NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

EQUALITY IMPACT ASSESSMENT

Intermediate care and reablement

The impact on equality has been assessed during guidance development according to the principles of the NICE equality policy.

1.0 Scope: before consultation (To be completed by the developer and submitted with the draft scope for consultation)

1.1 Have any potential equality issues been identified during the development of the draft scope, before consultation, and, if so, what are they?

Focus on all adults: By retaining a broad focus on all adults there is a risk that the guideline may marginalise older people who are by far the biggest demographic group using reablement and intermediate care services.

Younger adults: This group is less well represented in research and policy on promoting independence and it is unclear whether the design of traditional reablement services is appropriate to meet the needs and goals of younger adults. Services which focus solely on physical reablement or rehabilitation after an accident or illness are unlikely to enable younger adults to regain full independence, for example by returning to employment or participating in social activities. Stakeholders were also concerned that the needs of younger adults should be considered by the guideline.

Diversity in population: There is research to suggest that people from an ethnic minority background, recent migrants and people for whom English is not their first language can be disadvantaged when accessing services as they may be unaware of social care which is available to them. This issue is particularly relevant to older people from a minority background, particularly older people LGBT people and older people from minority groups and services should attempt to mitigate the difficulties

that these groups can experience in accessing services. Services should also be sensitive and responsive to different cultural, religious and LGBT requirements and ensure that individuals are able to achieve independence that is meaningful to them, for example by enabling them to participate in cultural or religious activities

Gender: Some people may prefer that professionals involved in their care are of the same gender and it is unclear whether reablement and intermediate care services will be able to accommodate such requests. The Health and Social Care Information Centre figures for 2012-13 shows that 60% of service users (of all ages) receiving community-based social care services are female. The guideline should consider gender issues relevant to service users and carers.

People with cognitive impairment including dementia: People with cognitive impairments such as dementia are often excluded from reablement services. They are also usually excluded from research on reablement and the guideline will need to consider the needs of this group. In contrast, some reablement services do accept people with cognitive impairments, including dementia but it is important that these services recognise the difficulties which this group may have in accessing care.

Adults who may lack capacity: It is important that reablement services consider communication strategies, quality of services, choice and control, and safeguarding issues in relation to this group.

People with communication difficulties, and/or sensory impairment: This group may have particular problems in accessing reablement services and the guideline may need to make specific recommendations to ensure that services are accessible and use appropriate communication strategies to enhance choice and control. The guideline should recognise that sensory impairment (e.g. affecting sight or hearing) and communication difficulties may develop with or be exacerbated by age and that adults with learning disabilities or people for whom English is not their first language may experience particular problems in this regard. Safeguarding procedures and quality of services are also issues which will need to be addressed in relation to these groups.

People at the end of life: Many services exclude people who are at the end of life

due to perceptions that they are unlikely to benefit from a reabling approach. However some reablement services do support people with end of life care needs, so it should be recognised that benefits can be achieved with this group, in terms of independence. This guideline will recognize that people with end of life care needs experience difficulties in accessing reablement.

Socio-economic status: There is evidence to suggest that lower socio-economic status is associated with poor access to information about care options.

Location: Reablement services have developed at a different pace throughout the country, geographical variation in services is common and there are a range of different delivery models in existence. The guideline should ensure that inequality of access due to regional variation in provision is addressed.

Residential and nursing care homes: Older adults who live in residential homes (including nursing homes) may experience difficulties in accessing intermediate care and community reablement services. The guideline should attempt to address this issue.

People who live alone: When reablement works well, the person who has used the service will be able to do things for themselves and will therefore not be referred for ongoing support, such as home care. For some people, especially those who live alone, this may lead to feelings of loneliness and isolation. The voluntary sector has a role to play in ensuring that people who have been reabled do not become isolated from their community, for example through the provision of befriending services.

People without a home: People without a settled residence (e.g. the homeless; gypsies and others with traveller lifestyle) are likely to be excluded from services, although searches oriented to their personal/social care will be undertaken and stakeholders noted that this group are within scope.

Family carers' gender and ethnicity: There is some evidence to suggest that women and ethnic minority carers are more likely to be expected to provide unpaid care than their male/white counterparts. Carers in general may be expected to provide more unpaid care if their family member has regained sufficient independence that they do not meet eligibility criteria for ongoing services but

nevertheless need some degree of support.

Prisoners: Stakeholders emphasized that Local authorities have new responsibilities for assessing the social care needs of prisoners including for reablement services under the Care Act.

1.2 What is the preliminary view on the extent to which these potential equality issues need addressing by the Committee? For example, if population groups, treatments or settings are excluded from the scope, are these exclusions justified – that is, are the reasons legitimate and the exclusion proportionate?

Plans for dealing with these aspects include sensitivity to equality and diversity issues, and search strategies specifically oriented to seek out material on these groups. The guideline will address the organisation and delivery of services that take account of these issues, including the provision of advice and information to support access to personalised services. The guideline will attempt to uncover and address some of the areas where there is well-documented discrimination. The Guideline Committee may also make recommendations specifically in relation to particular service users and carers.

It is proposed that rehabilitation services are excluded from the scope as these are usually medically supervised programs involving health practitioners such as doctors, nurses, dieticians, physical and occupational therapists and exercise specialists. Rehabilitation services may not involve any social care practitioners or local authority funding. If rehabilitation interventions, which are resourced entirely by the health service are included, the scope will be unmanageable. Furthermore, NICE has produced a number of guidelines on rehabilitation services and others are in development. Details can be found in the draft scope.

A number of stakeholders were concerned that the lower age limit of 18 was problematic given the problems which this group often experience in accessing services. However, the scoping group concluded that these were usually operational issues which were not specific to reablement services and were unlikely to be resolved by the guideline.

2.0 Scope: after consultation (To be completed by the developer and submitted with the final scope)

2.1 Have any potential equality issues been identified during consultation, and, if so, what are they?
No, although stakeholders' comments suggested we ensure that people with communication difficulties are adequately covered by the EIA. The scoping group agreed they are so no changes have been made.

2.2 Have any changes to the scope been made as a result of consultation to highlight potential equality issues?
Having reviewed the EIA, it was agreed there was no need for changes to be made.

2.3 Is the primary focus of the guideline a population with a specific disability-related communication need?   If so, is an alternative version of the 'Information for the Public' document recommended?   If so, which alternative version is recommended?   The alternative versions available are: • large font or audio versions for a population with sight loss;   • British Sign Language videos for a population who are deaf from birth;   • 'Easy read' versions for people with learning disabilities or cognitive impairment.
No, the primary focus is not a population with a specific disability related communication need.

3.0 Guideline development: before consultation (to be completed by the developer before draft guideline consultation)

3.1 Have the potential equality issues identified during the scoping process been addressed by the Committee, and, if so, how?

Focus on all adults – the draft recommendations do not marginalise older people because they advocate a person centred approach to assessment for and delivery of intermediate care. In particular, recommendation 1.1.6 specifically states that people should not be excluded from intermediate care on the basis of any diagnosis. The GC therefore believes that the recommendations promote intermediate care for people according to need and regardless of age.

Younger adults – the review of evidence supported the GC's concerns that reablement and intermediate care services can be too focused on physical rehabilitation, not addressing goals such as returning to employment or sports and social activities. Committee members were therefore able to recommend that social and leisure activities should be recognised as legitimate intermediate goals (rec 1.1.3) as well as the more general point that goal setting should be person centred and involved the person themselves (rec 1.1.1)

Diversity in population – the scoping phase identified that people for whom English is not their first language and people from a minority ethnic background may be disadvantaged in this context. On the basis of research evidence and the committees' expertise, they developed a small number of recommendations to try and address this. For example 1.1.1 recommends that a core principle of intermediate care is that it should take account of cultural differences and preferences. They also recommended that when planning intermediate care, a person's cultural preferences should be taken into account (rec 1.3.2) and that information to help people achieve their intermediate care goals should be offered in accessible formats, for example provided via an interpreter (rec 1.4.5).

Gender – this was not specifically addressed by the recommendations, other than stipulating that intermediate care should be person centred and planning the service should always involve the person to incorporate their choices and preferences.

People with cognitive impairment including dementia – there was little evidence about the use of intermediate care to support people living with dementia and the GC therefore developed an appropriate research recommendation (research rec 3) to plug this gap. The GC also invited an expert witness to provide testimony about using reablement to support people living with dementia and combined with their own expertise they did develop a number of recommendations on this basis, albeit that some were 'consider' recs to reflect the lack of evidence. These included recs

3.1 Have the potential equality issues identified during the scoping process been addressed by the Committee, and, if so, how?

1.1.6 and 1.2.9.

Adults who may lack capacity – through discussion about the evidence and their own expertise, the GC considered how intermediate care should address communication strategies, quality of services, choice and control, and safeguarding issues in relation to this group. The recommended that in planning intermediate care, account should be taken of a person's mental capacity (rec 1.3.2) and they also adapted recommendations from the NICE home care guideline about risk planning (recs 1.3.5 and 1.3.6) and from the medicines optimization guideline about assuming that people using bed based intermediate care can manage their own medication unless an assessment suggests otherwise (1.3.7).

People with communication difficulties – the committee sought to ensure that people with communication difficulties were not restricted from accessing intermediate care. They developed a general recommendation about the importance of good communication (rec 1.2.2) and they recommended that all reasonable adjustments be made so that people can be fully involved in assessment and planning for intermediate care (rec 1.2.1). They also recommended that people are given all necessary information to meet their intermediate care goals and that the information should be accessible and provided in a way they understand (rec 1.4.5)

People at the end of life – no evidence was identified to address this group of people and the issue was not specifically addressed by the recommendations.

Socio-economic status – socio economic status was not specifically addressed by the draft recommendations although there are a number, which promote information sharing and person centred approaches in a way which would mean that regardless of socio economic status people would have equal access to information and support options.

Location – some of the intermediate care service models, such as reablement have developed at a different pace throughout England. Based on research evidence and their own expertise, the GC was keen to promote equal access to intermediate care regardless of place of residence. They agreed recommendation 1.1.7, which states that all 4 service models should be available and organised to enable referrals between them.

Residential and nursing care homes – aware that people living in care homes may have restricted access to intermediate care, the recommendations are deliberately developed so that references to 'own homes' includes a care home or indeed setting considered to be the person's 'home'. There is also a specific recommendation that

3.1 Have the potential equality issues identified during the scoping process been addressed by the Committee, and, if so, how?

people should not be excluded from intermediate care based on where they live (rec 1.1.6).

People who live alone – recommendation 1.4.7 urging intermediate care staff not to miss visits, emphasises that particular care is taken in this regard when people live alone. This should also be addressed in planning intermediate care, for example assessing people's ability to self manage (rec 1.3.2) and in conducting risk assessments, both initially and on-going (rec 1.3.5).

People without a home – although there was no evidence relating to intermediate care for people without a home, the GC drew on their own expertise to emphasise that people should not be excluded from intermediate care on the basis of living in particular circumstances, for example in temporary accommodation.

Family carers' gender and ethnicity – the GC recommended that carers' wishes and preferences (recs 1.2.1, 1.3.2, 1.3.6 and 1.3.14) as well as their own support needs should be taken into account in assessment and planning for intermediate care (1.2.3 and 1.3.3) and in arrangements during exit from intermediate care (rec 1.5.3).

Prisoners - although there was no evidence relating to intermediate care for people in prison, the GC drew on their own expertise to emphasise that people should not be excluded from intermediate care on the basis of living in particular circumstances, for example in prison.

3.2 Have any **other** potential equality issues (in addition to those identified during the scoping process) been identified, and, if so, how has the Committee addressed them?
No other potential equality issues were identified during the guideline development phase.

3.3 Were the Committee's considerations of equality issues described in the consultation document, and, if so, where?
Where equality issues were discussed, these are described in the 'other

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considerations' sections of the LETR tables (section 3.9)

3.4 Do the preliminary recommendations make it more difficult in practice for a specific group to access services compared with other groups? If so, what are the barriers to, or difficulties with, access for the specific group?
The draft recommendations do not make it more difficult in practice for a specific group to access services compared with other groups.

3.5 Is there potential for the preliminary recommendations to have an adverse impact on people with disabilities because of something that is a consequence of the disability?
No, given the equalities issues that have been addressed in the development of the recommendations (see 3.1) there does not appear to be the potential for the draft recommendations to have an adverse impact on people with disabilities.

3.6 Are there any recommendations or explanations that the Committee could make to remove or alleviate barriers to, or difficulties with, access to services identified in questions 3.1, 3.2 or 3.3, or otherwise fulfil NICE's obligation to advance equality?
People at the end of life – although it was discussed with the GC, there do not appear to be any recommendations that can be made in this context due to a lack of evidence.

4.0 Final guideline (to be completed by the Developer before GE consideration of final guideline)

4.1 Have any additional potential equality issues been raised during the consultation, and, if so, how has the Committee addressed them?

People with ME: Two charities which support people with M.E. (Action for M.E. and The 25% ME Group) raised concerns that the Intermediate Care approach could be counter-productive for people with M.E. However, the person-centred approach which the Guideline specifies as a core principle (Recommendation 1.1.1) would mean that people receiving an Intermediate Care service, and their family, friends and carers if appropriate, would be involved in planning and reviewing the service. If working towards greater independence and being motivated was not the right plan for an individual, then that should not be in their IC plan. Indeed, if a person could not work towards greater independence (rec 1.1.3, a core principle) and if they did not wish to participate then a referral to intermediate care would not be appropriate.

Accessible information: The Stroke Association pointed out the importance of making communications accessible, highlighting that one in three people who have a stroke experience some degree of aphasia. The Guideline Committee accepted that ensuring good communication was crucial to providing a person-centred intermediate care service, and this is reflected in recs 1.5.12 (documenting goals in an accessible format) and 1.1.5 (offering information in a range of accessible formats). The GC decided against specifically mentioning aphasia, as the Guideline aims to avoid wherever possible providing comprehensive lists rather than one or two illustrative examples. Recommendation 1.1.5 gives braille and Easy Read as examples of accessible communication formats, but doesn't list conditions which might lead to them being required for communication.

4.2 If the recommendations have changed after consultation, are there any recommendations that make it more difficult in practice for a specific group to access services compared with other groups? If so, what are the barriers to, or difficulties with, access for the specific group?

There are no recommendations which have been changed in such a way that any particular group would find it more difficult in practice to access services, compared with other groups.

4.3 If the recommendations have changed after consultation, is there potential for the recommendations to have an adverse impact on people with disabilities because of something that is a consequence of the disability?
None of the changes made to the recommendations after consultation have the potential to have an adverse impact on people with disabilities because of something that is a consequence of the disability.

4.4 If the recommendations have changed after consultation, are there any recommendations or explanations that the Committee could make to remove or alleviate barriers to, or difficulties with, access to services identified in questions 4.2, 4.3 and 4.4, or otherwise fulfil NICE's obligations to advance equality?
There is no need for the Committee to make any recommendations or explanations that could remove or alleviate barriers to, or difficulties with, access to services, or otherwise fulfil NICE's obligations to advance equality. The explanation given in response to 4.1 outlines the GC's response to 2 specific instances that were raised during the consultation, but there are no barriers or access difficulties identified in the responses to 4.2, 4.3 and 4.4 which the committee needs to consider.

4.5 Have the Committee's considerations of equality issues been described in the final guideline document, and, if so, where?
Section 3.9, the LETR tables, describes how equalities issues were considered for inclusion in the Guideline. E.g.   • Rec 1.1.1 states that intermediate care practitioners should 'adopt a person-centred approach, taking into account cultural differences and preferences'. This was the result of GC consideration of research evidence that patient-centredness was a 'characteristic associated with positive intermediate care outcomes', and then reaching a consensus about what the recommendation should state.   • Rec 1.3,2 states '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, residential care or temporary accommodation'. This recommendation was based on research evidence, expert witness testimony, and the GC reaching a consensus about what the

4.5 Have the Committee's considerations of equality issues been described in the final guideline document, and, if so, where?
recommendation should state. • In making Research Recommendation 8 'Support for black and minority ethnic groups', the GC has considered the lack of research evidence on the effectiveness and cost effectiveness of different approaches to supporting people from black or minority ethnic groups using intermediate care', with the aim of addressing the barriers to accessing support.

Updated by Developer: Stephen Goulder

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Approved by NICE quality assurance lead Fiona Glen

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