Intermediate care including reablement

Consultation on draft guideline - Stakeholder comments table
11/04/17 to 26/05/17

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

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1.	Action for M.E.	Full	27 -273	General	**Meta-analyses of research relevant to the topics in this consultation, including a section on reablement.** Question 5: We would like to highlight that the research and evidence outlined throughout this section regarding reablement is not applicable to all patient groups. The research and evidence examines general trends amongst people who receive such care. People with M.E. experience post-exertional malaise which alters how effective a reablement approach is for them. This has been addressed above in comment 1. Therefore, the conclusions of the evidence do not represent the experiences of people with M.E. and are not a valid basis on which to justify reablement for people with M.E. This disparity between the research and the experiences of people with M.E. highlights the need for care planning to take into account the unique needs of each patient, and to personalise care so that each patient receives care that is appropriate to their individual health and circumstances.	Thank you for your comment. The issue of how the Guideline applies to people with particular conditions was raised by a number of organisations. The GC took the view that, rather than go into this kind of detail, it would be preferable to emphasise in the Introduction that IC requires a person-centred approach where each person's individual needs are assessed, which would include an assessment of whether Intermediate Care was the appropriate service to offer. Taking this approach, nobody should be ruled in or ruled out of intermediate care solely on the basis of having a particular condition.
2.	Action for M.E.	Full	274	19-24	**"Making sure the aims, objectives, and purpose of intermediate care are understood by people using services, their families and professionals from the wider health and social care system. There is currently a lack of understanding that the term 'intermediate care' includes health-funded intermediate care services and social care-funded reablement services, and that active rehabilitation/reablement is quite different to care".** Question 5: We agree with this comment and stress the need for a clearer distinction between rehabilitation/reablement and care. Action for M.E.'s 2015 survey found that there is an acute need amongst people with M.E. who for ongoing care so that they can complete daily tasks. In total, 97% of respondents had two or more difficulties with activities of daily living. This means that, if their difficulties were found to have a significant impact on their wellbeing, the vast majority of respondents would have eligible support needs under the Care Act 2014 for England. Respondents had on average six out of 10 of the difficulties with daily living listed in the Care Act 2014. As outlined earlier and throughout this submission, many people with M.E. have received care planned around reablement, which has been inappropriate to their needs and impacted negatively on their health. It is necessary that care practitioners receive clear guidance on when reablement is appropriate. M.E. is a long-term, fluctuating, neurological illness, and rehabilitative approaches such as reablement over the short-term do not address the care needs of patients. This draft guideline recommends reablement to be considered for all patients. The comment recognises this, but is only included in the 'Implementation' section of the draft guideline:	Thank you for your comment, which we will pass to our implementation colleagues.

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					"Making sure the aims, objectives, and purpose of intermediate care are understood by people using services, their families and professionals from the wider health and social care system. There is currently a lack of understanding that the term 'intermediate care' includes health-funded intermediate care services and social care-funded reablement services, and that active rehabilitation/reablement is quite different to care". There must be greater reference made to this consideration throughout the guideline, to ensure that patients who require care rather than rehabilitation are not recommended a reablement approach above more appropriate, long-term care options.	
3.	Action for M.E.	Full	9	6	Question 5: We are very concerned that recommendation 1.2.8 will lead to adverse outcomes for people with myalgic encephalomyelitis (M.E.) M.E. is a neurological condition that affects 250,000 people in the UK. One of the key features of M.E. is post-exertional malaise, where the body is unable to recover normally after expending even small amounts of energy. People with M.E., often referred to as chronic fatigue syndrome or CFS/M.E., have highlighted that reablement as a care approach can be counter-productive. Post-exertional malaise results in people with M.E. experiencing increased symptoms following periods of activity. Reablement, which aims to maximise a person's independence, is based upon increasing a person's activities. When a person with M.E. increases their levels of activity accordingly, they will experience post-exertional malaise and will require long periods of rest to recover (and therefore would not be able to continue increasing activity as part of reablement). This is particularly true because people with M.E. who receive care are likely to be part of the 25% with the condition who are severely affected. Action for M.E. conducted a survey into social care for people with M.E. in 2015, and received over 850 responses. The *Close to collapse* survey report found that of those receiving a care package, 65% rated their M.E. as either severe or very severe. Those receiving care are necessarily some of the most ill, and therefore will not be able to recover in a short-term period up to 6 months, which is what reablement aims to facilitate. Recommendation 1.2.8 states that reablement should be offered as a first option to people being considered for home care. This recommendation institutes an inflexible approach and reduces opportunities for personalised care. The outcome of such an approach, for people with M.E., is inappropriate care that fails to take into account the complex and fluctuating nature of their condition. Our 2015 survey found that the majority of people stated that the care they received enabled them to cope better with their symptoms, providing it was personalised and flexible. One person with M.E. told us: "My social worker believes that with a short-term care package (four to six months) there should be 'noticeable improvement' in my level of independence. If there isn't when my care is reviewed she said they will remove my carers as 'their goal is to promote independence and not dependence.' I've tried to explain that severe M.E. doesn't work like that, I often have paralysis, I've orthostatic intolerance, physically can't turn in bed etc. Managing personal care and giving me meal replacements isn't promoting dependence as there are things I physically cannot do. She replied, 'Well that's the way our care system works.'" Other people have told us how care service providers lack experience of M.E. and	Thank you for your comment. The Guideline Committee discussed your concern and agreed that the wording of this recommendation should be changed, in order to emphasise that the decision about whether reablement could improve a person's independence is based upon an assessment rather than a judgement.

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					consequently fail to understand what kind of support is required. One person said "I feel like the plan has been made by somebody with no experience in dealing with my condition," while another stated they didn't engage with care because "[I] can't risk the chance of further deterioration to my health by having to fight social services to understand what I am going through and what I need." Social care is extremely valuable to people with M.E., but reablement approaches – which aim at increasing the activity levels of the recipient and reducing their dependence on care – are not appropriate for people with long-term conditions whose symptoms are not alleviated by increased activity. This is particularly the case for people with M.E., who not only may not respond to reablement but can find their condition is worsened over the long-term through over-exertion beyond their capability.	
4.	Action for M.E.	Full	9	8	**Recommendation 1.2.9 "Consider reablement for people already using home care, as part of the review or reassessment process. This may mean providing reablement alongside home care. Take into account the person's needs and preferences when considering reablement".** Question 5: For the reasons we have outlined above in comment 1, we emphasise that reablement is not appropriate for people with M.E. While the recommendation does include taking account of patient needs and preferences, it is necessary to emphasise that reablement may not be appropriate for all patients and where this it is not appropriate it should not be imposed. Instead, people with M.E. should be provided with a personalised and tailored care plan that supports them in managing their symptoms and stabilising their daily routine. In doing so, a person can prevent a 'boom and bust' cycle of activity, where over-exertion is followed by an extended recovery period. Including an extra caution against reablement would prevent its use as the primary approach, and recognise that the needs of each individual patient should be the first consideration when determining what care approach to undertake.	Thank you for your comment. Committee members feel strongly that the need for a personalised approach to intermediate care – including assessing whether it would be beneficial – should be person centred and they believe the recommendations, as a whole, make this clear. They therefore did not make any changes to this recommendation in light of your comment although the recommendation has been edited to reflect the importance of working closely with the home care provider – as well as the person themselves – in any consideration of whether there may be a benefit from a short term period of reablement. The recommendation now reads, 'Consider reablement for people already using home care, as part of the review or reassessment process. Be aware that this may mean providing reablement alongside home care. Take into account the person's needs and preferences when considering reablement and work closely with the home care provider.'
5.	ADASS	Short	13	7-19	Para 1.6.5 Beyond voluntary services there are also a broader range of social activities, clubs, societies etc in a local community which people at risk of social isolation may benefit from being signposted to.	Thank you for your comment. The GC took the view that this recommendation is intended to provide some examples of services for which a referral could be made, rather than providing suggestions for signposting. The GC decided not to make the addition you suggested.
6.	ADASS	Short	7	27-28	Para 1.3.1. I wonder whether commencing an IC service within 2 days is too long, especially when it's an essential part of a D2A service. In my authority social care requires Reablement to commence with 24 hours. Whilst perhaps implicit, should there be more explicit reference to 7 day working, including acceptance of new referrals/service starts?	Thank you for your comment. After further careful reflection on the evidence and modelling, and taking account of stakeholder feedback, the recommendation now reads: 'Consider bed-based intermediate care for people who are in an acute but stable condition but not fit for safe transfer home. Be aware that if the move to bed-based intermediate care takes longer than 2 days it is likely to be less successful.'
7.	ADASS	Short	9	1-8	Para 1.3.6 Suggest include reference to telecare – when assessing how to meet needs think Telecare first.	Thank you for your comment. The GC did not agree with making this addition. They did not consider evidence which would support making such a specific reference, although the recommendation does already refer to 'specialist equipment' as part of the strategies for managing risk.
8.	ADASS	Short	General	General	Comments below are areas where whilst in some instances covered, they may be room to strengthen. Within the principles, set out the relationship with Discharge to Assess Pathways (primarily D2A P1). Something stronger on overall performance monitoring of the service's overall success in achieving rehabilitation goals. Need to be careful that a service setting the bar low doesn't as a consequence appear to be a high performer. Perhaps use of the	Thank you for your comment. The GC agrees that monitoring and evaluating the outcomes of providing an intermediate care service should be an essential component of that service. To this end they have changed the recommendations which now refer to 'measurable goals' and they have also amended the recommendations to say that intermediate care services should work towards 'an agreed approach to outcome measurement for reporting and benchmarking'.

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					old social care CSED categories of measuring outcomes into four categories – those who require no ongoing package of care (PoC); those who require a reduced ongoing PoC compared with assessed needs at start of IC service; those who require the same PoC; and finally those who despite IC service deteriorate and require a greater ongoing PoC after IC. Success of IC could perhaps also be judged by using ASCOF 2B – how many people who receive IC are still living independently at home 91 days later – and also ASCOF 2b part 2 on the coverage of the IC service. The latter helps observers to judge whether principle 1.1.6 is being applied or whether there is cherry-picking/screening in rather that a presumption of IC unless screened out. Perhaps some greater reference to best practice in scaling down/back services as the service user is rehabilitated/re-abled, not wasting resources that are needed by others, but also a safe process that for a few days at least the successful (if only partial) regaining of life skills is monitored and services can step back in if required.	
9.	Age UK	Short	10	1-17	Add 'Update and refer back to care goals regularly and as circumstances change' as an additional recommendation.	Thank you. The GC feels this is covered in the Guideline.
10.	Age UK	Short	10	3	We are concerned about the point which advises intermediate care goals 'are aligned with the remit of the service'. This runs contrary to the idea of person-centred care. We feel there is a danger of creating a 'one-size fits all' mentality where the person must fit the service and not vice versa. This is especially noticeable given the following recommendation (1.3.13) which states that 'participation in social and leisure activities are legitimate goals of intermediate care' which we fully support and will often go beyond what most services offer by default. A person's goals must be the starting point for a person's care plan and the latter should take account of, but not be dictated by, what is available.	Thank you for your comment. The GC agrees that this needs to be reworded, but without losing the sense that the service operates within particular parameters, and so the point is being redrafted. The updated draft of the bullet point now reads 'reflect what the intermediate care service is designed to achieve'.
11.	Age UK	Short	12	14-20	Add final bullet 'shared values for care'. These values should reflect those contained within the *NHS Constitution for England,* including: • Working together for patients. • Respect and dignity. • Commitment to quality of care. • Compassion. • Improving lives. • Everyone counts. We feel the addition of a bullet point about 'shared values' would again reiterate the importance of values-based approaches when providing services.	Thank you for your comment. The GC was of the view that this would not fit with the other points included in this recommendation, which all describe very specific actions to promote integration. However the GC did agree to edit one of the bullet points in this recommendation, which now states that intermediate care should be provided in an integrated way by working towards a 'shared understanding of what intermediate care aims to do'.
12.	Age UK	Short	14	1-9	Add bullet 'obligations around mental capacity, consent and compliance, including decisions to be made under the Mental Capacity Act 2005'.	Thank you for your comment. The GC decided not to include this additional bullet point. Although it is an important point, it will be covered thoroughly in a forthcoming NICE guideline about Decision Making and Mental Capacity.
13.	Age UK	Short	14	1	Amend this statement to 'Common conditions, such as diabetes; complications arising from multimorbidity; mental health and neurological conditions, including dementia; loss of personal reserves such as frailty; physical and learning disabilities; and sensory loss'. Regarding frailty, we recommend the definition and arrangements we outlined with the British Geriatrics Society in *Fit for Frailty (2014)* which we do not consider covered by default in the statement *as is.* The definition has been included in NICE Guideline NG16*, Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset,* as follows: 'Frailty typically means a person is at a higher risk of a sudden deterioration in their physical and mental health. Frailty is distinct from living with 1 or more long-term conditions or disabilities, although there may be overlaps in their management.'	Thank you for your comment. The GC recognised that where there was the evidence base, some additions could be made to the lists in this recommendation. The GC decided that frailty, stroke and multi-morbidity will be added to the list of common conditions, and continence could be added to 'support needs'. These changes will be included in the next draft of the Guideline.
14.	Age UK	Short	2	Information Box	In the bulleted list outlining who the guidance is for, we would encourage the explicit inclusion of the community and voluntary sector. In our joint report *Untapped Potential* (Richmond Group of Charities, 2015), we outlined the evidence behind the growing role for the voluntary sector in health and care. Age UK and others in the sector are offering more and more in the way of services and support to our communities. For example, the 'Home from Hospital' programmes delivered by some of our local Age UKs provide support for older people in settling back in to their homes and readjusting	Thank you, this has been added.

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					after a trip to hospital. The service takes the form of support with day to day tasks that a person might initially struggle with such as shopping or picking up prescriptions. It also involves some elements of informal social activity and very light-touch supervision with the aim of improving confidence and wellbeing. Having this available after a hospital discharge can make a difference to an older person during the early stages of the reablement process, complementing the intermediate care frameworks outlined in this guidance. We therefore feel this type of contribution can be acknowledged at this point in the guidance.	
15.	Age UK	Short	4	7	We recommend adding a third bullet in this section that reads 'builds on existing support structures around the patient including families, friends and carers'. This expands upon the collaborative aspects of the previous bullet point and reflects the different groups involved in a person's care and with a shared interest in achieving their outcomes and goals.	Thank you for your comment. The GC agrees with you about the importance of involving families and carers (where appropriate) in the intermediate care process and they feel that this is reflected well in the recommendations. However on the basis of your suggestion, they agreed to move this recommendation to the core principles.
16.	Age UK	Short	5	6	We would like to amend this line to read 'focus on building the person's confidence, resilience and emotional reserves'. Building confidence is an important aspect of reablement but it must occur alongside the development of emotional resilience and similar types of emotional reserve. These characteristics broadly speak to a person's ability to adapt and manage in the face of adverse circumstances. This might be the initial crisis that began the process leading to intermediate care or it may be the many smaller challenges associated with recovery. Having the right support in developing emotional resilience can be an important factor in sustaining independence and avoiding relapse. Guidelines NG32 and PH16 are relevant to this aspect of intermediate care. NG32 for example recommends guidelines users be aware of the signs of declining mental wellbeing and be proactive in helping combat when it occurs. This could either be through signposting or by commissioning social wellbeing services depending on who is using the guideline. For some older people, more psychologically-based approaches may be required to build the resilience needed for recovery. The report, *Investing in emotional and psychological wellbeing for patients with long-term conditions* (2012) produced by the NHS Confederation Mental Health Network presents the case for commissioning services to address the secondary effects of living with physical impairments. Through a series of case studies and their evaluations, it outlines the beneficial results mental health support strategies can have in improving physical health outcomes across a range of conditions. Many of the lessons and good practice, particularly, related to CBT, are applicable to intermediate care and reablement.	Thank you for your comment. The GC did agree with you that this bullet point needed to say more, although not using the exact wording you suggested. The bullet point will now refer to 'knowledge, skills, resilience and confidence'.
17.	Age UK	Short	6	1-4	Within the bulleted list on page 6, we would like to see 'Ensure benefits of care are sustainable' added. It is vital that recovery and reablement is achieved in a lasting way for an older person. This prompt should encourage guideline users to consider how their delivery of intermediate care can guarantee stable, lasting recovery beyond the care period. This might include signposting to other services or promoting self-care. These points are covered in more detail in our other comments.	Thank you for your comment. The GC decided against adding this bullet point, since it is not possible to stipulate that the benefits of Intermediate Care be sustainable. Some people using intermediate care will be affected by fluctuating or degenerative conditions, where improvements may not be sustainable and there may be a need for repeated intermediate care.
18.	Age UK	Short	6	20-22	Regarding point 1.2.4, we would recommend including examples of the types of 'advocacy service' that are relevant as a prompt for those using the guideline. For example, many older people may find that they or their carers are newly entitled to certain welfare benefits in light of their changed care needs. Attendance and Carers' allowance very often go unclaimed *(Agenda for Later Life,* Age UK, 2015) and have the potential to make a large difference to a person's life during the intermediate care period and beyond. Voluntary sector organisations like Age UK and many others in the field can provide support and advice in accessing these entitlements. More generally, around £3.7 billion of benefits go unclaimed by people of state pension age each year (*Agenda for Later Life,* Age UK, 2015*)*. This is especially important given the fact that ONS *Households Below Average Income* data for 2015/16 suggests that 1.9 million pensioners are now living below the poverty line. Having intermediate care professionals signpost to advocacy services can be important in making every contact count. This may help unlock historically unclaimed financial support as well as new entitlements. Additional health and care costs can make it very difficult for an older person to cope if they are already struggling financially so it is vital to maximise the	Thank you for your suggestion. The GC took the view that, as the types of advocacy services that can be offered is quite varied, naming particular examples could be limiting. The GC preferred to maintain advocacy within the Guideline as a general service that people using IC could benefit from in different ways. The GC therefore did not agree that the suggested change should be made.

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					support available.	
19.	Age UK	Short	6	5	Regarding section 1.2 and related to the point above, we feel that assessment for intermediate care is a natural point at which a person's other needs can be assessed. For example, if there are no current social care arrangements (either formal or informal) in place, then an assessment should determine whether they are now needed. If care is in place, the assessment should aim to decide if existing arrangements are adequate in light of changing circumstances. For many older people, recovery can only happen if there is good carer support in place, with opportunities for respite breaks. Incorporating a recommendation encouraging users (commissioners, healthcare practitioners) to develop or enable holistic assessments would help ensure intermediate care follows a more person-centred approach that cuts across needs.	Thank you for your comment. The GC noted that there are already other recommendations which refer to resources for supporting carers. The approach supported by the GC would be to wait until the person has regained as much independence as possible before referring to social care or assessing for other or ongoing support needs. The GC would not support specifying additional assessment at the time of assessment for provision of the Intermediate Care service.
20.	Age UK	Short	7	27	1.3.1 should state 48 hours rather than 'two **working** days'. If a two day standard is to be implemented, then it must be equally valid at weekends and during holidays as it is during work days. The *2015 National Audit of Intermediate Care* highlights the importance of the absolute two day standard at all times, both in terms of patient wellbeing and cost effectiveness. It finds that, 'seven day services are essential if intermediate care is to make an impact on admission avoidance'. Similarly, we agree with the authors of the audit on their conclusion that 'waiting times are a key measure of accessibility and are particularly important for older people who may deteriorate rapidly whilst waiting for an intermediate care service in an acute bed'. We therefore firmly believe that this guideline should recommend that providers seek to secure consistent two day standards at all times.	Thank you for your comment. After further careful reflection on the evidence and modelling, and taking account of stakeholder feedback, the recommendation now reads: 'Consider bed-based intermediate care for people who are in an acute but stable condition but not fit for safe transfer home. Be aware that if the move to bed-based intermediate care takes longer than 2 days it is likely to be less successful.'
21.	Age UK	Short	8	1	Regarding the section on 'planning the person's intermediate care', we feel there should be greater acknowledgement of the need to strike the right balance between risk mitigation and independence, i.e. maximising people's autonomy and wellbeing while also supporting their health and recovery. This balance will obviously vary based on the wishes and needs of the individual. As such, we would like to echo the recommendation in NICE Guideline NG27, *Transition between inpatient hospital settings and community or care home settings for adults with social care needs,* that all staff involved in the hospital discharge process (and, in the case of this guideline, those involved in intermediate care) receive training in 'helping people to manage risks effectively so that they can still do things they want to do' and learn to develop a 'risk enablement' mindset.	Thank you for your comment. The GC recognises this as an important point in providing Intermediate Care, and it will be acknowledged through the addition of an extra bullet point, to the effect that all staff delivering intermediate care should understand 'positive risk-taking in the context of intermediate care'.
22.	Age UK	Short	8	5	Line 5 here should be changed to read 'assess and promote the person's ability to self-manage'. This clarifies the point that intermediate care should work to support self-management as one of its objectives. Similar to the third point of recommendation 1.1.5, we agree that enabling personally fulfilling self-management, even if sometimes challenging, can support the wellbeing and recovery of older people. In addition to this, there is evidence that self-management, if correctly supported, can also reduce overall reliance on services (Panagioti et al*, Self-management support interventions to reduce health care utilisation without compromising outcomes: a systematic review and meta-analysis,* BMC Health Services Research 201414:356, 2014). In our 2010 report with the Richmond Group, *How to deliver high-quality, patient-centred, cost-effective care: Consensus solutions from the voluntary sector,* we outlined what we believe to be some of the core pillars for support that enables effective self-management. This includes personalised action plans, structured education or information, access to trained specialist advice and emotional, psychological or practical support. When planning intermediate care, services that work through these principles should be factored in and made available to promote and enable self-management and care. As we state in the report, these can increasingly be delivered by joining up health, care and voluntary sector organisations. However, we stress that supporting 'self-management' should not used as a justification to withhold services or care that a person may need.	Thank you for your comment. The GC decided to accept your suggestion, so that the bullet point will now read 'assess and promote the person's ability to self-manage'. In response to other suggestions, this bullet point will also be moved up the list, so that in the next draft of the Guideline it will become the first bullet point.
23.	Age UK	Short	General	General	Age UK welcomes the opportunity to comment on this draft guideline. We believe that	Thank you for responding to the draft guideline consultation.

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					good intermediate care and related care strategies are essential to enabling many older people to improve their health and wellbeing, and to maintain or regain their independence.	
24.	British Association of Social Workers	Short	9 10	27 12	"Discuss and agree intermediate care goals with the person" There is a tension in several parts of the document regarding engaging with the person who is being assessed for intermediate care services and their family and friends carers. The above line is followed on page 10 line 12 by "Include the person's family and carers in planning intermediate care, if the person agrees to this. Take into account their wishes and preferences alongside those of the person using the service". It is advised that involving family and friends carers should be seen as the norm where at all possible. One could also add in consultation should take place with other people who know the person, for example current home care staff and other professionals such as social workers. The caveat of "with the person's permission" is of course important, but there is a danger that the assessed person is not sufficiently encouraged to give this permission. It is recommended that a good practice statement is made at the beginning of the assessment process that captures the importance of involving people who know the person.	Thank you for this suggestion. In response the GC agreed to make this absolutely clear by changing one of the core principles to explicitly state that families and carers should be involved in discussions so long as the person agrees with this. The caveat has also been added to other recommendations to state that families should be involved if this is appropriate. Therefore the GC believes that your point has been addressed and hopefully this gives you some reassurance.
25.	British Association of Social Workers	short	General	general	The British Association of Social Workers is registered with NICE to respond to relevant consultations. You have expressly asked BASW to comment on the draft guidelines on Intermediate Care. Having looked at the questions and the draft guidance we have concluded that it would be difficult for us to comment. The questions are geared towards asking local authorities and health trusts about their experiences of implementation. As a member organisation of social workers we will have a significant number of members who are involved in intermediate care, however to collate their views and link that to specific local authorities and health authorities across the country would be a major task, which we do not have the capacity to do so. Comments are therefore confined to some general comments. I think the consultation document is generally fine. As you honestly say this is a time of significant resource constraint and therefore implementing some of the guidelines will be challenging. One could also add in significant policy uncertainty and policy challenges. If social care was free for all then many of the problems of the separation between health and social care and intermediate and non-intermediate care would disappear. Intermediate care services are currently earmarked for special funding, whereas main stream care services are really struggling, so once the six weeks is up then the availability of care services to continue the necessary good work of intermediate care is challenging, leading to the risk of deterioration in people's well-being and therefore potentially precipitating them back into the intermediate care sector or hospital admissions. This is compounded by the problem that intermediate care is free and that non intermediate care is means tested. We have heard many accounts of people refusing post intermediate care services because of the cost. This can then lead to a deterioration in the condition of the service user, leading to the revolving door of re-assessment for reablement etc. There is also a danger of a two tier service, with recruitment and retention of good care workers in the "non intermediate care sector being more difficult. There is a statement "that active rehabilitation or reablement is quite different to care." (11:6). One of the reported major problems of the intermediate care model is that there is a lack of continuity of care and care approach. Much of non-intermediate home care and residential care strives to seek similar outcomes for people - promoting independence for example and that is clearly identified in the Care Act. The statement page 17 could be seen as elitist and that it relegates non intermediate care to an inferior service. That approach stigmatises non intermediate care services.	Thank you for taking the time to provide this feedback.
26.	British Geriatrics Society	Full	10	1.3.2	We recommend splitting out "tell the person how long the service will last" from the first bullet point in to a separate bullet point. We also recommend removing the wording "will last" as this seems too definitive. We then recommend using the following phraseology instead:	Thank you for your comment. The GC agrees with your suggestion that the first bullet point could be split (although in response to other stakeholder suggestions it will no longer be the first bullet point in the final version of the Guideline). The GC also accepts that the reference to informing the person about a specific time limit could be

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					"Explain to the patient that their expected duration of stay will be tailored to their needs. Reviews will take place throughout the duration of stay. The service is time limited but they will be sign posted or referred on to appropriate services when intermediate care ends."	removed. In the final version of the Guideline, there will be two bullet points, reading 'tell the person what will be involved' and 'tell the person that intermediate care is a short-term services and explain what is likely to happen afterwards'.
27.	British Geriatrics Society	Full	10	1.3.5	Risk assessments – suggest referencing other NICE guidelines on risk assessments, for example, all relevant cognitive and falls assessment guidelines. Include a referencing 'positive risk taking'	Thank you for this suggestion. Since one NICE guideline (on home care) is already referenced the GC did not feel it was necessary to make any further additions, at the risk of complicating the recommendation.
28.	British Geriatrics Society	Full	11	1.3.9 - 11	Crisis response -- the ordering of these recommendations should be changed with the response time being the first.	Thank you for your suggestion, with which the GC agrees. The change to the order of the recommendations has therefore been made for the final guideline.
29.	British Geriatrics Society	Full	116	3.3	In the section "reporting views and experiences data for people using crises response", the results section explicitly states that the study was not specifically designed to elicit views on this model, therefore is it relevant?	Thank you for your question. Although the main focus of the study was to consider the question 'Does integrated governance lead to integrated patient care?', the abstract states 'Patient interviews (46) covered care received before, at the time of and following a health crisis. Additional interviews (66) were undertaken with carers and frontline staff. Grounded theory-based approaches showed examples of well-integrated care against a background of underuse of services for preventing health crises and a reliance on 'traditional' referral patterns and services at the time of a health crisis'. I.e. some elicited data was relevant to the review question and therefore made a contribution even although it was not the main focus of the study.
30.	British Geriatrics Society	Full	12	1.3.13	We support the fact that staff are being encouraged to think holistically – considering social and leisure activities, in addition to personal and domestic care tasks.	Thank you for your support.
31.	British Geriatrics Society	Full	12	1.3.15	We agree with the need for transparency and sharing of agreed goals.	Thank you for your support.
32.	British Geriatrics Society	Full	12	1.4.3	We suggest adding the words 'and services' at the end of the sentence – "Ensure that more specialist support is available to people who need it (for example, in response to complex health conditions), either by training intermediate care staff or by working with specialist organisations."	Thank you for your comment. The GC considered replacing the word 'organisations' with 'services', but decided to retain the original wording, as it is the organisations that provide the services. 'Services' would be included within the meaning of the word 'organisations'.
33.	British Geriatrics Society	Full	12, 22 + 242	1.4.2 + 2.4	Page 12, 1.4.2 and page 22, 2.4, refer to how services might need to last longer than 6 weeks, implying that longer input is a rarity or an outlying event. In the same vein page 242, 1.3.2 refers to telling people how long the service will last. The wording implies that there are time limitations set up front (as we know there are in reality) but we think there is a need to move away from the focus being purely on numbers put through the system and re-focus on outcomes for the patients (this is supported by the PREM data from the NAIC). Also, the emphasis on time limitations upfront is prejudicial to patients with dementia, as the bulk of evidence for rehabilitation in dementia points towards more intense input and for longer. We would recommend that the guidance should acknowledge that, at best, IC practitioners will be able to give an approximation of how long the service will last as, if IC is a needs and goals driven service, patients should have however long they need, therefore we doubt that any practitioner could accurately predict exactly how long that would be at the outset.	Thank you. The GC agrees with your points and they accept that there should be less emphasis throughout the Guideline on the 6 week timeframe for intermediate care, as the service should be tailored to individual need, including how long the service is needed by individuals with different conditions and different needs. The Guideline states 'Review people's goals with them regularly. Adjust the period of intermediate care depending on the progress people are making towards their goals.' The GC also agreed to address your point by changing the wording to state that when planning intermediate care, practitioners should tell people that the service is short term as opposed to how long it might last. We hope these changes address your concerns.
34.	British Geriatrics Society	Full	13	1.4.8	We strongly agree with this statement. In addition to basic courtesy, it can allay anxiety on behalf of the client.	Thank you for your support.
35.	British Geriatrics Society	Full	14	1.5.1	We recommend adding 'or other services or agencies' at the end of this sentence: "Before the person finishes intermediate care, give them information about how they can refer themselves back into the service."	Thank you for your suggestion, which the GC has discussed. They were of the view that this recommendation referred specifically to people referring themselves back to the IC service, and so decided not to make the suggested addition to the recommendation. The GC noted that the Guideline does specify elsewhere that there should be clear routes of referral to and engagement with other services.
36.	British Geriatrics Society	Full	14	1.6.1	"Shared goals that everyone in the team works towards" It is not clear which goals are being referred to. We recommend changing the word "goals" to "overarching principles of IC".	Thank you for your suggestion, which the Guideline Committee has considered. They agreed that the bullet point was not clear enough about which goals this referred to and decided to clarify with slightly different wording to the one you provided. The recommendation in the final guideline now contains the bullet, 'a shared understanding of what intermediate care aims to do'.
37.	British Geriatrics Society	Full	14	1.6.1	Consider adding *'an agreed approach to outcome measurement for benchmarking and reporting'* as a bullet point	Thank you for your comment. The GC accepted your suggestion of adding a bullet point specifying 'an agreed approach to outcome measurement for reporting and benchmarking', and this is included in the final version of the Guideline.
38.	British Geriatrics Society	Full	16	NA	"Terms used in this guidance" – the reference at the end of the first paragraph should	Thank you for your comment. Thank you for drawing this to our attention. We have

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					be 'Halfway Home' not NAIC. For the four service category definitions, the references to NAIC should make clear that these definitions were developed for the purposes of the audit and the reference is to the whole definition not just the last sentence of each paragraph.	changed the attribution in the Guideline.
39.	British Geriatrics Society	Full	162	3:5	'Intermediate Care for People Living with Dementia' – it is not clear whether the GDG is considering IC which is specifically aimed at mental health needs of people with dementia, irrespective of whether they also have physical health needs, or whether one is considering the impact of dementia on physical health needs which themselves warrant IC. These are two entirely different issues. The study by Culverwell and Milne would appear to be evaluating a mental health IC programme and the guidance does not make it clear whether there was also a physical health need being met within the home treatment service. The BGS thinks it is absolutely right that individuals with dementia, who have physical health needs that would justify referral and acceptance into a physical IC service, are not denied this due to their dementia. Intermediate care services that are specifically designed for people with dementia, which may predominantly be dealing with their mental health rather than their physical health issues, should be outwith this guidance and considered alongside, for example services which are solely delivered to people with single pathology, e.g. early supported discharge for stroke or fractured neck of femur. If the study by Culverwell and Milne continues to be included in the guidance then we would suggest that it is more relevant to see whether this type of IC service has an impact on admissions to acute hospitals as well as to mental health hospitals.	Thank you for your comment. You raised some queries about the nature of the programme that was the subject of the study by Culverwell and Milne. This study was of a multidisciplinary service that 'was set up to provide specialist mental health intermediate care for those with dementia.' The population in the study 'had a dementia with associated complex and multiple needs', and the service provided by the specialist team was in addition to health and social care services already being provided. The GC decided not to change the recommendations concerning IC for people with dementia. The Guideline promotes a holistic approach to delivering intermediate care services, which would address a patient's physical and mental health needs, and never purely about one or the other. This is recommended for all Intermediate Care services, including those being provided for people with dementia.
40.	British Geriatrics Society	Full	175	3.5	'Advocacy and training and support'... this section does not exclude advice on stroke services and includes a study by Hoffman et al relating to a hospital stroke unit. This further represents inconsistency with regard to inclusion/exclusion criteria for the evidence base reviewed by the GDG. We would argue that a hospital based stroke unit does not fit the NAIC definitions of IC.	Thank you for your comment. You are right to highlight that according to the review protocols and in line with the NAIC definition of intermediate care, single condition service models were meant to be excluded from the systematic review. However, in their role quality assuring the review protocols, the Guideline Committee pointed out that early supported discharge and other stroke rehabilitation services (for example, the one described in Hoffman et al) as described in the literature are, in the context of current practice, closely aligned with intermediate care. This is in terms of the needs of people using the service, the organisation of the service and the functions delivered by the teams. They also believed the same exceptions should be made for the Inglis and Mahomed studies. In light of your comment, amendments have been made to the reporting of the review work and we are grateful to you for having highlighted this oversight.
41.	British Geriatrics Society	Full	19	5-7	We agree that there remains confusion about the difference between reablement and care. Staff assessing and accepting a client on to the service need to be clear about service expectation, goal setting and the need for clients to actively engage in reablement rather than passively accept care. This ties in with earlier recommendations, e.g. written copies of agreed goals and expectations.	Thank you for your support, the GC certainly aimed to address this in the development of the recommendations.
42.	British Geriatrics Society	Full	19	2.1	Research Recommendations We are aware that studies of 'Team composition for home-based intermediate care' have previously been funded by NIHR but these were not RCTS and it would not be appropriate for them to be so. These studies have only been referenced in a limited way in this guideline. We do not think it is necessary to suggest this is a research recommendation again.	Thank you for making this point, which the GC considered. On balance and in the absence of published evidence to address this specific question GC members still wanted to make the recommendation for effectiveness studies to be conducted – while acknowledging the important contribution that qualitative studies would also make to answering this question.
43.	British Geriatrics Society	Full	212	3.9	Evidence to Recommendations – we can't draw fault with **recommendations 1:1:1, 1:1:2, 1:1:3.** It would seem that there is considerable scope for gathering evidence on patient experience which is an important outcome measure for any IC research and this is captured in 'our **research questions 2b and 4b'**. We don't agree with the GDG's conclusion that this was mainly about referring to existing support and services so that there should not be substantial resource implications. We think that the evidence gathered from the NAIC PREM would suggest that there is considerable unmet need and this may be because there are inadequate support services available.	Thank you for your comment. The GC have clarified that they felt there were no substantial resource implications associated with implementing these recommendations.

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44.	British Geriatrics Society	Full	212	3.9	We entirely agree that **recommendation 1:1:2** should apply to all four service models of intermediate care. Whilst the evidence base may be moderate, it is consistent in showing that there is poor communication and engagement of patients and families in IC which results in their lack of understanding of what IC entails and what the expectations should be, hence the comments of people feeling that they are "done to" rather than "involved in" by IC and reablement staff. We would suggest that some of this confusion and poor communication is because the staff themselves are not clear about what is expected of them and of the patients due to the wide range of terminology used and the confusion regarding how long someone may or may not be expected to be availed of IC/reablement services, i.e. the misperception that it is for no longer than six weeks. This links to our comment on 1.6.1. that staff should be clear on the principles of IC, i.e. that it is patient centred care.	Thank you for your support.
45.	British Geriatrics Society	Full	212	3.9	We entirely agree that **recommendation 1:1:3** should apply to all four models of intermediate care.	Thank you for your support.
46.	British Geriatrics Society	Full	215/ 216	3.9	We support recommendations 1:1:4, 1:1:5 and 1:1:6, although we would reflect back to our earlier comments regarding the lack of evidence for involvement of people with dementia in IC and the lack of clarity on the evidence base used by the GDG. We would, therefore, support research recommendation 3, but there needs to be clarity that this is about people with physical need requiring IC, who also happen to have dementia and is not about dementia-specific IC.	Thank you for your comment. As above the GC is clear that intermediate care should be considered for people living with dementia and they do not mean 'cognitive intermediate care' (or similar). On the contrary, intermediate care should address people's needs holistically and if someone with a dementia diagnosis is judged likely to benefit in terms of their independence and quality of life then they ought to be referred to the service. The GC is keen to emphasise that intermediate care should not be limited to addressing people's physical needs, regardless of any diagnoses they may have.
47.	British Geriatrics Society	Full	215/ 216	3.9	We agree that **recommendations 1:1:4, 1:1:5 and 1:1:6** are about referring to existing support and services and should not have substantial resource implications.	Thank you for your contribution.
48.	British Geriatrics Society	Full	215/ 216	3.9	**Evidence based statement HB1** is intuitive in the concept of holistic care as outlined in the evidence statements 1:1:1 to 1:1:6 and are not undermined by our comments about looking at IC for those with physical needs who happen to have dementia as well, as opposed to IC specifically for people with dementia who may or may not have physical needs.	Thank you – we have clarified the GC's position in relation to dementia and intermediate care. Basically the GC is keen to emphasise that intermediate care should not be limited to addressing people's physical needs, regardless of any diagnoses they may have.
49.	British Geriatrics Society	Full	219	3.9	We agree with **recommendations 1:1:7, 1:1:8 and 1:1:9,** although **recommendation 1:1:8** (Deploying staff flexibly across the different service models) may be difficult to meet.	Thank you for your support. The GC actually agreed to make some changes to these recommendations, which may go some way to addressing your concerns. For example, 'Consider making reablement, crisis response and bed based and home based intermediate care all available locally. Deliver these services in an integrated way so that people can easily move between them, depending on their changing support needs.' The Guideline now states that staff should be deployed flexibly and the GC did feel that this is feasible to implement, not least because it is already happening in some areas of England.
50.	British Geriatrics Society	Full	220	3.9	Research **recommendation 1** regarding effectiveness and cost-effectiveness in terms of team structure and composition is a very valid research question and must include patient reported experience and outcome measures.	Thank you. We accept your point and would say that the chosen outcomes measures would be down to the discretion of the commissioner and researchers but that yes, it would be important for patient reported measures to be included. Patient (user) experience and outcome measures are included in the PICO table for the research question.
51.	British Geriatrics Society	Full	221	3.9	Regarding the economic considerations, **recommendation 1:1:7**, the clinical reality is that not everybody is suitable for home-based IC and so whilst there is evidence that this could be as cost-effective as bed-based IC (studies undertaken in urban areas), there is insufficient evidence to warrant the lack of provision of one or other model of IC. In rural settings it is possible that the economic modelling may change and then a choice would need to be made by commissioners, in consultation with the public, as to which aspects of health care cannot afford to be provided.	Thank you. We accept your point and would say that the chosen outcomes measures would be down to the discretion of the commissioner and researchers but that yes, it would be important for patient reported measures to be included.
52.	British Geriatrics Society	Full	225 / 226	3.9	We agree with **recommendations 1:2:1 through to 1:2:5** and agree that this is not a priority area for research.	Thank you.
53.	British Geriatrics Society	Full	239	3.9	We support **recommendations 1:2:11 and 1:2:12 and research recommendation 2**	We agree that research is needed which investigates the cost-effectiveness of crisis

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					which should also look at the economic evaluation of crisis response services.	response intermediate care and this has been clarified in the final guideline.
54.	British Geriatrics Society	Full	24	2:5	We believe the research question regarding single point of access should ask whether a single point of access has any impact on time from referral to starting IC or reablement.	Thank you for your suggestion. The GC feel that this is implied in the way the research recommendation is explained when it states, 'a management structure that has a single point of access can…speed up referral and access to services'. Therefore they decided not to make any changes to the way the research recommendation is described.
55.	British Geriatrics Society	Full	241	3.9	We endorse **recommendation 1:3:1** and agree that this is not an area for research but is an area for audit and clinical governance.	Thank you for your support. Please note that the wording has been revised for the final guideline and now reads, 'Start the intermediate care service within 2 days of receiving an appropriate referral. Be aware that delays in starting intermediate care increase the risk of further deterioration and reduced independence.'
56.	British Geriatrics Society	Full	242	3.9	**Recommendations 1:3:2 and 1:3:3** we support with the caveat that in the first bullet point of 1:3:2 this is really an expectation of how fast one expects the individual to improve to the point at which they can be discharged from which ever model of IC they have been admitted to and should not be used as a means of time limiting the individual's stay within a service.	Thank you for your comment. The GC accepts that the reference to informing the person about a specific time limit could seem to be a means of limiting the time a person receives the service. In the final version of the Guideline, the bullet point will be moved to the bottom of the list, and state 'tell the person that intermediate care is a short-term service and explain what is likely to happen afterwards'.
57.	British Geriatrics Society	Full	243	3.9	We support **recommendation 1:3:4**. We agree that **1:3:2 to 1:3:4** are not areas for research priority but are areas that require audit and clinical governance review to ensure that IC and reablement are not being driven by time constraints but are delivering individualised patient care. We would agree with the GDG that there is no economic argument that can divert from the need for effective practice, person-centred care with excellent communication and information sharing and that these holistic aspects of care should indeed have minimal cost implications. Standardisation of good practice and good communication skills should improve the patient journey and patient experience; improve goal planning and goal attainment, thereby reducing costs or being cost neutral rather than increasing costs.	Thank you for your support.
58.	British Geriatrics Society	Full	245	3.9	We agree with the GDG discussion that if there is clarity of communication as to the purpose of IC; what can be expected to happen through the duration of IC; under which circumstances the spell in the IC service would come to an end and how this would happen; and what would be available after the period of IC, it would become evident that this is not time limited but that the amount of time taken for each individual will vary and will, therefore, be tailored to each individual, i.e. will truly be patient-centred. This should avoid confusion for staff, patients and families. We hope that by taking on board our comments this will help to ensure that the final version of the guidance ensures clarity of purpose for all engaged in commissioning, delivering, or receiving IC services.	Thank you for your support.
59.	British Geriatrics Society	Full	246	3.9	We agree with **recommendations 1:3:5, 1:3:6, 1:3:7 and 1:3:8** and would not prioritise this as an area for research.	Thank you for your support.
60.	British Geriatrics Society	Full	249	3.9	We support **recommendations 1:3:9, 1:3:10, 1:3:11** and would support **research recommendation 2**.	Thank you for your support.
61.	British Geriatrics Society	Full	25	2:6	On duration and intensity of home based IC. We believe the research question is: 'Do longer periods of IC meet more need, particularly that of loneliness'. In the assessment of the research question the outcome measures need to quantify loneliness within the health related quality of life measurements and whether there is a change in degree of loneliness before entering IC/reablement to when one leaves it. If one uses an old fashioned term such as rehabilitation and the goal orientated nature of this, then just because someone is lonely at the point of being discharged from IC/reablement does not mean that that those services should carry on for longer but perhaps that these needs should be met by an alternative provision. To some extent the guidance hints at this when it covers discharge arrangements and plans for care after the spell of IC has finished.	Thank you for this suggestion. The GC is in agreement with you about the important role that intermediate care could play in addressing goals around social engagement and participation and reducing loneliness. However this was not the particular focus that they felt this research recommendation should have and indeed they were limited in terms of the number of research recommendations they could include. On the basis of the evidence review they felt that the research recommendations they included would have the greatest impact in terms of the current evidence base.
62.	British Geriatrics Society	Full	251	3.9	We support **recommendations 1:3:12, 1:3:13, 1:3:14, 1:3:14, 1:3:15** and agree that this is not a priority area for research but that goal setting and goal mapping is an	Thank you for your support.

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					important area for audit and clinical governance.	
63.	British Geriatrics Society	Full	256	3.9	We support **recommendations 1:4:1, 1:4:2 and 1:4:3**. With regard to **research recommendation 4**, we wish to reflect back to **Section 2:4** which discuses repeated periods of reablement and periods of reablement that last longer than six weeks. It is unclear as to what the GDG is expecting to focus on or identify from this line of research. **Section 2:4** – the research question for reablement seems to assume that the length of reablement is somehow not defined by the needs of the individual. For example, the statement "there is no peer review study that measures the impact of different durations of reablement for different population groups" denies the basic concept that all forms of IC should be person centred not disease centred. Where that paragraph goes on to say that some people are offered reablement for periods of longer than six weeks, this is presumably because they need longer, i.e. it is patient focused. The NAIC has indeed shown that with increasing complexity of patients throughout the four years of the NAIC, lengths of stay have increased. It is highly likely that variations in length of stay are related to individual needs and comorbidities rather than the specific disease process for which they entered into IC, e.g. fall, fractured neck of femur or stroke. Equally, the concept of studying people who have repeated periods of reablement seems unclear in its understanding of why this might be. These individuals will presumably have had repeated episodes of illness; an obvious example group would be those with repeated falls necessitating periods of rehabilitation. We find it hard to see how a research study could identify optimum number of episodes of rehabilitation/reablement.	Thank you for highlighting this. We have a different approach to the issue. Whilst the provision of IC is person-centred, we are still interested in evaluating which active ingredients led to which outcomes at what costs and for whom; in fact designs such as realistic evaluations might be particularly suitable to capture the context – mechanisms – outcomes. Although funding for reablement is generally only available for periods of up to 6 weeks, some people require longer periods of support so research is needed to determine the CE of differing durations of reablement, likewise repeat provision.
64.	British Geriatrics Society	Full	256	3.9	Regarding **research recommendation 3**, we would refer to our earlier comments about IC for people with dementia and to seek clarification as to whether this is with respect to people with physical need for IC who also happen to have dementia, as opposed to people with dementia who may or may not have a physical need.	Thank you for your comment. In line with our response to the related points you have made, the GC have clarified that they are referring to intermediate care in general terms and how it can be used to support people living with dementia. This is not intended to refer to specific 'mental health' intermediate care because the point is that intermediate should be addressing people's needs holistically, regardless of any diagnosis they may have.
65.	British Geriatrics Society	Full	259	3.9	We support **recommendations 1:4:4, 1:4:5, 1:4:6** and we are neutral regarding **research recommendation 5.**	Thank you for your support.
66.	British Geriatrics Society	Full	261	3.9	We support **recommendations 1:4:7 and 1:4:8** and would be surprised if there were not economic implications of providing an adequate work force that could cope with sickness, maternity leave, holidays and work load demand!	Thank you for your query – in fact these recommendations are referring to missed or late calls rather than sickness, maternity leave and so on.
67.	British Geriatrics Society	Full	262	3.9	We support **recommendations 1:5:1, 1:5:2 and 1:5:3.**	Thank you for your support.
68.	British Geriatrics Society	Full	264	3.9	We support **recommendation 1:6:1, 1:6:2 and 1:6:3**, likewise **recommendations 1:6:4 and 1:6:5**. We would suggest that **"geriatrician" is added to the list for 1:6:5.**	Thank you for your support. The GC noted that the list is only intended to provide examples, and not to be exhaustive, and so they are not in favour of making the suggested addition to the list. However, just to flag that the Guideline now states that practitioners with specific skills should be included in the core intermediate care team. One such set of required skills is in conducting comprehensive geriatric assessment, which might help to address your point.
69.	British Geriatrics Society	Full	270	3.9	We support **recommendations 1:7:1, 1:7:2 and 1:7:3**.	Thank you for your support.
70.	British Geriatrics Society	Full	3	Introduction	The introduction requires a few amendments. It refers to the definitions used in NAIC and then states, 'services span acute and long-term care' - this is incorrect. Intermediate care services have been defined by NHS England as being time-limited and are frequently locally defined as between 6 and 8 weeks. This is clearly mentioned in the section on Terms Used in This Guideline Intermediate care services are time-limited, normally no longer than 6 weeks. The relevance of the 2nd paragraph is not clear to the reader. It would help if it was made clear that the objective of IC services was to prevent admissions and facilitate earlier discharge.	The GC accepts that the Introduction could benefit from some clarification of different terms, although they felt the distinction they wanted to make was between intermediate care and ongoing care and support. We have also made the changes you suggested – replacing 'between' with 'in' and have removed the reference to intermediate care spanning long-term care.

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					The following sentence is not very clear ---"This guideline covers all adults (aged 18 and older) using intermediate care, including reablement services between inpatient hospital, community or care home settings"--- we would suggest replacing the word 'between' with 'in': The following sentence should include 'commissioners'----"The guideline is for health and social care providers and practitioners delivering intermediate care and reablement, and for people who use the intermediate care and reablement services and their family carers". We would suggest that the introduction could be enhanced by clarifying the difference between care and rehabilitation and would suggest the following definitions be added: • **Care:** timely and appropriate assistance with daily tasks to reduce risk, sustain health, and improve well-being. Making sure people are looked after appropriately. • **Rehabilitation:** A complex process of trying to help people who have suffered some injury/disease or developmental disorder to maximise independence, functional ability, psychological wellbeing, and social integration.	
71.	British Geriatrics Society	Full	51	NA	'Studies reporting views and experiences data for people using home-based intermediate care, their families or carers, n=5' - Only Steve Aris' work on the PREM open narrative question from the NAIC is referenced, there is no mention of the rest of the PREM (15 questions) or Service User data from the NAIC. In our opinion this is a profound omission.	The Ariss et al paper, which provided useful data on people's views and experiences was included because it met one of the study design (survey) criteria set out in the review protocol, whereas the other sources you cite did not.
72.	British Geriatrics Society	Full	7	1.1.5	The phrase "Learn to observe and not automatically intervene" would be better stated as 'observe and guide and not automatically intervene'	Thank you for your comment. The Guideline Committee has considered the change of wording you have suggested. The GC agrees that this change would help to convey the meaning of the recommendation, and agrees that the suggested change should be made.
73.	British Geriatrics Society	Full	7	1.1.6	We recommend adding 'residential home' to the following definition: "Do not exclude people from intermediate care based on whether they have a particular condition, such as dementia, or live in particular circumstances, such as prison or temporary accommodation"	Thank you for your comment. The GC agreed that this would be an appropriate addition and the change has been made in the final version of the guideline.
74.	British Geriatrics Society	Full	7	1.1.6	We strongly support the recommendation that people with dementia should not be excluded from IC.	Thank you for your support.
75.	British Geriatrics Society	Full	7	1.1.9	List of team members – medical staff should be included within the list of disciplines.	Thank you for your suggestion. We received a number of comments about the list of core practitioners so the GC considered them in detail. They finally decided to list essential skills rather than specific roles and this is reflected in the final guideline. They felt that in terms of core team members, the most important skill required from medical staff (apart from the list of therapies) would be the competence to conduct comprehensive geriatric assessments so this is now reflected in the re-drafted recommendation.
76.	British Geriatrics Society	Full	7	1.1.9	"Ensure that intermediate care teams include staff from a broad range of disciplines. Core practitioners include" – we would suggest that the disciplines are reordered and that support staff are put at the end of the list and that it is made clear that support staff are supporting professionals in undertaking the care plan.	Thank you for your suggestion. We received a number of comments about the list of core practitioners so the GC considered them in detail. They finally decided to list essential skills rather than specific roles and this is reflected in the final guideline. Also just to note that the GC believes that the skills required to deliver an intermediate care package (which may be through support workers) are crucially important and agreed they should be listed first.
77.	British Geriatrics Society	Full	7	1.1.9	Make reference here to 1.6.5, links to other services.	Thank you for your suggestion. The GC feels that although the two recommendations are related there is no real need to add a link from one to the other. A number of the recommendations in the guideline could be said to be related and it is likely that linking between them all would cause confusion.
78.	British Geriatrics Society	Full	8	1.2	Assessment of need for IC – this should also include 'if client deemed as not appropriate, a full justifiable reason needs to be given'. This can assist with the wider aim of explaining service provision to future referrers.	Thank you for your comment. The GC took the view that the discussion about the aims and objectives of intermediate care would include a discussion about what type of referrals were and were not suitable. For this reason the GC did not feel that the addition you have suggested would be needed.
79.	British Geriatrics Society	Full	8	1.2.6	This is not a very clear statement – we suggest adding "to the home" after "adjustments" to make it clear what this is referring to.	Thank you for your comment. The GC agrees that this recommendation could be clearer. The wording will be updated to refer to 'making any adjustments needed to

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						their home'.
80.	British Geriatrics Society	Full	8 + 205	1.2.3 +1.6.4	A link should be made between recommendations 1.2.3 ("Through all stages of assessment and delivery, ensure good communication between IC staff and other agencies and between IC staff.") and 1.6.4 (pages 8 and page 205). Statements like "ensure good communication" can feel like lip service without the "how" being explained. The how is included within section 1.6.4 and therefore a link to this section should be included to support recommendation 1.2.3.	Thank you for this suggestion. The recommendations to which you refer are not quite as closely linked as you suggest. For example, 1.2.3 (in the draft guideline) was about communication between intermediate care teams and families (and other agencies) and the other rec you refer to was specifically about how to improve communication within intermediate care teams. In the final guideline 1.2.3 has actually been moved to the overarching principles (now rec 1.1.2), because having discussed it in more detail, the GC felt that communication with people and families ought to underpin every stage of intermediate care. There are a number of recommendations in subsequent sections which detail exactly how and at what critical points that communication should happen.
81.	British Geriatrics Society	Full	9	1.2.7	**Bed-based Intermediate Care** is unclearly worded and would be better worded as follows: *"for people who are in an acute but stable condition requiring intermediate care but who are not fit for home-based intermediate care or reablement, consider bed-based intermediate care; transfer from the acute care to the start of intermediate care service should take no longer than two days".*	Thank you for your comment. The GC accepted that the wording of the recommendation could be made clearer. After further careful reflection on the evidence and modelling, and taking account of stakeholder feedback, the recommendation now reads: 'Consider bed-based intermediate care for people who are in an acute but stable condition but not fit for safe transfer home. Be aware that if the move to bed-based intermediate care takes longer than 2 days it is likely to be less successful.'
82.	British Geriatrics Society	Full	General	general	As partner organisation to the National Audit of Intermediate Care (NAIC), we would recommend delaying the publication of these guidelines until the results of the NAIC 2017 are available (November 2017) and can be referenced; as this will provide one of the largest databases on Intermediate Care (IC) provision and patient reported outcomes and experience (PROM and PREM).	Thank you for all your suggestions. We have been in touch with the NAIC Steering Group and having considered the timing and likely content of the 2017 audit, do not feel there would be a benefit to delaying the publication of this guideline. However the guideline will be reviewed within the next 2 years and will draw on the most up to date audit data at that point.
83.	British Geriatrics Society	Full	General	General	Throughout the document there are numerous references to the 6-week timeframe for IC. We believe it is important to emphasise that whilst IC is a time limited service, the service provided should be tailored to the patient's individual needs and therefore the duration of stay for patients will vary and may, for some (particularly those with dementia), need to be longer than 6 weeks.	Thank you for your comment. The Guideline Committee has considered your suggestion. They agree with this point, and in the updated draft of the Guideline references to the 6-week timeframe have been removed, and instead it will be described as a time-limited service. However, the 'terms used' section of the Guideline will continue to state that the service normally lasts for no longer than 6 weeks, in accordance with the NAIC definition.
84.	British Geriatrics Society	Full	General	General	As noted below, the evidence referred to in the guideline relies heavily on randomised controlled trails (RCTs) related to single condition rehabilitation. Intermediate care is not a service related to a specific disease and consideration should be given to other relevant sources of information including mixed methods studies and the findings of the NAIC. Whilst the analysis of the PREM narrative question (within NAIC) is referenced the response to the 15 "I" statement questions within the PREM are ignored. The findings related to the "I" statements provide valuable evidence about what is important to patients and where improvements could be made, for example, in communication. The NAIC service user audit also provides a unique data set on outcomes in home, bed and re-ablement services, which have not been utilised in the guideline.	Thank you for your comment – we have explained our approach to the use of different study designs in the answer provided below. In relation to your point about the inclusion of NAIC service user experience data, these have been included in the review. The Ariss et al paper, which provided useful data on people's views and experiences was included because it met one of the study design (survey) criteria set out in the review protocol, whereas the other sources you cite did not.
85.	British Geriatrics Society	Full	General	General	We believe that the guideline development group (GDG) has focussed excessively on RCTs, of which there are few and even fewer of good quality, and would urge that the GDG look well beyond RCTs to other forms of evidence such as high quality case studies, big data from the NAIC, and pragmatic quality improvement studies. Previous NICE guidance (e.g. on Multimorbidity and frailty, Transitions from hospital, Health care for people with social care needs and vice versa [including those in care homes]) have all focussed less on single organ conditions and don't excessively centre on RCTs, which tend to exclude the very patients likely to benefit from IC.	Thank you for your comment. The systematic review work was based on review protocols which stipulated which study types would be considered for answering the different questions. For example, for the questions about people's views and experiences, the reviewers sought data from qualitative studies and from qualitative components of mixed methods studies as well as observational and cross sectional surveys of user experience. For the effectiveness questions, studies were sought which would provide the most robust data about the outcomes of an intervention, therefore studies with a controlled design. However other designs without a control were also considered for inclusion, such as before and after or mixed methods studies. Where a substantial volume of evidence was included on full text the reviewers further prioritised studies for review and presentation to the GC. In seeking to present the most robust data on which to develop recommendations in which the GC could have most confidence then – for effectiveness questions – randomised controlled studies were prioritised where they were available. However, having reviewed the best available evidence about the effectiveness of intermediate care models, the GC agreed to include an additional review question designed to elicit data about aspects of service delivery and approaches to intermediate care. The question (question 7) did not seek evidence about a causal link between elements of

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						intermediate care and outcomes so the included study types differed from questions 1-6, for example service and process evaluations would be considered as well as national audits. It is on this basis that the National Audit of Intermediate Care was included for question 7, providing valuable evidence which the GC used to develop recommendations.
86.	British Geriatrics Society	Full	General	General	It is explicitly stated that the guidance would exclude evidence from studies of single conditions rehabilitation such as stroke (pg 32) but then they go on to include the following studies specifically relating to single condition rehabilitation pg 36:Bjorkdahl (2006) et al: stroke pg 37: Bjorkdahl (2007) et al: stroke Pg 40: Fjaertoft et al: stroke Pg 41: Inglis et al: chronic heart failure Pg 42: Kalra et al: stroke Pg 44: Mahomed et al: primary unilateral knee replacement (additionally, we found the reporting of the evidence from this paper difficult to interpret due to very confusing description of the intervention and control) Pg 50: Thorsen etal: stroke Pg 50: Ytterberg et al: stroke Pg 54: Cobley et al: stroke Pg 61: Choiliara et al: stroke Again, evidence detailed in the bed based section explicitly stated that they were going to exclude single condition rehabilitation, namely stroke then they go on to describe evidence from hospital based stroke units and stroke teams (Kalra et al pg 83), and rehabilitation specifically following neck of femur fracture (Stenvall et al, pg 85). If the single condition studies remain in the guidance then this discrepancy should be acknowledged and less weight given to these studies.	Thank you for your comment. You are right to highlight that according to the review protocols and in line with the NAIC definition of intermediate care, single condition service models were meant to be excluded from the systematic review. However, in their role quality assuring the review protocols, the Guideline Committee pointed out that early supported discharge and other stroke rehabilitation services as described in the literature are, in the context of current practice, closely aligned with intermediate care. This is in terms of the needs of people using the service, the organisation of the service and the functions delivered by the teams. They also believed the same exceptions should be made for the Inglis and Mahomed studies. In light of your comment, amendments have been made to the reporting of the review work and we are grateful to you for having highlighted this oversight.
87.	British Geriatrics Society	Full	General	General	The British Geriatrics Society (BGS) strongly support the overall emphasis on individualised goal setting and person centred care that comes across in the guidance.	Thank you for your support.
88.	British Geriatrics Society	Full	General	general	Regarding how reablement is referred to in the guidance. The NAIC includes four functions of IC, reablement being one of these, and reablement is on an equal footing with the other three functions. If this guidance is going to use the NAIC definition of IC, it would be helpful if didn't keep referring to … 'intermediate care including reablement', as if it's something different. Referring to it in this way could lead to confusion or even undermine the importance of reablement. This comment also reflects on the title of the guideline.	Thank you for your comment. The Guideline Committee has considered the point you raised about using the term 'intermediate care including reablement'. The GC took the view that the term 'reablement' should not be removed from the title because it risks local authorities thinking the guideline is not for them, since IC can be perceived as being a health focused service. The GC agreed to keep reablement clearly in the title, but state in the introduction that it is seen as one service, and there is no need to separate the terms throughout the Guideline.
89.	British Geriatrics Society	**Short**	21	25	The word 'of' is missing – the sentence should read: "The skill mix and competency of a home-based intermediate care team can influence the quality of care and outcomes…"	Thank you for your comment. The word 'of' has been added to the wording of the recommendation, as you suggested.
90.	British Society of Rehabilitation Medicine	Short	11	1.4.6	It should be recognised that at its core Intermediate Care is an educational activity and people should have access to appropriate written and other material to support learning.	Thank you for this suggestion. The GC felt that the provision of accessible written materials to support the achievement of intermediate care goals is adequately covered in the Guideline.
91.	British Society of Rehabilitation Medicine	Short	13	1.7	Might also include a recommendation that training should cover: Safeguarding of vulnerable adults; Principles of the Mental Capacity Act; Principles of Rehabilitation.	Thank you for your comment. The GC took the view that the areas of understanding listed in this recommendation are all aimed at ensuring staff who participate in providing an IC service understand what the service is and how it works, and so they would not wish to add your suggestions, which would seem to have a different purpose.
92.	British Society of Rehabilitation Medicine	Short	13	1.6.4	There needs to be clear links and referral routes to also specialist and longer term community rehabilitation services, and some community facing but hospital based professionals such as specialist nurses and Consultants in Palliative Medicine, Elderly Care and Rehabilitation Medicine.	Thank you for your suggestion. The GC as happy to add 'specialist and longer term community rehabilitation service' but did not add community facing hospital professionals as it may be a little unclear to the audience who these professionals would be.

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93.	British Society of Rehabilitation Medicine	Short	21	18	Recommendations for Research: There is a need for further research also in bed based intermediate care. The existing literature is not clear about its effectiveness particularly in care homes	Thank you for this suggestion. On the basis of the evidence underpinning the guideline the GC did not feel this should be a priority area for future research.
94.	British Society of Rehabilitation Medicine	Short	8	1.3.2	Assessment. Staff should identify the person's core values and aspirations, their key relationships and their valued roles. This should be in the context of the person's social and physical environment and their own personal resources and state of health.	Thank you for your comment. The GC recognises the importance of the matters you have raised, but considers they are already covered within the Guideline through the core principle of making the Guideline person centred.
95.	British Society of Rehabilitation Medicine	Short	9	1.3.12	It is important that goals should describe what the person wants to achieve and not what the service wants to do. These goals should have a clear link to the person's assessed values and aspirations.	Thank you for highlighting this. The fact that goals should reflect the person's wishes and aspirations is already present in the Guideline.
96.	British Society of Rehabilitation Medicine	Short	General	General	Rehabilitation Medicine Consultants make use of Intermediate Care Services when planning the discharge of vulnerable patients into the community, often to the bridge the gap until more specialist services are available. Primary Care and Community Rehabilitation Services may also refer severely disabled people to Intermediate Care to help them through intercurrent illnesses and thus prevent a possibly risky admission to hospital. The BSRM views these services as a form of community based rehabilitation, and the following comments reflect on various ways in which rehabilitation principles and the International Classification of Functioning and Health should inform the guideline.	Thank you for this information.
97.	British Society of Rehabilitation Medicine	Short	General	General	The BSRM has particular concern about the term 'Reablement' and the assertion that there is a strong evidence base for it. Attention is drawn to a recent publication: *Legg L, Gladman J, Drummond A and Davidson A. A Systematic Review of the Evidence on Home Care Reablement Services. Clinical Rehabilitation 2016; 30: 741-749* We understand Reablement to mean 'Social Service Funded Short Term Community Rehabilitation' and ask that such an explanation might be included in your definition.	The definition of reablement which the GC agreed to use is the one defined in the National Audit of Intermediate Care so this is how the term is defined in the guideline. It is also the definition which underpinned our systematic review of the evidence for reablement. The reviewers did not report a 'strong evidence base for reablement', instead they found a moderate amount of evidence to support certain outcomes or certain experiences relating to reablement.
98.	Care & Repair England	General	General	General	**Question 1 and 4.** One of the areas that have the most impact is collaborative working across all sectors and this has proved to be a challenge across health and social care and is even more of a challenge to engage with housing. We argue that at both a strategic and operational level housing organisation must be engaged especially as the guideline promotes care at home as the goal. This will be a challenge for health and care partners – needing to understand the importance of housing and to contact and engage the right agencies locally that can support people to assess a person's home environment and help with any adjustments needed. One agency in relation to Intermediate Care at home will be the local Home Improvement Agency which offers help with repairs, adaptations and improvements to the home. Details of local agencies from http://www.findmyhia.org.uk/ There are some resources from NHS England aimed at engaging housing that NICE might like to refer to in relation to this aspect. See https://www.england.nhs.uk/commissioning/health-housing/ which refers to the health and housing quick guide **Question 4.** We have some examples of where home adaptations services have worked with health and social care to support discharge home. One of these – Ealing – has done specific work on reablement. Here is a link to these case studies, including Ealing, which might be of interest as a group of practical examples showing an integrated approach where going/staying at home is the goal https://homeadaptationsconsortium.wordpress.com/good-practice/ A further example of a reablement approach is identified on Page 23-24 of the evaluation of the Warwickshire integrated housing options advice service. In this case the setting is in extra care housing and identifies the difference in approach to	CONS QUESTIONS – info for NICE colleagues?

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					rehabilitation and the role of a housing setting in that process	
99.	Care & Repair England	Short	10	2	Suggest adding an extra goal – 'take into account the environment in which the person lives and its suitability for both intermediate care and long term independence' it is important to ensure that the place in which the care is offered is suitable to provide the best support and service.	Thank you for this suggestion. Because this recommendation is specifically about goal setting, the GC did not think it was appropriate to make this change. However please note that the potential for changes having to be made to the home environment in order to support intermediate care has been added to the final guideline.
100.	Care & Repair England	Short	11	1	Add a section that offers people access to advocacy, as appropriate, not just information	Thank you for your suggestion. The point about advocacy is covered in the final version of the Guideline.
101.	Care & Repair England	Short	13	15	Housing services - add 'such as repairs, adaptations, handypersons and other housing support services'	Thank you for your comment. The GC would prefer that the bullet point remain without any additions, so that it clearly refers to a broad range of housing services, and not just specific examples on a list. For this reason the GC is not in favour of making the suggested change to the bullet point.
102.	Care & Repair England	Short	14	7	Add a new section 'health, safety and comfort concerns about the environment in which the intermediate care takes place especially where this is in a person's home'. This is to make sure that the home is safe, warm and comfortable for the person receiving intermediate care	Thank you for your comment. The GC decided not to make this addition. The recommendation is adapted from the NICE Guideline on Home Care, and the GC would not wish to extend what is recommended there without having evidence to support doing so.
103.	Care & Repair England	Short	5	25	Add housing staff (there will be circumstances when people will have a warden or other staff member offering housing support and they also need to be part of the core practitioners)	Thank you for your comment. The GC took the view that the core group needed to have access to some practitioners, rather than always including them as members. This is reflected in statements that intermediate care team members should have a clear route of referral to various services including housing.
104.	Care & Repair England	Short	6	28	Define reasonable adjustments – We assume this might include adjustments to the home environment including any adaptations and repairs needed to the home to ensure that it is safe, secure, warm and manageable for the person needing intermediate care	Thank you for your comment. The GC accepts that the term, which was meant to refer to aids and adaptations to the home does not provide enough clarity. The GC are therefore changing the wording to 'making adjustments to their home'.
105.	Care & Repair England	Short	9	4	Add not only specialist equipment but also adaptations and repairs to the home to provide safety and comfort for the person receiving intermediate care at home. Assessing the home environment should be part of the risk assessment. This should include Occupational Therapists and local Home improvement agencies as appropriate.	Thank you for your comment. The GC understands the reason for making this suggestion, but it is not supported by the evidence base for this guideline. This particular recommendation was adapted from the NICE guideline on Home Care, and the GC considers that it would be problematic to extend the scope of what that guideline recommends without having the evidence to support doing so.
106.	Guide Dogs	Full	13	1.4.5	(third bullet point). The alternative format that is likely to be the most useful is large print. (in that it will inevitably make the material accessible for the largest number of patients/service users). We don't suggest removing braille or easy read, but do suggest adding large print.	Thank you for your suggestion. The GC felt that since the list is intended only to provide examples, it was not necessary to add any more items. The fact that the recommendation is to provide a range of 'accessible' formats implies any format, which makes the information accessible for that individual.
107.	Guide Dogs	Full	17	No line number	Reablement section: Apologies, there is some narrative and explanation before our recommendation but we feel that it is important to provide some context. When the Care Act Statutory Guidance was being written, those drafting it drew from a position statement by the Association of Directors of Adult Social Services issued in December 2013 which included the line: "Rehabilitation for visually impaired people is a specific form of reablement. There are some intrinsic characteristics which define rehabilitation as being distinct from other forms of reablement." This was felt to be a vital message as it highlighted how visual impairment rehabilitation is very much a specialist preventative intervention, but does not mirror exactly the format of traditional intermediate care or reablement. For instance, it tends to be delivered over a longer period of time than six weeks, but is less intensive. So time limited but not time-prescribed. The statement was signed by the Joint Chairs of the ADASS Workforce Development Network and the Joint Chairs of the ADASS Physical Disability, Sensory Impairment and HIV/AIDS Network. Some of the exact wording from the position statement made it into the Care Act	Thank you for this information.

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					Guidance itself. Paragraph 22.22 includes direct reference to the statement and pointing out that: "This makes it clear that rehabilitation for sight impaired people is a specific form of reablement. However, there are some intrinsic characteristics which define rehabilitation as being distinct from other forms of reablement." There is also recognition in the Care Act Guidance that the nominal six-week time limit on reablement may not be appropriate in the case of visual impairment rehabilitation. Paragraph 2.62 states: "Whilst they are both time-limited interventions, neither intermediate care nor reablement should have a strict time limit, since the period of time for which the support is provided should depend on the needs and outcomes of the individual. In some cases, for instance a period of rehabilitation for a visually impaired person (a specific form of reablement), may be expected to last longer than 6 weeks." We therefore recommend that the short paragraph on reablement in this draft NICE guidance is extended to make explicit reference to this discrete form or reablement We believe this could be achieved by adding some text at the end of the paragraph at the bottom of page 18 (immediately after reference to the National Audit of Intermediate Care, 2014) along the lines of the following: "The majority of local authorities offer a specific type of reablement for people with sight loss, provided by a qualified rehabilitation worker/rehabilitation officer. The Care Act Statutory Guidance makes it clear that whilst this shares many of the characteristics and principles of traditional reablement, it has unique characteristics, including that it may often take longer than six weeks and so the nominal six-week time limit should not be routinely placed on people with sight loss undertaking a rehabilitation skills training programme."	Thank you for this suggestion. Since vision rehabilitation was not included in our review of evidence or our definition of intermediate care, we would not be able to make these additions at this stage of guideline development. It may be that when the guideline is updated the scope is altered to encompass these types of services.
108.	Guide Dogs	Full	18	1	The link to the jargon buster does not work	Thank you for highlighting this. The correct link will be provided in the final version of the Guideline.
109.	Guide Dogs	Full	6	1.1	We recommend that the heading of this section be changed to reflect the title of the document as a whole. Eg, that if is changed to: "Core principles of intermediate care (**including reablement)**" (bold has only been used to show the suggested addition). As well as mirroring the title of the document, it will also help to ensure that it is understood that the principles apply to reablement as much as they do the various other models of intermediate care. Reablement is the only one that does not have "intermediate care" in its name and so there is perhaps a danger that people might assume that reablement is not covered by these principles.	Thank you for your comment. The GC agreed with your comment, and the heading of the section will be changed accordingly.
110.	Guide Dogs	Full	6	1.1.4	We recommend adding "and/or sensory" after "physical" as set out at the end of this comment. We have been long aware since Social Services Inspectorate inspections into older people's services in 2002/2003 identified the problem that sensory needs (especially when not always apparent) are often overlooked in generic assessments including those for older people. Intermediate care teams are unlikely to have specialists in sensory impairment amongst their number, but a need resulting from sensory impairment could be addressed by referring the individual into a specialist service such as a rehabilitation worker working with people with sight loss. Address people's social, emotional, communication and cognitive needs, as well as their physical **and/or sensory** needs as part of intermediate care	Thank you for your comment. The GC discussed your suggestion and came to the conclusion that the list as it stands will be understood to mean that people's range of needs should be considered and addressed, without having to itemise each potential area of need, and so the recommendation does not need this addition.
111.	Guide Dogs	Full	9	1.2.10	We suggest adding sensory loss here too. Our assumption is that people with dementia may not be considered to be suitable for intermediate care as it seems to have a primary focus on physical frailty or impairment. But sensory impairment can have a significant impact on a person's health and wellbeing. It is for this reason that the Royal College of General Practitioners (RCGP) had a three-year clinical priority on	Thank you for your comment. The GC understood your reasons for making this suggestion, but noted that the recommendation was based on evidence from a wider population, and would not wish to make this addition unless there was research evidence to support it. As there is not the evidence base to support it, the GC does not agree that the recommendation should be changed.

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					ageing and eye health/sight loss culminating in a guide for RCGP members. http://www.rcgp.org.uk/~/media/Files/CIRC/Eye%20Health/RCGP-Sight-Loss-in-Older-People-A-Guide-for-GPs.ashx Also the National Dementia Declaration point 5 which states: We have the right to be respected, and recognised as partners in care, provided with education, support, services, and training which enables us to plan and make decisions about the future. http://www.dementiaaction.org.uk/nationaldementiadeclaration	
112.	Guide Dogs	Full	General	General	The Statutory Guidance published in the wake of the Care Act (2014) explicitly acknowledges rehabilitation for people with visual impairment as a vital and distinct type of reablement. This is the first time ever that this discrete specialist intervention has been recognised within an official statutory document. Given the significant year on year increase in the numbers of people with sight loss (due to demography) and the volume of evidence around the impact of sight loss on independence, health and wellbeing we believe that there is a strong case for this NICE guidance to acknowledge sight loss and to highlight the importance of responding to needs resulting from it appropriately. This is the key focus of our submission which is aimed at strengthening the guidance and hopefully in doing so, improving outcomes for people with sight loss. Not only that, there is an explicit connection drawn between this discrete specialist intervention and reablement. There is a clear position statement on this topic published by the Association of Directors of Adult Social Services https://www.adass.org.uk/adass-position-statement-on-vision-rehabilitation-may-2016	Thank you for your comment, and for providing the link to the ADASS position statement. The focus of this guideline is on intermediate care for people with all conditions. The review work was informed by the definition of intermediate care used by the National Audit of Intermediate Care, which excludes single condition services (for example vision rehabilitation) so the reviewers had to exclude any such studies. For this reason, unfortunately they would not be able to add the research you have referenced. Nevertheless the GC have been careful to recommend a very inclusive approach to supporting people though intermediate care, ensuring that no one is excluded on the basis of having a particular condition or diagnosis. Nevertheless you may have noticed that some evidence about stroke rehabilitation was in fact included in the review. This is because the Guideline Committee pointed out that early supported discharge and other stroke rehabilitation services as described in the literature are, in the context of current practice, closely aligned with intermediate care. This is in terms of the needs of people using the service, the organisation of the service and the functions delivered by the teams. They did not feel the same principle applied to vision rehabilitation.
113.	Guide Dogs	General	General	General	Opening comment: This response has been prepared by Guide Dogs but is supported by VISION 2020UK http://www.vision2020uk.org.uk/ We would be happy to provide further information or to discuss our response with NICE.	Thank you for responding to the guideline consultation.
114.	Home Group Ltd	Full	general	1.1.6	Question 1: Point 1.1.6 states that people with certain conditions e.g. dementia, should not be excluded from intermediate care. In order not to exclude these individuals additional funding is likely to be needed to train staff to respond to special needs arising from such conditions and meet fundamental standards of care. It's likely that some providers will be constrained in the breadth / range of services they can offer and to whom, depending on the availability of funding.	Thank you for your comment. This information will be used as part of the resource impact work published alongside this guideline
115.	Home Group Ltd	Full	general	1.4.3	Question 2: The provision of specialist support to people who need it (e.g. people with complex health conditions – paragraph 1.4.3) is likely to have significant cost implications in regards to training intermediate care staff , especially if access to specialist providers is limited due to restrictions in funding.	Thank you for your comment. Your feedback will be passed to the Resource Impact team in NICE.
116.	Home Group Ltd	General	general	general	Question 1: We think that main challenges will be around sufficient funding being available to commission intermediate care services of all types to meet the needs of local communities.	Thank you for this information, which we will pass to our resource impact and implementation colleagues.
117.	Home Group Ltd	General	general	general	Question 2: The educational funding routes for providers who are not NHS or statutory adult social care need to be reflected alongside the NICE guidance. Funding routes need to support all providers of intermediate care, including voluntary sector, and Health education England needs to recognize this in their work alongside the development of such guidelines from NICE.	Thank you for this information, which we will pass to our implementation colleagues.
118.	Home Group Ltd	General	general	general	Question 3: Flexible commissioning arrangements which allow social care providers to recruit, train and retain stable teams of paid support staff would be beneficial. Larger scale services with paid staff, which are not overly reliant on volunteers, would facilitate greater flexibility and responsiveness	Thank you for this information, which we will pass to our implementation colleagues.

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119.	Home Group Ltd	General	general	general	Question 3: It would be helpful to see increased emphasis on the importance of working in partnership, including effective information sharing with community voluntary sector social care and housing providers. It would be helpful to include links to related NICE guidance on transitions from hospital to community settings.	Thank you for this information, which we will pass to our implementation colleagues.
120.	Home Group Ltd	General	general	general	Question 4: Home Group's 'Home from Hospital' service offers basic short-term support to elderly people in Surrey who have been discharged from hospital. The service includes help with day-to-day activities such as: • Food preparation • Shopping • Light domestic duties • Admin tasks, such as filling in forms	Thank you for this information, which we will pass to our implementation colleagues.
121.	Home Group Ltd	general	general	general	Question 6: As a provider of intermediate social care, we are able to respond to requests to initiate service within a timescale of two working days.	Thank you for this information, which has been incorporated in discussions about the final recommendations relating to response times.
122.	Home Group Ltd	general	general	general	Question 7: In relation to crisis response being initiated within 2 hours of a referral being made, this would very much depend on available capacity. Larger intermediate social care service providers, with greater flexibility in staff deployment are more likely to be able to respond. A 2 hour time frame for response is likely to be challenging for smaller services with limited capacity	Thank you for this information, which has been incorporated in discussions about the final recommendations relating to response times.
123.	Mencap	Full	General	General	Mencap are pleased to see that the needs of people with a learning disability have been considered throughout this draft guidance. In this response, we will highlight areas of the guidance we believe will encourage good practice and provide additional information as to how intermediate care services can better ensure they meet the needs of people with a learning disability. Firstly, the guidance describes a core principle of intermediate care as being "person centred". We welcome this as person centred care is key to effective care and support for people with a learning disability. We know that knowledge of person centred care for people with a learning disability varies across healthcare settings and between individual members of staff, including commissioners. We would therefore recommend that the document provide some examples of what good person centred care looks like for people with a learning disability. We were pleased to see that the guidance notes that reasonable adjustments need to be made to enable disabled people to understand and contribute to decision making about their care (1.2.2, 1.2.6). We would recommend that whilst reasonable adjustments to include people in decision making are vital, that this guidance reminds providers and commissioners to make reasonable adjustments to all elements of a service, including those affecting day to day care. We also recommend that the guidance includes some examples of what reasonable adjustments may look like for patients with a learning disability, including those with complex health, communication or behaviour needs. The guidance states that information should be given in accessible formats (1.3.15) and that care diaries should be accessible to patients (1.4.6), we recommend some examples of good practice when creating accessible care plans and diaries, as we know that knowledge of accessible information is highly variable. To ensure good quality care for patients with a learning disability we would recommend that they are treated by clinicians that know them well, wherever possible. Therefore, we were pleased to see the recommendation that a particular member of staff follow a person through their journey in intermediate care, we would ask that as a reasonable adjustment, where such resources are limited, that they are prioritised for patients with a learning disability.	Thank you for your support. Thank you for your comment. As you have seen, the GC felt it was important to emphasise the person centred nature of intermediate care and this is reflected in the recommendations. We have defined 'person centred' in the terms used in the guideline and because the recommendations cover all adults, it would not be possible to further explain what person centred looks like for every client group. There are other NICE guidelines, which focus in more detail on care and support for people with learning disabilities and make recommendations about what a person centred approach would look like. One of these is the NICE guideline on 'care and support for older people with learning disabilities', which is currently in development and will be published in 2018. Thank you for this suggestion, which we will pass to our implementation team so they can consider including some examples in their implementation support tools. Although you make an important point, we did not locate any research evidence specifically about people with learning disabilities and intermediate care and since the population for this guideline is all adults, the GC did not feel there was a basis to make this reference to people with learning disabilities. The GC agrees with your point. The final guideline emphasises the importance of intermediate care working with existing networks, including family, friends and carers. We can see that the point you make would be particularly pertinent for adults with learning disabilities – however the evidence contributing to this recommendation

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					It can also be extremely valuable to patients with a learning disability to ensure that they are still able to access their existing support networks, which may take the form of family carers or paid support staff. People that know a patient well can also help to establish baselines prior to needing to access intermediate care. We recommend the guideline includes this. The guidance states the importance of the involvement of families and carers (1.3.2). We recommend that this is redrafted to be clear that this includes paid carers as well as other relevant professionals. We also recommend that this section reminds professionals of their duties under the Mental Capacity Act to include people in decision making, include family and others who know the person well where they lack capacity and the requirements around access to independent advocacy. We appreciate that advocacy is also mentioned separately in the guidance and that advocacy forms a strong element of the accompanying research recommendations. We appreciate the emphasis on partnership working in the provision of intermediate care services. We believe that it is important for there to be strong links between intermediate care providers, the local authority learning disability team and the learning disability liaison nurse in the relevant local trust. We therefore recommend that both these services are included in statement 1.6.5. The draft guidance emphasises the importance of the ability to provide specialist support either by training existing intermediate care staff or by partnership working with organisations that can provide this kind of support directly. We welcome this and that the guidance recommends health care professionals be trained to recognise and respond to patients with a learning disability (1.7.2). We would also recommend this training requirement explicitly requires staff to have an understanding of accessible communication, the mental capacity act and making reasonable adjustments. It is important that it covers the range of needs people with a learning disability may have including those who may not use formal communication such as words, signs and symbols but will rely on non-formal communication such as body language and facial expressions and who may have very complex health needs, for example people with profound and multiple learning disabilities. We also ask that an understanding of person centred care is included in the list in statement 1.7.1 as this will enable health care professionals delivering intermediate care to fully plan and commission care around the needs of the patient.	emphasised the importance of involving families and carers (rather than paid care workers or other professionals), which explains why the GC agreed this recommendation. They do not feel there is a basis in the evidence to make the change you have suggested. In relation to your other point, there are references in the recommendations, which alert practitioners to considerations around mental capacity. In addition, the text at the start of the recommendations highlights that this guideline should be read and interpreted in the context of important legislation including laws relating to mental capacity. You may also find it helpful to know that a NICE guideline on decision-making and mental capacity for people with care and support needs is due to be published in 2017. Thank you for your suggestion. The issue of whether particular conditions should be discussed was raised by a number of organisations. The GC took the view that, rather than go into this kind of detail, it would be preferable to emphasise in the Introduction that IC requires a person-centred approach where each person's individual needs are assessed, including their needs arising from any particular condition. In this recommendation it was decided to use the list to provide examples of the most commonly used services, without portraying this as an exhaustive list. Thank you for your suggestion. The GC felt that they had included as much detail as possible. By stating that practitioners should be able to recognise and respond to people living with those conditions it is implied that that this would include being able to communicate with them and support them according to their needs and preferences. In addition, as highlighted above, the introduction to the guideline states that the recommendations are underpinned by important mental capacity legislation.

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124.	National Community Hearing Association	Full	290	NA	We welcome and support highlighting the importance of sensory loss in this guideline. We also support making stakeholders aware of audiology. However there is an error in the glossary section, as it currently reads • *"Audiology. A medical practice specialism which includes the 'assessment, management and therapeutic rehabilitation of people with hearing and balance problems, and associated disorders' (British Academy of Audiology)"* page 290 first paragraph. This is incorrect - for example audiology is not a medical practice specialism and this definition also narrowly defines the workforce in the context of this NICE guideline. Please replace existing wording with the definition used by NHS England in its National Commissioning Framework: • *"Audiology is a healthcare science encompassing hearing, tinnitus and balance and is predominantly provided by NHS healthcare science staff and hearing aid dispensers in conjunction with many partners. In the UK, it has developed with combined functions as a diagnostic and treatment discipline and is a cost effective use of knowledge and skills. In general, use of the term audiology refers to audiology departments and hearing care providers and "audiologist" refers to audiologists, clinical scientists and Hearing Aid Dispensers (HADs)"* **Reference:** NHS England 2016, Commissioning Services for People with Hearing Loss: A Framework for Clinical Commissioning Groups, page 55. Link to guidance - https://www.england.nhs.uk/wp-content/uploads/2016/07/HLCF.pdf **Or,** alternatively use a shorter version of NHS England's text as follows: • Audiology is a healthcare science encompassing hearing, tinnitus and balance. In general, use of the term audiology refers to audiology departments and hearing care providers and "audiologist" refers to audiologists, clinical scientists and Hearing Aid Dispensers (HADs).	Thank you for your comment. We will be using the second definition you suggested in the final version of the Guideline.

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					Either of the suggested alternatives are advantageous because, they are more accurate, come from a neutral source (NHS England) and better reflect the range of service providers across the English NHS.	
125.	NHS Benchmarking Network	Full	10	1.3.2	Suggest splitting out the 'tell the person how long the service will last' from the first bullet point. Also suggest removing the wording "will last" - this seems too definitive, instead use "explain to the patient that their expected duration of stay will be tailored to their needs. Reviews will take place throughout the duration of stay. The service is time limited but they will be sign posted or referred on to appropriate services when intermediate care ends.	Thank you for your comment. The GC agrees with your suggestion that the first bullet point could be split (although in response to other stakeholder suggestions it will no longer be the first bullet point in the final version of the Guideline). The GC also accepts that the reference to informing the person about a specific time limit could be removed. In the final version of the Guideline, there will be two bullet points, reading 'tell the person what will be involved' and 'tell the person that intermediate care is a short-term services and explain what is likely to happen afterwards'.
126.	NHS Benchmarking Network	Full	10	1.3.5	Risk assessments – suggest referencing other NICE guidelines on risk assessments, for example, all relevant multimorbidity (NG56), cognitive and falls assessment (CG161 and QS86) guidelines. Include a reference the 'positive risk taking'	Thank you for this suggestion. Since one NICE guideline (on home care) is already referenced the GC did not feel it was necessary to make any further additions, at the risk of complicating the recommendation.
127.	NHS Benchmarking Network	Full	11	1.3.9 - 11	Crisis response-- the ordering of these recommendations should be changed with the response time being the first	Thank you for your suggestion, with which the GC agrees. The change to the order of the recommendations has therefore been made for the final guideline.
128.	NHS Benchmarking Network	Full	116	3.3	In the section 'reporting views and experiences data for people using crises response', the results section explicitly states that the study was not specifically design to elicit views on this model, therefore is it relevant?	Thank you for your question. Although the main focus of the study was to consider the question 'Does integrated governance lead to integrated patient care?', the abstract states 'Patient interviews (46) covered care received before, at the time of and following a health crisis. Additional interviews (66) were undertaken with carers and frontline staff. Grounded theory-based approaches showed examples of well-integrated care against a background of underuse of services for preventing health crises and a reliance on 'traditional' referral patterns and services at the time of a health crisis'. I.e. some elicited data was relevant to the review question and therefore made a contribution even although it was not the main focus of the study.
129.	NHS Benchmarking Network	Full	12	1.3.13	We support the fact that staff are being encouraged to think holistically – considering social and leisure activities, in addition to personal and domestic care tasks.	Thank you for your support.
130.	NHS Benchmarking Network	Full	12	1.3.15	We agree with the need for transparency and sharing of agreed goals.	Thank you for your support.
131.	NHS Benchmarking Network	Full	12	1.4.3	'Ensure that more specialist support is available to people who need it (for example, in response to complex health conditions), either by training intermediate care staff or by working with specialist organisations.' - suggest adding the words 'and services' at end of the sentence.	Thank you for your comment. The GC considered replacing the word 'organisations' with 'services', but decided to retain the original wording, as it is the organisations that provide the services. 'Services' would be included within the meaning of the word 'organisations'.
132.	NHS Benchmarking Network	Full	12, 22 + 242	1.4.2 + 2.4	Page 12, 1.4.2 and page 22, 2.4, refer to how services might need to last longer than 6 weeks, implying that longer input is a rarity or an outlying event. In the same vein page 242, 1.3.2 refers to telling people how long the service will last. We think, at best, IC practitioners will be able to give an approximation of how long the service will last as we doubt if this was purely a needs and goals driven exercise, and patients would have however long they needed, that any practitioner could accurately predict exactly how long that would take at the outset. This implies that there are time limitations set up front (as we know there are in reality) but we think we need to move away from the focus being purely on numbers put through the system and re focus it on outcomes for the patients. Also, the emphasis on time limitations upfront is prejudicial to patients with dementia, we would argue, as the bulk of evidence for rehabilitation in dementia points towards more intense input and for longer.	Thank you. The GC agrees with your points and they accept that there should be less emphasis throughout the Guideline on the 6 week timeframe for IC&R, as the service should be tailored to individual needs, including how long the service is needed by individuals with different conditions and different needs. The updated draft of this recommendation will state 'Review people's goals with them regularly. Adjust the period of intermediate care depending on the progress people are making towards their goals.' We hope this addresses your concerns.
133.	NHS Benchmarking Network	Full	13	1.4.8	We strongly agree with this statement. In addition to basic courtesy, it can allay anxiety on behalf of the client.	Thank you for your support.
134.	NHS Benchmarking Network	Full	14	1.5.1	'Before the person finishes intermediate care, give them information about how they can refer themselves back into the service.' - suggest adding 'or other services or agencies' at the end of this sentence.	Thank you for your suggestion, which the GC has discussed. They were of the view that this recommendation referred specifically to people referring themselves back to the IC service, and so decided not to make the suggested addition to the recommendation. The GC noted that the Guideline does specify elsewhere that there should be clear routes of referral to and engagement with other services.
135.	NHS Benchmarking Network	Full	14	1.6.1	It is not clear which goals this is talking about. "Shared goals that everyone in the team works towards" – recommend changing the word "goals" to "overarching principles of IC".	Thank you for your suggestion, which the Guideline Committee has considered. They agreed that the bullet point was not clear enough about which goals this referred to and decided to clarify with slightly different wording to the one you provided. The recommendation in the final guideline now contains the bullet, 'a shared understanding of what intermediate care aims to do'.

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136.	NHS Benchmarking Network	Full	14	1.6.1	Consider adding 'an agreed approach to outcome measurement for benchmarking and reporting' as a bullet point	Thank you for your comment. The GC accepted your suggestion of adding a bullet point specifying 'an agreed approach to outcome measurement for reporting and benchmarking', and this is included in the final version of the Guideline.
137.	NHS Benchmarking Network	Full	16	NA	'Terms used in this guidance' – the reference at the end of the first paragraph should be to Halfway Home. For the four service category definitions, the references to NAIC should make clear that these definitions were developed for the purposes of the audit and the reference is to the whole definition not just the last sentence of each paragraph.	Thank you for drawing this to our attention. We have changed the attribution in the full Guideline.
138.	NHS Benchmarking Network	Full	162	3:5	Intermediate Care for People Living with Dementia – it is not clear whether the guideline development group is considering intermediate care which is specifically aimed at mental health needs of people with dementia, irrespective of whether they also have physical health needs, or whether one is considering the impact of dementia on physical health needs which themselves warrant intermediate care. These are two entirely different issues. The study by Culverwell and Milne would appear to be evaluating a mental health intermediate care programme and the guidance does not make it clear whether there was also a physical health need being met within the home treatment service. We think it is absolutely right that individuals with dementia, who have physical health needs that would justify referral and acceptance into a physical intermediate care service, are not denied this due to their dementia. Intermediate care services that are specifically designed for people with dementia, which may predominantly be dealing with their mental health rather than their physical health issues, should be out with this guidance and considered alongside, for example services which are solely delivered to people with single pathology, e.g. early supported discharge for stroke or fractured neck of femur. Having said all this, if the study by Culverwell and Milne continues to be included in the guidance then we would suggest that it is more relevant to see whether this intermediate care service had an impact on admissions to acute hospitals as well as to mental health hospitals.	Thank you for your comment. You raised some queries about the nature of the programme that was the subject of the study by Culverwell and Milne. This study was of a multidisciplinary service that 'was set up to provide specialist mental health intermediate care for those with dementia.' The population in the study 'had a dementia with associated complex and multiple needs', and the service provided by the specialist team was in addition to health and social care services already being provided. The GC decided not to change the recommendations concerning IC for people with dementia. The Guideline promotes a holistic approach to delivering intermediate care services, which would address a patient's physical and mental health needs, and never purely about one or the other. This is recommended for all Intermediate Care services, including those being provided for people with dementia.
139.	NHS Benchmarking Network	Full	175	3.5	Advocacy and training and support section... this section does not exclude advice on stroke services and includes a study by Hoffman et al relating to a hospital stroke unit. This just represents inconsistency with regard to inclusion/exclusion criteria (even though the exclusion criteria are not actually followed) and we would argue that a hospital based stroke unit does not fit the NAIC definitions of IC.	Thank you for your comment. You are right to highlight that according to the review protocols and in line with the NAIC definition of intermediate care, single condition service models were meant to be excluded from the systematic review. However, in their role quality assuring the review protocols, the Guideline Committee pointed out that early supported discharge and other stroke rehabilitation services as described in the literature are, in the context of current practice, closely aligned with intermediate care. This is in terms of the needs of people using the service, the organisation of the service and the functions delivered by the teams. They also believed the same exceptions should be made for the Inglis and Mahomed studies. In light of your comment, amendments have been made to the reporting of the review work and we are grateful to you for having highlighted this oversight.
140.	NHS Benchmarking Network	Full	19	5-7	We agree that there remains confusion about the difference between reablement and care. Staff assessing and accepting a client on to the service need to be clear about service expectation, goal setting and the need for clients to actively engage in reablement rather than passively accept care. This ties in with earlier recommendations e.g. written copies of agreed goals and expectations.	Thank you for your support, the GC certainly aimed to address this in the development of the recommendations.
141.	NHS Benchmarking Network	Full	19	2.1	Research Recommendations - Team composition for home-based intermediate care - studies of this have been funded by NIHR - as these were not randomised controlled trials and it would not be appropriate for them to be so - they were only referenced in a limited way in this guideline. Is it appropriate to suggest this is a research recommendation again? We support the other research recommendations.	Thank you for making this point, which the GC considered. On balance and in the absence of published evidence to address this specific question GC members still wanted to make the recommendation for well-designed comparative studies to be conducted – while acknowledging the important contribution that qualitative studies would also make to answering this question.
142.	NHS Benchmarking Network	Full	212	3.9	Evidence to Recommendations – we agree with **recommendations 1:1:1, 1:1:2, 1:1:3.** It would seem that there is considerable scope for gathering evidence on patient experience which is an important outcome measure for any intermediate care research and this is captured in our **research questions 2b and 4b**. We don't agree with the Guideline Committee's conclusion that this was mainly about referring to existing support and services so that there should not be substantial resource implications. We think that the evidence gathered from the NAIC Patient Experience would suggest that there is considerable unmet need and this may be because there	Thank you for your comment. The GC clarified that they felt there were no substantial resource implications associated with implementing these recommendations.

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					are inadequate support services available.	
143.	NHS Benchmarking Network	Full	212	3.9	We would entirely agree that **recommendation 1:1:2** should apply to all four service models of intermediate care. Whilst the evidence base may be moderate, it is consistent in showing that there is poor communication and engagement of patients and families in intermediate care which results in their lack of understanding of what intermediate care entails and what the expectations should be, hence the comments of people feeling that they are "done to" rather than "involved in" by intermediate care and reablement staff. We would suggest that some of this confusion and poor communication is because the staff themselves are not clear about what is expected of them and of the patients due to the wide range of terminology used and the confusion regarding how long someone may or may not be expected to be availed of intermediate care/reablement services, i.e. the misperception that it is for no longer than six weeks. This links to our comment on 1.6.1. that staff should be clear on the principles of IC i.e. patient centred care.	Thank you for your support.
144.	NHS Benchmarking Network	Full	212	3.9	Once again, we would entirely agree that **recommendation 1:1:3** should apply to all four models of intermediate care.	Thank you for your support.
145.	NHS Benchmarking Network	Full	215/ 216	3.9	We would support recommendations 1:1:4, 1:1:5 and 1:1:6, although we would reflect back to the earlier comments regarding the lack of evidence for involvement of people with dementia in intermediate care and the lack of clarity on the evidence base used by the Guideline Committee. We would, therefore, support the research recommendation 3, but there needs to be clarity that this is about people with physical need requiring intermediate care, who also happen to have dementia and is not about dementia-specific intermediate care.	Thank you for your comment. The GC is clear that intermediate care should be considered for people living with dementia and they do not mean 'cognitive intermediate care' (or similar). On the contrary, intermediate care should address people's needs holistically and if someone with a dementia diagnosis is judged likely to benefit in terms of their independence and quality of life then they ought to be referred to the service. The GC is keen to emphasise that intermediate care should not be limited to addressing people's physical needs, regardless of any diagnoses they may have.
146.	NHS Benchmarking Network	Full	215/ 216	3.9	We would agree that **recommendations 1:1:4, 1:1:5 and 1:1:6** are about referring to existing support and services and should not have substantial resource implications.	Thank you for your input.
147.	NHS Benchmarking Network	Full	215/ 216	3.9	Evidence based statement HB1 is intuitive in the concept of holistic care as outlined in the evidence statements 1:1:1 to 1:1:6 and are not undermined by the comments about looking at intermediate care for those with physical needs who happen to have dementia as well, as opposed to intermediate care specifically for people with dementia who may or may not have physical needs.	Thank you – we have clarified the GC's position in relation to dementia and intermediate care. Basically the GC is keen to emphasise that intermediate care should not be limited to addressing people's physical needs, regardless of any diagnoses they may have.
148.	NHS Benchmarking Network	Full	219	3.9	We agree with **recommendations 1:1:7, 1:1:8 and 1:1:9,** although **recommendation 1:1:8** (Deploying staff flexibly across the different service models) may be difficult to meet.	Thank you for your support. The GC actually agreed to make some changes to these recommendations, which may go some way to addressing your concerns. For example, 'Consider making reablement, crisis response and bed based and home based intermediate care all available locally. Deliver these services in an integrated way so that people can easily move between them, depending on their changing support needs.' The Guideline now states that staff should be deployed flexibly and the GC did feel that this is feasible to implement, not least because it is already happening in some areas of England.
149.	NHS Benchmarking Network	Full	220	3.9	Research recommendation 1 regarding effectiveness and cost-effectiveness in terms of team structure and composition is a very valid research question and must include patient reported experience and outcome measures.	Thank you. We accept your point and would say that the chosen outcomes measures would be down to the discretion of the commissioner and researchers but that yes, it would be important for patient reported measures to be included. Patient (user) experience and outcome measures are included in the PICO table for the research question.
150.	NHS Benchmarking Network	Full	221	3.9	Regarding the economic considerations, **recommendation 1:1:7**, the clinical reality is that not everybody is suitable for home-based intermediate care and so whilst there is evidence that this could be as cost-effective as bed-based intermediate care, there is insufficient evidence to warrant the lack of provision of one or other model of intermediate care. In rural settings it is possible that the economic modelling may change and then a choice would need to be made, in consultation with the public, as to which aspects of health care cannot afford to be provided.	Thank you for the comment. We accept the point that home-based IC might not be clinically appropriate for everyone and also that the evidence does not support the lack of provision of one or the other model of IC. It is possible that costs could be quite different dependent on a range of factors including the nature of the setting. We have added the following text: "In rural settings it is possible that the economic modelling may change and then a choice would need to be made by commissioners, in consultation with the public, as to

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						which aspects of health care cannot afford to be provided."
151.	NHS Benchmarking Network	Full	225 / 226	3.9	We agree entirely with recommendations 1:2:1 through to 1:2:5 and agree that this is not a priority area for research.	Thank you.
152.	NHS Benchmarking Network	Full	239	3.9	We support **recommendations 1:2:11 and 1:2:12 and research recommendation 2** should also look at the economic evaluation of crisis response services.	We agree that research is needed which investigates the cost-effectiveness of crisis response intermediate care and this has been clarified in the final guideline.
153.	NHS Benchmarking Network	Full	24	2:5	The research question regarding single point of access should surely ask whether a single point of access has any impact on time from referral to starting intermediate care or reablement.	Thank you for your suggestion. The GC feel that this is implied in the way the research recommendation is explained when it states, 'a management structure that has a single point of access can…speed up referral and access to services'. Therefore they decided not to make any changes to the way the research recommendation is described.
154.	NHS Benchmarking Network	Full	241	3.9	Recommendation 1:3:1 we fully endorse and agree that this is not an area for research but is an area for audit and clinical governance.	Thank you for your support. After further careful reflection on the evidence and modelling, and taking account of stakeholder feedback, the Guideline now states: 'Consider bed-based intermediate care for people who are in an acute but stable condition but not fit for safe transfer home. Be aware that if the move to bed-based intermediate care takes longer than 2 days it is likely to be less successful.'
155.	NHS Benchmarking Network	Full	242	3.9	Recommendations 1:3:2 and 1:3:3 we support with the caveat that in the first bullet point of 1:3:2 this is really an expectation of how fast one expects the individual to improve to the point at which they can be discharged from which ever model of intermediate care they have been admitted to and should not be used as a means of time limiting the individual's stay within a service.	Thank you for your comment. The GC accepts that the reference to informing the person about a specific time limit could seem to be a means of limiting the time a person receives the service. In the final version of the Guideline, the bullet point will be moved to the bottom of the list, and state 'tell the person that intermediate care is a short-term services and explain what is likely to happen afterwards'.
156.	NHS Benchmarking Network	Full	243	3.9	We support recommendation 1:3:4. Again, we agree that 1:3:2 to 1:3:4 are not areas for research priority but are areas that require audit and clinical governance review to ensure that intermediate care and reablement are not being driven by time constraints but are delivering individualised patient care. We would agree with the Guideline Committee that there is no economic argument that can divert from the need for effective practice, person-centred care with excellent communication and information sharing and that these holistic aspects of care should indeed have minimal cost implications. Standardisation of good practice and good communication skills should improve the patient journey and patient experience, improve goal planning and goal attainment, thereby reducing costs or being cost neutral rather than increasing costs.	Thank you for your support.
157.	NHS Benchmarking Network	Full	245	3.9	We would agree with the Guideline Committee discussion that if there is clarity of communication as to the purpose of intermediate care; what can be expected to happen through the duration of intermediate care; under which circumstances the spell in the intermediate care service would come to an end and how this would happen; and what would be available after the period of intermediate care, it would become evident that this is not time limited but that the amount of time taken for each individual will vary and will, therefore, be tailored to each individual, i.e. will be patient-centred. This should avoid confusion for staff, patients and families.	Thank you for your support.
158.	NHS Benchmarking Network	Full	246	3.9	We agree with **recommendations 1:3:5, 1:3:6, 1:3:7 and 1:3:8** and would not prioritise this as an area for research.	Thank you for your support.
159.	NHS Benchmarking Network	Full	249	3.9	We support **recommendations 1:3:9, 1:3:10, 1:3:11** and would support research recommendation 2.	Thank you for your support.
160.	NHS Benchmarking Network	Full	25	2:6	On duration and intensity of home based intermediate care. We think the research question is, do longer periods of intermediate care meet more need, particularly that of loneliness, and in the assessment of the research question the outcome measures need to quantify loneliness within their health related quality of life measurements and whether there is a change in degree of loneliness before entering intermediate care/reablement to when one leaves it. If one uses an old fashioned terms such as rehabilitation and the goal orientated nature of this, then just because someone is lonely at the point of being discharged from intermediate care/reablement does not mean that that intermediate care service should carry on for longer but perhaps that those needs should be met by an alternative provision. To some extent the guidance hints at this when it covers discharge arrangements and plans for care after the spell of intermediate care has finished.	Thank you for this suggestion. The GC is in agreement with you about the important role that intermediate care could play in addressing goals around social engagement and participation and reducing loneliness. However this was not the particular focus that they felt this research recommendation should have and indeed they were limited in terms of the number of research recommendations they could include. On the basis of the evidence review they felt that the research recommendations they included would have the greatest impact in terms of the current evidence base.

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161.	NHS Benchmarking Network	Full	251	3.9	We support **recommendations 1:3:12, 1:3:13, 1:3:14, 1:3:14, 1:3:15** and agree that this is not a priority area for research but that goal setting and goal mapping is an important area for audit and clinical governance.	Thank you for your support.
162.	NHS Benchmarking Network	Full	256	3.9	We support recommendations 1:4:1, 1:4:2 and 1:4:3. With regard to research recommendation 4, we would reflect back to the earlier comments in respect of Section 2:4 about repeated periods of reablement and periods of reablement that last longer than six weeks because we feel it is unclear as to what the Guideline Committee is expecting to focus on or identify from this line of research. Section 2:4 – the research question for reablement assumes that the length of reablement is somehow not defined by the needs of the individual. For example, the statement "there is no peer review study that measures the impact of different durations of reablement for different population groups" denies the basic concept that all forms of intermediate care should be person centred not disease centred. Where that paragraph goes on to say that some people are offered reablement for periods of longer than six weeks, this is presumably because they need longer, i.e. it is patient focused. The National Audit of Intermediate Care has indeed shown that with increasing complexity of patients throughout the four years of the National Audit of Intermediate Care, lengths of stay have increased and it is highly likely that variations in length of stay are related to individual needs and comorbidities rather than the specific disease process for which they entered into intermediate care, e.g. fractured neck of femur or stroke. Equally, the concept of studying people who have repeated periods of reablement seems unclear in its understanding of why this might be. These individuals will presumably have had repeated episodes of illness; an obvious example group would be those with repeated falls necessitating periods of rehabilitation. We find it hard to see how a research study could identify optimum number of episodes of rehabilitation/reablement.	Thank you for highlighting this. We have a different approach to the issue. Whilst the provision of IC is person-centred, we are still interested in evaluating which active ingredients led to which outcomes at what costs and for whom; in fact designs such as realistic evaluations might be particularly suitable to capture the context – mechanisms – outcomes. Although funding for reablement is generally only available for periods of up to 6 weeks, some people require longer periods of support so research is needed to determine the CE of differing durations of reablement, likewise repeat provision.
163.	NHS Benchmarking Network	Full	256	3.9	Regarding **research recommendation 3**, we would also refer to the earlier comments about intermediate care for people with dementia and to seek clarification as to whether this is with respect to people with physical need for intermediate care who also happen to have dementia as opposed to people with dementia who may or may not have a physical need.	Thank you for your comment. In line with our response to the related points you have made, the GC have clarified that they are referring to intermediate care in general terms and how it can be used to support people living with dementia. This is not intended to refer to specific 'mental health' intermediate care because the point is that intermediate should be addressing people's needs holistically, regardless of any diagnosis they may have.
164.	NHS Benchmarking Network	Full	259	3.9	We support **recommendations 1:4:4, 1:4:5, 1:4:6** and we are neutral regarding **research recommendation 5.**	Thank you for your support.
165.	NHS Benchmarking Network	Full	261	3.9	We support **recommendations 1:4:7 and 1:4:8** and would be surprised if there were not economic implications of providing an adequate work force that could cope with sickness, maternity leave, holidays and work load demand.	Thank you for your query – in fact these recommendations are referring to missed or late calls rather than sickness, maternity leave and so on.
166.	NHS Benchmarking Network	Full	262	3.9	We would support **recommendations 1:5:1, 1:5:2 and 1:5:3.**	Thank you for your support.
167.	NHS Benchmarking Network	Full	264	3.9	We support **recommendation 1:6:1, 1:6:2 and 1:6:3**, likewise **recommendations 1:6:4 and 1:6:5**. We would suggest that **"geriatrician" is added to the list for 1:6:5.**	Thank you for your support. The GC noted that the list is only intended to provide examples, and not to be exhaustive, and so they are not in favour of making the suggested addition to the list. However, just to flag that the Guideline now states that practitioners with specific skills should be included in the core intermediate care team. One such set of required skills is in conducting comprehensive geriatric assessment, which might help to address your point.
168.	NHS Benchmarking Network	Full	270	3.9	We support **recommendations 1:7:1, 1:7:2 and 1:7:3**.	Thank you for your support.
169.	NHS Benchmarking Network	Full	3	Introduction	The introduction requires a few amendments. It refers to the definitions used in NAIC and then states, 'services span acute and long-term care' - this is incorrect. Intermediate care services have been defined by NHS England as being time-limited and are frequently locally defined as between 6 and 8 weeks. This is clearly mentioned in the section on Terms Used in This Guideline Intermediate care services are time-limited, normally no longer than 6 weeks.	Thank you for your suggestions. The GC accepts that the Introduction could benefit from some clarification of different terms, although they felt the distinction they wanted to make was between intermediate care and on-going care and support. We have also made the changes you suggested – replacing 'between' with 'in' and have removed the reference to intermediate care spanning long-term care.

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					The relevance of the 2nd paragraph is not clear to the reader. It would help if it was made clear that the objective of intermediate care services was to prevent admissions and facilitate earlier discharge. The following sentence does not make sense----replace the word 'between' with 'in': This guideline covers all adults (aged 18 and older) using intermediate care, including reablement services between inpatient hospital, community or care home settings Commissioners should be referred to in the following sentence: The guideline is for health and social care providers and practitioners delivering intermediate care and reablement, and for people who use the intermediate care and reablement services and their family carers. We would suggest that the introduction could be enhanced by clarifying the difference between care and rehabilitation e.g. ☐ Care: timely and appropriate assistance with daily tasks to reduce risk sustain health and improve well-being. Making sure people are looked after appropriately. ☐ Rehabilitation: A complex process of trying to help people who have suffered some injury/disease or developmental disorder to maximise independence, functional ability, psychological wellbeing, and social integration.	As you rightly say, the aim of paragraph 2 is to explain the aim of intermediate care, which is actually broader than facilitating transfer from hospital and preventing avoidable admissions. Intermediate care also aims to support people to maximise their independence where specific support and rehabilitation is likely to help with this. We have clarified this in the second paragraph and hope you find that it's clearer.
170.	NHS Benchmarking Network	Full	51	NA	'Studies reporting views and experiences data for people using home-based intermediate care, their families or carers, n=5' - Only Steve Aris' work on the PREM open narrative question is reference, there is no mention the rest of the PREM (15 questions) and SU audit.	The Ariss et al paper, which provided useful data on people's views and experiences was included because it met one of the study design (survey) criteria set out in the review protocol, whereas the other sources you cite did not.
171.	NHS Benchmarking Network	Full	7	1.1.5	'Learn to observe and not automatically intervene' - suggest changing this to 'observe and guide and not automatically---'	Thank you for your comment. The Guideline Committee has considered the change of wording you have suggested. The GC agrees that this change would help to convey the meaning of the recommendation, and agrees that the suggested change should be made.
172.	NHS Benchmarking Network	Full	7	1.1.6	'Do not exclude people from intermediate care based on whether they have a particular condition, such as dementia, or live in particular circumstances, such as prison or temporary accommodation' - suggest adding residential home to the above definition	Thank you for your comment. The GC agreed that this would be an appropriate addition and the change has been made in the final version of the guideline.
173.	NHS Benchmarking Network	Full	7	1.1.6	We strongly support the recommendation that people with dementia should not be excluded from IC.	Thank you for your support.
174.	NHS Benchmarking Network	Full	7	1.1.9	List of team members – medical staff should be included within the list of disciplines.	Thank you for your suggestion. We received a number of comments about the list of core practitioners so the GC considered them in detail. They finally decided to list essential skills rather than specific roles and this is reflected in the final guideline. They felt that in terms of core team members, the most important skill required from medical staff (apart from the list of therapies) would be the competence to conduct comprehensive geriatric assessments so this is now reflected in the re-drafted recommendation.
175.	NHS Benchmarking Network	Full	7	1.1.9	'Ensure that intermediate care teams include staff from a broad range of disciplines. Core practitioners include' - suggest that the disciplines are reordered and that support staff are put at the end and that it is made clear that support staff are supporting professionals in undertaking the care plan.	Thank you for your suggestion. We received a number of comments about the list of core practitioners so the GC considered them in detail. They finally decided to list essential skills rather than specific roles and this is reflected in the final guideline. Also just to note that the GC believes that the skills required to deliver an intermediate care package (which may be through support workers) are crucially important and agreed they should be listed first.
176.	NHS Benchmarking Network	Full	7	1.1.9	Make reference here to 1.6.5, links to other services.	Thank you for your suggestion. The GC feels that although the two recommendations are related there is no real need to add a link from one to the other. A number of the recommendations in the guideline could be said to be related and it is likely that linking between them all would cause confusion.
177.	NHS Benchmarking Network	Full	8	1.2	Assessment of need for intermediate care - Should also include 'if client deemed as not appropriate, a full justifiable reason needs to be given'. This can assist with the wider aim of explaining service provision to future referrers.	Thank you for your comment. The GC took the view that the discussion about the aims and objectives of intermediate care would include a discussion about what type of referrals were and were not suitable. For this reason the GC did not feel that the addition you have suggested would be needed.
178.	NHS Benchmarking Network	Full	8	1.2.6	This is not a very clear statement – add "to the home" after "adjustments" to make it clear what this is referring to.	Thank you for your comment. The GC agrees that this recommendation could be clearer. The wording will be updated to refer to 'making any adjustments needed to their home'.

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179.	NHS Benchmarking Network	Full	8 + 205	1.2.3 +1.6.4	A link should be made between recommendations 1.2.3 and 1.6.4 (page 8 and page 205). "Through all stages of assessment and delivery, ensure good communication between IC staff and other agencies and between IC staff. " Statements like "ensure good communication" can feel like lip service without the "how" explained. The how is included within section 1.6.4 and therefore a link to this section should be included to support recommendation 1.2.3.	Thank you for this suggestion. The recommendations to which you refer are not quite as closely linked as you suggest. For example, 1.2.3 (in the draft guideline) was about communication between intermediate care teams and families (and other agencies) and the other rec you refer to was specifically about how to improve communication within intermediate care teams. In the final guideline 1.2.3 has actually been moved to the overarching principles (now rec 1.1.2), because having discussed it in more detail, the GC felt that communication with people and families ought to underpin every stage of intermediate care. There are a number of recommendations in subsequent sections which detail exactly how and at what critical points that communication should happen.
180.	NHS Benchmarking Network	Full	9	1.2.7	**Bed-based Intermediate Care** is unclearly worded and might be better worded as follows, *"for people who are in an acute but stable condition requiring intermediate care but who are not fit for home-based intermediate care or reablement, consider bed-based intermediate care. Transfer from acute care to start of intermediate care service should take no longer than two days".*	Thank you for your comment. The GC accepted that the wording of the recommendation could be made clearer. After further careful reflection on the evidence and modelling, and taking account of stakeholder feedback, the recommendation now reads: 'Consider bed-based intermediate care for people who are in an acute but stable condition but not fit for safe transfer home. Be aware that if the move to bed-based intermediate care takes longer than 2 days it is likely to be less successful.'
181.	NHS Benchmarking Network	Full	General	General	As the NAIC Steering Group, we would recommend delaying the publication of these guidelines until the results of the NAIC 2017 are available and can be referenced. Finding from the NAIC will be published in November 2017.	Thank you for your suggestion. We have been in touch with the NAIC Steering Group and having considered the timing and likely content of the 2017 audit, do not feel there would be a benefit to delaying the publication of this guideline. However the guideline will be reviewed within the next 2 years and will draw on the most up to date audit data at that point.
182.	NHS Benchmarking Network	Full	General	General	Throughout the document there are numerous references to the 6-week timeframe for intermediate care. Whilst intermediate care is a time limited service, the service provided should be tailored to the patient's individual needs and therefore the duration of stay for patients will vary.	Thank you for your comment. The Guideline Committee has considered your suggestion. They agree with this point, and in the updated draft of the Guideline references to the 6-week timeframe have been removed, and instead it will be described as a time-limited service. However, the 'terms used' section of the Guideline will continue to state that the service normally lasts for no longer than 6 weeks, in accordance with the NAIC definition.
183.	NHS Benchmarking Network	Full	General	General	As noted below, the evidence referred to in the guideline relies heavily on RCTs related to single condition rehabilitation. Intermediate care is not a service related to a specific disease and consideration should be given to other relevant sources of information including mixed methods studies, high quality case studies, pragmatic quality improvement studies and the findings of the NAIC. Whilst the analysis of the PREM narrative question (within NAIC) is referenced the response to the 15 "I" statement questions within the PREM are ignored. The findings related to the "I" statements provide valuable evidence about what is important to patients and where improvements could be made, for example, in communication. The NAIC service user audit also provides a unique data set on outcomes in home, bed and re-ablement services, which have not been utilised in the guideline. The NICE guidance on multimorbidity and frailty, transitions from hospital and health care for people with social care needs, focus less on single organ conditions and don't excessively centre on RCTs.	Thank you for your comment. The systematic review work was based on review protocols which stipulated which study types would be considered for answering the different questions. For example, for the questions about people's views and experiences, the reviewers sought data from qualitative studies and from qualitative components of mixed methods studies as well as observational and cross sectional surveys of user experience. For the effectiveness questions, studies were sought which would provide the most robust data about the outcomes of an intervention, therefore studies with a controlled design. However other designs without a control were also considered for inclusion, such as before and after or mixed methods studies. Where a substantial volume of evidence was included on full text the reviewers further prioritised studies for review and presentation to the GC. In seeking to present the most robust data on which to develop recommendations in which the GC could have most confidence then – for effectiveness questions – randomised controlled studies were prioritised where they were available. However, having reviewed the best available evidence about the effectiveness of intermediate care models, the GC agreed to include an additional review question designed to elicit data about aspects of service delivery and approaches to intermediate care. The question (question 7) did not seek evidence about a causal link between elements of intermediate care and outcomes so the included study types differed from questions 1-6, for example service and process evaluations would be considered as well as national audits. It is on this basis that the National Audit of Intermediate Care was included for question 7, providing valuable evidence which the GC used to develop recommendations. The Ariss et al paper, which provided useful data on people's views and experiences was included because it met one of the study design (survey) criteria set out in the review protocol, whereas the other sources you cite did not.
184.	NHS Benchmarking Network	Full	General	General	It is explicitly stated that the guidance would exclude evidence from studies of single conditions rehabilitation such as stroke (pg 32) but then they go on to include the following studies specifically relating to single condition rehabilitation	Thank you for your comment. You are right to highlight that according to the review protocols and in line with the NAIC definition of intermediate care, single condition service models were meant to be excluded from the systematic review. However, in

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					pg 36:Bjorkdahl (2006) et al: stroke pg 37: Bjorkdahl (2007) et al: stroke Pg 40: Fjaertoft et al: stroke Pg 41: Inglis et al: chronic heart failure Pg 42: Kalra et al: stroke Pg 44: Mahomed et al: primary unilateral knee replacement (additionally, we found the reporting of the evidence from this paper difficult to interpret due to very confusing description of the intervention and control) Pg 50: Thorsen etal: stroke Pg 50: Ytterberg et al: stroke Pg 54: Cobley et al: stroke Pg 61: Choiliara et al: stroke Again, evidence detailed in the bed based section explicitly stated that they were going to exclude single condition rehabilitation, namely stroke then they go on to describe evidence from hospital based stroke units and stroke teams (Kalra et al pg 83), and rehabilitation specifically following neck of femur fracture (Stenvall et al, pg 85). If the single condition studies remain in the guidance then this discrepancy should be acknowledged.	their role quality assuring the review protocols, the Guideline Committee pointed out that early supported discharge and other stroke rehabilitation services as described in the literature are, in the context of current practice, closely aligned with intermediate care. This is in terms of the needs of people using the service, the organisation of the service and the functions delivered by the teams. They also believed the same exceptions should be made for the Inglis and Mahomed studies. In light of your comment, amendments have been made to the reporting of the review work and we are grateful to you for having highlighted this oversight.
185.	NHS Benchmarking Network	Full	General	General	The NAIC Steering Group strongly support the overall emphasis on individualised goal setting and person centred care that comes across in the guidance.	Thank you for your support.
186.	NHS Benchmarking Network	Full	General	General	The NAIC includes four functions of IC, reablement being one of these, and it's on an equal footing with the other three functions. If this guidance is going to use the NAIC definition of IC, it would be helpful if didn't keep referring to 'intermediate care including reablement', as if it's something different. Referring to it in this way could lead to confusion or even undermine the importance of reablement. It would be helpful if it wasn't separated out throughout the document, including the title.	Thank you for your comment. The Guideline Committee has considered the point you raised about using the term 'intermediate care including reablement'. The GC took the view that the term 'reablement' should not be removed from the title because it risks local authorities thinking the guideline is not for them, since IC can be perceived as being a health focused service. The GC agreed to keep reablement clearly in the title, but state in the introduction that it is seen as one service, and there is no need to separate the terms throughout the Guideline.
187.	NHS Benchmarking Network	Short	21	25	Word missing – should read: "The skill mix and competency OF a home-based intermediate care team can influence the quality of care and outcomes…"	Thank you for your comment. The word 'of' has been added to the wording of the recommendation, as your suggested.
188.	NHS England	All	General	general	Outlined below are a significant number of substantive comments. These reference a high proportion of items for which the NAIC 2017 audit, to be published in November 2017, will provide further evidence. Therefore we would recommend delaying publication of this NICE Guidance until the content of the 2017 audit can be referenced.	Thank you for all your suggestions. We have been in touch with the NHS Benchmarking Group and having considered the timing and likely content of the 2017 audit, do not feel there would be a benefit to delaying the publication of this guideline. However the guideline will be reviewed within the next 2 years and will draw on the most up to date audit data at that point.
189.	NHS England	Full	32	1	The exclusions clear state studies of single condition rehabilitation should be excluded for question1, however several single condition research projects are included in the subsequent review (this exclusion is not present for questions 3-6)	Thank you for your comment. You are right to highlight that according to the review protocols and in line with the NAIC definition of intermediate care, single condition service models were meant to be excluded from the systematic review. However, in their role quality assuring the review protocols, the Guideline Committee pointed out that early supported discharge and other stroke rehabilitation services as described in the literature are, in the context of current practice, closely aligned with intermediate care. This is in terms of the needs of people using the service, the organisation of the service and the functions delivered by the teams. They also believed the same exceptions should be made for the Inglis and Mahomed studies. In light of your comment, amendments have been made to the reporting of the review work and we are grateful to you for having highlighted this oversight.
190.	NHS England	Full	6-18	general	All comments above assigned to the short document apply to the corresponding items in the Full document (pages 4-16 of the Short guidance correlating to Pages 6-18)	Thank you for the clarification.
191.	NHS England	Full	73	27	The exclusions clearly state studies of single condition rehabilitation should be excluded for question 2, however two single condition research projects are included in the subsequent review (this exclusion is not present for questions 3-6)	Thank you for your comment. You are right to highlight that according to the review protocols and in line with the NAIC definition of intermediate care, single condition service models were meant to be excluded from the systematic review. However, in their role quality assuring the review protocols, the Guideline Committee pointed out that early supported discharge and other stroke rehabilitation services as described in the literature are, in the context of current practice, closely aligned with intermediate care. This is in terms of the needs of people using the service, the organisation of the

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						service and the functions delivered by the teams. They also believed the same exceptions should be made for the Inglis and Mahomed studies. In light of your comment, amendments have been made to the reporting of the review work and we are grateful to you for having highlighted this oversight.
192.	NHS England	Full	General	General	The tone of the discussion of evidence does not reflect the core principle on P4 line 10 that person centred care is a core principle.	Thank you. It is unclear from your comment exactly how the tone of discussions could be improved. Reporting the results of review work is intended to be objective and analytical in style and in large part is dictated by the data located in the evidence base. The GC interpret the evidence review and develop recommendations based on their own expertise in delivering, commissioning and using services. It is at this point that messages derived from the research may be translated into recommendations which are person centred and reflect the ethos the GC is trying to promote.
193.	NHS England	Full	General	27-212	There are several single condition studies referenced throughout the research section at odds with the approach outlined to avoid these.	You make a helpful point about the use of evidence about single condition rehabilitation, which highlights an oversight in our reporting within the draft guideline. According to the review protocols and in line with the NAIC definition of intermediate care, single condition service models were meant to be excluded from the systematic review. However, in their role quality assuring the review protocols, the Guideline Committee pointed out that early supported discharge and other stroke rehabilitation services as described in the literature are, in the context of current practice, closely aligned with intermediate care. This is in terms of the needs of people using the service, the organisation of the service and the functions delivered by the teams. In light of your comment, amendments have been made to the reporting of the review work and we are grateful to you for having highlighted this oversight.
194.	NHS England	Short	10	2	Add new bullet after this – • Take into account their knowledge, skills and confidence to manage their health and care well	Thank you for your comment. The GC decided against adding the suggested bullet point to the recommendation, since it is not supported by the evidence underpinning this guideline.
195.	NHS England	Short	10	10	1.3.13: We suggest that formal and informal employment and occupational activities are also included, for example a person's role as a carer.	Thank you for your comment. The GC did not believe there was support in the evidence to make these changes to the recommendation. However there are recommendations in the overarching principles which recommend taking a broad approach to identifying a person's needs.
196.	NHS England	Short	10	15	1.3.15: We suggest that emphasis also be placed on documenting agreed and robust outcome measures.	The GC agrees with your observation, and is of the view that it is essential that goals should be measurable so that the outcomes of the intervention are quantifiable. The GC would not wish the Guideline to be prescriptive about which tool to use, as long it was valid or psychometrically robust. Rather than changing this recommendation, they agreed to edit the Guideline which now refers to 'measurable goals' and they have also amended the Guideline to say that intermediate care services should work towards 'an agreed approach to outcome measurement for reporting and benchmarking'.
197.	NHS England	Short	10	24	..conditions or those who have low levels of knowledge, skills and confidence), either	Thank you for this suggestion. The GC did not change this recommendation, not least because it is adapted from the NICE guideline on home care.
198.	NHS England	Short	10	27	1.4.4: We suggest that care coordination and/or navigation has an important role to play in delivering integrated care across complex systems as per NICE NG 22	Thank you for this. Although the GC agreed with your point they did not feel any changes to the recommendations were necessary.
199.	NHS England	Short	11	10	Where possible, the care diary/record should be made available electronically	Thank you for your comment. The GC considered that while this would be an aspirational recommendation to make, it would be an unrealistic expectation to make of many service providers and furthermore it is not supported by the evidence underpinning the guideline. The GC therefore decided not to make this change.
200.	NHS England	Short	12	2	1.5.1: We agree in principle with this recommendation: however in practice it may be difficult to implement for some service elements dependent upon local configuration and resources. Given the above noted pre-existent delays for assessment and delivery of service we question whether this recommendation risks creating false expectations among service users and their carers/family.	Thank you for your comment. The GC took the view that, while recognising the concerns that you have raised, they believe that it is legitimate for people and their families to be able to refer back to the IC service, so that rather than creating false expectations this recommendation is just describing how the service ought to operate.
201.	NHS England	Short	12	16	1.6.1: We strongly support this recommendation for all elements of the intermediate care service.	Thank you for your support.
202.	NHS England	Short	12	18	1.6.1: Accountability depends on the specific responsibilities for which an individual is accountable: in complex services this may involve service level managerial and governance accountability and/or clinical accountability for example: we suggest this requires further consideration though in principle we support the recommendation.	Thank you for raising this. On the basis of the evidence the GC did not feel they could be any more specific in terms of recommending accountability.
203.	NHS England	Short	13	21	This recommendation should include a requirement that staff are trained in the skills of care and support planning	Thank you for your comment. The GC agreed that a bullet point along these lines could be added, though the focus would be described in terms of goal-setting, which

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						is more relevant to the delivery of intermediate care than 'care and support planning'. The bullet in the final guideline reads, 'how to work collaboratively with people to agree person-centred goals'.
204.	NHS England	Short	13	27	1.7.2: We suggest the inclusion of frailty, multimorbidity, falls risk assessment, medicines optimisation, continence, communication and mental capacity for care decisions are included in this list.	Thank you for your comment. The GC considered which of your suggested items could be included on the basis of the evidence they reviewed and in light of their own expertise in delivering, providing and using intermediate care. They agreed to add 'frailty' and 'multimorbidity' to the list of common conditions, and 'continence' to the 'support needs'. These changes are included in the final version of the Guideline.
205.	NHS England	Short	14	6	1.7.2: We suggest inclusion of reference to palliative care skills.	Thank you for highlighting this. The GC feels that is adequately covered in the recommendation with the bullet that refers to 'dealing with bereavement and end of life'
206.	NHS England	Short	14	8	1.7.2: We suggest inclusion of reference to skills in comprehensive geriatric assessment. All points above are very biomedical. Add another bullet point here: People with different levels of knowledge, skills and confidence to manage their health and care	Thank you for your comments. The GC has decided that 'skills in comprehensive geriatric assessment' should be included in the list of attributes that core members of an IC team have. This will be part of the 'core principles' section of the Guideline, and will appear in the final version. With regard to the suggestion that a new bullet point should be added, stating 'People with different levels of knowledge, skills and confidence to manage their health and care', the GC was unclear whether the people referred to were the people receiving the IC service or the staff providing it. The GC took the view that there would be no need to include such a statement about staff in the Guideline, and if the point was intended to refer to people receiving the IC then this was not the appropriate recommendation for such an addition, as it deals with the capabilities of staff.
207.	NHS England	Short	16	5	'These service ….independence' – very important point	Thank you for your support.
208.	NHS England	Short	19	10	Intermediate care should also aim to help develop people's knowledge, skills and confidence to manage their health and care well so they can take appropriate action in case of future acute episodes.	Thank you – the GC has captured this in the recommendation which states that intermediate care should assess and promote people's ability to self-manage.
209.	NHS England	Short	4	8	1.1.1: We suggest that any reference to 'goals' for care related to the outcomes of independence and well-being should also include reference to means of measuring these.	Thank you for your comment. The GC agrees with your suggestion and they have changed the Guideline which now refers to 'measurable goals'. They have also amended the Guideline to say that intermediate care services should work towards 'an agreed approach to outcome measurement for reporting and benchmarking'.
210.	NHS England	Short	4	11	…preferences as well as people's knowledge, skills and confidence to manage their health and care.	Thank you for this suggestion. The GC decided not to include the additional wording you suggested, as they took the view that the suggestion of drawing on people's knowledge, skills and confidence was already implied by the recommendation that the service should be person-centred.
211.	NHS England	Short	4	14	The wording of this sentence sounds a little patronising. Removing "why work closely together and" would address this.	Thank you for your comment. The GC does not consider that this recommendation sounds patronising but they have accepted another suggestion for the same bullet point, that the word 'why' should be replaced with the word 'how'. We hope this goes some way to addressing your concern.
212.	NHS England	Short	4	16	1.1.2: The use of the term 'more independently' requires clarification, as this is a relative term, which implies the need for measurement: more than what? We also question whether this is a realistic outcome for older people with frailty and/or multimorbidity. We suggest a better term is 'optimisation of functional ability'. In addition reference to 'a better quality of life' suggests that this is a measurable outcome which requires further clarification as to how it would be measured in practice.	The GC agrees with your observation, and is of the view that it is essential that goals should be measurable so that the outcomes of the intervention are quantifiable. The GC would not wish the Guideline to be prescriptive about which tool to use, as long it was valid or psychometrically robust. They agreed to edit the Guideline which now refers to 'measurable goals' and they have also amended the Guideline to say that intermediate care services should work towards 'an agreed approach to outcome measurement for reporting and benchmarking'.
213.	NHS England	Short	4	18	1.1.3: Reference to people 'recognising their own strengths' may be rather aspirational. We suggest that the focus should be on supporting people to understand their condition and prognosis for achievement of functional recovery. …strengths (including their knowledge, skills and confidence) to realise their potential	Thank you for your suggestion. The GC did not agree that this recommendation was too aspirational. The evidence highlighted the importance of people feeling motivated to engage with intermediate care and the GC felt that helping people to recognise their own strengths is an important part of encouraging and motivating people.
214.	NHS England	Short	4-7	General	There is a need for an explicit definition for rehabilitation and for this to be clearly linked.	The term rehabilitation in the sense of being a service is not referenced in the recommendations so the GC do not feel there is a need to explicitly define the term.
215.	NHS England	Short	5	19-27	1.1.9: We suggest that given the age and anticipated needs profile of the service user group with high levels of frailty and/or multimorbidity, the core team must include 1.1.9 (geriatricians and/or GP with interest in older people) with skills in comprehensive geriatric assessment and the management of older people with escalating care needs.	Thank you for your suggestion. The GC discussed this recommendation in detail as a number of stakeholders made various suggested additions. They actually decided to change the recommendation so that instead of listing specific practitioners who should be core members of the intermediate care team, it now lists the skills needed within

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					The need for medical cover of all types of IC is highlighted in NAIC 2015.	an intermediate care team. One such set of required skills is in conducting comprehensive geriatric assessment, which might help to address your point.
216.	NHS England	Short	5	19-27	The inclusion of the voluntary sector in the introduction to this list would be appropriate acknowledging that the team comes from a broad range of disciplines and sectors	Thank you for your suggestion. The GC discussed this recommendation in detail as a number of stakeholders made various suggested additions. They actually decided to change the recommendation so that instead of listing specific practitioners who should be core members of the intermediate care team, it now lists the skills needed within an intermediate care team. The sector and disciplines are not the focus – rather the skills that are required.
217.	NHS England	Short	5	1	1.1.4: We question how realistic it is for the 'emotional needs' of people to be addressed within the range of IC settings and whether this falls strictly within the remit of IC.	Thank you for your comment. The GC took the view that this is a realistic expectation, and that it should be retained, since IC aims to address the needs of the whole person.
218.	NHS England	Short	5	6	..person's knowledge, skills and confidence	Thank you for your comment. The GC did agree with you that this bullet point needed to say more, although not using the exact wording you suggested. The bullet point will now refer to 'knowledge, skills, resilience and confidence'.
219.	NHS England	Short	5	10	1.1.6: We support the right of people with cognitive disorder to be included in IC but suggest that cognition requires careful assessment and evaluation to ensure that delirium and dementia are recognised and appropriately managed.	Thank you for highlighting this. Although the GC were strongly in support of this recommendation – not to exclude people living with dementia – they are also well aware of the importance of proper assessment to ensure people's conditions are appropriately managed and supported. The GC felt that this element is addressed in the final guideline, which states that during assessment, people's needs, wishes and abilities should be identified to ensure they are referred for the most appropriate support, thereby acknowledging that intermediate care may, after all not be the most suitable approach to supporting some people. We would also refer you to the NICE guideline on dementia: https://www.nice.org.uk/guidance/cg42 which is currently being updated.
220.	NHS England	Short	5	28	1.1.10: As noted in NAIC 2015 we suggest that there is clear reference to clinical leadership which varies across the various service models: crisis response was nurse led in 67%, home based was therapist led in 51%, bed based was nurse led in 50% and reablement was social worker/care manager led in 53%.	Thank you for your suggestion. The GC decided that they did not wish to recommend any particular leadership model, and would only specify what the composition of the teams should be.
221.	NHS England	Short	6	4	Add bullet point Tailor their approach to people's knowledge, skills and confidence with skills such as motivational interviewing health coaching, etc	Thank you for your comment. The Guideline Committee did not review evidence specifically about the effectiveness of MI or health coaching so they did not feel they could make this addition.
222.	NHS England	Short	6	6	1.2.1: Given the age profile of service users we suggest that clear reference is made to the use of comprehensive geriatric assessment by an appropriately constituted multi-disciplinary team. We suggest this is particularly important where hospital admission is being avoided to ensure that a person's clinical diagnoses and needs are fully understood when choosing the best model and location of IC to meet their needs.	Thank you for your suggestion. A number of other stakeholders commented on this recommendation and the GC actually took the view that it should focus on the skills or competencies required as part of an intermediate care service. They also agreed with you about the importance of having the skills to carry out CGA within the context of an intermediate care team so this has been added to the newly drafted recommendation which lists core intermediate care skills and competencies.
223.	NHS England	Short	6	15	Add after this – Signpost people appropriately or provide them with tailored support, e.g. intensive support for people with low levels of knowledge, skills and confidence	Thank you for your comment. The GC noted that there is already a statement that IC staff should refer on to other services where appropriate. The GC felt that signposting introduces a concept not now present, and so would lead to a lack of clarity about what the recommendation was saying.
224.	NHS England	Short	7	8-13	Discussions with the home care worker should also occur to ensure joined up care where an existing home care package is being reviewed	Thank you for your suggestion. The GC accepts that the process could be improved through discussions with the home care provider, and the next draft of the Guideline will be amended to include the following: '…Take into account the person's needs and preferences when considering reablement and work closely with the home care provider.'
225.	NHS England	Short	7	2	1.2.7: The description "if transfer from acute care takes no longer than 2 days…." Would benefit from redefinition. Though text later in the document gives further information the lack of clarity at this point is at best misleading and at worst open to interpretation as being service availability focused. We suggest this be reworded, at a minimum, to reflect the NAIC 2015 recommendation for a "refer to assess" standard for bed based IC.	Thank you for your comment. While the GC accepted that the wording of the recommendation as presented in the consultation draft could be made clearer, the aim of this recommendation is not about 'refer to assess', it is about the time it takes between the decision to transfer and the transfer taking place. After further careful reflection on the evidence and modelling, and taking account of stakeholder feedback, the recommendation now reads: 'Consider bed-based intermediate care for people who are in an acute but stable condition but not fit for safe transfer home. Be aware that if the move to bed-based intermediate care takes longer than 2 days it is likely to be less successful.'
226.	NHS England	Short	7	6	1.2.8: We support this recommendation but note that the assessment times for reablement were noted to be increasing in 2015. Given the lack of data for 2016 we	Thank you for your comment. While noting your observation that there could be resource implications in offering reablement as a first option to people being

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					do not know if this trend has continued but given reported increases in delayed transfer of care (https://www.nao.org.uk/wp-content/uploads/2015/12/Discharging-older-patients-from-hospital.pdf) we anticipate that this is likely to be the case. This recommendation is likely to have a resource impact on the provision of adequate reablement capacity.	considered for home care, the GC would refer to economic evidence, which showed that reablement compared with standard home care was cost saving.
227.	NHS England	Short	7	8	1.2.9: The provision of reablement in addition to home care is, we suggest, unlikely to occur given that reablement is often provided to expedite hospital discharge prior to provision for home care. There are also operational and funding implications from this recommendation both for recipients and care commissioners given that home care is funded separately and means tested.	Thank you for your comment. The GC note that hospital discharge is only one of the circumstances in which reablement and home care may be provided, and basing the recommendation on those circumstances would make the focus of the recommendation too narrow. For that reason, the GC decided not to amend the recommendation.
228.	NHS England	Short	7	11	…reablement; as well as their knowledge, skills and confidence and provide tailored support according to their needs.	Thank you for your comment. The GC agrees that it is important to take account of knowledge, skills and confidence in providing Intermediate Care. However, the GC is recommending that these be included in the section specifying core principles.
229.	NHS England	Short	7	15	1.2.11: We suggest that there is a recommendation for people referred for crisis response to be assessed expediently using comprehensive geriatric assessment or equivalent. For people with rapidly escalating and undifferentiated needs it is important to ensure that acute medical illness or occult injury is identified or excluded early in the assessment process to reduce the potential for poor outcomes. This is particularly the case for people with falls and deteriorating cognition.	Thank you for your comment. The GC recognises the need for any health deterioration to be understood so the appropriate response can be provided, but also notes that while some crisis response service have the necessary expertise, this is not true of all of them. The recommendation will have changed wording: 'Refer people to crisis response if they have experienced an urgent increase in health or social care needs and: • the cause of the deterioration has been identified • their support can be safely managed in their own home or care home • they are likely to benefit from the service • the need for more detailed medical assessments has been addressed.'
230.	NHS England	Short	7	27	1.3.1: We broadly support this recommendation but also note that assessment of the in-scope user group must then also be started early. In 2016 54% hospitals reported that discharge planning does not commence early enough to minimise delays for older people: https://www.nao.org.uk/wp-content/uploads/2015/12/Discharging-older-patients-from-hospital.pdf . In NAIC 2015 it was noted that in the preceding 3 years waiting times for the various service elements were increasing: 6.3 days for home-based, 3.0 days for bed-based and 8.7 days for reablement services. We suggest that the time scales may need to be adjusted to reflect the current observed trends and differential waits for various service elements. We also suggest that data from NAIC 2017 may help to assess how realistic this recommendation is likely to be in practice and therefore delaying publication of the guidance to assess impact may be appropriate. (as per comment no 1)	Thank you for this information in response to the consultation question.
231.	NHS England	Short	8	2-12	The first bullet point implies that the planning starts with a presumption about how long the service will last, rather than this judgement being based on an assessment of the person's needs, (made jointly with them), prior to the decision about the extent of the service. It would be better for this bullet point to be deleted from this recommendation. A separate recommendation can be written which focuses on the decision about the planned duration of the service based on the assessment and plan of care agreed jointly with the person.	Thank you for your comment. The GC agrees that the recommendation should not include a presumption about how long the IC service will last, and in the final guideline the first bullet point simply states 'tell the person what will be involved'. The list will conclude with a bullet point stating 'tell the person that intermediate care is a short-term services and explain what is likely to happen afterwards', so as to communicate that the service will be time limited.
232.	NHS England	Short	8	20	1.3.5: We suggest this includes a specific recommendation for falls risk assessment as per NICE CG161 and QS86. We also suggest that there is specific reference to the need for a cognitive assessment as per NICE CG 103.	The GC recognises that there may be a risk of falls for some people being assessed for IC, however they consider that there are many specific risks which the Guideline could list as needing to be assessed, but the Guideline as framed should cover the variety of potential risks without being specific about each of them.
233.	NHS England	Short	9	11	1.3.7: We suggest that given the age profile and anticipated user case mix it should be explicit that a risk assessment be undertaken for suitability to self-manage medicines *before* a person is accepted for IC.	Thank you for your comment. The GC agreed not to make this change since they did not consider evidence that would support it.
234.	NHS England	Short	9	14	1.3.8: We suggest that emphasis be placed on the need for *multidisciplinary* team working being central to coordination and reassessment.	Thank you for your comment. The GC accepts that the recommendation should include such a reference.
235.	NHS England	Short	9	21	It is not clear whether the 2 hour limit applies at all times of day or night, or whether this is a daytime weekday limit. We suggest it should be the former and requires rewording.	Thank you for your comment. The GC recognises why you have drawn this issue to their attention, but feel that they do not have enough evidence to make the recommendation any clearer. They also noted that in some circumstances, e.g. dealing with several referrals at once or in rural areas, the 2 hour time limit could be hard to meet so they did not feel they had grounds to make a more specific

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						requirement.
236.	NHS England	Short	9	23	1.3.11; We suggest that full clinical assessment should be undertaken for older people with undifferentiated needs relating to worsening cognition and/or falls presenting acutely as a matter of routine to ensure that delirium and occult injury have been excluded.	Thank you for highlighting this. Two recommendations in particular have been reworded and we hope that they address your concerns. First the recommendation about core skills to be included in an intermediate care team includes the competence to conduct comprehensive geriatric assessment. Secondly, the final guideline states that people should be referred to crisis response as long as the need for more detailed medical assessments has been addressed.
237.	NHS England	Short	9	27	1.2.12: We suggest that this be aligned to specific outcome measures as set out above to include patient related outcome and experience measures (PROMs and PREMs). We also suggest that emphasis be placed on the role of the multidisciplinary team as central to goal/outcome setting, reassessment and measurement.	Thank you for your suggestion. The GC agreed with the principle that goals should be measurable and this has been added to the very first recommendation under core principles. In addition, they agreed to edit the Guideline to highlight that intermediate care services should work towards an agreed approach to outcomes measurement for reporting and benchmarking.
238.	NHS England	Short	General	general	While the development of Intermediate Care (IC) guidance is much needed to support a uniform approach to service configuration and delivery, it is suggested that in its present form, this draft guideline does not align sufficiently with the data set out in the most recent report from the National Audit of Intermediate Care NAIC (2015). We also suggest it does not align sufficiently with recent developments in the NHS England GMS Contract 2017/18 which require routine frailty identification, falls risk identification (aligned to NICE CG 161 and QS 86) and annual medications review aligned to NG 56 Multi-morbidity The draft does not, in our view, adequately reflect the current range of care pathways or user profiles (case mix and care needs) currently in receipt of IC and the current levels of demand for each service element as demonstrated within the 2015 NAIC report (link above). Demand for the different elements is not uniform (for example ranging from 266 referrals per 100K population for bed based service to 808 referrals per 100K population for home based service). Waiting times for each service element vary considerably (for example referral to assess times varied in the 2015 audit from 1.3 days for bed based service to 8.7 days for reablement). A potential consequence of this is that recommendations in the guidance may carry more or less weight depending on local demand and service configuration. This is particularly important when considering the way in which IC services operate currently to support system wide flow and provide either hospital admissions avoidance or rehabilitation and recovery after an episode of hospital-based care. We suggest that the guidance should contain greater focus on the care pathways operating for patients in receipt of IC from the perspectives of step-up care and step-down care, both of which should be defined. In particular we suggest that for patients leaving hospital, the guidance should contain specific reference to Discharge to Assess care models The 2015 audit suggested that overall 62% of IC capacity was being used for step-up care, the majority within home based care and reablement. Approximately one third of home-based capacity was used for step-down and the rest for step-up care. For bed-based services the opposite was true in 2015, with 71% capacity being used for step-down, which was noted to have grown from 60% the preceding year. We will not know until later in 2017 when the NAIC reports again, whether this trend has continued. However the GP Forward View and Five Year Forward View support development of community services capability and capacity to increase the proportion of step up care. This was noted to be a concern in the NAIC 2015 report which commented 'commissioners should also consider the balance of step-up and step-down provision in their intermediate care systems and ensure, in particular, there is adequate step-up bed capacity which may come under pressure from step down demand'. This places greater emphasis on community (primary care) based	The National Audit of Intermediate care played a key role in the development of this guideline with the definitions of the Intermediate care service models informing the context and also the review protocols. The review team therefore searched for and included studies that met the NAIC definition although an exception is the exclusion of single condition interventions. The GC felt that the NAIC definition didn't quite match current practice and they agreed for example that rehabilitation and early supported discharge for stroke patients was close enough to intermediate care as it is currently provided that research on those interventions ought to be included.

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					assessment and care and we suggest this current approach to NHS delivery could be more strongly reflected within the guidance. The guidance does not specifically reflect the needs of older people who form the majority of service users. In NAIC 2015 over 90% users were aged 65 and over in all service categories. In bed-based services 51% were aged over 85 compared to 39% in home based, and 43% in reablement. In 2015 the proportion of bed based service users aged over 90 was noted to be rising. The guidance does not draw attention to the current evidence base supporting comprehensive geriatric assessment which is available from : http://www.bmj.com/content/343/bmj.d6553.long . Given the age profile of service users we suggest that this is an omission. In addition it does not refer specifically to the role of geriatricians and old age psychiatrists as specialists in the delivery of acute and community based care for older people despite these professional groups being part of core older people's multidisciplinary teams. We suggest the guidance should also contain specific reference to validated outcomes measures and tools. The NAIC 2015 used the Modified Barthel Index for bed-based services (Sam Salek. *Compendium of quality of life instruments*. Vol. 1. Wiley, 1998) and two domains of the Therapy Outcomes Measures (wellbeing and participation) for home-based and reablement services. The ICHOM Standard Set for Older People also provides a comprehensive set of validated outcome measures for older people available from: http://www.ichom.org/medical-conditions/older-person In line with the NAIC we also suggest that consideration be given to the inclusion of Patient Related Experience Measures be included in this guidance. A database of measures for Person Centred Coordinated Care is available at http://p3c.org.uk/full-database The document needs more on addressing people's knowledge, skills and confidence, as well as building the workforce skills to address these effectively. This asset based approach will help people to manage their health and care better and take control when similar episodes happen again. Suggest strengthening focus on building community capacity to support people to stay well using referral to social prescribing as an example.	Thank you for your comment. The GC recognised that people being provided with intermediate care services are predominantly older people, many living with frailty, and that this needs to be recognised so that they are not disadvantaged compared to younger people. This issue has been considered by the GC as part of the equalities impact assessment. However it should be noted that the population for this guideline is all adults (18 years and over) so the recommendations are targeted accordingly. The GC also considered your suggestion that the Guideline should make specific reference to validated outcomes measures. The GC agreed that this would be a useful addition to the Guideline, although as we do not review evidence to recommend a specific tool the GC agreed to make a more general reference to goals being measurable. They have also amended the Guideline to say that intermediate care services should work towards 'an agreed approach to outcome measurement for reporting and benchmarking'. The research located by the systematic reviewers and considered by the Guideline Committee led to some specific recommendations about the skills required within the intermediate care team and about training and development of the workforce. The GC did not feel there was evidence to make further recommendations in the way you suggest.
239.	Parkinson's UK	Short	10	10-11	Parkinson's UK strongly supports the recognition that *'participation in social and leisure activities are legitimate goals of intermediate care'.* We strongly support the principle of the Care Act which focuses on the importance of meeting self-defined outcomes. Paragraph 6.19 of the Care and Support Statutory Guidance states: *'The carer's assessment must also consider the outcomes that the carer wants to achieve in their daily life, their activities beyond their caring responsibilities, and the impact of caring upon those activities. This includes considering the impact of caring responsibilities on a carer's desire and ability to work and to partake in education, training or recreational activities, such as having time to themselves.'* We are therefore pleased that the draft guideline also takes a more person-centred view of a person's reablement objectives.	Thank you for your support.
240.	Parkinson's UK	Short	10	25	Although we welcome the recommendation that '*more specialist support is available to people who need it either by training intermediate care staff or by working with specialist organisations'* we are unclear as to what 'specialist organisations' mean in this context.	Thank you for your query. 'Specialist organisations' refers to any organisation providing care and support which addresses particular conditions of particular needs which would not normally be in the remit of the intermediate care service. People would be referred to those organisations for additional support or those organisations could provide training to intermediate care staff so they were able to provide adequate

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					For example, Multidisciplinary teams (MDTs) and, in particular, Parkinson's Nurse Specialists provide expert help to people with the condition. They would be ideally placed to offer specialist support Parkinson's patients in receipt of intermediate care. We therefore recommend that 'specialist organisations' are more clearly defined to clarify whether specialist nurses and MDTs are able to provide specialist support for patients in care homes.	support themselves. This might involve people with Parkinson's disease or indeed a range of other conditions.
241.	Parkinson's UK	Short	5	10-11	We strongly support the requirement not to exclude people from intermediate care based on 'whether they have a particular condition, such as dementia, or live in particular circumstances' as a 'core principle'. People with Parkinson's are up to six times more likely to be diagnosed with Lewy Body Dementia – a particularly complex form of dementia characterised by severe hallucinations and psychotic episodes. Forthcoming research which explores the experiences of people with Parkinson's in care homes suggests that, in many cases, care home staff are unprepared for these often complex and difficult symptoms. We therefore warmly welcome the requirement not to discriminate against people based on their condition, particularly people with dementia.	Thank you for your support.
242.	Parkinson's UK	Short	7	6-13	Parkinson's UK welcomes the ambition of the guideline to consider reablement as a route to 'improving independence'. However, it is important to recognise that this is not an appropriate outcome for people with degenerative conditions such as Parkinson's. Despite this, reablement is still useful for people with Parkinson's. It can help to maintain their current level of need and stop it progressing further. We therefore recommend that the wording in line seven is updated to mirror line 13, by recognising the role of maintaining support. The line should be updated to read as follows: '*Offer reablement as a first option to people being considered for home care, if it is judged that reablement could improve* ***or maintain*** *their independence'*	Thank you for your comment. The GC considers that Intermediate Care should not be seen as maintaining people at a particular level of independence. IC aims to optimise people's independence to the best level they can achieve, at which point further assessments could be made so that services aimed at maintaining that level of independence could be considered. The GC also noted that that people with degenerative conditions can sometimes lose independence and with the support provided by Intermediate Care can regain at least some measure of it – e.g. make some relative gains in terms of independence. For these reasons, the GC decided not to change the recommendation in the way suggested.
243.	Parkinson's UK	Short	8	5, 10	We are pleased that the draft guideline includes a reference to assessing a person's mental capacity and ability to self-administer medication when undergoing assessment by the intermediate care service. However, we are disappointed that the guideline does not go further to explore how such assessments should be undertaken. We are particularly concerned that this is not assessed simply on the basis of whether a person has, or does not have, mental capacity or the ability to self-administer their medication. This is of particular importance for people with Parkinson's, given the complex, fluctuating nature of its symptoms – which includes confusion and cognitive difficulties. Parkinson's is a condition which requires medication to be taken at very specific times to an individual (maybe up to 5 or 6 times a day). Missing doses of medication, even by a short period of time, can have a severe, detrimental impact on a person's condition, which is not possible to recover from. When someone with Parkinson's doesn't get their medication at the time prescribed for them, their symptoms become uncontrolled – increasing their care needs considerably. A person may not be able to move, get out of bed or walk down the corridor. Once this balance of chemicals has been upset it may take hours, days or even weeks for a person's Parkinson's to stabilise. A carer of someone with Parkinson's explains: *'My wife was unable to get her medication at the right times and her health went downhill rapidly. As well as developing problems swallowing, she became rigid, which meant she wasn't able to have physiotherapy to help keep her moving. I can't overstate how crucial it is for*	Thank you for your comment. The GC considers that if a person had a medical condition that might make it difficult to self-administer medication, such as Parkinson's, then a risk assessment would be carried out. The GC considers that this would avert the risky situations that you have described. Linked with this, there is a NICE guideline on Parkinson's disease, which has recommendations on managing medication, and another guideline which is in development, on managing medication in the community. Finally, a guideline on decision making and mental capacity is currently in development and this is likely to make recommendations about how capacity assessments should be undertaken.

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					people with Parkinson's to get their medication on time.' We therefore recommend that the final guideline sets out recommendations for methods of assessing mental capacity. We also feel that the ability to self-administer medication should be assessed based on whether a person can undertake this activity repeatedly and reliably.	
244.	Royal College of General Practitioners	Short	10	1.3.12, line 1 1.3.13	• The recommendation that goals should be SMART derives from management practice, and is fashionable in medical circles, but how helpful it is here? For instance, when a patient is recovering from a stroke, it is impossible to know at the outset how much will be *achieved* and how quickly. How *measurable* are improvements in a sense of wellbeing? Regarding time, the full guideline notes that some patients felt that the 6-week period was too short (see HB4, on p66). This implies that it may be difficult to apply any time constraint. This conflicts with the firm commitment to a 6-week limit on p15, line 12 of the short guideline. • Surely participation in social and leisure activities are the primary goals of intermediate care (rather than merely legitimate).	Thank you for your comment. With regard to the first point, the GC notes that there is no firm commitment to a 6 week time limit in the Guideline, and parts of the Guideline are being reworded to make it absolutely clear that while this is a short term service the length of provision will be guided by the needs of the person receiving the IC service. The GC's view is that it is possible for people involved in assessment and goal setting to estimate how achievable certain goals will be, and so they have decided to retain SMART goals in this recommendation. With regard to the second point, the GC noted that the view of social and leisure activities as being the primary goals of Intermediate Care was not supported by evidence from research or expert witnesses, and the GC decided to retain the wording in the consultation draft of this recommendation.
245.	Royal College of General Practitioners	Short	17	27	• A lead would ideally be practice based and with the authority and experience of a community matron as some practices have done with immense help.	Thank you, we will pass your suggestion on to our implementation team.
246.	Royal College of General Practitioners	Short	4	1.1.2	• Patients generally want to work with professionals and take an active part in their care; having to explain the obvious to them risks appearing patronising, as well as superfluous. • If any explanation is required, why do they not include here a requirement to explain that the purpose is to enable patients to achieve their own objectives?	Thank you for your comment. The GC agreed that this addition would strengthen what the Guideline is saying, by making its intentions more explicit, and agrees with the suggested addition.
247.	Royal College of General Practitioners	Short	5	1.1.7 line 21	• There appears to be confusion caused by the distinction between the different service models. From a generalist point of view there would appear to be a lot of overlap between them, both in terms of staff and setting. The recommendation that all 4 should be available may create more silos and result in further confusion between different teams. • 1.1.9 - The GP is a core person in the community as the practice has long standing information and often understanding of the case.	Thank you for your comment. The GC recognises there is overlap between the service models, but would wish to emphasise that while the service models describe different functions of IC, they do not need to be provided by different teams. It is possible for teams to incorporate integrated functions. The aim of recommending that all 4 intermediate care service models should be available locally refers to the person moving between types of service model, which may include location. The GC recognises that the recommendation could be reworded in order to make this clearer, and the wording is being changed in the re-drafting of the Guideline. The redrafted recommendation now reads: 'Consider making reablement, crisis response and bed based and home based intermediate care all available locally. Deliver them in an integrated way so that people can easily move between them, depending on their changing support needs.' The Guideline Committee has also considered your suggestion of including a GP in the core Intermediate Care team. The GC discussed this in detail as a number of stakeholders made various suggested additions. They actually decided to change the recommendation so that instead of listing specific practitioners who should be core members of the intermediate care team, it now lists the skills needed within an intermediate care team. We hope you will feel that your point has been addressed by the inclusion of 'conducting comprehensive geriatric assessments' as one of these skills. Comprehensive geriatric assessments, are usually – although not always – conducted by GPs or geriatricians.
248.	Royal College of General Practitioners	Short	6	line24	• One of the reviewers had experience of this approach where an elderly brother and sister looked after each other – both becoming more frail although the sister seemed to be suffering from memory problems more rapidly than the brother. The sister was discharged home from hospital with reablement. He was very worried about continuing to cope at home and wanted her to be considered for nursing/dementia care. This could take time and in the meantime they are both at risk. He felt disloyal at telling the GP who fed it back to the team	Thank you for this account, which highlights the importance of involving families and carers in discussions about intermediate care and the most appropriate support.

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249.	Royal College of General Practitioners	Short	8	1.3.2 1.3.5	• Consider the order. Should 'involve the person in setting goals, and their family or carers. If the person agrees to this' come first? • Telling how long the service will last may be difficult, and inconsistent with other recommendations. See comment on 1.3.12 below. • Please congratulate the committee on the wording of this paragraph. Important to ensure that concerns for safety do not trump patients' own wishes.	Thank you for your comment. The GC agreed to make changes to take account of your suggestions. The first bullet point will now read 'assess and promote the person's ability to self-manage', to be followed by a bullet point stating 'tell the person what will be involved', and there will be a new final bullet point stating 'tell the person that intermediate care is a short-term services and explain what is likely to happen afterwards'.
250.	Royal College of General Practitioners	Short	9	line 21	• If there is this time limit in an area, they will often be informing referrers that they "lack capacity" because of the demand.	Thank you for your comment. The GC noted that the crisis response service only has to be started within 2 hours if it is considered appropriate, which could ease some of the pressure anticipated by your comment.
251.	Royal College of General Practitioners	Short	General	General	• The recommendations do seem on the whole to be sensible and admirably centred round the patients. Intermediate care has to be seen in the context of an integrated system rather then just by itself. A system that identifies vulnerable people before they enter the system, has streamlined hospital processes and "pulls" people back out of hospital ideally with the social package of care still intact It seems that psychiatric patients are not included in this guideline unless being discharged from a medical or surgical ward. • The evidence on which the full guideline is based does not appear to be very substantial and there is much more learning to do. The research questions are particularly important, as is the emphasis on joint and updated records with regular audit. • Is it possible to infer that the recommendations seem sensible because they were reached by committee consensus and therefore avoid being the product of vested interests? • There appears to the absence of GP representation on the committee. This may explain why Primary care appears so little in the recommendations and yet this is quite a large part of GPs' work.	Thank you for your support. All adults are included in this guideline and the GC was keen to emphasise that people should not be excluded from intermediate care on the basis of a particular condition or diagnosis. We would agree that the evidence for certain areas was lacking - for example crisis response intermediate care and also the use of intermediate care to support people living with dementia. The GC are seeking to address these gaps by making research recommendations. Evidence for some of the other areas such as bed based and home based intermediate care was on the whole good and certainly relative to other social care topics covered by NICE guidelines in this programme. It is true that the Guideline Committee initially lacked involvement by a GP but during the development phase a GP was co-opted to support the development of recommendations.
252.	Royal College of Nursing	Full	General	General	The Department of Health Guidance: *Intermediate care: halfway home: updated guidance for the NHS and local authorities* is a useful resource to reference: http://www.scie-socialcareonline.org.uk/intermediate-care-halfway-home-updated-guidance-for-the-nhs-and-local-authorities/r/a11G00000017sWXIAY	Thank you for your suggestion. This document provides valuable context for this guideline although it does not meet the inclusion criteria for the systematic review which informs the recommendations.
253.	Royal College of Nursing	General	General	General	The RCN is a member of the NHS Benchmarking Network. The RCN support the Network's submission on this draft guideline consultation.	Thank you for responding to the draft guideline consultation.
254.	Royal College of Nursing	Question 1	1		*Which areas will have the biggest impact on practice and be challenging to implement?* The areas that would have the largest impact on practice would involve integration. There is currently a great deal of overlap of services with resources wasted as a result of this. Creating a single pathway with people moving between the expertise of a single team would see the most benefits. The challenges to this as a model would be the tight financial constraints particularly on social care budgets which are forcing local authorities to make difficult choices to pull back from integration in some areas. Rotational posts, mental health input into teams, pooled budgets and robust education and training of support staff and professionals to work in an interdisciplinary way to reduce duplication and enable the right practitioner to undertake the visit such as that adopted in South Gloucestershire and Bristol prior to 2010. There are also examples of facilitating early supported which can reduce morbidity and length of stay i.e. discharge following elective surgery 3 days post hip or knee replacement in Bristol. Early supported discharge for Stroke patients in Portsmouth.	Thank you for this information, which we will pass to our implementation colleagues.
255.	Royal College of Nursing	Question 2	2		*Would implementation of any of the draft recommendations have significant cost implications?* Apart from the financial issues discussed in point one above, other cost implications would be training, setting up single points of access which can be expensive when covering wide access times. The need to improve on research knowledge would also	Thank you for this information, which we will pass to our implementation colleagues.

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					be a cost pressure.	
256.	Royal College of Nursing	Question 3	3		*What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.)* Honest examples of practice are always helpful, particularly patient case studies. There could also be some gain to commissioning intermediate care via one single provider to reduce waste from multiple management structures or administrative costs. It may also provide a single focus and help with integration. Pooled budgets are a good way to reduce duplication and maximize the resources available.	While we recognise that case studies can produce interesting and informative data, they were not included in the review protocols for type of studies to be included.
257.	Royal College of Nursing	Question 4	4		*Recommendation 1.2.6 recommends that home-based intermediate care is the preferred approach. Are local services configured or being reconfigured to enable this? Please provide brief details of, or signposts to, examples or case studies of approaches to configuring intermediate care services.* Home based Intermediate Care should be the primary focus and there are increasing national studies which indicate this is widely in place in the U.K. Home based - i.e. in the person's usual place of residence which may be a care home is the preferred option as it is in familiar surroundings and has a better chance of success. We are aware that this approach is used in Dorset. - Dorset have provided community based Intermediate Care services for a number of years with an emphasis on early supported discharge and avoiding hospital admission for adults with acute illness that can be managed in their own home (including care homes). Recent developments are attempting to create further integration in the form of locality hubs that bring together multiple providers with the aim of putting the patients' needs at the centre of provision. These 'hubs' are running in Weymouth and Christchurch and in the planning stage for other areas in Dorset as well.	Thank you for this information, which we will pass to our implementation colleagues.
258.	Royal College of Nursing	Question 5	5		*Recommendation 1.2.8 recommends offering reablement as a first option to people being considered for home care. Is this the approach used in your local area? Please provide brief details of, or signposts to, examples of the use of reablement at a local level.* In theory Reablement is the first option considered by most hospital discharge pathways but in reality when there are delays to accessing this, less ideal pathways are also used. For example, temporary care home placement or long term care. The pressure to free up hospital beds is still an understandably primary concern for most acute hospitals in order to provide urgent care to other patients. Reablement should also be used if someone living at home is beginning to struggle, this is not solely an acute hospital issue and people are often offered a placement instead of reablement or supported home care. Sirona Care – now Virgin Health in South Gloucestershire and Bath and North East Somerset do offer this.	Thank you for this information, which we will pass to our implementation colleagues.
259.	Royal College of Nursing	Question 6	6		*Recommendation 1.3.1 recommends that the time between a referral and an intermediate care service being started is no more than 2 working days. Is this the approach in your local area? How feasible is this in practice?* Two working days is the correct time to access intermediate care and this is the time most clinicians see most intermediate care services using this as a criteria. However there are certainly delays in some areas for people to access intermediate care with anecdotal references of some given up to 1 week. There are national examples of teams that do manage the 48 hour response reasonably well. There are examples in Dorset and Hampshire of this.	Thank you for this information, which has been incorporated in discussions about the final recommendations relating to response times.
260.	Royal College of Nursing	Question 7	7		*Recommendation 1.3.10 recommends that crisis response intermediate care services should be initiated within 2 hours of a referral being made (on the premise that the referral is appropriate). Is this the approach in your local area? How feasible is this in practice?* For any crisis team to be effective a fast and effective team is required and for acute health problems 2 hours is the correct response time in our opinion. However for other urgent issues, 4 hours could be offered and in reality this is likely what happens in practice with patients 'triaged' over the telephone before being assessed. By working this way it allows crisis teams to see some patients quicker than 2 hours if it is	Thank you for this information, which has been incorporated in discussions about the final recommendations relating to response times.

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					essential to do so. We are aware of some examples of this in clinical practice. All crisis response teams should be able to deliver intravenous therapy in order to enable people to remain in their usual place of residence.	
261.	Royal College of Occupational Therapists	Full	General	General	Occupational therapists aim to maximise people's independence and ability to participate in occupations. The Royal College of Occupational Therapists, therefore, welcomes this guideline for health and social care providers and practitioners delivering intermediate care and reablement services. A significant number of occupational therapists work within intermediate care and reablement services. From RCOT members we are aware that the challenges to implementing these recommendations will be: 1. Ensuring a seamless service 2. For people requiring ongoing support - timeliness of onward services and homecare providers maintaining a reablement ethos. Social Services Improvement Agency in Wales highlighted this in a review of reablement services in 2016 (https://socialcare.wales/cms_assets/file-uploads/25a-reablement-themed-review-report-july-16.pdf). 3. In Northern Ireland, occupational therapy-led reablement has been successfully commissioned for older adults (Health and Social Care Board (2015)). Within existing resources it would not be possible to extend the service to adults over the age of 18 without additional resources.	Thank you for your comment, and for drawing our attention to the Welsh report on Reablement Services in Wales. While this report was not considered for inclusion for the section of the Guideline dealing with reablement, it should be noted that it would not have been eligible for inclusion in the Guideline, as in presenting its findings the report does not present information about the methodologies for collecting and assessing the information it presents. The Guideline is based on research findings whose methodology and validity have been evaluated by the research team working on the Guideline.
262.	Royal College of Occupational Therapists	Short	17	5-7	We agree that there still remains confusion about the difference between reablement and care. Staff assessing and accepting a person on to the service need to be clear about service expectation, goal setting and the need for people to ***actively engage*** in reablement rather than ***passively accept*** care. This ties in with earlier recommendations, e.g. written copies of agreed goals and expectations. The College recommends that occupational therapists are deployed to provide '*advice and training for reablement workers' (Social Care Institute for Excellence and ADASS Older Persons Network 2012)* and act *'as a supervisor (Winkel et al 2015). Supervision by occupational therapists has been correlated with reablement workers' confidence in carrying out their role (Health and Social Care Board 2015)*.' Ref: College of Occupational Therapists (2015) *Fact Sheet: Reablement.* London:RCOT. Available at: https://www.rcot.co.uk/about-occupational-therapy/ot-evidence-factsheets Training, ongoing supervision and review by professional staff is an essential component in the creation of effective support staff. Aspinal et al (2016) argues that skilled professionals are crucial to reablement. (Aspinal F, Glasby J, Rostgaard T, Tuntland H, Westendorp RJL (2016) New horizons: Reablement - supporting older people towards independence. *Age and Ageing; 45:* 574–578 doi: 10.1093/ageing/afw094)	Thank you for your input. The GC agrees with your points and feels they are reflected in the recommendations.
263.	Royal College of Occupational Therapists	Short	5	19-27	List of team members - the intermediate care team often includes a doctor or geriatrician. Some teams also include Advanced Nurse or Therapist Practitioners.	Thank you for your suggestion. The GC discussed this recommendation in detail as a number of stakeholders made various suggested additions. They actually decided to change the recommendation so that instead of listing specific practitioners who should be core members of the intermediate care team, it now lists the skills needed within an intermediate care team. We hope you will feel that your point has been addressed by the inclusion of 'conducting comprehensive geriatric assessments' as one of these skills. Comprehensive geriatric assessments, are usually – although not always – conducted by GPs or geriatricians.
264.	Royal College of Occupational Therapists	Short	6	5	Consider *the assessment of need for intermediate care* including: If a person is deemed as not appropriate for immediate care, the reasoning is clearly given to assist with the wider aim of explaining service provision to referrers.	Thank you for your suggestion. The GC considers that the Guideline already recommends helping referrers to understand Intermediate Care, and so it is not necessary to add this requirement.
265.	Royal College of Occupational Therapists	Short	7	2-4	Bed-based intermediate care: 'If transfer from acute care **TO** (*delete word* **no**) home takes longer than 2 days,	Thank you. In discussing your suggestion, the GC accepted that the wording could be changed, but felt that they wanted to stress the importance of the transfer from acute

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					consider bed-based intermediate care for people who are in an acute but stable condition, but not fit for safe transfer home.'	care to IC taking place within 2 days. The GC decided that the recommendation should be reworded as follows: 'Consider bed-based intermediate care for people who are in an acute but stable condition but not fit for safe transfer home. Be aware that if transfer takes longer than 2 days the intermediate care is likely to be less successful.'
266.	Royal College of Occupational Therapists	Short	7	27	1.3.1 'Start the intermediate care service within 2 working days of receiving an appropriate referral'. Many services report that contact is made within 2 working days but due to pressures on capacity intervention starts later.	Thank you for this information in response to the consultation question. After further careful reflection on the evidence and modelling, and taking account of stakeholder feedback, the recommendation now reads: 'Consider bed-based intermediate care for people who are in an acute but stable condition but not fit for safe transfer home. Be aware that if the move to bed-based intermediate care takes longer than 2 days it is likely to be less successful.'
267.	Royal College of Speech and Language Therapists	Full	27		**Evidence review and recommendations** We believe that some of the reports in this section are not relevant to intermediate care and may be distracting. Furthermore, it would be helpful if it was made clearer which comparator group the results referred to. For example the report states: *Results: At 6 months follow-up, there was significant improvement in*: However, it must be made clear which group the significant improvement was determined in (presumably the intervention and not the control group)	Thank you for your query. The review team have checked the study to which you refer and assuming it is the paper by Aimonino et al. (2007), reported on p35 of the draft version of the Full Guideline, they cannot see that the details about the intervention can be made any clearer. The text already explains that the 2 groups being compared are the geriatric home hospitalisation service (GHHS) group and the general medical ward (GMW) group. GHHS are considered to be the treatment group and GMW the usual treatment or control group. The scores are already explicitly attributed to these groups, and the difference between them explained.
268.	Royal College of Speech and Language Therapists	Full	274		Implementation: getting started (*Starting intermediate care services within 2 working days…)* We suggest adding 'and increasing learn dependence' to the end of that sentence.	Thank you for your comment, which we will pass to our implementation colleagues. In addition the GC agreed to add an explanation to the recommendation, which now states that 'delays in starting intermediate care increase the risk of further deterioration and reduced independence'. We hope this addresses your point.
269.	Royal College of Speech and Language Therapists	General			The RCSLT suggest adding the phrase 'promoting greater independence' to the definitions of home-based and bed based services	Thank you. The GC discussed your suggestion and did not agree that this phrase needs to be added to the descriptions, which already contain the phrase 'maximise independent living'.
270.	Royal College of Speech and Language Therapists	Short	10	23	The RCSLT suggest adding the words 'and services' to the end of this sentence.	Thank you for this suggestion. The GC decided to retain the original wording, as it is the organisations that provide the services. 'Services' would be included within the meaning of the word 'organisations'.
271.	Royal College of Speech and Language Therapists	Short	10	23	1.5.1 We suggest adding 'or other services or agencies' at the end of this sentence.	Thank you for this suggestion. The GC decided to retain the original wording, as it is the organisations that provide the services. 'Services' would be included within the meaning of the word 'organisations'.
272.	Royal College of Speech and Language Therapists	Short	12	14	1.6.1 We suggest you consider adding 'an agreed approach to outcome measurement for benchmarking and reporting'	Thank you for your comment. The GC accepted your suggestion of adding a bullet point specifying 'an agreed approach to outcome measurement for reporting and benchmarking', and this will be included in the final version of the Guideline.
273.	Royal College of Speech and Language Therapists	Short	5	7	*1.1.5. learn to observe and not automatically intervene* We suggest changing this to 'observe and guide and not automatically…'	Thank you for your comment. The GC agrees that the change you have suggested would make the intended sense of the recommendation clearer, and so agrees to the suggested change being made.
274.	Royal College of Speech and Language Therapists	Short	5	10	1.1.6 – the RCSLT suggest adding residential home to the above definition.	Thank you for your comment. The Guideline Committee has discussed your suggestion, that residential home should be added to the list of particular living circumstances in this recommendation. The GC accepted that this would be an appropriate change to make and it has now been added to the list.
275.	Royal College of Speech and Language Therapists	Short	5	19	1.1.9 - We recommend that the disciplines are reordered and that support staff are put at the end and that is made clear that the support staff are supporting professionals in undertaking the care plan	Thank you for your suggestion. We received a number of comments about the list of core practitioners so the GC considered them in detail. They finally decided to list essential skills rather than specific roles and this is reflected in the final guideline. Also just to note that the GC believes that the skills required to deliver an intermediate care package (which may be through support workers) are crucially important and agreed they should be listed first.
276.	Royal College of Speech and Language Therapists	Short	7	2	1.2.7 - We believe the wording of this statement could be improved and as it currently reads it could lead to different interpretations.	Thank you for your comment. The GC accepted that the wording of the recommendation could be made clearer. After further careful reflection on the evidence and modelling, and taking account of stakeholder feedback, the recommendation now reads: 'Consider bed-based intermediate care for people who are in an acute but stable condition but not fit for safe transfer home. Be aware that if the move to bed-based intermediate care takes longer than 2 days it is likely to be less successful.'
277.	Royal College of Speech	Short	7	14	**Crisis response:** We believe the ordering of these recommendations should be	Thank you for your suggestion, with which the GC agrees. The change to the order of

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	and Language Therapists				changed with the response time being the first	the recommendations has therefore been made for the final guideline.
278.	Royal College of Speech and Language Therapists	Short	General		The RCSLT suggest that the introduction could be enhanced by clarifying the difference between care and rehabilitation, for example: **Care:** timely and appropriate assistance with daily tasks to reduce risk sustain health and improve well-being. Making sure people are looked after appropriately. **Rehabilitation:** A complex process of trying to help people who have suffered some injury/disease or developmental disorder to maximise independence, functional ability, psychological well-being, and social integration.	Thank you for your suggestion. The GC accepts that the Introduction could benefit from some clarification of different terms, although they felt the distinction they wanted to make was between intermediate care and on-going care and support.
279.	Society for Research In Rehabilitation	full	12-14		**Crisis response--** the ordering of these recommendations should be changed with the response time being the 1st *1.4.3 Ensure that more specialist support is available to people who need it (for example, in response to complex health conditions), either by training intermediate care staff or by working with specialist organisations.* Suggest adding the words 'and services' at end of sentence. *1.5.1 Before the person finishes intermediate care, give them information about how they can refer themselves back into the service.* Suggest adding 'or other services or agencies' at the end of this sentence. 1.6.1 consider adding 'an agreed approach to outcome measurement for benchmarking and reporting'	Thank you for your comment. The GC agreed with your suggestion, and the change has been made in the final version of the Guideline. The GC also considered replacing the word 'organisations' with 'services' in this recommendation, but decided to retain the original wording, as it is the organisations that provide the services. 'Services' here would be included within the meaning of the word 'organisations'. The GC considered your suggestion of adding the words 'or other services or agencies'. The GC was of the view that this recommendation referred specifically to people referring themselves back to the IC service, and so do not agree that 'or other services or agencies' should be included in this recommendation. The GC noted that the Guideline does specify elsewhere that there should be clear routes of referral to and engagement with other services. The GC accepted your suggestion of adding a bullet point specifying 'an agreed approach to outcome measurement for reporting and benchmarking', and this has been included in the final version of the Guideline.
280.	Society for Research In Rehabilitation	full	16		**Terms used in this guideline** Suggest adding the phrase 'promoting greater independence' to the definitions of home-based and bed based services	Thank you. The GC discussed your suggestion and did not agree that this phrase needs to be added to the descriptions, which already contain the phrase 'maximise independent living'.
281.	Society for Research In Rehabilitation	full	19-20		**Research Recommendations** *2.1 Team composition for home-based intermediate care*----studies of this have been funded by NIHR--- as these were not randomised controlled trials and it would not be appropriate for them to be so- they were only referenced in a limited way in this guideline. Is it appropriate to suggest this is a research recommendation again?	Thank you for your comment. The GC felt that this specific area represented a gap in the evidence base, which they want to address through further research, including – but not limited to - studies using a controlled design.
282.	Society for Research In Rehabilitation	full	27 onwards		**3 Evidence review and recommendations** The Guideline Committee expressed concern with regard to the appropriate city of the research that was incorporated on whether it was relevant to intermediate care. Should this be made explicit? The heterogeneous nature of the population requires different methodological approaches. Some of the reports in this section-- are not relevant to intermediate care and may be distracting. Furthermore, it would be helpful if it was made clearer which comparator group the results referred to. For example the report states:	Thank you for your comment. It is not clear exactly which papers you do not believe were relevant to intermediate care however a number of stakeholders queried why papers about single condition (e.g. stroke) intermediate care or rehabilitation have been included. If this is something you were concerned about, the reason they were included is that on the basis of their experience and expertise, the GC felt that early supported discharge and other stroke rehabilitation service are in the context of current practice essentially the same as intermediate care in terms of their organisation, delivery and the needs of people using the services. Thank you for your query. The review team have checked the study to which you refer and assuming it is the paper by Aimonino et al. (2007), reported on p35 of the draft version of the Full Guideline they cannot see that the details about the intervention can be made any clearer. The text already explains that the 2 groups being compared are the geriatric home hospitalisation service (GHHS) group and the general medical ward (GMW) group. GHHS are considered to be the treatment group and GMW the usual treatment or control group. The scores are already explicitly attributed to these groups, and the difference between them explained.

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					Results: At 6 months follow-up, there was significant improvement in: but it must be made clear which group the significant improvement was determined in (presumably the intervention and not the control group) The 2nd study cited --2. Bjorkdahl A, Nilsson AL, Grimby G et al. (2006)--- included only younger stroke patients. 7. Jackson JC, Ely EW, Morey MC et al. (2012) Cognitive and physical rehabilitation of intensive care unit survivors: results of the RETURN randomized controlled pilot investigation. Critical Care Medicine 40: 1088–97--- is a feasibility study, had no power, included baseball numbers of patients and should have been excluded Many of the studies included in this review were of one condition only e.g. heart failure, stroke, hip and knee replacement or COPD. It is strange that other studies of intermediate care specifically, funded by NIHR and published in peer-reviewed journals have not been included.	The study by Bjorkdahl et al included 58 stroke patients, with a mean age of 53, so the term 'younger' was being used in a relative sense and given that the population for this guideline as all adults, over 18 years of age then it was legitimate to include it. The fact that it was a feasibility study would not be a criterion for exclusion and although we would agree that the study is lacking in power, the GC would have taken this into consideration when discussing the weight to attach to the study and the extent to which it could be used to inform recommendations.
283.	Society for Research In Rehabilitation	full	274 onwards		**4 Implementation: getting started** *Starting intermediate care services within 2 working days (2 hours for crisis response) of receiving an appropriate referral. The rapid provision of the right intermediate care service will have benefits for people using the services, and may help reduce the pressure on hospital beds.* Suggest that one adds 'and increasing learn dependence' to the end of that sentence.	Thank you for your comment, which we will pass to our implementation colleagues.
284.	Society for Research In Rehabilitation	full	6-7		1.1.5- *learn to observe and not automatically intervene* suggest changing this to 'observe and guide and not automatically---'	Thank you for your comment. The Guideline Committee has considered the change of wording you have suggested. The GC agrees that this change would help to convey the meaning of the recommendation, and agrees that the suggested change should be made.
285.	Society for Research In Rehabilitation	full	7		*1.1.6 Do not exclude people from intermediate care based on whether they have a particular condition, such as dementia, or live in particular circumstances, such as prison or temporary accommodation.* Suggest adding residential home to the above definition	Thank you for your comment. The GC agreed that this would be an appropriate addition and the change has been made in the final version of the guideline.
286.	Society for Research In Rehabilitation	full	7		*1.1.9 Ensure that intermediate care teams include staff from a broad range of disciplines. Core practitioners include* suggest that the disciplines are reordered and that support staff are put at the end and that is is made clear that support staff are supporting professionals in undertaking the care plan	Thank you for your suggestion. We received a number of comments about the list of core practitioners so the GC considered them in detail. They finally decided to list essential skills rather than specific roles and this is reflected in the final guideline. Also just to note that the GC believes that the skills required to deliver an intermediate care package (which may be through support workers) are crucially important and agreed they should be listed first.
287.	Society for Research In Rehabilitation	full	9		*1.2.7 If transfer from acute care takes no longer than 2 days, consider bedbased intermediate care for people who are in an acute but stable condition but not fit for safe transfer home.* This is poorly phrased and very hard to understand and would lead to different interpretations	Thank you for your comment. The GC accepted that the wording of the recommendation could be made clearer. After further careful reflection on the evidence and modelling, and taking account of stakeholder feedback, the recommendation now reads: 'Consider bed-based intermediate care for people who are in an acute but stable condition but not fit for safe transfer home. Be aware that if the move to bed-based intermediate care takes longer than 2 days it is likely to be less successful.'
288.	Society for Research In Rehabilitation	full	general		Thank you for the opportunity to comment. Our particular concern is the interpretation of what was appropriate research to support this guideline. We agree that randomised controlled trials are often the most appropriate design for evaluating complex rehabilitation interventions however given the degree of heterogeneity (of both service users and the timing and content of services and staffing) this suggests a need to include other design types inform the guidance. There are several good quality mixed	Thank you for your comment. The systematic review work was based on review protocols which stipulated which study types would be considered for answering the different questions. For example, for the questions about people's views and experiences, the reviewers sought data from qualitative studies and from qualitative components of mixed methods studies as well as observational and cross sectional surveys of user experience. For the effectiveness questions, studies were sought

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					methods studies which should have had more influence. It is a shame that studies of single conditions such as heart disease were included which may be less relevant than the studies of older people with a broad range of aetiologies.	which would provide the most robust data about the outcomes of an intervention, therefore studies with a controlled design. However other designs without a control were also considered for inclusion, such as before and after or mixed methods studies. Where a substantial volume of evidence was included on full text the reviewers further prioritised studies for review and presentation to the GC. In seeking to present the most robust data on which to develop recommendations in which the GC could have most confidence then – for effectiveness questions – randomised controlled studies were prioritised where they were available. However, having reviewed the best available evidence about the effectiveness of intermediate care models, the GC agreed to include an additional review question designed to elicit data about aspects of service delivery and approaches to intermediate care. The question (question 7) did not seek evidence about a causal link between elements of intermediate care and outcomes so the included study types differed from questions 1-6, for example service and process evaluations would be considered as well as national audits. It is on this basis that the National Audit of Intermediate Care was included for question 7, providing valuable evidence which the GC used to develop recommendations. You make a helpful point about the use of evidence about single condition rehabilitation, which highlights an oversight in our reporting within the draft guideline. According to the review protocols and in line with the NAIC definition of intermediate care, single condition service models were meant to be excluded from the systematic review. However, in their role quality assuring the review protocols, the Guideline Committee pointed out that early supported discharge and other stroke rehabilitation services as described in the literature are, in the context of current practice, closely aligned with intermediate care. This is in terms of the needs of people using the service, the organisation of the service and the functions delivered by the teams. In light of your comment, amendments have been made to the reporting of the review work and we are grateful to you for having highlighted this oversight.
289.	Society for Research In Rehabilitation	full	general		On reading the NICE guidelines for reablement there is no mention of eye services or vision in the document. Could we please make a recommendation that orthoptics be added to the bullet list in point sensory and also sensory needs added at point 1.1.4 of the draft document?	Thank you for your comment. The issue of whether particular conditions should be discussed in the Guideline was raised by a number of organisations. The GC took the view that, rather than go into this kind of detail, it would be preferable to emphasise in the Introduction that IC requires a person-centred approach where each person's individual needs are assessed, including their needs arising from any particular condition. The GC decided not to make the addition to the Guideline which you have suggested.
290.	Society for Research In Rehabilitation	full	general		We are uncertain about the inclusion criteria and specifically whether it does or does not include stroke. On page 32 it says single condition rehabilitation for example stroke are excluded but later (pages 36-onwards) many included studies are stroke and some are exclusively stroke. Our members felt the guidance was quite a long way off what we see in practice e.g. "if not discharged within 2 days of admission consider transfer to bed based IC…" "don't exclude people….eg dementia…" One comment/request for clarification was "I assume the guidance does not think this relates to people with stroke as stroke guidelines have very specific recommendations about ESD; here they are talking about home based IC which in stroke would presumably be ESD plus reablement. I could not see anything I would disagree with, but it might be worth ascertaining that this is not meant to relate to stroke?"	Thank you for your comment. You make a helpful point about the use of evidence about single condition rehabilitation, which highlights an oversight in our reporting within the draft guideline. According to the review protocols and in line with the NAIC definition of intermediate care, single condition service models were meant to be excluded from the systematic review. However, in their role quality assuring the review protocols, the Guideline Committee pointed out that early supported discharge and other stroke rehabilitation services as described in the literature are, in the context of current practice, closely aligned with intermediate care. This is in terms of the needs of people using the service, the organisation of the service and the functions delivered by the teams. In light of your comment, amendments have been made to the reporting of the review work to clarify the inclusion of evidence relating to stroke rehabilitation.
291.	Society for Research In Rehabilitation	Full	General/ introduction	There was no line numbering and it wasn't feasible	A member comments that the introduction is the weakest part of this document. It refers to the definitions used in NAIC and then states 'services span acute and long-term care'--- this is incorrect. Intermediate care services have been defined by NHS England as being time-limited and are frequently locally defined as between 6 and 8 weeks. This is clearly mentioned in the section on Terms Used in This Guideline *Intermediate care services are time-limited, normally no longer than 6 weeks*	Thank you for your suggestions. The GC accepts that the Introduction could benefit from some clarification of different terms, although they felt the distinction they wanted to make was between intermediate care and ongoing care and support. As you rightly say, the aim of paragraph 2 is to explain the aim of intermediate care, which is actually broader than facilitating transfer from hospital and preventing avoidable admissions. Intermediate care also aims to support people to maximise

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				to count them for each page	The relevance of the 2nd paragraph is not clear to the reader. It would help if it was made clear that the objective of intermediate care services was to prevent admissions and facilitate earlier discharge. The following sentence does not make sense----replace the word 'between' with 'in': *This guideline covers all adults (aged 18 and older) using intermediate care, including reablement services between inpatient hospital, community or care home settings* My understanding is that these guidelines will also be used by commissioners---should they be referred to in the following sentence: *The guideline is for health and social care providers and practitioners delivering intermediate care and reablement, and for people who use the intermediate care and reablement services and their family carers.* I would suggest that the introduction could be enhanced by clarifying the difference between care and rehabilitation e.g. ○ **Care**: timely and appropriate assistance with daily tasks to reduce risk sustain health and improve well-being. Making sure people are looked after appropriately. ○ **Rehabilitation**: A complex process of trying to help people who have suffered some injury/disease or developmental disorder to maximise independence, functional ability, psychological well being, and social integration.	their independence where specific support and rehabilitation is likely to help with this. We have clarified this in the second paragraph and hope you find that it's clearer. We have also made the changes you suggested – replacing 'between' with 'in' and have removed the reference to intermediate care spanning long-term care.
292.	Stroke Association	Short	10	9	Insert "are understandable and reviewable". It is essential that those with communication difficulties and their families/carers fully understand and are fully supported when developing goals, values and priorities. We would like this to be explicitly set out in the guideline.	Thank you. The committee felt that your point is already adequately covered in the final guideline.
293.	Stroke Association	Short	10	15	We welcome the documentation of goals in an "accessible" format but we would like specific guidance around the documents also being aphasia friendly. As mentioned previously, aphasia affects many stroke survivors and it is essential that their communication needs are considered at this important stage.	Thank you for your comment. The GC feels that the term 'accessible' includes ensuring that documents are accessible to people whatever their needs and conditions. This would include people with aphasia. The GC therefore did not feel any more specific examples needed to be added.
294.	Stroke Association	Short	10	25	We strongly welcome this statement and encourage training of care staff in a condition-specific way. The Stroke Association provides stroke-specific training to professionals, including one-day workshops, stroke qualifications and distance learning.	Thank you for your support.
295.	Stroke Association	Short	11	7	Insert "aphasia friendly"	Thank you for your comment. The GC decided to amend the wording of the 3rd bullet point, so that in the updated draft it will now read 'in other accessible formats, such as braille or Easy Read', so as to emphasise the principle of making the information as accessible as possible, in whatever format is suitable for the person.
296.	Stroke Association	Short	11	11	We welcome immediate care diaries which are important for goal-setting and meeting. However, we would like mention given to the various technologies available to assist with this, and other key components of intermediate care. For example, the Stroke Association's online tool, My Stroke Guide, provides information on stroke but also a personalised goal-setting and performance-tracking tool which reflects an individual's progress through their care and recovery. It also provides peer-to-peer support, including an active social forum and local area support finder. Finally, it contains a calendar through which people can track their appointments and record diary entries on their recovery.	Thank you for your comment. The GC recognises the usefulness of the examples you have provided. However, they felt that specifying these in the Guideline would place unrealistic expectations on service providers and furthermore it is not supported by the evidence underpinning the guideline. It is also not an addition to the recommendation which is supported by the evidence collected by the research team. The GC therefore decided not to make this change.
297.	Stroke Association	Short	12	3	We welcome this line. People should – before they finish intermediate care – absolutely be given information on how they can refer themselves back into the service if necessary. We know that new effects of stroke can emerge at any time, not just in the immediate weeks following a stroke. It is therefore vital that a route is open back to intermediate care.	Thank you for your support.
298.	Stroke Association	Short	12	29	As per previous comments, insert "and quality of life".	Thank you, the GC agreed to add this.
299.	Stroke Association	Short	13	19	We would like to see the intermediate care team referring people, if necessary, to those who can assist with the navigation of the benefits system or those who can	Thank you for your comment. The GC noted that the list is only intended to provide examples, and not to be exhaustive. The bullet point recommending engagement with

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					provide financial advice. Stroke is the leading cause of disability in the UK and a quarter of strokes happen in working-age people. Thousands of survivors are therefore reliant on the benefits system and many struggle with money worries. Referring to specialist support and advice services such as Citizens' Advice or the Stroke Association's Helpline should be set out in this guideline. We would also like to see condition-specific sources of advice mentioned as a route for people to take.	specialist advice should be understood to include all types of specialist advice, not just the specific examples given and could include advice about welfare rights and finance. For this reason the GC is not in favour of making the suggested addition to the list.
300.	Stroke Association	Short	16	7	While interventions may last up to 6 weeks for the majority of people, recovery from stroke may require much longer interventions and the guideline should recognise that.	Thank you. The GC agrees with your point and this is exemplified in the final guideline which reads, 'Review people's goals with them regularly. Adjust the period of intermediate care depending on the progress people are making towards their goals.'
301.	Stroke Association	Short	4	10	We welcome the acknowledgement that intermediate care should be person-centred and account for cultural differences and preferences. Those from some cultures and backgrounds have increased risk of stroke due to their ethnicity. We know, for example, that people with their origins in South Asian countries are more likely to have high blood pressure, high cholesterol and diabetes than white people. These are all factors that increase the risk of stroke.[1] With this in mind, it is important that cultural differences are respected and accommodated within the intermediate care system, particularly when consideration is given to evidence suggesting that people from BME communities sometimes avoid engaging with mainstream social care services to avoid feelings of stress or powerlessness.[2]	Thank you for your support and for the information provided.
302.	Stroke Association	Short	4	10	Intermediate care also needs to take into account someone's socioeconomic status and those involved need to be aware that someone's access to money can impact on their ability to, for example, travel to consultations. This particularly affects the stroke community. In general, people from more deprived areas have an increased risk of stroke and people from more deprived areas are likely to experience more severe strokes.[3]	Thank you for highlighting this. The GC understand your point but do not feel there was evidence to make this specific addition. However they feel that considerations such as socio economic status and people's living environment and so on would be addressed by recommendations which promote a person centred approach and the tailoring of intermediate care to people's needs, preferences and circumstances.
303.	Stroke Association	Short	4	19	Insert "and family or carer" after "Explain to the person". 41% of stroke survivors need help with activities of daily living when they are discharged and almost a third receive no social service visits, suggesting that they are often dependent upon their carers. In 2015, 1 in 3 commissioning areas in England, Wales and Northern Ireland did not commission family and carer support services.[4] Currently, many families and carers do not feel prepared when a stroke survivor is discharged. According to our recent survey of stroke survivors, almost 40% did not feel that their carer had enough support when they returned home. 53% of carers either disagreed or strongly disagreed with the statement, "I felt prepared when the person I care for was discharged from hospital". When the needs of families and carers are met, it has a positive impact. For instance, an evaluation of our own services shows that when families and carers are provided with the support they need, there is a huge rise in their reported confidence and ability to cope. This is an area where improvement is clearly needed, which would benefit from being explicitly set out in this guideline. The issue is well summed-up by a stroke survivor with experience of this: *"I was in hospital for 12 weeks. When I came out there was no one to help me or understand what I was going through. My partner had very little explained to him and consequently he was frustrated looking after me. A nurse came in to help me, but no one had given any indication toward how to deal with a stroke. He would be frustrated and I was in tears."*	This evidence is about the person – we have another rec about explaining to and involving family. GC agree? Thank you for your comment. On balance the GC did not feel they had a basis on which to specifically add 'and family or carer' to the recommendation you cite, because the evidence underpinning this recommendation was specifically about people using intermediate care. However in re-drafting the Guideline, a recommendation about involving the family and carers is being moved into the Core Principles section. This is intended to ensure that involving family or carers is a consideration throughout the Guideline.
304.	Stroke Association	Short	5	19	We welcome the proposed make-up of intermediate care teams, particularly the inclusion of speech and language therapists which are so crucial to those stroke	Thank you for your comment. The GC accept that this is a useful suggestion, but consider that it would be better if it was located in the recommendation which includes

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[1] Banerjee S, Biram R, Chataway J, Ames D (2009). South Asian strokes: lessons from the St Mary's stroke database. Q J Med 2010 103: 17-21.

[2] Carr, S (2014) Social Care for Marginalised Communities: Balancing self-organisation, micro-provision and mainstream support. University of Birmingham Health Services Management Centre. Available: http://www.birmingham.ac.uk/Documents/college-social-sciences/social-policy/HSMC/publications/PolicyPapers/policy-paper-18-sarah-carr.pdf Last accessed 10 May 2017.

[3] Marshall IJ, et al (2015) 'The effects of socioeconomic status on stroke risk and outcomes'. Lancet Neurology 14: 1206-1218.

[4] Royal College of Physicians Sentinel Stroke National Audit Programme (SSNAP). Post-acute audit 2015 prepared on behalf of the Intercollegiate Stroke Working Party. Available: https://www.strokeaudit.org/Documents/Results/National/2015/2015-PAOrgPublicReportPhase2.aspx

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					survivors left with communication problems. We would, however, like to see, where possible, those nurses and support staff on the intermediate care team being specifically trained in stroke. Stroke survivors need stroke-specific support because stroke is a unique condition and there is good evidence to suggest that recoveries are improved when support is provided by those trained in stroke. Currently, however, there is no requirement for social care staff to be stroke trained. We believe insisting upon stroke trained team members would encourage more providers to ensure their staff are stroke trained. We would also like to see an explanation set out by NICE as to why it has recommended these specific core practitioners in its guidance.	a list of conditions that intermediate care staff should be able to recognise and respond to. The list of core practitioners was based on testimony from the NAIC expert witness, which outlined the make-up of a rapid response team achieving positive outcomes at the individual and system level. Combined with their own expertise, the guideline committee felt this was a sound basis for recommending the make-up of a core intermediate care team.
305.	Stroke Association	Short	5	21	As part of an intermediate care team, we would like to see staff dedicated to providing information and advice added to the guideline. Many stroke survivors have told us that they had lots of questions after their stroke, ranging from why the stroke happened in the first place to what they could do to avoid a recurrence. This was a typical experience from a stroke survivor: *"I couldn't understand why I had the stroke. Nobody gave me an answer to what causes a stroke. Why have I got this? What have I done to deserve it? That sort of thing, and I couldn't answer it."* This is a key part of the Stroke Association's Stroke Recovery Service, which is often the first service used by carers in particular. Information and advice can help with the feelings of anxiety and a lack of confidence felt by both the stroke survivor and the carer(s). Indeed, an evaluation of our services showed they led to a significantly better level of understanding of stroke.	Thank you for your comment. The GC considered that this wasn't supported by the evidence which had led them to draw up the list of core personnel in Recommendation 1.2.9. However, they did feel that an ability to recognise this as a support need could be added to the recommendations which deal with matters that intermediate care staff should be able to recognise and respond to – and this includes stroke. The GC also felt that the importance of ensuring people have all the information they require to fully participate in and benefit from intermediate care – regardless of their condition or needs – is covered by the guideline.
306.	Stroke Association	Short	5	26	We welcome the inclusion of speech and language therapists (SLTs) as part of the recommended intermediate care team. SLTs can provide invaluable support for stroke survivors who have been left with communication difficulties as a result of their stroke. Indeed, around a third of stroke survivors experience some level of aphasia.[5] Despite there being good evidence around the economic advantages of providing SLT[6], stroke survivors' access to it is poor, particularly in hospital, so it is vital that intermediate teams provide this service.	Thank you for your support and the information provided.
307.	Stroke Association	Short	5	27	We would like to see a psychologist as one of the core practitioner on the intermediate care team. Mental health problems can be one of the most serious hidden effects of stroke. Emotionalism, or difficulty controlling emotional responses, is common after stroke, with 1 in 5 survivors experiencing it in the first 6 months after stroke.[7] Around a third of stroke survivors experience depression after their stroke[8] and over half experience anxiety at some point in the 10 years after their stroke.[9]	Thank you for your comment. The GC recognise that the need for mental health support can be a factor for stroke survivors as well as others receiving Intermediate Care. However, the GC did not feel that the evidence supported the specific inclusion of a psychologist as a member of the core team. The GC did consider though that the Guideline could state that there should be a clear route of referral to a psychologist. There is more detail of the sort you describe in the NICE guideline on Stroke rehabilitation in adults: https://www.nice.org.uk/guidance/cg162
308.	Stroke Association	Short	6	15	We welcome the guidance around actively involving families and carers in intermediate care decision-making. We would, however, like to see carers given more explicit consideration throughout the guideline. Stroke and other sudden-onset conditions can be incredibly traumatic for families and carers who, very suddenly, may find their own lives radically different. The guideline should make clear that carers should be offered support, particularly given that – as NICE's own assessment has shown – fewer people involved in delivering social care are actually getting paid for it. This suggests that families and unpaid carers are playing an ever-increasing role in helping those with social care needs.	Thank you for your comment. The GC considers that the Guideline already includes carers, where there is underpinning evidence to do so. The Guideline repeatedly makes clear that families and carers should be involved in the assessment process. The Guideline refers to making sure that family and carers are 'given information about the service' as well as about 'resources in the local community that can support families and carers'. The Guideline recommends that family and carers should be kept 'fully informed about what has been provided and about any incidents or changes'. The Guideline suggests providing 'information about other sources of support available at the end of intermediate care, including support for carers'. Please also refer to the NICE guideline, currently in development about support for adult carers.

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[5] Engelter ST, et al (2006). Epidemiology of Aphasia Attributable to First Ischemic Stroke. Stroke 37:1379-1384.
[6] Royal College of Speech and Language Therapists 'The economic value of speech and language therapy', Available: https://www.rcslt.org/speech_and_language_therapy/docs/factsheets/economic_value
[6] https://www.strokeaudit.org/Documents/National/Clinical/AugNov2016/AugNov2016-PublicReport.aspx
[7] Hackett ML, Yapa C, Parag V, Anderson CS (2005). Frequency of Depression After Stroke A Systematic Review of Observational Studies. Stroke 36:1330-1340.
[8] Ayerbe L, et al (2015). Explanatory factors for the association between depression and longterm physical disability after stroke. Age Ageing 44:1054-1058
[9] Ayerbe L, et al (2014). Natural history, predictors and associated outcomes of anxiety up to 10 years after stroke: the South London Stroke Register. Age Ageing 43:542-547.

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					41% of stroke survivors need help with activities of daily living when they are discharged and almost a third receive no social service visits, suggesting that they are often dependent upon their carers. In 2015, 1 in 3 commissioning areas in England, Wales and Northern Ireland did not commission family and carer support services.[10] Currently, many families and carers do not feel prepared when a stroke survivor is discharged. According to our recent survey of stroke survivors, almost 40% did not feel that their carer had enough support when they returned home. 53% of carers either disagreed or strongly disagreed with the statement, "I felt prepared when the person I care for was discharged from hospital". This is an area where improvement is clearly needed, which would benefit from being explicitly supported in this guideline.	
309.	Stroke Association	Short	6	20	We welcome the guidance around the signposting of advocacy services to people in care and those assisting them. The Stroke Association is the biggest provider of stroke-specific services and we provide a range of services including information, advice, support, advocacy, representation, tailored recovery planning, self-management tools, peers support and signposting to other local services, including our own specialist support services (such as communication or emotional support teams) where available.	Thank you for this information.
310.	Stroke Association	Short	7	6	We agree that where possible, reablement should be moved to a home setting as soon as possible. Evidence shows that for stroke survivors, Early Supported Discharge (ESD), which helps stroke survivors earlier so they can have the majority of their care at home, results in better recoveries.[11] ESD also makes good economic sense. For every extra patient given Early Supported Discharge, the NHS could save £1600 over 5 years (along with 0.14 QALYs).[12] Yet only a third (34.5%) of stroke survivors receive ESD.[13]	Thank you for your support.
311.	Stroke Association	Short	8	6	We strongly welcome the guidance around involving the person in setting goals in consultation with family or carers if consented to. In order to make their best possible recovery and live the fullest possible life, stroke survivors should be asked about their goals, values and priorities so we welcome this quality statement. We want stroke survivors to make their best possible recovery and a significant factor in this is setting and then assessing goals and priorities. We also want stroke survivors to avoid future strokes and goal-setting is effective in reducing secondary risk factors such as being overweight or smoking. Unfortunately, only 56% of survivors are discharged from hospital having been assessed for all appropriate therapies and with agreed rehabilitation goals.[14] Without these goals, rehabilitation, if it exists at all, can lack focus and structure. It is essential that those and their families/carers fully understand and are fully supported when developing goals, values and priorities. When planned effectively, goals are set and then met successfully. With our support, 94% of stroke survivors who develop a stroke recovery plan with us achieve the outcomes that matter to them. We would like this to be explicitly set out in the statement. Care plans are absolutely essential. Without them, stroke survivors leave hospital with no idea if they will receive vital rehabilitation, let alone who will administer it and how often. Too many stroke survivors feel like they have 'fallen off a cliff' when they leave hospital because they are not supported with their additional needs resulting from their stroke. The Stroke Association carried out a survey last year and found that almost 40% of stroke survivors did not have a care plan in place when they went home from hospital. 30% of stroke survivors did not feel prepared when it was time to return home.	Thank you for your support and for taking the time to respond to the consultation on the draft guideline.

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[10] Royal College of Physicians Sentinel Stroke National Audit Programme (SSNAP). Post-acute audit 2015 prepared on behalf of the Intercollegiate Stroke Working Party. Available: https://www.strokeaudit.org/Documents/Results/National/2015/2015-PAOrgPublicReportPhase2.aspx

[11] Fearon P, Langhorne P & Early Supported Discharge Trialists, 2012. Services for reducing duration of hospital care for acute stroke patients. Cochrane Database of Systematic Reviews, 9, CD000443.

[12] Royal College of Physicians (2016) Sentinel Stroke National Audit Programme (SSNAP). Stroke health economics: Cost and Cost-effectiveness analysis

[13] https://www.strokeaudit.org/Documents/National/Clinical/AugNov2016/AugNov2016-PublicReport.aspx

[14] Royal College of Physicians Sentinel Stroke National Audit Programme (SSNAP). Acute organisational audit 2016 prepared on behalf of the Intercollegiate Stroke Working Party. Available http://bit.ly/2ivXRdv

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					There is a need for joined up working between health and social care when preparing for the discharge of a stroke survivor. According to the latest Sentinel Stroke National Audit Programme (SSNAP) data, 10% of stroke survivors do not receive a joint health and social care plan on discharge[15], and our survey shows an even greater problem in this area than the SSNAP figures suggest.[16] Given that 48% of stroke survivors and their carers report problems caused by either poor or non-existent co-working between health and social care, this is clearly an area where improvements need to be made.[17]	
312.	Stroke Association	Short	8	10	As per previous comments, the person's potential communication issues, as well as socioeconomic status should be taken into account when planning care.	Thank you for your comment. The Guideline Committee did not feel there was evidence to support this inclusion. However, they did note that good communication is one of the core principles set out in the final version of the Guideline.
313.	Stroke Association	Short	9	14	We would like explicit mention given to the need for longer-term reassessments to be 'booked in', even if they are several months in the future and not part of the intermediate reablement phase. The Royal College of Physicians recommends that stroke survivors should be offered a structured health and social care review at 6 months and 1 year after the stroke and then annually.[18] These reviews are crucial for assessing recovery and ensuring people are being supported and medicated (if necessary) in the most appropriate way. Unfortunately, only around 3 in 10 of those stroke survivors who need a six month review actually receive one.[19]	Thank you for your suggestion. The GC recognised the reasons for raising this matter, but concluded that it is outside the remit of intermediate care and therefore beyond the scope of this guideline.
314.	Stroke Association	Short	General	general	We welcome the guideline's mention of the need to address people's "social, emotional, communication and cognitive needs". Communication and cognition: Around a third of stroke survivors experience some level of aphasia – a complex disorder of language and communication caused by damage to the language centres of the brain. People with aphasia can have difficulty speaking, reading, writing or understanding language.[20] It is essential that those with communication difficulties and their families/carers fully understand and are fully supported by those delivering intermediate care. Information provision for those who have communication difficulties (aphasia) needs to be carefully tailored to those with the difficulty and we would like to see this explicitly flagged in the guideline. The Stroke Association publishes guidance on 'aphasia-friendly' communications[21] – any information for stroke survivors following a stroke should be clear to follow these guidelines. Our guidance advises using a short message, clear sentences, easy words, a good layout, and making a set of messages. Tools such as communication aids can be extremely important for facilitating stroke survivors to communicate decisions. For example, we suggest using tools such as a small card explaining that a communication difficulty is present and word and picture charts to help stroke survivors communicate. These tools are cost-effective ways of helping stroke survivors to get their message across when suffering from aphasia.[22] There are also benefits to providing services which understand and support those with aphasia. Our evaluation showed that 80% of the stroke survivors we support in this area reported improved communication skills.	Thank you for your comment. The issue of whether particular conditions should be discussed in the Guideline was raised by a number of organisations. The GC took the view that, rather than go into such detail, it would be preferable to emphasise in the Introduction that IC requires a person-centred approach where each person's individual needs are assessed, including their needs arising from any particular condition. The GC feels that the recommendations themselves advocate a person centred approach to intermediate care which sets goals with people and addresses their needs holistically, whatever their needs or conditions. Finally, the Guideline states that people should be given information in formats that are accessible to them and this would include aphasia friendly communications.

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[15] RCP Sentinel Stroke National Audit Programme Acute Organisational Audit Report (November 2016), Available: https://www.strokeaudit.org/Documents/Results/National/2016/2016-AOANationalReport.aspx

[16] Royal College of Physicians, 'SSNAP Clinical Audit October-December 2015 Public Report', March 2016, https://www.strokeaudit.org/Documents/Results/National/OctDec2015/OctDec2015-PublicReport.aspx

[17] Stroke Association 'Struggling to recover' (2012), Available: https://www.stroke.org.uk/sites/default/files/Struggling_to_recover_report.pdf

[18] Royal College of Physicians (2016) National clinical guideline for stroke 5th edition. Available: https://www.strokeaudit.org/SupportFiles/Documents/Guidelines/2016-National-Clinical-Guideline-for-Stroke-5t-(1).aspx

[19] Royal College of Physicians Sentinel Stroke National Audit Programme (SSNAP). National clinical audit annual results portfolio March 2015-April 2016. Available: http://bit.ly/1M5R3Op

[20] Stroke Association (2017) 'State of the Nation' Available: https://www.stroke.org.uk/sites/default/files/state_of_the_nation_2017_final_1.pdf

[21] Stroke Association, July 2012, 'Accessible Information Guidelines', https://www.stroke.org.uk/sites/default/files/Accessible%20Information%20Guidelines.pdf(1).pdf

[22] Stroke Association, 'Communication Aids' accessed 11 June 2016, https://www.stroke.org.uk/professionals/resources-professionals/communication-aids

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					Emotional: Stroke can bring with it significant mental health problems or other problems which make it more difficult for survivors and/or their families to cope. We know that around a third of stroke survivors experience depression after their stroke[23] and a quarter said that their stroke had a negative impact on their family.[24]	
315.	Stroke Association	Short	General	General	Stroke is the leading cause of disability in the UK, with almost two thirds of stroke survivors in England, Wales and Northern Ireland leaving hospital with a disability as a result of their stroke. Intermediate care, such as that provided by the Stroke Association, is essential to put survivors' recoveries on the correct course.	Thank you for this information.
316.	Stroke Association	Short	General	General	While we welcome the general focus throughout this guideline on regaining independence, given that stroke is very often a regenerative rather than a degenerative condition (unlike many long-term conditions), we would like specific mention also given to improving quality of life.	Thank you for this suggestion. The GC agreed to specific reference to the role of intermediate care in promoting quality of life.
317.	The 25% ME Group	Equality Impact Assessment	General	General	We note that the Equality & Human Right Commission state that there is a legal requirement to: • ensure that your decisions impact in a fair way: where there is evidence that particular groups will be negatively affected by a decision, action should be taken to address this • make your decisions based on evidence REF: Public Sector Equality Duties and financial decisions - a note for decision makers We trust that this will be reflected more fully in the final version of the guideline.	Thank you. The ethos of NICE guidance is that recommendations for practice are based on the best available evidence, so we trust that this provides you with reassurance. In addition, we do conduct an equalities impact assessment (EIA) as part of the guideline development process so equalities issues have been uppermost in the minds of the GC throughout. The EIA will be published alongside the final guideline.
318.	The 25% ME Group	Full	3	Para 2	This is a crucial paragraph, placing the aim of 'Intermediate Care' squarely in terms of preventing otherwise avoidable hospital admissions and facilitating timely hospital discharge. This helps provide a starting point for delineating the scope and relevance. (Otherwise, on the basis of the present draft, this is likely to become a pervasive approach with adverse consequences both for some service users and in terms of misspent funds.) It is implicit in the title 'Intermediate care' that this is an interim response, between stages. Further thought should be given as to what the relevant stages are.	Thank you for your comment. Intermediate care does play an important role in preventing avoidable hospital admissions and facilitating transfer of care from hospital. However this is not the only function. The GC was also keen to emphasise the central role played by intermediate care in supporting people at home who are experiencing difficulties and who would benefit from time-limited support to increase their independence and quality of life.
319.	The 25% ME Group	Full	3	Para 2 (line 3)	This describes the intended outcome of involving a multi disciplinary team geared towards 'intermediate care' *i.e.* to "*help people recover, regain independence, and return home [from hospital]".* We suggest that this introductory context is of value when considering whether or not a person is a suitable candidate for this type of approach. However the implications are not reflected in the present draft.	Thank you for your suggestion. Having considered consultation comments, the GC agreed to add a new recommendation, which may go some way to addressing your point. The recommendation reads, 'Assess people for intermediate care if it is likely that specific support and rehabilitation would improve their ability to live independently and they: • are at risk of hospital admission or have been in hospital and need help to regain independence or • are living at home and having increasing difficulty with daily life.' We hope you will agree that the new recommendation highlights the contribution made by intermediate care in preventing hospital admissions, facilitating transfer of care and also supporting people in their own homes when they experience difficulties.
320.	The 25% ME Group	Full	7; 217-218	Rec 1.1.5 and evidence	In terms of evidence, we note: (1) This recommendation is based on a reablement review involving 7 studies, only one of which was rated as 'good' [P217]. This is not a robust evidence base. (2) The related evidence statements [RA6 and RA8, P217-218] identify motivation emerging as an important factor in the studies concerned. While this may be perfectly relevant in respect of the client groups involved in the studies concerned (1 of which was 'good'), this cannot be taken to legitimate a conclusion that any and all sick people can achieve 'independence', provided they are motivated.	Thank you for your comment. The Guideline Committee has discussed your observation. This recommendation was not intended to imply that all people with a health condition, illness or disability can achieve complete independence if they are motivated, nor does the GC believe that this is implied by the wording. However, the GC used the available evidence, strengthened by their own expertise to reach the conclusion that people are far more likely to benefit from intermediate care if they are motivated to engage with the aims of

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[23] Hackett ML, Yapa C, Parag V, Anderson CS (2005). Frequency of Depression After Stroke A Systematic Review of Observational Studies. Stroke 36:1330-1340.
Ayerbe L, et al (2015). Explanatory factors for the association between depression and longterm physical disability after stroke. Age Ageing 44:1054-1058.

[24] McKevitt C, et al (2011). Self-Reported Long-Term Needs After Stroke. Stroke 42:1398-140

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						the service and try and improve their independence. The GC therefore have not made any changes to the recommendation in response to your comment.
321.	The 25% ME Group	Full	7-8; 222, 224	1.1.11 and evidence	In terms of evidence, there is reference at RA6 [P222] in terms of studies showing ‘”the important role played by staff in motivating people”. [P224] Again, we are of the view that this should not be applied across the board. We can point the Institute to clients living stoically and resourcefully in the face of terrible suffering, frustrated by the consistently adverse impact of attempting even the smallest activity, who are being demoralised by exposure to professionals who fail to recognise this. What's more, the professional may consider that staff can supply the ‘necessary’ motivation and that this will can have the person living a full and ‘independent life’. We have encountered this mindset in practice, in the face of a bedbound person unable to sit upright, speak, or swallow.	Thank you for your comment. The GC considers that the Guideline recognises that independence is relative, and in this recommendation this is conveyed through the phrase ‘as much independence as possible’. The GC does not agree that the recommendation needs to be amended.
322.	The 25% ME Group	Full	8; 214, 228	Rec 1.2.5 and evidence	In terms of evidence supporting this recommendation, this hinges solely on RA5 [P214] refers to studies identifying ‘resistance’ to reablement by families and clients. There is no evidence statement at all in support of the feasibility of the achievement of the stated aims of ‘intermediate care’ by this or other means. Yet it is recommended that people should ‘understand the aims of the service - in particular, how it will help them optimise independence’. [P228]. It is astonishing that a NIHCE Guideline might view the value of the intervention concerned as having been established as a starting point, in advance of consideration of the evidence for and against. NB: These comments regarding exercise apply to all forms of prescription of behavioural change: *“from the medico-legal point of view, health professionals who prescribe exercise programmes must do so with just as much caution as would be taken with medication. … prescriptions for exercise must be given with exactly the same care as with a prescription drug. Failure to do so is likely to result in litigation if harm occurs as a result of inappropriate advice. The MEA continues to receive reports from people with ME/CFS whose condition has relapsed following inappropriate advice about exercise”* REF: Charles Shepherd, Medical Adviser, ME Association; British Journal of Nursing, vol 15, No 12, 2006, pp 662-669	The Guideline Committee has discussed your observation. This recommendation was based on evidence that families often do not know what to expect of an intermediate care service and when they do understand and engage with what the service is trying to achieve they can work with the person to support progress toward their goals. The evidence was strengthened by the expertise and experience of the GC, enabling them to reach the conclusion that involving families and ensuring they understand the aims of intermediate care will support the intermediate care process. However, the GC is also keen to explain that they are not suggesting that this explanation (to the families) alone will guarantee success – the recommendation of course has to be considered within the context of the whole guideline.
323.	The 25% ME Group	Full & short	General	General	We are greatly concerned that the draft Guideline fails to recognise limits on the scope and relevance of ‘intermediate care’ in providing an appropriate service response to citizens presenting with health and/or social care needs. Relatedly, there is no recognition of the possibility that an ‘intermediate care’ approach to their presenting needs is positively harmful to some. We submit that in the absence of a coherent attempt to address these issue, the present draft is fundamentally flawed. It does not provide a blueprint for care excellence on this subject. The draft Guideline must be strengthened to protect people from inappropriate and harmful service responses. Much of our submission flows from this consideration, urging caution before further entrenching this approach across the board.	Thank you – we have responded to your specific comments.
324.	The 25% ME Group	Full & short	General	general	We note that the thrust of ‘intermediate care’ is along similar lines to the interventions identified in the highly contentions NICE clinical guideline 53 on ‘CFS/ME’ *i.e.* encouraging people to do more, with or without a cognitive element in the shape of an ‘explanation’ of ‘why this will help’. Far from being substantiated, the fear-avoidance-deconditioning notion flies in the face of a range of evidence to the contrary in respect of this illness. We are gravely concerned that this mindset is now being summoned to support the use of ‘reablement’ as a response to functional incapacity in social care for this patient group. Existing biomedical research, as well as patient testimony, refute this cognitive-behavioural model of myalgic encephalomyelitis (M.E.)* and strongly support the case that management approaches associated with increasing activity levels are not only ineffective but cause lasting deterioration in functional ability, as well as greatly increased suffering. REF: *Severely Affected ME (Myalgic Encephalomyelitis) analysis report on*	Thank you for your comment. The Guideline Committee noted your observation that reablement may not be the appropriate response to patients with M.E. The issue of whether particular conditions should be discussed in the Guideline was raised by a number of organisations. The GC took the view that, rather than go into this kind of detail, it would be preferable to emphasise in the Introduction that IC requires a person-centred approach where each person's individual needs are assessed, including the type of service which it would be appropriate to provide. The GC also feel that the whole of the guideline is based on the premise that intermediate care should be person centred and tailored to the needs and strengths of individuals. It therefore follows that intermediate care would never be used to support someone who would be unlikely to benefit and for whom such an approach would be harmful.

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					questionnaire; 25% ME Group 1st March 2004. This feedback exercise identified that some people with severe ME were *not* severely affected until trying 'GET' ('graded exercise 'therapy'). Yet this intervention was later recommended by NICE CG53 2007. After ten difficult years NICE CG53 is currently under preliminary review, taking into account recent publications. *NB: This and other comments from the 25% ME Group apply equally to the many people with ME who are given another diagnostic label, such as chronic fatigue syndrome (CFS).	
325.	The 25% ME Group	Full & Short	General	General	The evidence base on this subject is thin. Indeed for many client groups, including the group we represent, no relevant evidence has been identified for consideration by the Guideline Development Group. In developing guidance, NIHCE follows a rigid formula. This is not a guarantor of strength of conclusions, depending as it does on the availability and strength of the evidence that it is applied to. Clearly this issue is crucial in terms of securing robust recommendations for excellence and avoiding harm. With no research evidence on outcomes in respect of many client groups, it is vital that due consideration be given to the experiences of people - including the people with ME encountered by our service. There is no available published evidence on the effectiveness or harm of reablement on people with M.E. therefore it is crucial that NIHCE take into account patient testimony of harms.	Thank you for your comment. The GC feels that the whole of the guideline is based on the premise that intermediate care should be person centred and tailored to the needs and strengths of individuals. It therefore follows that intermediate care would never be used to support someone who would be unlikely to benefit and for whom such an approach would be harmful.
326.	The 25% ME Group	Full & Short	General	General	The 25% ME Group is a user-led, user-driven UK charity, devoted to supporting and representing people who are severely affected by the long term, presently incurable, neuro immune illness myalgic encephalomyelitis (ME). This illness is often labelled 'chronic fatigue syndrome' (CFS) and researched under this rubric, including research on quality of life which indicates that this is one of the most debilitating disorders, with a high sickness impact profile and low quality of life. Against this background, our advocacy service is painfully aware of the problems faced by sick people when 'intermediate care' approaches are mis-applied. We are being asked by increasingly desperate members to support them by providing a rational and humane defence in response to professional insistence on 'reablement' or 'rehabilitation' as a service response. These approaches are being misused on people with ME with highly detrimental consequences to their health and wellbeing. 'Merciless' was the term most recently heard on this subject from a service user. Encounters with a professional mindset that is at odds with reality can be seriously damaging - to both physical and mental health - while leaving basic needs such as nutrition, hydration, toileting and cleanliness unmet. This is not speculation - real life examples are available and will be shared on request. There is no available published evidence on the effectiveness or harm of reablement on people with M.E. therefore it is crucial that NIHCE take into account patient testimony of harms.	Thank you. We are aware of the lack of evidence for the use of intermediate care for people with certain support needs and conditions. The GC were careful to ensure that the recommendations did not make sweeping generalisations and this is reflected in the central importance placed on involving people in discussions, understanding their preferences and ensuring intermediate care is person centred.
327.	The 25% ME Group	Full & Short	General	General	In our view, the pervasive ambit of the draft carries freight in the shape of a degree of distortion of the concept of independent living promoted in the United Nations Convention on the Rights of People with Disabilities [UNCPRD]. Article 19 of the UNCRPD makes clear that independent living is not necessarily about disabled people doing things for themselves but rather about having choice and control over the support they need to achieve their goals. A focus on 'independence' for all is both unrealistic and implies a highly restrictive understanding of independent living, where 'Autonomy' is the core principle.	Thank you. The recommendations which refer to regaining independence are carefully worded to ensure that the meaning is relative. The aim of intermediate care is not to help people become completely independent but to support them to make relative gains in independence and try to fulfil the goals that are important to them.
328.	The 25% ME Group	Full & Short	General	General	While outcomes are a core concept, there is little or no coverage in the guideline of a need to monitor outcomes and evaluate: What measures would be used to monitor the success or failure of reablement? Who is responsible for the monitoring of adverse events such as loss of independence, loss of function, larger long-term care packages, admission to residential care following withdrawal of a long-term care package and introduction of reablement? Who would decide if the deterioration was attributable to the loss of care and implementation of reablement?	Thank you for your comment. The GC agrees with your observation, and is of the view that it is essential that goals should be measurable so that the outcomes of the intervention are quantifiable. The GC would not wish the Guideline to be prescriptive about which tool to use, as long it was valid or psychometrically robust. They agreed to edit the recommendations which now refer to 'measurable goals' and they have also amended the recommendations to say that intermediate care services should work towards 'an agreed approach to outcome measurement for reporting and benchmarking'.

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					Who is accountable for adverse outcomes'? What are the respective responsibilities of the Department of Health, clinical commissioning groups, Department for Communities and Local Government? Who is responsible if a function is outsourced?	
329.	The 25% ME Group	Full and Short	General	General	As well as a difficulty with regard to the United Nations Convention on the Rights of People with Disabilities [UNCPRD], we suggest that there is a need for adjustments to ensure that the emerging Guideline is in keeping with other legislative provisions. If implemented in its present form, aspects of professional practice may well breach of the law on Equality, Human Rights and the Care Act, as well as United Nations Conventions on Children and women.	Thank you for highlighting this. The GC discussed your important point and do not see how the guideline possibly contravenes the Acts to which you refer.
330.	The 25% ME Group	Short	13	21-26 Rec 1.7.1	Reablement is highly unlikely to be an appropriate care option for people with ME. Therefore, we recommend that the section on training opening "Ensure that all staff delivering Intermediate Care understand" should include this further bullet point: **- Which patient groups are not well served by reablement and are better served by long term home care e.g. ME, often diagnosed as chronic fatigue syndrome (CFS).**	Thank you for your comment. There was no support for this point in the research underpinning the guideline and therefore the GC has decided not to include the suggested additional point.
331.	The 25% ME Group	Short	13-14	27-28 1.7.2	For the reasons set out in our comment to 1.7.1 we recommend that intermediate care staff should have the requisite training are able to recognise this illness, which is characterised by post-exertional malaise (cardinal medical feature) and that pushing to do more is unhelpful and results in deterioration in their health.	Thank you for your comment. We appreciate your concern, that people being provided with IC should be supported in the way that is appropriate to their condition, However, the GC chose not to consider evidence or make recommendations about particular conditions. It is anticipated that by following guideline recommendations and providing a person-centred service, information about appropriate support would be provided by the referrer and by the person receiving the service. The GC did not consider evidence that would support this addition.
332.	The 25% ME Group	Short	14	10-14 Rec 1.7.3	Could some form of oversight and learning from experience be adopted, perhaps with a scheme similar to the General Medical Council's medical morbidity and mortality meetings? 'The aim is to improve patient care by developing a culture of awareness of quality and encouraging front line staff to identify harm, report problems and share lessons to prevent recurrence." http://www.gmc-uk.org/education/27799.asp Also an equivalent of the Medicines and Healthcare Products Regulatory Agency's 'yellow card' scheme for reporting adverse drug and appliance reactions may be helpful.	Thank you for your comment. The GC took the view that the aims of this recommendation are very similar to the aims of the morbidity and mortality meetings, although the learning format is different, as the M&M meetings involve 'tightly-structured monthly meetings' involving large numbers of professionals from various disciplines. The GC decided however not to specify any particular format for achieving the learning and development goals, and so will not be acting on your suggestion.
333.	The 25% ME Group	Short	4	14-15 Rec 1.1.2	"taking an active part in support" may - or may not - produce "the best outcomes". It depends. We consider that it is the role of this Guideline to look seriously at this issue and temper the scope of the conclusions reached in keeping with the evidence, gaps in evidence, and indeed in keeping with a rational appraisal of the nature of any illness suffered and its impact on a person.	Thank you for your comment. The evidence reviewed for the Guideline did suggest that outcomes are improved if the person being provided with the service is engaged and active in their own intermediate care. Indeed, if a person was unable to be engaged and active in their own care, due to a condition such as M.E., then a referral to intermediate care would not be appropriate. The GC therefore decided that there was no need to reconsider their recommendations or conclusions.
334.	The 25% ME Group	Short	4	18-19 Rec 1.1.3	This is a highly patronising view of sick and disabled people - implying as it does that they will sit back and fail to live life to the fullest extent they can manage, unless and until a professional intervenes, 'supporting' them to do so.	Thank you for your comment. This recommendation refers to the importance of ensuring people are motivated to participate in intermediate care. It acknowledges that sometimes people will need help to recognise that they do have the potential to make relative gains in terms of independence, especially in the context of stressful periods of recovery from illness.
335.	The 25% ME Group	Short	4	19-20 Rec 1.1.3	Any 'explanation' needs to be underpinned by a rationale for why intermediate care will support the service user concerned. There are no ready made overarching 'explanations'.	Thank you for your comment. The GC did not wish to change the focus of this recommendation since the reasons why intermediate care is being provided will be different for each person, and there is no one explanation that will fit everyone.
336.	The 25% ME Group	Short Full	4 6; 213-215	Rec 1.1.2 Rec 1.1.2 and evidence	In terms of evidence, we note: (1) that this recommendation is based on a review of a small number of effectiveness studies of bed based care in a hospital setting, with 2 studies from the UK; mainly 'moderate quality' studies. [P213]. This does not permit sweeping generalisations. (2) the related evidence statement [BB5, P214] (i) identifies the expectation of people and their families that the service will provide care as a problem and (ii) identifies provision of information about the nature of the service as a solution [P215]. However there is no core evidence cited relating to the validity - or otherwise - of what the	Thank you for your comment. After giving the matter consideration the GC decided against changing the recommendation, since it was based on their careful consideration of the evidence and supported by their own expertise. The Guideline Committee also considered your observation about Evidence Statement BB5. The evidence statement shows that there is a lack of information about Intermediate Care and that this is problematic in terms of the motivation of individuals and cooperation of families and carers. Since the recommendation is

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					professionals are being advised to share i.e. regarding the relevance, value and likely outcomes of such an approach.	aimed at addressing this problem, the GC saw no need to amend it.
337.	The 25% ME Group	Short Full	4 6; 213-215	Rec 1.1.3 Rec 1.1.3 and evidence	In terms of evidence, we note: (1) that this recommendation is based on a review of a small number of 'reablement' studies of mixed quality, with only one study rated as 'good'. [P213] This does not permit sweeping generalisations. (2) that the related evidence statement [RA5, P214] refers to studies identifying 'resistance' to reablement by families and clients. There is no evidence statement in support of the 'explanations' that are to be purveyed nor the validity of 'realisation' that 'potential to regain independence' exists and can be achieved. [P215]	Thank you for your comment. The GC reconsidered this recommendation and felt that it is supported by the evidence and strengthened by their own expertise.
338.	The 25% ME Group	Short	4	1 & 2	We strongly agree with the principle that "*People have the right to be involved in discussions and make informed decisions about their care".* However this has to move beyond lip service. In our experience, this principle is not being observed 'on the ground'. As a safeguard, we would like to add: *"including the right to decide whether or not intermediate care including reablement is an appropriate response to their needs."*	Thank you for raising this. The GC believe that they have made the requirements to involve people as explicitly as they can. For example the Guideline states that even before referral to intermediate care people should be actively involved in discussions (supported via reasonable adjustments) about whether this would be the most appropriate means of support.
339.	The 25% ME Group	Short	4	1 & 2	Truly informed decisions necessitate staff providing the service user with all of the information required to make an informed decision, including information about hazards or contra indications. See court judgement: https://www.supremecourt.uk/cases/docs/uksc-2013-0136-judgment.pdf	Thank you for raising this. The GC believes that the importance of providing fully accessible information at various stages of the pathway has been adequately covered in the guideline.
340.	The 25% ME Group	Short	5	19-27 Rec 1.1.9	We note that the list of professionals does not include doctors of medicine. While a dedicated doctor may not be required as core part of the team, they do have a place. Specifically, we are of the view that: In order to reach an informed view on whether or not to offer 'reablement' to a client social services staff should be obliged to seek medical advice on the potential value or otherwise of this approach for the person concerned, preferably from the person's own GP. In terms of other forms of 'intermediate care' - i.e. those provided by the NHS - in the absence of robust evidence indicating the suitability of this approach for the patient concerned, staff should be obliged to obtain guidance from an appropriate medical doctor before advocating 'intermediate care'.	Thank you for your comment. The GC has taken the view that, for the most part, this recommendation should focus on the skills that are required within the core intermediate care team, rather than particular job roles. The recommendation has therefore been updated in the final guideline and states that one of the core skills and competencies should be in conducting comprehensive geriatric assessment. Although this is not a skill set that is exclusive to GPs, it is likely that a GP would provide this input and would therefore be able to provide qualified guidance on other issues such as the one you raise. However just to reiterate, the recommendations as a whole are very clear in ensuring that intermediate care is person centred and people will only be referred to the service it is felt – by qualified assessors – that they are likely to benefit and if participating in intermediate care is what the person wants.
341.	The 25% ME Group	Short	5	4-6 Rec 1.1.5	Identifying goals to achieve and establishing motivation is intrinsic to an 'intermediate care' approach. However this focus can be soul destroying when the person's life is severely limited by illness, especially when the person has had the illness for many years and there is no cure or even effective symptomatic relief on the horizon. In such circumstances, implying that achievement of what the person wishes for their life is possible and that motivation is the key to achievement, is both irrational and potentially damaging. Furthermore it does not foster patient confidence in the professionals charged with their care. A default assumption that a lack of confidence is holding the person back is both patronising and misplaced. Example: *I'm paralysed in 3 limbs with the other one regularly joining in. Tho the social worker must no something we don't as he was talking about me getting a job volunteering the other week! Carers are turning up whenever they like, rolling me and hoisting me as much as they like, then are confused when I say I can't brush my teeth! I'm coming back in my next life as a bird to deposit things on all these people!*	Thank you for your comment. The GC is clear that this recommendation is based on evidence about the importance of motivation and working together to achieve goals, and if this is not the appropriate way of working with particular individuals, e.g. those with a long-term illness who could not benefit from this approach, then a referral to Intermediate Care would not be appropriate in the first place. It should be noted that the underlying ethos of Intermediate Care is one of doing with, not doing for, hence the inclusion in this recommendation of 'working in partnership', which would mean that an unsuitable approach would not be imposed on individuals who were being provided with Intermediate Care when it was not what they wanted.
342.	The 25% ME Group	Short	5	7-9 Rec 1.1.5	Staff observing clients should have awareness that performing an activity - with or without a struggle - may have adverse consequences on the client at a later stage. In M.E. the hallmark feature is an abnormally adverse, severe, and potentially very long lasting response in reaction to pushing to carry out activities. This may even occur when when an activity is carried out with no apparent strain at the time, a person with M.E. may still experience a severe flare of symptoms and reduced functional capacity following the activity. This key defining feature of this illness is the nub of the matter when it comes to distinguishing these patients from those for whom 'intermediate care' may be a suitable and beneficial approach. Depending on how frequently and how deeply their limits have been breached, the	Thank you for your comment. As explained above, the GC is clear that this recommendation is based on evidence about the importance of motivation and working together to achieve goals, and if this is not the appropriate way of working with particular individuals, e.g. those with a long-term illness who could not benefit from this approach, then a referral to Intermediate Care would not be appropriate in the first place. It should be noted that the underlying ethos of Intermediate Care is one of doing with, not doing for, hence the inclusion in this recommendation of 'working in partnership', which would mean that an unsuitable approach would not be imposed on individuals who were being provided with Intermediate Care when it was not what they wanted.

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					adverse reaction can be severe and long lasting. Therefore, we recommend adding: ***"Take due cognisance of the potential for adverse consequences of performing an activity on wider functional capacity and wellbeing, before encouraging or obliging any client to do so."***	
343.	The 25% ME Group	Short Full	5 7; 218-219	10-12 Rec 1.1.6 Rec 1.1.6 and evidence	If intermediate care is not intended to be applied across the board, this should be made clear in the guidance. This 'do not exclude' instruction effectively opens the door to application of 'intermediate care' across the board. Such an approach would be irrational, unhelpful and wasteful of resources. As well as harmful to some, notably the client group we represent. In terms of evidence, it is quite shocking that a small amount of evidence of a low quality specific to people with dementia and suggesting that they may possibly benefit from 'intermediate care' approaches [Ps 218-219] has been transmuted into a recommendation that no one at all should be excluded. We note that in this regard the draft runs directly counter to the Institute's response to our concerns, as expressed in the course of consultation on guideline scope, when NIHCE repeatedly advised: *"We agree that reablement may not be appropriate for all people and anticipate that this will be an important issue for the Guideline Committee to discuss."* REF: Scope comments consultation table: https://www.nice.org.uk/guidance/indevelopment/gid-scwave0709/documents	Thank you for your comment. The GC discussed your point and took the view that stating that no one should be excluded from Intermediate Care does not imply that that everyone should be included. They are confident that the intended meaning of the recommendation clear.
344.	The 25% ME Group	Short	5	10-12 Rec 1.1.6	We consider that this distorts the United Nations Convention on the Rights of People with Disabilities [UNCPRD] (see comment number 5) and flouts other legislative provisions including the Equality Act 2010.	Thank you for your comment. The GC referred to the Article of the UNCPRD which your comment cited, and noted that it refers to 'independence' without using the word 'autonomy'. The GC took the view that the Guideline does not flout the convention in the way you stated.
345.	The 25% ME Group	Short	5	10-12 Rec 1.1.6	We are strongly of the view that people with ME (or a diagnosis of Chronic Fatigue Syndrome) should be explicitly excluded. Feedback from advocacy client with severe M.E.: *My real abilities and care needs have not been provided for and assistance needed has been withheld. As a result I continue to deteriorate. To access the care I need it seems I have to undergo gruelling Rehabilitation/Re-enablement interventions that are impossible for me to do and harmful with my level of Severe ME. Therefore I am being neglected and withering away in pain and sickness.*	Thank you for your comment. The GC does not agree that this change should be made. The research underpinning the Guideline would not support this exclusion. Also, based on their own expertise, including that gained through experience of using services, the GC supports the importance of graded activity (with rest), and therefore takes the view that some kind of rehabilitation can be appropriate even for people even with M.E. As the IC being recommended by the Guideline would be person centred, it would therefore be aligned with their strengths / needs / condition.
346.	The 25% ME Group	Short	6	10-15 Rec 1.2.2	The 25% ME group appreciate the guidance citing that different formats for communication may be used. Our client group contains people who are unable to speak or may have limited ability to speak, they also suffer from sensory overload so the time taken for assessment and discussion may need to be restricted to avoid the service user's condition worsening.	Thank you for your support.
347.	The 25% ME Group	Short	6	1-4 Rec 1.1.11	Effectively 'intermediate care' is a form of 'cognitive behavioural therapy' (CBT) - aiming as it does to secure changes in a person's behaviour to the specified ends, underpinned by a rationale for why the changes are appropriate to this end. As with any CBT, this approach will be helpful in so far - and only in so far - as the behaviour changes are actually beneficial to the person concerned and the explanations valid. Only to the extent that these conditions are fulfilled does this approach have scope to assist a person to "take control of their lives" and "regain as much independence as possible". As regards "optimise recovery" we are not clear how it might be that exposure to an 'intermediate care' approach can assist a person to 'recover' from an ongoing physical illness. Clearly some delineation is necessary. The notion that any and all patients can recover and furthermore will be helped to do so by placing them under the ambit of staff who subscribe to a 'reablement / rehabilitation' ethos would be irrational. Quote from person with severe M.E.: *'There is a great lack and misunderstanding of the illnesses and the way they affect individuals and how this impacts on their needs. Some are not able to recover so Rehabilitation is not suitable and <u>these people need acceptance and support for where they are</u>."*	Thank you for your comment. On the basis of the evidence, the policy and practice context and the committee's expertise they do not believe that intermediate care could be described as cognitive behavioural therapy.
348.	The 25% ME Group	Short	6	6-9	This recommendation presupposes that the outcome of any assessment will be that one of the four models of Intermediate Care is appropriate.	Thank you for your comment. The GC accepted that this recommendation could be reworded to incorporate this and other points that were made, so that the redrafted

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				Rec 1.2.1	It should be amended to read: ***"so that they can be offered referral to whichever model of intermediate care is appropriate, if any".***	recommendation now reads: 'Assess people for intermediate care if they are at risk of hospital admission or have been in hospital and need help to regain independence. Also assess people living at home who are having increasing difficulty with daily life, and where specific support and rehabilitation is likely to improve their ability to live independently or avoid a hospital admission. During the assessment identify the person's abilities, needs and wishes so that they can be referred for the most appropriate support.'
349.	The 25% ME Group	Short	6	23-24 Rec 1.2.5	This recommendation involves a professional making their mind up in advance about impact and outcome, and indeed predicting the future - to the extent that before 'intermediate care' has begun they can talk to family and carers in terms of 'what it will achieve'.	Thank you for your comment. This recommendation has now been deleted and the final guideline states that discussions should take place with the person (and their families, if appropriate) including about what the service aims to achieve (rather than asserting what it *will* achieve).
350.	The 25% ME Group	Short	7	6-7 Rec 1.2.8	Our concern is that adult social care and NHS intermediate care staff are not equipped to judge whether a person with ME might benefit from 'reablement' rather than long term home care. Our experience indicates that, far from improving independence, offering 'reablement' as a solution to the care needs of people with ME results in distress, deterioration in functional capacity and a higher level of need for long term care. Rehabilitation techniques used for other conditions such as stroke or accident, for example, can cause deterioration in people with ME due to Post Exertional Malaise, the cardinal feature of this disease. We therefore suggest an amendment along the following lines: ***"Offer reablement as a first option to people with stroke, etc*** **[list all conditions with evidence for the effectiveness of reablement,"** This is our preferred option and indeed the only option that is consistent with the 'NICE' approach of not recommending anything in the absence of evidence. Alternatively: **"Offer reablement as a first option to people being considered for home care, if and only if there is reason to believe that (i) reablement has potential to benefit a person in their circumstances by improving their independence, and (ii) the absence of direct care support and encouragement to do more for themselves will not be detrimental to their health and wellbeing."**	Thank you for your suggestion. The GC decided against introducing these changes. The GC would anticipate that if a person was unable to benefit from reablement, whether this was due to having a particular condition or for any other reason, this would be picked up during assessment and before the person is referred for intermediate.
351.	The 25% ME Group	Short	7	6-7 Rec 1.2.8	Typically, people with ME enter the social care system after they have struggled to manage by themselves with self-care at the expense of all other activities, e.g. social and leisure, and at great personal cost to their wellbeing. At this point their wishes are for support with self-care to enable better a quality of life (for example, reduction of symptoms; preserving some functional capacity for social connectedness). In common with many other patient groups, having to "admit defeat" and to finally ask for support with self-care when they reach breaking point and can no longer cope is distressing in itself. Demonstrating eligibility for support with a poorly understood condition where the NHS offers little or no testing and medical care is often a traumatic and protracted process. For many of our clients the pressure to do more for themselves when they are given reablement as a first response to their care needs feels perverse and is a highly distressing outcome to an already fraught process	Thank you for raising these issues, which are unfortunately outside the scope of this guideline. There is an existing NICE guideline (CG53) on diagnosis and management of ME and a decision will be published in summer 2017 about whether it needs to be updated in light of new evidence. https://www.nice.org.uk/guidance/cg53
352.	The 25% ME Group	Short	7	8-9 Rec 1.2.9	Points made in respect of recommendation 1.2.8 also apply here. In our experience use of 'reablement' as part of a review or reassessment is particularly problematic, and inappropriate and unacceptable to the clients we support. We do not accept that 'reablement' workers are necessarily equipped to assess care need. The ramifications of uprooting a care provider and supplanting with 'reablement' staff can cause problems in a number of ways. For example, the 'reablement' team may not be able to make calls at the same times as the prior care provider. We have experience of an advocacy client who experienced a great deal of stomach pain and tachycardia, after the local authority insisted on such a course of action. To avoid pain and discomfort through the exacerbation of digestive problems she must eat at particular times, with meals spaced out appropriately. The 'reablement' team could not deliver on the requisite times. No one at the local authority viewed this as a valid consideration. (Perhaps the logical conclusion when 'reablement' are at someone's	Thank you for your comment. The GC would wish to point out that, if the Guideline is being followed, then nobody would be referred for or provided with Intermediate Care if they objected. The situation you describe should be avoided if the Guideline is being followed. The GC also noted your concern about whether reablement workers would be equipped to assess care need. The GC takes the view that it is one of the expectations of the Guideline that Intermediate Care staff should be trained and equipped to deal with all aspects of the IC service, including carrying out assessments, and doing so collaboratively, so that people's own views about their support needs are taken into account.

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					home with a blank sheet and social care staff take the view that, despite many years of ill health and service provision, care needs must be reestablished by visits from said team.) This situation effectively damaged her health. This also relates to our point regarding need to seek medical opinion as the GP was in a position to support her patient's need for stable consistent mealtimes, appropriately spaced. Social services took no steps to initiate such medical input in this or any other regard.	
353.	The 25% ME Group	Short	7	6 Rec 1.2.8	NOTE: 'Offer' and 'option'. 'First option' does not mean 'only option'. In 'offering' reablement it must be clear at all times that the professional judgement of staff regarding suitability (i.e. the scope to of 'reablement' to 'improve their independence') does not take priority over the judgement of the person needing care. The latter would imply a breach of Care Act 2014. The key assumption of the Care Act 2014 with regard to the wellbeing duty must take priority - *i.e.* local authorities must have regard to a) "the assumption that the individual is best-placed to judge the individual's well-being; b) the individual's views, wishes, feelings and beliefs." Care Act 2014 1(3)	Thank you for your suggestion. The GC did not feel any change was required because the fact that intermediate care assessment, planning and delivery should be person centred and according to the person's needs and preferences is fundamental to the guideline and set out in the core principles.
354.	The 25% ME Group	Short	7	6 Rec 1.2.8	At present it is not only at review and reassessment stage [rcd 1.2.9] that 'reablement' may be brought in to assess. This can happen at the outset. Viewing 'reablement' calls as part of an assessment creates a paradox whereby people are having workers in to 'assess' whether or not they require care support, with a starting point being that this requires to be demonstrated in this way, and only in this way. This is both flawed in principle and can be highly dangerous in practice. Case example from M.E. support: 'We were called for by a woman with ME and other conditions. She was sound and light sensitive and had lost several stones in weight and was not coping with eating. Had fridge and freezer stocked but too weak to eat. We asked for an assessment of her condition and she was allocated two Carers to see her for 6 weeks reablement. The only way to get her any kind of help. They encouraged her to engage with them in the kitchen to prepare food despite her extreme weakness and grossly swollen legs. The reablement had to run for 6 weeks before future help would be decided so Social Services would not discuss her needs further. She regularly called out the ambulance for severe breathing condition CPOD but would not go into hospital with them because of previous experience of A&E's noise and bright lights. We prepared her for admission to hospital. Only way was through A&E, so called GP. GP would not have her admitted even though we could see she was dying (weighed less than 5 stones). Finally Carers visited and found her unconscious, admitted straight to Ward and medical staff asked where she had been and why she was not admitted earlier. Fought to save her for a week and she then died."	Thank you for drawing our attention to this. Your illustration of the potentially severe or even fatal consequences of people receiving an inappropriate response to a particular condition is well taken. We hope that the stress within the IC Guideline on person centred care will go some way to avoiding a repetition of such events, where an intermediate care service is being provided.
355.	The 25% ME Group	Short	8	20-27 Rec 1.3.5	The assessment of risk must include the *after effects* of carrying out an activity. It must also look at the impact of *repeating* an activity. It must take into consideration that the person may be able to do an activity at some points but not necessarily when the activity requires to be carried out to meet a need. It should also take into account risks incurred through carrying out an activity at the cost of ability to later carry out other activities necessary to the wellbeing. The very poor stamina and post exertional malaise that is characteristic of ME means that managing activity is fraught, and patient experience and judgement must be respected to a very high degree. People should not be set goals to perform activities independently if doing so will undermine their health and/or their broader wellbeing. Under risk assessment we suggest adding: **"Consider whether an activity can be performed as often as required, when required, and safely when setting goals"**	The GC notes your concerns that the potential impact on people with M.E. should be recognised and captured in the risk assessment, by recognising the potential after effects of an activity. The GC considers that these issues should be recognised and included by adopting the collaborative and person-centred approach specified in the core principles. They have decided not to amend the recommendation as you have suggested.
356.	The 25% ME Group	Short	8	20-27	Win that we refer to a risk of even deterioration that is intrinsic to the 'reablement' approach in respect of people with ME, the Guideline Development Group may wish	Thank you for your comment. The GC believes that if the recommendations are followed, this will ensure that intermediate care is not 'inflicted' on anyway.

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				Rec 1.3.5	to be aware that the law on informed consent changed following a Supreme Court judgment in 2015. See court judgement: https://www.supremecourt.uk/cases/docs/uksc-2013-0136-judgment.pdf Doctors must now ensure that patients are aware of any 'material risks' involved in a proposed treatment, and of reasonable alternatives. The Supreme Court's ruling: "The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it." http://www.medicalprotection.org/uk/for-members/news/news/2015/03/20/new-judgment-on-patient-consent	Assessment for and provision of intermediate care should be person centred and take into account people's needs and preferences.
357.	The 25% ME Group	Short	8	26-27 Rec 1.3.5	The thrust of the final point here is problematic, as it implies that a person's "wishes, wellbeing, independence and quality of life" can only point towards *taking* a risk. We are painfully aware that people with severe M.E. are encountering exactly the opposite: that professionals are encouraging them to undertake activities and expose themselves to environments that are not just risky but guaranteed to bring about deterioration. Patient views are being ignored on this point, up to and including sectioning under the Mental Health Act (NB: ME is not a mental or behavioural disorder; it is classified by the World Health Organisation as a neurological disorder - at G93.3).	Thank you for your comment. The GC considered whether the wording appeared to encourage risk-taking, as you suggest, but decided that the wording did not need to be changed. The aim of this recommendation is to ensure that an assessment of risk is carried out, and then repeated regularly, so that the service providers and people receiving the service will fully understand the risks. The GC would not want to deny anybody an IC service because there was a risk, but the GC did want to stress the importance of risks being assessed and understood.
358.	The 25% ME Group	Short	9-10	27-29 Rec 1.3.12	We welcome this section as it reflects, albeit only partially, the person-centred emphasis of the Care Act 2014. However, this guidance should apply at an earlier stage of the process. The person-centred approach should be in force during the discussion with the person over whether intermediate care including reablement is suitable and appropriate to their needs, as well as once the decision to offer IC has been made**.**	Thank you for your comment. The GC notes that making IC collaborative and person-centred is the very first core principle set out in the Guideline, which means it should be applied throughout the process. We would also highlight that the Guideline states that considerations about which is the most appropriate support for a person should include the identification of their needs and wishes and they should be actively involved in all discussions at this stage. Therefore the GC did not feel there was a need to make further additions in order to emphasise the point.
359.	Thomas Pocklington Trust	General	General	General	We have seen a draft of the response from Guide Dogs and are supportive of the recommendations made therein.	Thank you, this is noted.
360.	Thomas Pocklington Trust	Short	13	1.7.1	Please can you include understanding the roles and responsibilities of external partners/agencies as well as understanding the roles and responsibilities of all team members.	Thank you for your comment. The GC took the view that the areas of understanding listed in this recommendation are all aimed at ensuring staff who participate in providing an IC service understand the IC service, and so they would not wish to add your suggestion, which is aimed at ensuring an understanding of external services.
361.	Thomas Pocklington Trust	Short	13	1.7.1	Please can you be more explicit that all staff delivering intermediate care should understand how the care provided impacts on a patient's life when delivered properly and when it is failed to be delivered properly. This may be implied by the aim to support independence but is not explicit.	Thank you for your comment. The GC took the view that the purpose of this recommendation is to ensure that IC staff understand what the service is and how it works. To include an understanding of the impact that service delivery has on people receiving the service would go outside of what this recommendation is aiming to achieve. For this reason, the GC decided not to include the point you have suggested.
362.	Thomas Pocklington Trust	Short	13	1.6.5	Please can you include sensory service teams	Thank you for your comment. The GC noted that the list is only intended to provide examples, and not to be exhaustive, and so they are not in favour of making the suggested addition to the list.
363.	Thomas Pocklington Trust	Short	16	7	Please can you be explicit that interventions can last longer than the 6 weeks noted. This reduces misinterpretation where people may deem any provision beyond 6 weeks is not allowed which we do not want to see.	Thank you for highlighting this. The GC agrees with your point and has made this explicit in the final guideline which reads, 'Review people's goals with them regularly. Adjust the period of intermediate care depending on the progress people are making towards their goals.'
364.	Thomas Pocklington Trust	Short	2		Please could voluntary sector partners be added as a bullet point. They may not always be captured under the provider bullet point but have an important role to play in enabling independent living and supporting intermediate care and reablement teams.	Thank you, this has been added.
365.	Thomas Pocklington Trust	Short	5	1.1.4	Refer people to the NHS Accessible Information Standard for clarity and guidance as to how to meet the communication needs of individuals.	Thank you for your comment. The GC did not agree that this needs to be added, as the aim is that the IC service provision should involve communicating with each individual in the way that is suitable for that individual. The GC noted that the Accessible Information Standard can already be accessed at the start of the Guideline, by following the link 'Making decisions using NICE guidelines'. We hope you agree that this is sufficient.
366.	Thomas Pocklington Trust	Short	5	1.1.5	Include a bullet point advising staff to refer to other qualified professionals if the required intervention is not in their skillset.	Thank you for your comment. The GC was of the view that this is already implicit in the emphasis throughout the Guideline on working in partnership with other

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						professionals, e.g.: 'Ensure that more specialist support is available to people who need it (for example, in response to complex health conditions), either by training intermediate care staff or by working with specialist organisations.'
367.	Thomas Pocklington Trust	Short	5	1.1.9	Please can you include vision rehabilitation workers and low vision practitioners here.	Thank you for your comment. The GC took the view that the core group needed to have access to these practitioners, rather than always including them as members. The GC decided not to add vision rehabilitation workers and low vision practitioners to the core membership list.
368.	Thomas Pocklington Trust	Short	6	1.1.11	Clarity on how people ensure staff have the skills required would be useful. For example, is this through qualifications, experience in the field, etc?	Thank you for your comment. The GC considers that this issue is addressed through section 1.8, dealing with staff training and development.
369.	Thomas Pocklington Trust	Short	General	General	In the Care Act 2014 specific mention is made of vision rehabilitation services and their distinct nature in terms of reablement. We would recommend the guidelines production team reviews these aspects in the Care Act 2014 to ensure that they take these into account.	Thank you for this suggestion. Since vision rehabilitation was not included in our review of evidence or our definition of intermediate care, we would not be able to make these additions at this stage of guideline development. It may be that when the guideline is reviewed the scope is altered to encompass these types of services.
370.	VISION 2020 UK	Full	10	1.3.2	We suggest adding **Sensory impairments** To : 'take into account the person's: • cultural preferences • mental capacity'	Thank you for your comments. The GC recognised the importance of taking sensory impairments into account, but took the view that along with a range of other needs, this would be done as part of a holistic assessment of a person's needs. The GC decided not to add sensory impairments to this recommendation as distinct from any other particular needs.
371.	VISION 2020 UK	Full	13	1.4.5	(Third bullet point). The alternative format that is likely to be the most useful is large print. (in that it will inevitably make the material accessible for the largest number of patients/service users). We do not suggest removing braille or easy read, but do suggest adding large print.	Thank you for your suggestion. The GC felt that since the list is intended only to provide examples, it was not necessary to add any more items. The fact that the recommendation is to provide a range of 'accessible' formats implies any format, which make the information accessible for that individual.
372.	VISION 2020 UK	Full	17	No line number	Reablement section: Apologies, there is some narrative and explanation before our recommendation but we feel that it is important to provide some context. When the Care Act Statutory Guidance was being written, those drafting it drew from a position statement by the Association of Directors of Adult Social Services issued in December 2013 which included the line: "Rehabilitation for visually impaired people is a specific form of reablement. There are some intrinsic characteristics which define rehabilitation as being distinct from other forms of reablement." This was felt to be a vital message as it highlighted how visual impairment rehabilitation is very much a specialist preventative intervention, but does not mirror exactly the format of traditional intermediate care or reablement. For instance, it tends to be delivered over a longer period of time than six weeks, but is less intensive. So time limited but not time-prescribed. The statement was signed by the Joint Chairs of the ADASS Workforce Development Network and the Joint Chairs of the ADASS Physical Disability, Sensory Impairment and HIV/AIDS Network. Some of the exact wording from the position statement made it into the Care Act Guidance itself. Paragraph 22.22 includes direct reference to the statement and pointing out that: "This makes it clear that rehabilitation for sight impaired people is a specific form of reablement. However, there are some intrinsic characteristics which define rehabilitation as being distinct from other forms of reablement." There is also recognition in the Care Act Guidance that the nominal six-week time limit on reablement may not be appropriate in the case of visual impairment rehabilitation. Paragraph 2.62 states: "Whilst they are both time-limited interventions, neither intermediate care nor	Thank you for this information.

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					reablement should have a strict time limit, since the period of time for which the support is provided should depend on the needs and outcomes of the individual. In some cases, for instance a period of rehabilitation for a visually impaired person (a specific form of reablement), may be expected to last longer than 6 weeks." We therefore recommend that the short paragraph on reablement in this draft NICE guidance is extended to make explicit reference to this discrete form or reablement We believe this could be achieved by adding some text at the end of the paragraph at the bottom of page 18 (immediately after reference to the National Audit of Intermediate Care, 2014) along the lines of the following: "The majority of local authorities offer a specific type of reablement for people with sight loss, provided by a qualified rehabilitation worker/rehabilitation officer. The Care Act Statutory Guidance makes it clear that whilst this shares many of the characteristics and principles of traditional reablement, it has unique characteristics, including that it may often take longer than six weeks and so the nominal six-week time limit should not be routinely placed on people with sight loss undertaking a rehabilitation skills training programme."	Thank you for this suggestion. Since vision rehabilitation was not included in our review of evidence or our definition of intermediate care, we would not be able to make these additions at this stage of guideline development. It may be that when the guideline is updated the scope is altered to encompass these types of services.
373.	VISION 2020 UK	Full	18	1	The link to the jargon buster does not work	Thank you for highlighting this. The correct link will be provided in the final version of the Guideline.
374.	VISION 2020 UK	Full	6	1.1	We recommend that the heading of this section be changed to reflect the title of the document as a whole. Eg, that if is changed to: "Core principles of intermediate care (**including reablement)**" (bold has only been used to show the suggested addition). As well as mirroring the title of the document, it will also help to ensure that it is understood that the principles apply to reablement as much as they do the various other models of intermediate care. Reablement is the only one that does not have "intermediate care" in its name and so there is perhaps a danger that people might assume that reablement is not covered by these principles.	Thank you for your comment. The GC agreed with your comment, and the heading of the section will be changed accordingly.
375.	VISION 2020 UK	Full	6	1.1.4	We recommend adding "and/or sensory" after "physical" as set out at the end of this comment. We have been long aware since Social Services Inspectorate inspections into older people's services in 2002/2003 identified the problem that sensory needs (especially when not always apparent) are often overlooked in generic assessments including those for older people. Intermediate care teams are unlikely to have specialists in sensory impairment amongst their number, but a need resulting from sensory impairment could be addressed by referring the individual into a specialist service such as a rehabilitation worker working with people with sight loss. Address people's social, emotional, communication and cognitive needs, as well as their physical **and/or sensory** needs as part of intermediate care	Thank you for your comment. The GC discussed your suggestion and came to the conclusion that the list as it stands will be understood to mean that people's range of needs should be considered and addressed, without having to itemise each potential area of need, and so the recommendation does not need this addition.
376.	VISION 2020 UK	Full	9	1.2.10	We suggest adding sensory loss here too. Our assumption is that people with dementia may not be considered to be suitable for intermediate care as it seems to have a primary focus on physical frailty or impairment. But sensory impairment can have a significant impact on a person's health and wellbeing. It is for this reason that the Royal College of General Practitioners (RCGP) had a three-year clinical priority on ageing and eye health/sight loss culminating in a guide for RCGP members. http://www.rcgp.org.uk/~/media/Files/CIRC/Eye%20Health/RCGP-Sight-Loss-in-Older-People-A-Guide-for-GPs.ashx Also the National Dementia Declaration point 5 which states: We have the right to be respected, and recognised as partners in care, provided with education, support, services, and training which enables us to plan and make decisions about the future. http://www.dementiaaction.org.uk/nationaldementiadeclaration	Thank you for your comment. The GC understood your reasons for making this suggestion, but noted that the recommendation was based on evidence from a wider population, and would not wish to make this addition unless there was research evidence to support it. As there is not the evidence base to support it, the GC does not agree that the recommendation should be changed.
377.	VISION 2020 UK	Full	General	General	The Statutory Guidance published in the wake of the Care Act (2014) explicitly acknowledges rehabilitation for people with visual impairment as a vital and distinct type of reablement. This is the first time ever that this discrete specialist intervention has been recognised within an official statutory document. Given the significant year on year increase in the numbers of people with sight loss (due to demography) and	Thank you for your comment, and for providing the link to the ADASS position statement. The focus of this guideline is on intermediate care for people with all conditions. The review work was informed by the definition of intermediate care used by the National Audit of Intermediate Care, which excludes single condition services (for example vision rehabilitation) so the reviewers had to exclude any such studies.

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					the volume of evidence around the impact of sight loss on independence, health and wellbeing we believe that there is a strong case for this NICE guidance to acknowledge sight loss and to highlight the importance of responding to needs resulting from it appropriately. This is the key focus of our submission which is aimed at strengthening the guidance and hopefully in doing so, improving outcomes for people with sight loss. Not only that, there is an explicit connection drawn between this discrete specialist intervention and reablement. There is a clear position statement on this topic published by the Association of Directors of Adult Social Services https://www.adass.org.uk/adass-position-statement-on-vision-rehabilitation-may-2016	For this reason, unfortunately they would not be able to add the research you have referenced. Nevertheless, you may have noticed that some evidence about stroke rehabilitation was in fact included in the review. This is because the Guideline Committee pointed out that early supported discharge and other stroke rehabilitation services as described in the literature are, in the context of current practice, closely aligned with intermediate care. This is in terms of the needs of people using the service, the organisation of the service and the functions delivered by the teams. They did not feel the same principle applied to vision rehabilitation. However the GC have been careful to recommend a very inclusive approach to supporting people though intermediate care, ensuring that no one is excluded on the basis of having a particular condition or diagnosis.
378.	Wigan Council	Short	5	13	The Early Intervention services is now part of an integrated health and social care service which enables smooth transition between services. There is a locality hub where daily huddles take place with a range of professionals including Early Intervention, District Nurses, Community Matrons and social care. Hospital @ Home (rapid response). This enables quick responses to peoples changing needs.	Thank you for this information.
379.	Wigan Council	short	5	16	The Reablement service now provides a Reablement with care service to support hospital discharge when additional care and support is needed. These cases are then either progress seamlessly to Reablement if there is potential to improve, or refer to social work team for a support plan once their ongoing care needs have been identified during the assessment process.	Thank you for this information.
380.	Wigan Council	Short	5	10	We do not exclude any particular conditions unless for example the dementia very advanced. If a person was in prison we would make a decision on a case by case basis.	Thank you for this information.
381.	Wigan Council	short	6	1	There is a comprehensive training plan in place all support workers complete a 6 week induction, Trusted assessor, NVQ 3 in Health and Social care, medication management safeguarding,, mental capacity training, first aid, food hygiene.	Thank you for this information.
382.	Wigan Council	short	7	6	All community referrals received by the Initial Assessment Team (The council's one front door for all referrals) are considered for Early Intervention first, This includes Reablement, Equipment and/or adaptations, Assistive Technology. All hospital discharges where ongoing care and support is required are considered for Reablement and if they have care needs for Reablement with care.	Thank you for this information.
383.	Wigan Council	Short	9	9	It would prove useful if it was included in the guidelines that people in bed based services were encouraged to look after their own medication, or a risk assessment was completed to identify if prompting or administering was needed before discharge.	Thank you – the GC believes that this is already stated and therefore no change to this recommendation is required.
384.	Wigan Council	short	9	21	Reablement services have access to the Hospital @ Home services if required and they are able to respond within 2 hours.	Thank you for this information.
385.	Wigan Council	Short	General	General	Wigan Council Reablement services forms part of an Integrated Early Intervention Team consisting of Occupational Therapy Reablement services, sensory rehabilitation and assistive technology. The recent review by the Care Quality Commission (CQC) of the Wigan Reablement rated the service as Outstanding; the report is available on the CQC web site. The management team have reviewed the draft consultation document against our current practice and feel that is a good reflection of the way our service operates. We are willing to share our model of practice.	Thank you very much for making this offer. We will pass your details to our implementation team.

**None of the stakeholders who commented on this guideline have declared any links to the tobacco industry.*