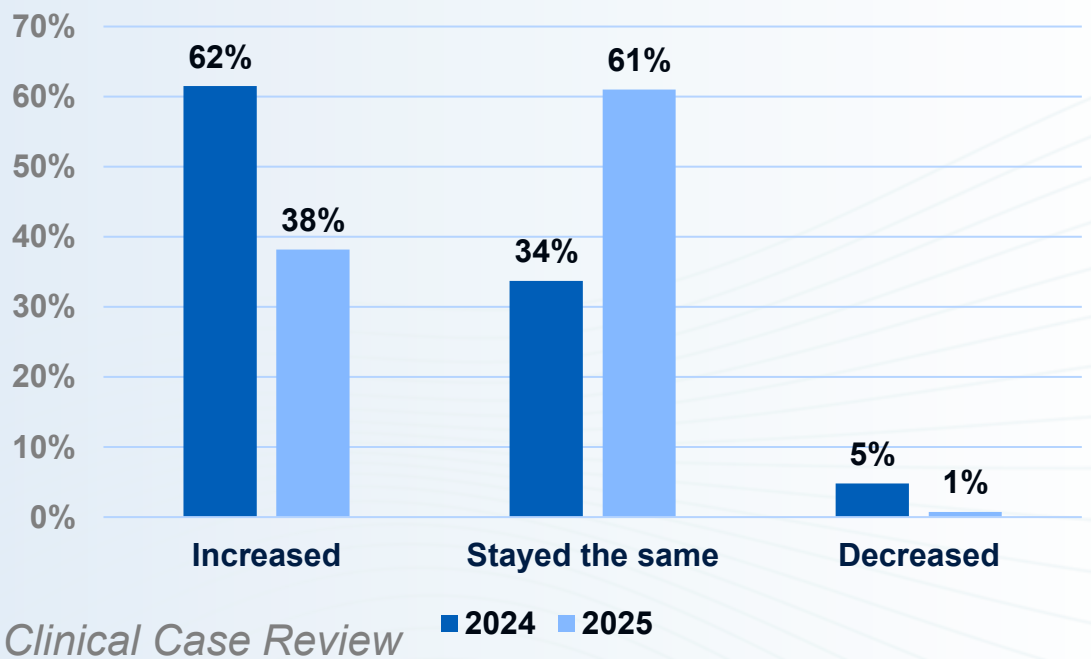
47% of service user captured in the CCRs successfully met the intermediate care goals set on start of service provisions.



Clinical Case Review

Change in Care Requirements

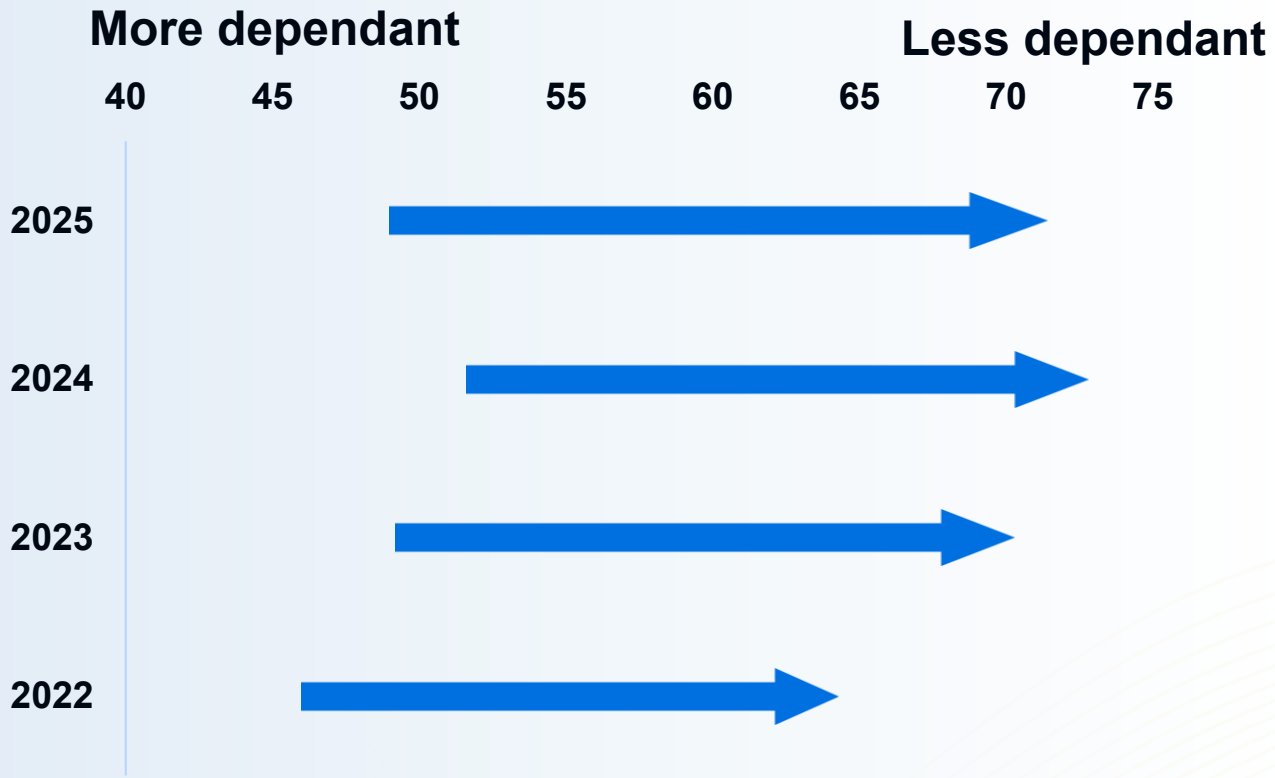
61% of service user captured in the CCRs were discharged with no change/decreased care package.



Clinical Case Review

Outcomes

Barthel Score



Clinical Case Review

The Modified **Barthel score** is a tool used to assess the degree of independence a patient has in performing activities of daily living.

A higher score indicates greater independence, whilst a lower score indicated increased dependency.

Harm from falls in care

The rate of harm from falls was **3.4** per 100 service users accepted, down from 3.8 in the previous year.

Patient Reported Experience Measures (PREM)

91.4%

of users were aware of what care aims the service was aiming to achieve.

88.9%

of users agreed they definitely had confidence in the staff that were treating/supportin g them.

94.5%

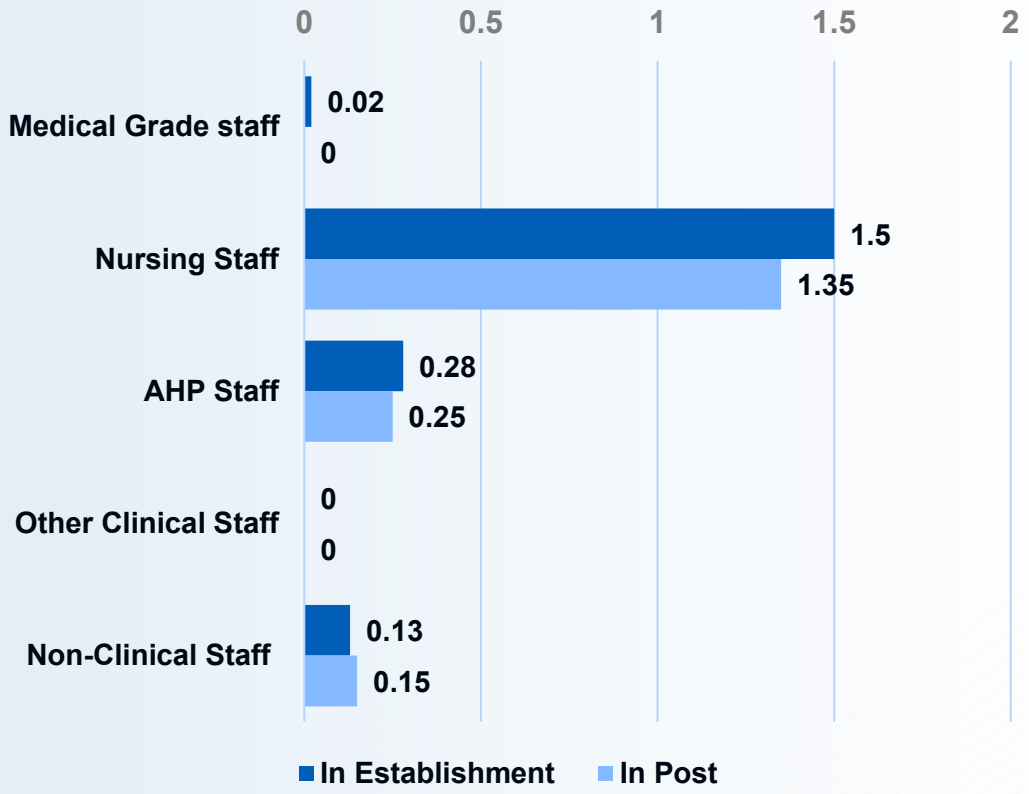
of users agreed that they were as involved with decisions about their care as they wanted to be.

76.5%

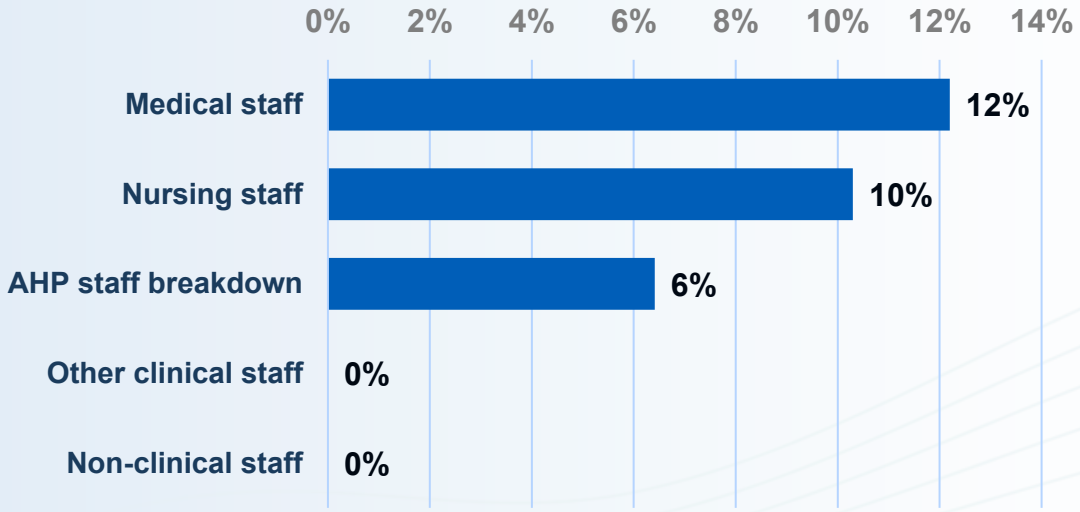
of users agreed that they were given enough information about their condition or treatment.

Workforce

Total staff per bed



Vacancy Rate %

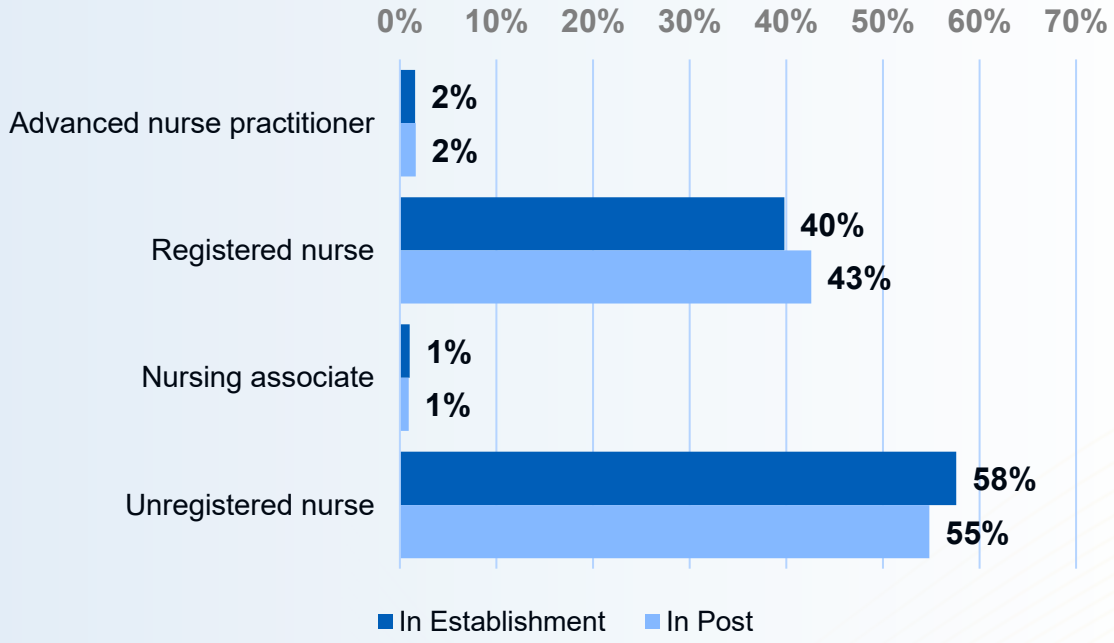


15% of total pay spend was spent on **bank and agency** staff.

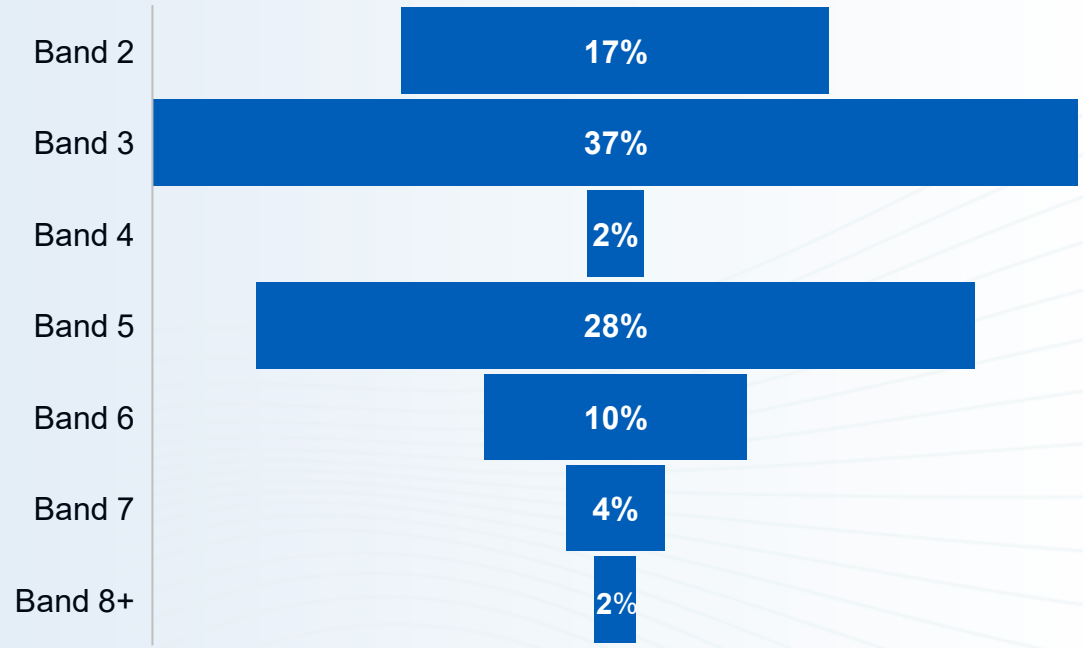
Workforce

The nursing workforce is responsible for the majority share of the staffing. The median service had 15.4 WTE staff in post per 100 new assessments, with 11.8 WTE being nursing staff and 2.1 WTE allied health professionals (AHPs).

Nursing Staff Discipline Mix



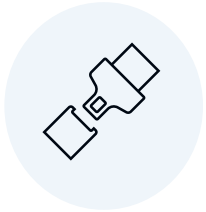
Nursing Staff Band Mix (In post)



Staff Surveys Findings

100%

of respondents agreed that their role makes a difference to patients/service users.



94.5%

of respondents agreed that their organisation has done enough to ensure their safety at work.

76.4%

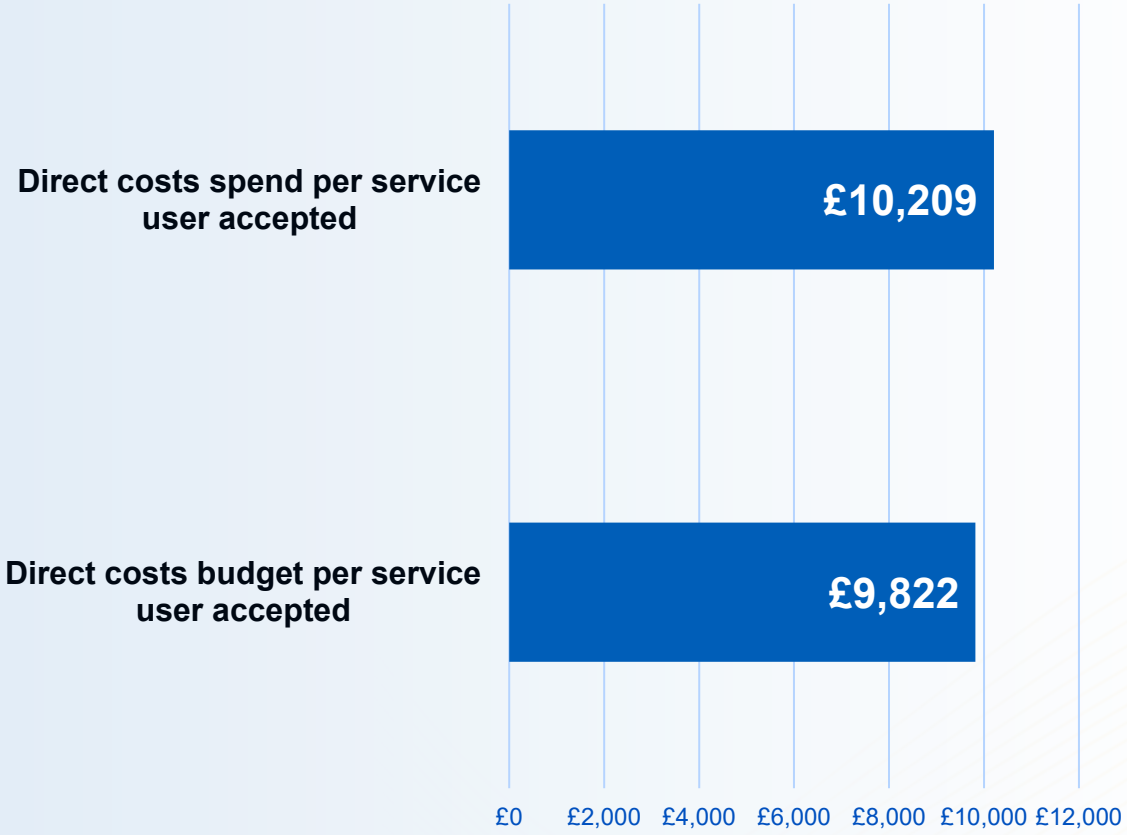
respondents agreed that working in Intermediate Care has affected their work–life balance and emotional wellbeing.

76.4%

of respondents agreed that their service integrates well with other healthcare services and departments.

Finance

Direct budget vs spend per service user accepted



% of direct spend on pay vs non-pay costs

92% on pay costs

8% on non-pay costs

Using benchmarking to drive change in community bed-based intermediate care at NCHC

The context we're working in

Norfolk Community Health and Care NHS Trust

Intermediate Care beds are under sustained and increasing pressure.

In the last 12 months alone:

- Community Access Team (CAT) referrals are up **37%**
- Demand for rehab beds is up **46%**
- Admissions and discharges are up **26–27%**
- Occupancy sits consistently at **98%**

At the same time, patient complexity, frailty and acuity are all rising.

What benchmarking told us

Norfolk Community Health and Care NHS Trust

The first metric we really leaned into was Average Length of Stay.

From our own data:

- 2023: **36** days
- 2024: **28** days
- 2025: **27** days

But what the NHSBN report showed us was critical.

The national median ALoS is **24** days.

The real issue wasn’t clinical LOS

Norfolk Community Health and Care NHS Trust

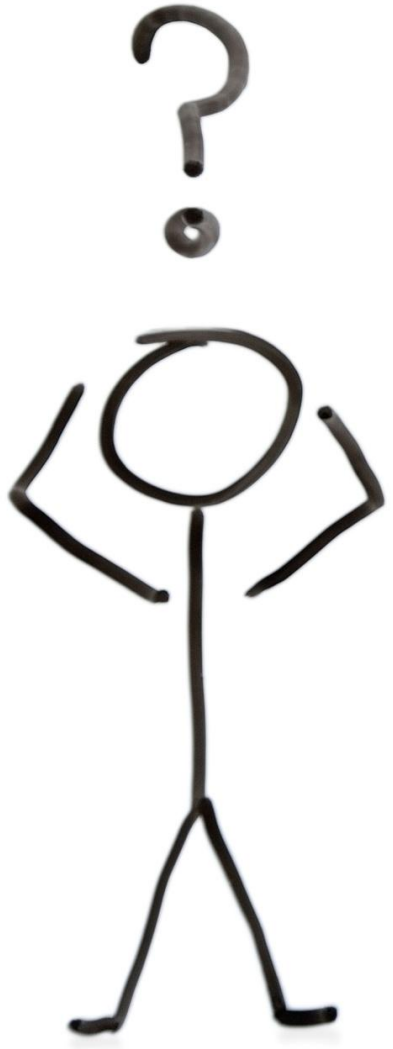
Our clinical length of stay is **19** days.

Our reported total length of stay is **27–28** days.

The gap is Non-Criteria to Reside (NCTR).

Benchmarking shows OBDs utilised by patients meeting discharge criteria has a median of **25.5%.**

We were sitting at **37.3%** in 24/25.



What we did because of that

We took action:

- Recruited a discharge coordinator
- Expanding to **+1.5** WTE in line with the CAT model
- IDAT process review with social care and community colleagues
- Earlier frailty identification and work with the frailty hub / virtual ward
- Joint MDT assessments to avoid sequential delays

And the impact?

NC2R reduced from **37.3% → 29.4%**

Which is now just below the national benchmarking threshold of **29.5%.**

That is a direct line from benchmarking → operational change → measurable impact.

Willow Therapy Unit and flow

Norfolk Community Health and Care NHS Trust

Willow opened with **48** beds and an ALoS of **21.7** days.

Willow wasn't just extra capacity; it was a flow accelerator.

Willow now accounts for **30%** of admissions and is one of the reasons we can run at **200–220** admissions per month while keeping ALoS stable.

Demand, occupancy and the hidden risk

Norfolk Community Health and Care NHS Trust

When we looked at our CAT data:

2024: 51% of CAT demand admitted
2025: 56% admitted

That’s 67 more patients per month needing a rehab bed.

NHSBN shows a median occupancy of around **93%**.

We sit at **98% - 99%.**

Where benchmarking changed conversations

Norfolk Community Health and Care NHS Trust

Benchmarking has changed the conversation in three ways:

1. From “we’re busy” to “we are an outlier here”
2. From “this feels slow” to “NC2R is our system issue”
3. From “we need more beds” to “we need better flow”

It has helped us have evidence-based discussions with:

- social care
- acute colleagues
- frailty hub
- workforce planning
- and commissioners

Where we're using it next

Norfolk Community Health and Care NHS Trust

We are now using the NHSBN data to focus on:

- Frailty screening and Comprehensive Geriatric Assessment rates
- PREM involvement in discharge timing
- Workforce sickness and vacancy comparison
- OBD utilisation by discharge-ready patients

Summary

Norfolk Community Health and Care NHS Trust

Benchmarking has helped us:

- Reduce ALoS by **9** days in **3** years
- Reduce NC2R by **8%**
- Increase throughput by **27%**
- Absorb **37%** more demand

Any Questions

My contact details

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An introduction for

NHS Benchmarking Network

Concluding remarks

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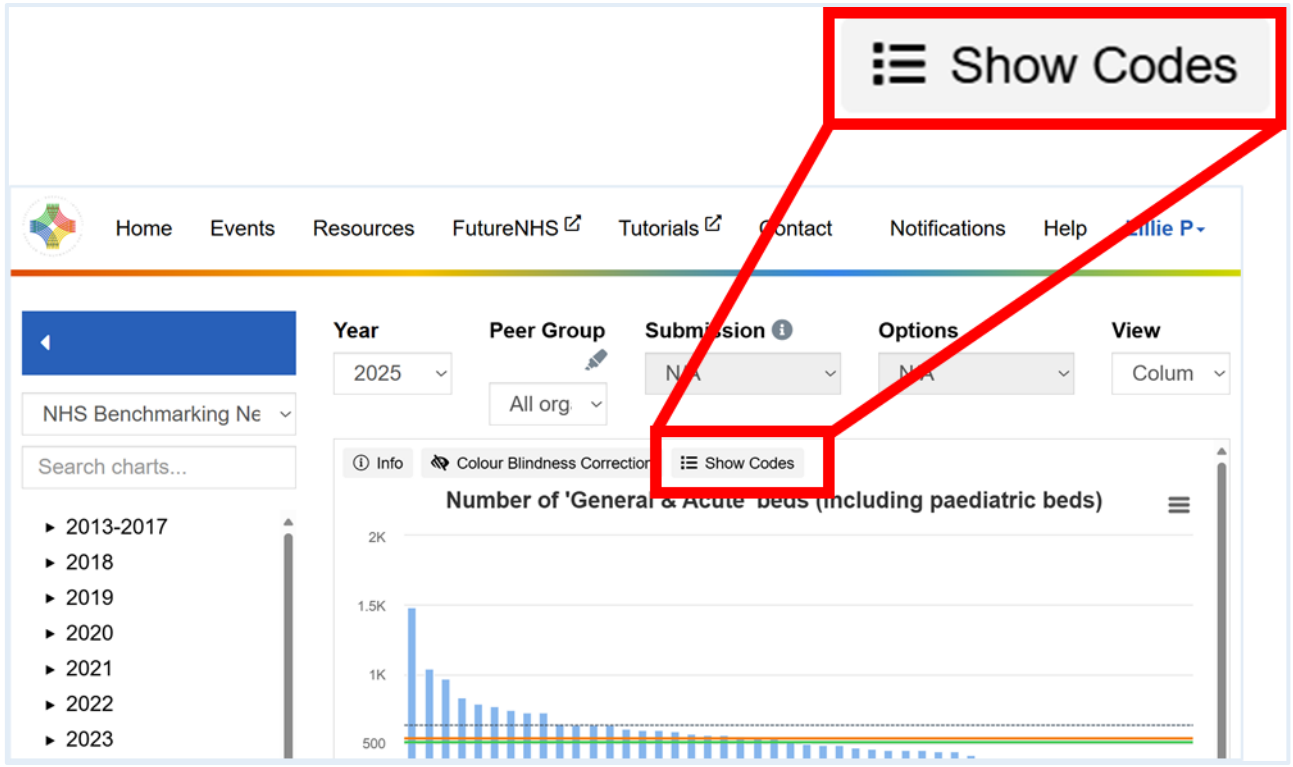
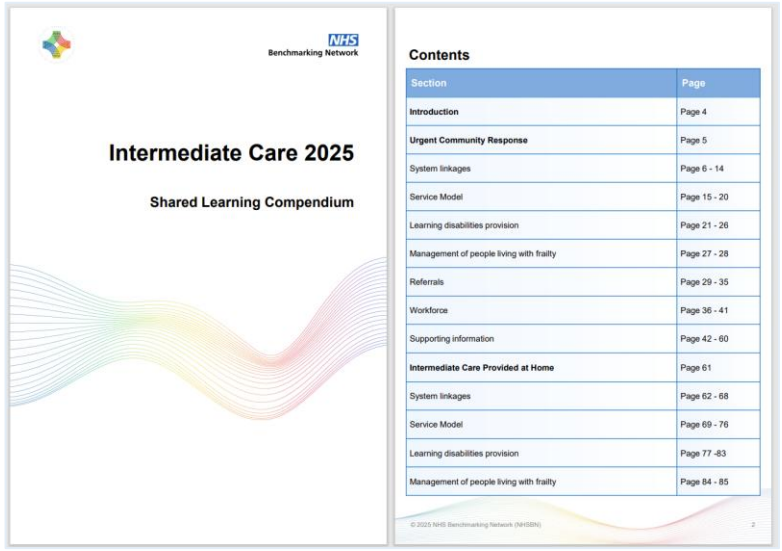
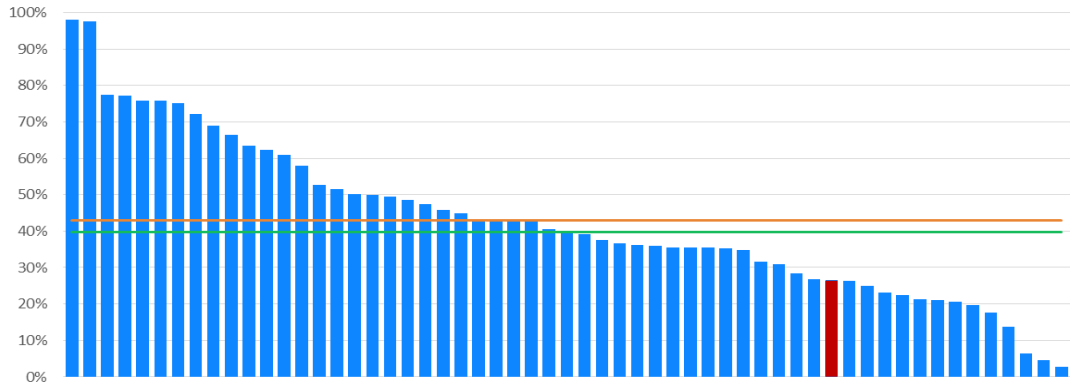
Where are the opportunities?







Next Steps

Catch up on other Lunch & Learns

- Catch up on previous lunch & learn by viewing the slides and recordings on our events page

View the project outputs

- Download the reports
- View more metrics on the toolkit
- Read the shared learning compendium

Feedback your thoughts

- How did you find participating in the project?
- Are there any other metrics you'd like us to collect?
- Did you enjoy today's session?

Keep Learning, Keep Connecting:

Explore more Member Programme events at:

www.nhsbenchmarking.nhs.uk/events

For more information on anything you've heard today or for general enquiries contact us: enquiry@nhsbenchmarking.nhs.uk

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