**NHS Digital**

**Indicator Supporting Documentation**

**IAP00139 The proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into re-ablement / rehabilitation services**

**About the Indicator Assurance Process**

This form can be used to seek assurance for indicators, methodologies and other statistics that may be used for the purpose of decision making. The process involves reviewing the proposed indicator, statistic, or method to determine if it is fit for the intended audience. **For the purpose of this form, all indicators, statistics or methodologies will be referred to as ‘indicator’.**

The assurance process is managed by the NHS Information Centre, on behalf of the NHS Quality Information Committee.

Information from this application will be available to IC staff dealing with the application and external collaborators who will provide advice. Once the application has been assured, all information other than personal details of the applicant will be available publicly via our website, as part of the IC’s transparency agenda.

More information about the process can be found [insert link to info pack]

**How to complete the Application Form**

* This document is a template, so please copy it and save as a .doc for each application.
* If you are submitting more than one application, we suggest you complete Section B with your contact details and save as your own template to save filling this in for every application.

You can navigate to the desired section of the report by holding Ctrl and clicking on the section headings below:

[Section A](#Section_A) – Summary Application Details

[Section B](#Section_B) – Application contact details

[Section C](#Section_C) – Users of the Proposed Indicator

[Section D](#Section_D) – Rationale for Indicator

[Section E](#Section_E) – Management and production of Indicator

[Section F](#Section_F) – Methodology

[Section G](#Section_G) – Data sources

We appreciate that some applicants might not have the full details pertaining to a proposed indicator. Please complete the form as best as possible but be aware that the IC won’t be able to progress the indicator for assurance until it has sufficient information to consider its suitability. If you have difficulty completing the form, please contact the IC Clinical Indicators Team (CIT) who will provide advice at the e-mail address below.

**How to submit the form**

We are developing a website to help us manage the applications to IAP, but in the meantime please email [pipeline@ic.nhs.uk](mailto:pipeline@ic.nhs.uk) for more information about how to submit the form.

|  |  |
| --- | --- |
| Indicator Title, this is the short title, a concise concept. Do not include details of calculation, geography, time period or population characteristics | Application Code (IC Use only) |
| The proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services | IAP00139 |

|  |
| --- |
| **Section A – Summary Application Details** |
| 1. Indicator Definition, this is the longer description of the indicator. Include a description of the calculation, measurement units, geographical range, and characteristics of the population such as age and gender. |
| The indicator is a two-part measure to reflect the effectiveness of rehabilitation and the coverage of the service. The two parts are: i) The proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into rehabilitation services. ii) The proportion of older people aged 65 and over offered rehabilitation services following discharge from acute or community hospital.  The indicator reflects both the effectiveness of rehabilitation services and the coverage of the service.  The first part of the measure refers to the proportion of people aged 65 and over discharged from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting) who are at home (or in extra care housing or an adult placement scheme setting) three months after the date of their discharge from hospital.  Those who are in hospital or in a registered care home (other than for a brief episode of respite care from which they are expected to return home) at the three month date and those who have died within the three months are not reported in the numerator.  The collection of the denominator will be from 1 October to 31 December every year with a 91-day follow-up for each case included in the denominator to populate the numerator, starting in 2011.  The second part refers to the proportion of older people aged 65 and over offered rehabilitation services following discharge from acute or community hospital. This measure will take the denominator from part i) as its numerator (the number of older people offered rehabilitation services). The new denominator will be the total number of older people discharged from acute or community hospitals based on Hospital Episode Statistics (HES). |

|  |  |  |
| --- | --- | --- |
| 1. Does this indicator measure a | process | outcome including process as proxy |
| 1. This measure is… | …compared against a national average | …compared against an optimum value |
| ...a comparison against an absolute evidence based standard | ...compared against self / baseline over time | …not compared against any other values |

|  |
| --- |
| 1. List any indicators which overlap with the proposed indicator Are there other similar indicators currently in use? The IC will provide a library of existing indicators as a later part of this project development. For now, please list any indicator sources you have checked. |
| During the consultation process for the NHS Outcomes Framework there was wide checking of other indicator sets for overlap. This indicator was selected as being fit for purpose of the NHS outcomes indicators.  The indicator is replicated in the Adult Social Care Outcomes Framework (ASC OF). |
| 1. What value does the proposed indicator offer over existing indicators? |
| Data for both numerators have been published by the NHS IC. This was previously NI125 in CLG’s National Indicator List and the latest data (along with historical data) are available at http://www.ic.nhs.uk/statistics-and-data-collections/social-care/adult­social-care-information/social-care-and-mental-health-indicators-from­the-national-indicator-set-2010-11-provisional-release.  This previous indicator focussed on the success of the reablement service only. The two-part measure in the NHS Outcomes Framework captures the volume of reablement offered as well as the success of the reablement service offered. This will avoid past situations where an area scores well on the measure having offered reablement to only a very small number of people. |

1. How is the indicator to be derived from its source data?

|  |  |  |
| --- | --- | --- |
| (a)  Re-use of existing data for an indicator, using data that are already aggregated or pre-calculated to answer the indicator question. | (b)  Existing raw data that require further calculation to answer the indicator question. | (c)  New data source will be created or an existing source changed to meet the requirement for this indicator |

|  |
| --- |
| 1. Is this indicator linked to another that has been submitted to pipeline? Give the name and relationship |
| No |
|  |

**Section B – Application contact details (please note all contact details will be treated confidentially)**

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Applicant Name   Name of person who is completing this application. | Panos Zerdevas | 1. Applicant Role / Job Title | Economic Advisor |
| 1. Applicant Organisation | DH | 1. Applicant Email | [Panos.zerdevas@dh.gsi.gov.uk](mailto:Panos.zerdevas@dh.gsi.gov.uk) |
| 1. Applicant Telephone | 020 7972 1393 | 1. Sponsor name 2. Name of the person who is paying for the production of the indicator | Clinical Quality and Efficiency Analytical Team/ Social Care Strategic Policy and Finance |
| 1. Sponsor Role / Job Title | Delivery of NHS Outcome Indicators for SoS to use to hold NHS Commissioning Board to account | 1. Sponsor Organisation | Department of Health |
| 1. Acknowledgements Please list any contributors to the development of the indicator you wish accredited |  | 1. Please list any other stakeholder groups 2. Name specific groups of users who may wish to be involved in assurance of this indicator | NHS IC |

**Section C – Users of the Proposed Indicator**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Primary User | Secondary User | Not intended for |
| National Government |  |  |  |
| Local Government |  |  |  |
| Governing Boards (NHS, local government etc) |  |  |  |
| Providing Managers |  |  |  |
| Commissioning Managers |  |  |  |
| Regulators |  |  |  |
| Clinicians |  |  |  |
| Patients |  |  |  |
| Public |  |  |  |
| Other (please specify) |  |  |  |
| Other (please specify) |  |  |  |

|  |
| --- |
| **Section D – Rationale for Indicator** |
| 1. Relevant policies, strategies or programmes |
| At the 2010 Spending Review, DH announced that, over the four years to 2014/15, £2.7 billion would be transferred to local authorities from the NHS to promote better joined-up working across the health, care and support system.  The health system will transfer a further £100 million and £200 million in 2013/14 and 2014/15 respectively, over and above the funding set out at the Spending Review. The new funding will further support local areas to deliver social care services that benefit people’s health and wellbeing, by promoting more joint working between health and care. This will enable local areas to transform their services and to deliver better integrated care that saves money across the two systems: for example, by supporting people to maintain their independence in the community for as long as possible.  The Department has started a new piece of work on Recovery, Rehabilitation and Reablement (RRR). The aim of this programme is to improve the quality of patient care and outcomes, by delivering a seamless Recovery, Rehabilitation and Reablement service for acute admitted patients – based on their clinical and bio-psycho-social needs, rather than just their diagnosis or where their care is delivered. The principles of the RRR redesign will be to change the responsibility for care, and the tariff, at the point when the patients’ needs change, not at the point when they change institutions. |

1. High level subject area

|  |  |  |
| --- | --- | --- |
| 1. Preventing people from dying prematurely | 1. Enhancing quality of life for people with long term conditions | 1. Helping people recover from episodes of ill health or following injury |
| 1. Ensuring people have positive experiences of care | 1. Treating and caring for people in a safe environment and protecting them from avoidable harm | 1. Helping people to stay healthy |
| 1. Equitable access to care | 1. Other (specify) |  |

|  |
| --- |
| 1. Evidence base for the indicator Provide a paragraph summarising the evidence for the rationale, noting quality of evidence where appropriate. Please extract salient messages, list the relevant documents in Question 4. |

|  |
| --- |
| Indicator has been selected as part of the set of NHS Outcome indicators – evidence produced and considered for the set. The indicator is part of domain 3 of the set – this domain reflects the importance of helping people to recover from episodes of ill health or following injury. This can be seen as two complementary objectives: preventing conditions from becoming more serious (wherever possible) and helping people to recover effectively.  This indicator helps measuring people who are recovering effectively. It  measures the benefit to individuals from reablement, intermediate care and rehabilitation following a hospital episode, by determining whether an individual remains living at home 91 days following discharge – the key outcome for many people using reablement services.  It captures the joint work of social services and health staff and services commissioned by joint teams, as well as adult social care reablement.  As the previous indicator focussed on the success of the reablement service only without any measurement of the volume of reablement services offered, it was decided to expand the indicator to capture this. This will avoid past situations where an area scores well on the measure having offered reablement to only a very small number of people. |

|  |
| --- |
| 1. References List up to six key references or documents. If available on the internet, please give the URL |
| 1. Extensive consultation – see transparency in outcomes – a framework for the NHS, The NHS Outcomes Framework 2011-12   http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\_122944 |
| 1. Adult Social Care Outcomes Framework-Handbook of Definitions v3 March 2012   http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\_133334 |
| 1. Transparency in Outcomes-a framework for adult social care   http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH\_125464 |
|  |
|  |
|  |

|  |
| --- |
| 1. Clinical Advice Provide details of any clinical advice or support already given in development or preparation of indicator. |
|  |

**Section E – Management and production of Indicator**

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Commissioner Organisation This may be the same as the stakeholder in Section B, Question 8 | DH | 1. Producer of indicator This is the organisation who will publish or provide the indicator and may be the same as the proposer in Section B, Question 3 | NHS IC |

|  |
| --- |
| 1. Expected ‘improvement actions’ as a result of this indicator State where responsibility will lie, and what actions will be expected as the result of a ‘poor’ rating of this indicator. For example, poor performance will lead to letter being sent to Chief Executive of organisation, to stimulate them to take action. |
| The NHS Outcomes Framework sets out the national outcome goals that the SoS will use to monitor the progress of the NHS Commissioning Board. It does not set out how these outcomes should be delivered; it will be for the NHS Commissioning Board to determine how best to deliver improvements by working with GP commissioning consortia to make use of the tools at their disposal. |
| 1. Have costs of collection, construction, dissemination and presentation been fully identified? Please provide, even if the indicator is not to be produced by the NHS IC. This is a useful measure of how committed the sponsor is to this indicator and helps us prioritise applications through the process.   The NHS Outcomes Framework Impact Assessment provides details on costs of collection, construction, dissemination and presentation of the indicators. |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. Funding status | Secured | Being sought | Not identified | Not applicable |

|  |
| --- |
| 1. What are the timescales you envisage for developing / producing this indicator Give specific dates for key stages or publication or development of indicator |
| This indicator will be published in the ASC OF in September 2012. We aim at publishing it in the NHS Indicator Portal in the NHS OF area by the end of September. |
| 1. Risks, assumptions and impact of producing indicator Are there any external factors that need to be understood, such as changes to policy, data collections, finances or political changes. |
| The indicator includes older people who had received a joint multi-disciplinary assessment prior to or following their discharge from hospital before going on to receive a rehabilitation service and people who had received reablement services through ASC only. It does not include people who receive reablement from NHS services only because these people are not captured by the LA data collection. |
| 1. Risks of perverse incentive and gaming by healthcare providers to what extent can organisations influence the value of the indicator in ways which may not benefit patients? |
| As the indicator is now a two-part measure of effectiveness and volume of reablement services, the perverse incentive of focussing only on a small proportion of people that would score well is removed. |
| 1. Risks, assumptions and impact of not producing indicator |
| This is not an option as there has been a public commitment made to doing so. This indicator is part of the NHS Outcome Framework 2012-13 indicator set. |
| **Section F - Methodology** |

Select the calculation type

|  |  |  |
| --- | --- | --- |
| Count For example volume of procedures, number of patients | Percentage For example percentage of patients treated | Rate per for example, rate per 100,000 population |
| Ratio For example observed deaths to expected deaths | Score For example score from suite of survey questions, or score against predicted or estimated value | Index score |
| Mean This is the sum of all values divided by the number of values, or common ‘average’. | Median This is the middle value observed | Mode This is the most common value observed |
| Interquartile range | Other Please use this if you are proposing a complex indicator which cannot be described in simple terms, such as Standardised Hospital Mortality Rates |  |

1. Select the adjustment or standardisation type used Select all that apply

|  |  |  |
| --- | --- | --- |
| No adjustment or standardisation | Direct standardisation | Indirect standardisation |
| Non-response weighting | Risk adjustment | Pooled data |
| Rolling averages | Confidence limits or intervals applied |  |

|  |
| --- |
| 1. Descriptions of the calculation Describe the calculation required in words. Where this is insufficient, please submit a document with formulae in addition to this application |
| The indicator is a two-part measure that presents i) proportion of successful reablement and ii) proportion of reablement offered using the following formula:  X/Y  For more details on X and Y please see following section on numerator and denominator  Worked example:  Part 1  Suppose the number of people aged 65+ on discharge and who were discharged and benefited from intermediate care/ rehabilitation still living at home 3 months after discharge = 217.  And if the number of people discharged from hospital aged 65+ and entering into joint ‘intermediate care’ or a ‘rehabilitation service’ = 306.  Therefore, the percentage achieving independence = (217 /306) x 100 = 70.9%  Part 2  If the number of people discharged from hospital aged 65+ and entering into joint ‘intermediate care’ or a ‘rehabilitation service’ = 306 (using same figure as above)  And if the total number of people aged 65+ discharged from hospital = 6,857  Then, the proportion offered reablement services = (306/6,857) x 100 = 4.5% |
| 1. Statistical Methods Type of analysis (any methods used), risk adjustment (predictive power of model), special techniques (dealing with dispersion, constant risk), statistical process control |
|  |
| 1. Risk adjustment variables the purpose of risk adjustment is to remove the effect of aspects beyond the direct control of the organisation or group monitored. Where risk adjustment is used, summarise the application of risk adjustment and selection of relevant variables. If not used, state why. |
|  |
| 1. Quality assurance process Detail the quality assurance processes in place to check data, identify anomalies. Note any processes or arrangements in place to discuss issues with the suppliers of the raw data if required. |
| Quality Assurance process is carried out by the Social Care team in the NHS IC. |
| 1. Test or sample data Test or sample data are required as proof of concept. Please submit a document or spreadsheet with this application |
| 1. Interpretation Describe how this indicator is planned to be used, what questions the indicator is planned to answer, and any known limitation(s) |
| Indicator has been selected as part of the set of NHS Outcome indicators – See ‘The NHS Outcomes Framework 2012/13’ document. The indicator is part of domain 3 of the set – this domain reflects the importance of helping people to recover from episodes of ill health or following injury.  The aim is to provide an indication of the number of older people offered reablement and of them how many were still at home 91 days after discharge as an approximation of a successful outcome. |
| 1. Format of presentation Describe the final published format, such as interactive website, csv file etc. Please submit a document with an example or screenshot (or mock version) of how the final presentation of the data will appear. Include any interpretive text as well as figures |
| CSV file to DH |
| **Section G – Data sources** |
| If you answered (a) in [Section A](#Section_A) Question 6, please complete only the numerator part of this section. If you answered (b) or (c) and the indicator is based on more than one data source answer both numerator and denominator parts. |
| 1. Numerator definition Word description of the cases or events to be counted. The numerator should be a subset of the denominator |
| As this is a two part measure there are two numerators:  i) Number of older people discharged from acute or community hospitals to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital. This should only include the outcome for those cases referred to in the denominator.  ii) Number of older people discharged from acute or community hospitals from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting). |
| 1. Numerator source Organisation and data collection name |
| Adult Social Care Combined Activity Return (ASC-CAR) table I1 for both numerators |
| 1. Numerator construction Which data fields (specify) and values (specify codes) are combined to arrive at the count. Include any special rules or filters |
| All discharges for older people are included. |
| 1. Numerator completeness Are all relevant cases / events counted. List any known exclusions, shortfalls or collection issues which will affect the required count. How do counts compare with other sources? |
|  |
| 1. Numerator quality of data Issues with accuracy or known variability of recording. For example, coding by untrained staff. Please list any indicators of data quality available (by field or whole numerator) |
|  |
| 1. Numerator data availability Are the data publicly available / published? Are they available only upon request, or only to groups of people meeting specific criteria / conditions? |
| Data for both numerators have been published by the NHS IC. This was previously NI125 in CLG’s National Indicator List and the latest data (along with historical data) are available at <http://www.ic.nhs.uk/statistics-and-data-collections/social-care/adult-social-care-information/social-care-and-mental-health-indicators-from-the-national-indicator-set--2010-11-final-release>. It will continue to be available annually |
| 1. Numerator timeliness Frequency and timeliness of data. State how the publication / release of data relates to envisioned indicator productions timescales |
| Annual.  Information for numerator i) will be collected from 1 January to 31 March as it refers to a 90 day follow up to the information presented in the denominator (1st October to 31 December).  Information for numerator ii) will be collected from 1st October to 31st December each year.    Provisional data will be published in September/October 2012. |
| 1. Numerator ISB compliance Some data items used across the NHS and social care have been approved as an Information Standard by the Information Standard Board for health and social care and is a measure of quality and consistency. Please give the Information Standard number and release version where appropriate |
|  |
| 1. Numerator ROCR approval Data collected by NHS and social care staff other than that required for day-to-day treatment of patients must be approved by the Review of Central Returns. Please give the ROCR Reference number and date for review where appropriate. |
|  |
| 1. Numerator comments Please detail any caveats not already covered |
|  |
| 1. Denominator definition Word description of the cases or events to be counted. |
| As this is a two-part measure, there are two denominators   1. Number of older people discharged from acute or community hospitals from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting).   ii) Total number of people, aged 65 and over, discharged alive from hospitals in England between 1 October 2011 and 31 December 2011. This includes all specialities and zero-length stays. Data for geographical areas is based on usual residence of patient. |
| 1. Denominator source Organisation and data collection name |
| i)Adult Social Care Combined Activity Return (ASC-CAR) table I1  ii) Hospital Episode Statistics |
| 1. Denominator construction Which data fields (specify) and values (specify codes) are combined to arrive at the count. Include any special rules |
| All specialities and zero length stays |
| 1. Denominator completeness Are all relevant cases / events counted. List any known exclusions, shortfalls or collection issues which will affect the required count. How do counts compare with other sources? |
| Yes |
| 1. Denominator quality of data Issues with accuracy or known variability of recording. For example, coding by untrained staff. Please list any indicators of data quality available (by field or whole numerator) |
|  |
| 1. Denominator data availability Are the data publicly available / published? Are they available only upon request, or only to groups of people meeting specific criteria / conditions? |
| Data for denominator i) and ii) is available.  Data for ii) has been put in the IC website to be accessed by LAs (relating to the 3-month period), and annually thereafter. |
| 1. Denominator timeliness Frequency and timeliness of data. State how the publication / release of data relates to envisioned indicator productions timescales |
| Annual  Both denominators refer to the period 1st October to 31st December.  Provisional data for (i) available in September/October 2012.  There is an approximately 4-month time lag in the availability of HES data due to data quality processes |
| 1. Denominator ISB compliance Some data items used across the NHS and social care have been approved as an Information Standard by the Information Standard Board for health and social care and is a measure of quality and consistency. Please give the Information Standard number and release version where appropriate |
|  |
| 1. Denominator ROCR approval Data collected by NHS and social care staff other than that required for day-to-day treatment of patients must be approved by the Review of Central Returns. Please give the ROCR Reference number and date for review where appropriate. |
|  |
| 1. Denominator comments Please detail any caveats not already covered |
|  |

Application Checklist – Clinical Indicator Team use only

|  |  |  |  |
| --- | --- | --- | --- |
| [Section A](#Section_A) – Summary Application Details | Requires additional information | Satisfactory | Comments include all issues, even minor ones to be resolved outside the major meetings |
| [Section B](#Section_B) – Application contact details | Requires additional information | Satisfactory | Comments include all issues, even minor ones to be resolved outside the major meetings |
| [Section C](#Section_C) – Users of the Proposed Indicator | Requires additional information | Satisfactory | Comments include all issues, even minor ones to be resolved outside the major meetings |
| [Section D](#Section_D) – Rationale for Indicator | Requires additional information | Satisfactory | Comments include all issues, even minor ones to be resolved outside the major meetings |
| [Section E](#Section_E) – Management and production of Indicator | Requires additional information | Satisfactory | Comments include all issues, even minor ones to be resolved outside the major meetings |
| [Section F](#Section_F) – Methodology | Requires additional information | Satisfactory | Comments include all issues, even minor ones to be resolved outside the major meetings |
| [Section G](#Section_G) – Data sources | Requires additional information | Satisfactory | Comments include all issues, even minor ones to be resolved outside the major meetings |

Issues for consideration Record all major issues to be considered before indicator can be ‘assured’

|  |  |  |  |
| --- | --- | --- | --- |
| Area where issue resides | Group to discuss | Summary of issue | Actioned / resolved |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Record of meetings Choose meeting type and add hyperlink to the meeting minutes

|  |  |  |  |
| --- | --- | --- | --- |
| Meeting type | Date | Issues discussed | Minutes please insert the hyperlink to the minutes of the meeting |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Caveats to apply to indicator

|  |  |
| --- | --- |
| **IAS Ref Code** | **IAP00139** |
| **Indicator Title** | **3.6 - The proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services** |
| **Indicator Set** | **NHS Outcomes Framework** |

|  |  |  |  |
| --- | --- | --- | --- |
| Version | Date | Changed By | Summary of changes |
| v.01 | 20/11/12 | Chris Wilson | Document Created |
| v.02 | 7/12/12 | Chris Wilson | Document updated following discussion at IGB |
| v.03 | 28/5/13 | Gavin Harrison | Updated template & MRG details |
| v.04 | 03/06/17 | Andrew Besch | Updated with outcome of IGB meeting of 30/11/2012 |
|  |  |  |  |

Contents

|  |  |
| --- | --- |
| * Assurance Summary…………………………………….…………………………………… | Page 3 |
| * Peer Review Summary……………………………………………………………………… | Page 4 |
| * MRG Application for Consideration…………………….……………………………. | Page 5 |
| * MRG Recommendations & Updates……………………………………………….… | Page |
| * MRG Application Revisions………………………………………………………………. | Page |
| * IGB Presentation Summary………………………………………………………………. | Page |
| * IGB Recommendations……………………………………………………………………… | Page |

**Assurance Summary**

|  |  |
| --- | --- |
| **IAS Ref Code** | About the Indicator Application Process (NHS IC Pipeline Process) |
| **Indicator Title** | 3.6 - The proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services |
| **Indicator Set** | NHS Outcomes Framework |

|  |  |  |  |
| --- | --- | --- | --- |
| Assurance Stage |  | Date(s) | Comments |
| Application Received | ☐ |  |  |
| Initial Appraisal Completed | ☐ |  |  |
| Peer Review Appraisal | ☐ |  |  |
| Methodology Review Group Discussion | ☒ | 21/9/12, 26/10/12 |  |
| Indicator Governance Board Discussion | ☒ | 30/11/12 |  |
| Signed-off | ☒ | 30/11/12 |  |

Peer Review

|  |  |
| --- | --- |
| Peer Reviewer(s) / Organisations : | No peer review undertaken at present for assurance of NHSOF indicator. |

|  |  |  |  |
| --- | --- | --- | --- |
| Outcome of Peer Review consideration: | 1. **Proposal signed off, with or without caveats** | ☐ |  |
|  | 1. **Minor changes recommended** | ☐ |  |
|  | 1. **Declined to sign-off** | ☐ |  |

Methodology Review Group (MRG)

|  |  |  |  |
| --- | --- | --- | --- |
| Outcome of MRG consideration: | 1. **No significant issues identified** | ☐ |  |
|  | 1. **No significant issues on basis of completion of outstanding actions** | ☐ |  |
|  | 1. **Some concerns expressed as caveats or limitations** | ☐ |  |
|  | 1. **Significant reservations** | ☐ |  |
|  | 1. **Unresolved issues** | ☐ |  |

Indicator Governance Board (IGB)

|  |  |  |  |
| --- | --- | --- | --- |
| Final Appraisal Status | 1. **Assured** | ☐ |  |
|  | 1. **Assured with Comments** | ☒ |  |
|  | 1. **Failed Assurance** | ☐ |  |

**Peer Review** Summary

|  |  |  |  |
| --- | --- | --- | --- |
| **Indicator Title** | **3.6 - The proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services** | IAS Ref Code: | About the Indicator Application Process (NHS IC Pipeline Process) |
| Indicator Set | NHS Outcomes Framework |  |  |

|  |  |
| --- | --- |
| Date of Peer Review | No peer review undertaken at present for assurance of NHSOF indicator. |
| Peer Reviewer(s) / Organisations : |  |
| Peer Review Comments: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Outcome of MRG consideration: | 1. **Proposal signed off, with or without caveats** | ☐ |  |
|  | 1. **Minor changes recommended** | ☐ |  |
|  | 1. **Declined to sign-off** | ☐ |  |

|  |  |
| --- | --- |
| Link to Peer Review Appraisal |  |

Indicator Methodology for Consideration - **Methodology Review Group**

|  |  |  |  |
| --- | --- | --- | --- |
| **Initial Indicator Title** | [Indicator title submitted pre - MRG discussion]  **NOF 3.6 - The proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into re-ablement / rehabilitation services** | IAS Ref Code: | About the Indicator Application Process (NHS IC Pipeline Process) |
| Indicator Set | NHS Outcomes Framework |  |  |

|  |
| --- |
| Introduction |
| The indicator is part of domain 3 of the set of NHS Outcome indicators. This domain reflects the importance of helping people to recover from episodes of ill health or following injury. This can be seen as two complementary objectives: preventing conditions from becoming more serious (wherever possible), and helping people to recover effectively. |

Indicator Details - Initial MRG Submission

|  |  |
| --- | --- |
| Date of Initial Discussion: | 21/09/12 |
| Rationale / usefulness  Evidence and action ability of indicator [take this directly from the application if possible] | This indicator measures people who are recovering effectively. It measures the benefit to individuals from reablement, intermediate care and rehabilitation following a hospital episode, by determining whether an individual remains living at home 91 days following discharge – the key outcome for many people using reablement services. The aim is to provide an indication of the number of older people offered reablement and of them how many were still at home 91 days after discharge as an approximation of a successful outcome.  Previously, the indicator focussed on the success of the reablement service only. The indicator is now a two-part measure to reflect both the effectiveness of rehabilitation and the coverage of the service. This will avoid past situations where an area scores well on the measure having offered reablement to only a very small number of people. The two parts of the indicator are:  i) the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into rehabilitation services and,  ii) the proportion of older people aged 65 and over offered rehabilitation services following discharge from acute or community hospital.  The first part of the measure refers to the proportion of people aged 65 and over discharged from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting) who are at home (or in extra care housing or an adult placement scheme setting) three months after the date of their discharge from hospital.  The second part refers to the proportion of older people aged 65 and over offered rehabilitation services following discharge from acute or community hospital. This measure will take the denominator from part i) as its numerator (the number of older people offered rehabilitation services). The new denominator will be the total number of older people discharged from acute or community hospitals based on Hospital Episode Statistics (HES). |
| Data source | Denominator:  i) Adult Social Care Combined Activity Return (ASC-CAR) table I1  ii) Hospital Episode Statistics  Numerator:  Adult Social Care Combined Activity Return (ASC-CAR) table I1 |
| Construction  Summary of construction, including the numerator, denominator, statistical method(s), presence of risk adjustment variables (age, sex, casemix etc.), specific codes and filters.  For more complex indicators, summarise here and supply detail in an appendix | **Summary description of the calculation:**  The indicator is a two-part measure.  **Part 1: The proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into rehabilitation services.**  Denominator: Number of older people discharged from acute or community hospitals  • to their own home or  • to a residential or nursing care home or extra care housing for rehabilitation,  with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting).  Numerator: Number of older people discharged from acute or community hospitals  • to their own home or  • to a residential or nursing care home or extra care housing for rehabilitation,  with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital.  This should only include the outcome for those cases referred to in the denominator.  Those who are in hospital or in a registered care home (other than for a brief episode of respite care from which they are expected to return home) at the three month date and those who have died within the three months are not reported in the numerator.  **Part 2: The proportion of older people aged 65 and over offered rehabilitation services following discharge from acute or community hospital**  Denominator: Total number of people, aged 65 and over, discharged alive from hospitals in England between 1 October 2011 and 31 December 2011. This includes all specialities and zero-length stays. Data for geographical areas is based on usual residence of patient.  Numerator: (as Denominator Part 1) Number of older people discharged from acute or community hospitals  • to their own home or  • to a residential or nursing care home or extra care housing for rehabilitation,  with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting).  Data for both numerators have been published by the HSCIC. This was previously NI125 in CLG’s National Indicator List and the latest data (along with historical data) are available at http://www.ic.nhs.uk/statistics-and-data-collections/social-care/adult-social-care-information/social-care-and-mental-health-indicators-from-the-national-indicator-set--2010-11-final-release. It will continue to be available annually  Reporting period – Annual  See ‘Additional information’ for worked examples of calculating both parts of the indicator.  **Calculation type:** Percentage (numerator/denominator)  **Statistical Methods / Risk adjustment variables:**  No adjustment or standardisation  **Other (Quality assurance/interpretation/known limitations):** |
| Potential Issues  Highlight any of the following that apply  -data source(s) do not collect 100% of events  -data source(s) organisation or geographic coverage shortfalls  -codes or filters not matching the policy question  -data source(s) definitions not meeting policy question  -data source(s) quality problems or inconsistency of reporting  -statistical methods not appropriate for test or audience  -risk adjustment not considered  -long term security of the data source(s)  -timing of data availability for use in indicator  presentation of data likely to mislead or give false confidence in findings | The indicator includes older people who had received a joint multi-disciplinary assessment prior to or following their discharge from hospital before going on to receive a rehabilitation service and people who had received reablement services through ASC only. It does not include people who receive reablement from NHS services only because these people are not captured by the LA data collection. |
| Supporting Documents  Provide links to any additional documentation used to support discussion at MRG |  |

Additional Information / Sample Data :

Calculating the indicator: A worked example

Part 1:

Suppose the number of people aged 65+ on discharge and who were discharged and benefited from intermediate care/ rehabilitation still living at home 3 months after discharge = 217.

And if the number of people discharged from hospital aged 65+ and entering into joint ‘intermediate care’ or a ‘rehabilitation service’ = 306.

Therefore, the percentage achieving independence = (217 /306) x 100 = 70.9%

Part 2:

If the number of people discharged from hospital aged 65+ and entering into joint ‘intermediate care’ or a ‘rehabilitation service’ = 306 (using same figure as above)

And if the total number of people aged 65+ discharged from hospital = 6,857

Then, the proportion offered reablement services = (306/6,857) x 100 = 4.5%

Definitions: Rehabilitation/re-enablement services

People should be included in the table of return I1 if they have been provided, on discharge from a hospital, with a rehabilitation/re-enablement service AND who;

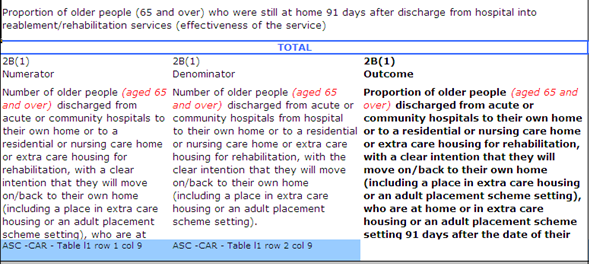
* Would otherwise face an unnecessarily prolonged stay in acute in-patient/community hospital care, or be permanently admitted to long term residential or nursing home care, or potentially use continuing NHS inpatient care; and
* Have a planned outcome of maximising independence and enabling them to resume living at home; and
* Are provided with care services on the basis of either a joint assessment from NHS and social care services or an assessment from social care services only, resulting in
* an individual support plan that involves active therapy, treatment or opportunity for recovery.
* Are to receive short-term rehabilitative interventions, typically lasting no longer than 6 weeks, and frequently as little as 1-2 weeks or less.

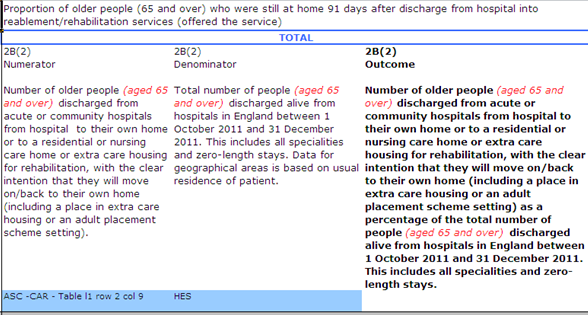
Therefore, on the basis of a joint, multi-disciplinary assessment or an assessment from social care services only prior or following their hospital discharge, the patient will subsequently have received services specifically aimed at rehabilitation/re-enablement and the patient’s return to living at home. It requires inputs commissioned/provided by the NHS and/or the CASSR to re-enable or rehabilitate the patient so that they can continue to live at home, with or without the on-going need for support by formal care staff.

Rehabilitation/re-enablement should not solely comprise of the provision of, for example, an item of equipment, wound nursing or provision of meals on wheels or getting up / putting to bed services, nor simply restarting of service(s) already in place at the time of admission to hospital unless the service(s) were specifically intended to provide rehabilitative/reenablement support.

The data collection covers both residential and non-residential 'rehabilitation/re-enablement services'.

ASCOF publication on the Indicator Portal; September 2012





MRG Recommendations, Comments & Updates:

|  |  |  |  |
| --- | --- | --- | --- |
| **Indicator Title** | **3.6 - The proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services** | IAS Ref Code: | About the Indicator Application Process (NHS IC Pipeline Process) |
| Indicator Set | NHS Outcomes Framework |  |  |

|  |  |
| --- | --- |
| Ref code  **2012/254**  Made: 21/09/12 | MRG recommended that deaths should be excluded from the denominator as well as the numerator in part one of the indicator. |
| Update:  Made: 26/10/12 | DH comment:  We do not agree with this. An indication of a successful reablement is that the individual has not died within 91 days of discharge into reablement.  For this reason, we include all people offered reablement (including people who died during the 91 day period) in the denominator but do not include them in the numerator (as we measure success of reablement services). |
| Further Rec:  **2012/254**  Made: 26/10/12 | MRG noted that any research base for the rationale for the indicator had not been presented and as such there was no basis on which to assess the validity of the exclusions, or to assess the use of the 91 day time period.   * It was recommended that contextual information on extent of exclusions would be of use.   MRG re-iterated their view that deaths should be excluded from the denominator on the principle that everyone included in the denominator should have the opportunity to be in the numerator, and as the cause of death may not be attributable to re-ablement.   * MRG suggested that any evidence of an association between re-ablement and death be asked for.   The Quality Statement should describe the shortcomings of the indicator as described above. |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Rec Status: | **Further Information Required** | ☐ | **Resolved / No Action Required** | ☒ |

|  |  |
| --- | --- |
| Ref code  **2012/255**  Made: 21/09/12 | MRG also seeks clarification on the exclusions and their extent – e.g. people residing out of areas, not knowns. |

Update Made: 26/10/12

DH comment:

People included are older people aged 65+ on discharge from hospital who:

- Would otherwise face an unnecessarily prolonged stay in acute in-patient care, or be permanently admitted to long term residential or nursing home care, or potentially use continuing NHS in-patient care;

- Have a planned outcome of maximising independence and enabling them to resume living at home;

- Are provided with care services on the basis of a multi-disciplinary assessment or an assessment from social care services only resulting in an individual support plan that involves active therapy, treatment or opportunity for recovery (with contributions from both health and social care, or social care only);

- Are to receive short-term interventions, typically lasting no longer than 6 weeks, and frequently as little as 1-2 weeks or less.

**People excluded:**

- Rehabilitation/re-enablement services following hospital discharge which are provided solely by health with social care consideration of needs in the assessment/care planning process. (PCTs may wish to collate evidence on such activity and its outcomes for local consideration)

- continuing care services provided solely by health

- palliative / end of life care

A hospital discharge is defined as an individual who has been formally admitted to hospital (not simply an attendance at A and E or outpatients) and then discharged. The length of time between admission and discharge will vary from a few hours (e.g. in a clinical decision unit) to days or weeks.

If an individual has had more than one discharge to rehabilitation/re-enablement services during the reporting period, then each discharge is included. If they also have multiple reviews then the correct review is also attached to each discharge.

The number of discharges is collected during the period 1 October to 31 December. These people are then contacted during the period 1 January to 31 March to see if they are still living at home. This could be done via a formal process such as a review or could be done informally, e.g. via a telephone call to the service user.

Discharges of those aged 65 and over from both acute and community hospitals should be included (discharges from psychiatric units and EMI units should be excluded). Councils and NHS partners may, however, want to extend the local reporting process to cover these discharges and / or instances where a joint rehabilitation plan is arranged to avoid admission to hospital.

Living at home is defined as those people living in their own home in the community, including in extra care housing or an adult placement scheme setting. Those people who are in hospital (other than for a brief episode of care from which they are expected to return home) or are in a registered care home (other than for a brief period of respite care from which they are expected to return home) are not considered to be living at home.

If there are discharges where social services have no details of the person 91 days after discharge, e.g. the person is not listed on the social care records or on the books to receive social care services, then social services have to use a variety of methods to trace these cases.

For example:

- social care records

- patient registrations from Primary Care Trusts

- address details from GPs

- benefits data from housing team

- details of deaths from local Registrars

For discharges where the person cannot be traced after 91 days, **they should be included in the denominator, but not in the numerator.**

Information is from IC 2012 guidance on ASC Combined Activity Returns (ASC-CAR)

http://www.ic.nhs.uk/webfiles/Services/Social\_care/Collections\_201112/ASC-CAR/ASC\_CAR\_Guidance\_2011\_12\_v1.0.pdf

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Rec Status: | **Further Information Required** | ☐ | **Resolved / No Action Required** | ☒ |

|  |  |
| --- | --- |
| Ref code  **2012/256**  Made: 21/09/12 | Feedback is to be sought from HES/Social Care/Policy teams as to whether the denominator can be better defined to make it more related to population covered in part one of the indicator. |
| Update:  Made: 26/10/12 | DH comment:  We agree in theory but in practice this is not possible due to lack of data. We already tried to do this!  The original indicator was only part 1 of the current indicator and therefore did not provide any information on coverage. It did not tell us whether there was sufficient capacity locally to support all who could benefit from rehabilitation/reablement, e.g. Hertfordshire’s below average ‘success rate’ of 78.4% represents 3,330 individuals regaining independence, while York’s 100 per cent ‘success rate’ only benefitted 10 people.  To mitigate this, we incorporated the extent to which local councils offer reablement services. The ideal measure would be the number of people still at home after 91 days out of the total number who should have entered reablement. However, this is not possible from existing data sources.  Several alternative proposals were investigated and adding a separate indicator that measures the proportion of older people offered reablement services following discharges from hospital during the same period was considered the best. Creating this additional indicator to be used alongside the original indicator could **contextualise** the success rate of the reablement services relative to the capacity of the councils in offering these services. There was never the intention to achieve 100% in this additional sub-indicator as we acknowledge that not all hospital discharges need reablement. |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Rec Status: | **Further Information Required** | ☐ | **Resolved / No Action Required** | ☒ |

|  |  |
| --- | --- |
| Ref code  **2012/276**  Made: 26/10/12 | MRG recommended giving further consideration (future indicator re-development) to individuals who were re-admitted to hospital within the 91 days, thus being potentially offered/subject to re-ablement services more than once during that period. At present they appeared to be counted more than once with their 91 days period starting again at each discharge; making indicator difficult to interpret.  This recommendation to capture these individuals in the future data collection to be put forward to policy team at DH. |
| Ref code  **2012/277**  Made: 26/10/12 | **Indicator recommended for consideration by IGB recognising that the indicator is already in production, but with reservations expressed about the numerator / denominator mis-match and the understanding that the limitations and potential difficulties in interpretation will be described in the Quality Statement.** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Rec Status: | **Further Information Required** | ☐ | **Resolved / No Action Required** | ☒ |

Revisions:

To be completed where changes to the methodology are made by the applicant during the appraisal [i.e. subsequent to the initial application form]

A new section is to be added for each new set of revisions to go to MRG.

|  |  |
| --- | --- |
| Revision Date: |  |
| General Comments / Reasoning: |  |
| Revisions: |  |
| Indicator Title |  |
| Data source |  |
| Construction |  |
| Updated Potential Issues |  |

Record of Assurance provided by **Indicator Governance Board**

|  |  |  |  |
| --- | --- | --- | --- |
| **Indicator Title** | **3.6 - The proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services** | IAS Ref Code: | About the Indicator Application Process (NHS IC Pipeline Process) |
| Indicator Set | NHS Outcomes Framework |  |  |

|  |  |
| --- | --- |
| Construction Summary | * The indicator is a two-part measure.   + Part 1: The proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into rehabilitation services.   + Part 2: The proportion of older people aged 65 and over offered rehabilitation services following discharge from acute or community hospital |

|  |  |  |  |
| --- | --- | --- | --- |
| Initial IGB discussion | 30/11/12 | Further discussed |  |

**Strategic Considerations & Implications**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Applicant / Sponsor Organisation | Department of Health - Clinical Quality and Efficiency Analytical Team/ Social Care Strategic Policy and Finance  \*Costing for assurance appraisal included in development cost | Assurance process funded? | **Yes**  ☒  **No**  ☐ |  |

|  |  |
| --- | --- |
| Indicator rationale | This indicator measures people who are recovering effectively. It measures the benefit to individuals from reablement, intermediate care and rehabilitation following a hospital episode, by determining whether an individual remains living at home 91 days following discharge – the key outcome for many people using reablement services. The aim is to provide an indication of the number of older people offered reablement and of them how many were still at home 91 days after discharge as an approximation of a successful outcome. The indicator is a two-part measure to reflect both the effectiveness of rehabilitation and the coverage of the service. |
| Basis for rationale  [Details of quality statement, policy etc.] | Policy basis - The Department has started a new piece of work on Recovery, Rehabilitation and Reablement (RRR). The aim of this programme is to improve the quality of patient care and outcomes, by delivering a seamless Recovery, Rehabilitation and Reablement service for acute admitted patients – based on their clinical and bio-psycho-social needs, rather than just their diagnosis or where their care is delivered. |
| Risks & assumptions | The indicator includes older people who had received a joint multi-disciplinary assessment prior to or following their discharge from hospital before going on to receive a rehabilitation service and people who had received reablement services through Adult Social Care only. It does not include people who receive reablement from NHS services only because these people are not captured by the LA data collection. |
| IG Considerations [e.g. release of under-lying data, intermediaries access to data, data ownership impact on production] | Data Source: Adult Social Care Combined Activity Return (ASC-CAR), Hospital Episode Statistics  The Adult Social Care Combined Activity Return collects aggregated data from Local Authorities. |
| Potential impacts on other business areas [inc outstanding generic issues] | None Identified |
| Implementation Method  [inc production funding] | * Funding Secured * Data for both numerators have been published by the HSCIC. This was previously NI125 in CLG’s National Indicator List * The indicator is replicated in the Adult Social Care Outcomes Framework (ASC OF) * This indicator will be published in the ASC OF in September 2012 with the aim to publish in the NHS Indicator Portal (in the NHS OF area) by the end of September |

**Record of MRG Discussion**

|  |  |
| --- | --- |
| Discussion dates: | * 21/9/12, 26/10/12 |
| By: | * HSCIC - John Varlow, Andy Sutherland, Alyson Whitmarsh, Azim Lakhani; NICE – Daniel Sutcliffe; UHB – Daniel Ray, Irena Begaj; ISB – Neil McCrirrick |
| Summary of MRG discussions: | * MRG recommended that deaths should be excluded from the denominator as well as the numerator in part one of the indicator on the principle that everyone included in the denominator should have the opportunity to be in the numerator. The applicant was not in agreement maintaining an indication of successful reablement is that the individual has not died within 91 days of discharge into reablement. * MRG suggested that any evidence of an association between re-ablement and death be asked for. * MRG noted that any research base for the rationale for the indicator had not been presented and as such there was no basis on which to assess the validity of the exclusions, or to assess the use of the 91 day time period. Clarification sought on the exclusions and their extent – e.g. people residing out of areas, not knowns. Contextual information on extent of exclusions would be of use. * Feedback sought as to whether the denominator for the sub indicator could be better defined to make it more related to the population covered in part one of the indicator. Applicant responded that the ideal measure would be the number of people still at home after 91 days out of the total number who should have entered reablement. However, this is not possible from existing data sources and that there was never the intention to achieve 100% in this additional sub-indicator acknowledging not all hospital discharges need reablement. * MRG recommended giving further consideration in future indicator re-development, to individuals who were re-admitted to hospital within the 91 days, thus being potentially offered/subject to re-ablement services more than once during that period. At present they appeared to be counted more than once with their 91 days period starting again at each discharge; making indicator difficult to interpret. |

|  |  |  |  |
| --- | --- | --- | --- |
| Outcome of MRG consideration: | 1. **No significant issues identified** | ☐ |  |
|  | 1. **No significant issues on basis of completion of outstanding actions** | ☐ |  |
|  | 1. **Some concerns expressed as caveats or limitations** | ☒ |  |
|  | 1. **Significant reservations** | ☐ |  |
|  | 1. **Unresolved issues** | ☐ |  |

|  |  |
| --- | --- |
| MRG statement of recommendation: | The indicator recommended for consideration by IGB recognising that the indicator is already in production, but with reservations expressed about the numerator / denominator mis-match and the understanding that the limitations and potential difficulties in interpretation will be described in the Quality Statement. |

**Additional Assurance Details**

|  |  |
| --- | --- |
| Peer Reviewers: | No Peer Review conducted at present |
| Peer Review summary: | n/a |
| Range of input  [Have relevant business areas contributed e.g. clinical assurance?] |  |

IGB – Additional Recommendations:

[Add new section as necessary]

**Recommendations & Updates**

|  |  |
| --- | --- |
| Made: | 30/11/12 |
| Comments & Recommendations  [List additional comments and recommendations raised by IGB] | IGB noted that there had been no representation within the assurance panels from members of the Social Care team for indicator 3.6 re-ablement (IAP00122). At the point of review Social Care members are to be asked to participate. The corresponding ASCOF indicator is to be appraised at the same time. As a general point it was agreed that ASCOF indicators should be reviewed through the IAS. |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Action required: | **IGB Update Not Required** | ☒ | **Further Update IGB** | ☐ | **Refer to MRG** | ☐ |  |

|  |  |
| --- | --- |
| Update:  Made: xx/xx/xx |  |

Review:

**Review**

|  |  |
| --- | --- |
| Review Timescale |  |
| **1 year** | ☐ |
| **3 years** | ☒ |
| **Other:** | ☐ |

Rationale [Issues to consider – Changes to process, policy data source, coding definitions HES definitions]

The indicator should be reviewed in line with any changes to the underlying data collection as per MRG feedback. Timescales to be determined.

IGB Sign-off:

**Indicator Assurance Process Output**

|  |  |  |  |
| --- | --- | --- | --- |
| Final Appraisal Status | 1. **Assured** | ☐ |  |
|  | 1. **Assured with Comments** | ☒ |  |
|  | 1. **Failed Assurance** | ☐ |  |

|  |  |
| --- | --- |
| Basis of Sign-off  [Detail caveats and limitations ] | In light of recommendations raised at MRG, i.e. that there are reservations about a potential numerator denominator mis-match and that the limitations need clearly stating in the Quality Statement, this methodology has been appraised as being “assured with comments” |
| Sign-off Date | 30/11/12 |

See our [accessibility statement](https://www.nice.org.uk/accessibility#what-to-do) if you’re having problems with this document.