NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Health and social care directorate

Quality standards and indicators

Briefing paper

Quality standard topic: Intermediate care including reablement

Output: Prioritised quality improvement areas for development.

Date of Quality Standards Advisory Committee meeting: 9th January 2018

Contents

1 Introduction

This briefing paper presents a structured overview of potential quality improvement areas for intermediate care including reablement. It provides the committee with a basis for discussing and prioritising quality improvement areas for development into draft quality statements and measures for public consultation.

1.1 Structure

This briefing paper includes a brief description of the topic, a summary of each of the suggested quality improvement areas and supporting information.

If relevant, recommendations selected from the key development source below are included to help the committee in considering potential statements and measures.

1.2 Development source

The key development source referenced in this briefing paper is:

Intermediate care including reablement NICE guideline 74 (2017)

Next review: September 2020

2 Overview

2.1 Focus of quality standard

This quality standard will cover referral and assessment for intermediate care and how to deliver the service. It will not include rehabilitation for specific conditions.

2.2 Definition

Intermediate care is a multidisciplinary service that helps people to be as independent as possible. It provides support and rehabilitation to people at risk of hospital admission or who have been in hospital. It aims to ensure people transfer from hospital to the community in a timely way and to prevent unnecessary admissions to hospitals and residential care.

The concept of intermediate care was developed by the Department of Health and implemented in England through the National Service Framework for Older People. Reablement specifically received policy support in 2010 when it was recognised as a means of prolonging or regaining independence.

The Care and Support White Paper subsequently announced the transfer of funds from the NHS Commissioning Board to local councils in 2013–14. NHS commissioners and local authorities have been required, via various recent initiatives

including the NHS Five Year Forward View, to take a more integrated approach to planning. This has included pooling budgets to support models of integrated care and support, including reablement and intermediate care.

2.3 Incidence and prevalence

The NHS and social care sectors are experiencing unprecedented pressure due to increasing demand from people living longer, often with complex needs or impairments and 1 or more long-term conditions. Admission to hospital and delays in hospital discharge can create significant anxiety, physical and psychological deterioration, and increased dependence. Multidisciplinary services that focus on rehabilitation and enablement can support people and their families to recover, regain independence, and return or remain at home.

In 2016/17, the daily average number of delayed transfers of care per 100,000 population (aged 18+) was 14.9, compared to 12.0 in 2015/16. The proportion of acute care delays increased over the year from 65.9% in 2015/16 (quarter 4) to 66.5% 2016/17 (quarter 4). A fifth (20.3%) of delays in 2016/17 were because the patient was awaiting a care package in their own home. (Delayed transfers of care: annual statistical report 2016-17, NHS England).

In 2015/16 34% (42,510) of older people (65 and over) were offered rehabilitation following discharge from an acute or community hospital. This compares to 33% (43,384) in 2014/15 and 30% (43,790) in 2013/14. (NHS Outcomes Framework – Indicator 3.6.ii).

The National Audit of Intermediate Care indicates that the average number of beds (for bed-based intermediate care) commissioned (including spot purchased beds) per 100,000 weighted population was 20.9 beds in 2017, compared to 25.6 reported in 2015. Overall, in 2017, 59% of intermediate care capacity was being used for step up (admission avoidance), the majority of this within home based and re-ablement services, with the remaining 41% of total capacity being used for step down (following admission).

2.4 Management

Local areas may take different approaches to configuring their intermediate care service depending on existing resources and team structures, but the pathway should always include:

- assessing the need for intermediate care
- acceptance by the intermediate care service
- delivery of the service
- a formal review.

These services are for adults aged 18 years or over and are delivered in a range of settings, such as:

- community settings, including:
    - people's own homes
    - temporary accommodation
    - specialist housing, such as sheltered, warden-supported or extra care housing
    - supported living housing (including shared lives schemes)
    - day centres
- residential and nursing care homes
- dedicated intermediate care and reablement facilities
- acute, community and day hospitals
- prisons.

Intermediate care uses a range of service models to help people be as independent as possible. The 4 service models identified in the National Audit of Intermediate Care are:

- bed-based intermediate care
- home-based intermediate care
- crisis response
- reablement.

Intermediate care including reablement services are commissioned by local authorities and clinical commissioning groups (CCGs). Services may be jointly commissioned as part of an integrated working approach. There are a number of providers including NHS hospital trusts, local authorities, community providers and not-for-profit social enterprises.

2.5 National audit

The fifth National Audit of Intermediate Care was carried out by the NHS Benchmarking Network in 2017, with previous audits in 2012, 2013, 2014 and 2015. The aim of the audit is to examine variation and effective use of resources in intermediate care. There are separate audit reports for England, Wales and Northern Ireland.

All commissioners and providers of intermediate care across the NHS in England were invited to participate on a voluntary basis. The audit was structured with organisational (separate sections for commissioners and providers) and service user level components. The service user questionnaire included a patient reported experience measure (PREM) which was given to service users on discharge.

99 CCGs (48% of all CCGs in England) and 55 Local Authorities participated in the audit. Responses were received for 56 crisis response services, 134 home based

intermediate care services, 227 bed based intermediate care services and 44 reablement services. Questionnaires for 12,216 service users and 5,313 PREM questionnaires were returned.

2.6 National outcome frameworks

Tables 1 and 2 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

Table 1 NHS outcomes framework 2016–17

Domain	Overarching indicators and improvement areas
2 Enhancing quality of life for people with long-term conditions	***Overarching indicator*** 2 Health-related quality of life for people with long-term conditions** ***Improvement areas*** **Ensuring people feel supported to manage their condition** 2.1 Proportion of people feeling supported to manage their condition **Reducing time spent in hospital by people with long-term conditions** 2.3 i Unplanned hospitalisation for chronic ambulatory care sensitive conditions **Enhancing quality of life for carers** 2.4 Health-related quality of life for carers** **Enhancing quality of life for people with dementia** 2.6 *ii A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life*,*** **Improving quality of life for people with multiple long-term conditions** *2.7 Health-related quality of life for people with three or more long-term conditions***
3 Helping people to recover from episodes of ill health or following injury	***Overarching indicators*** 3a Emergency admissions for acute conditions that should not usually require hospital admission 3b Emergency readmissions within 30 days of discharge from hospital* ***Improvement areas*** **Improving recovery from stroke** *3.4 Proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months* **Improving recovery from fragility fractures** 3.5 Proportion of patients recovering to their previous levels of mobility/walking ability at i 30 and ii 120 days

	Helping older people to recover their independence after illness or injury 3.6 i Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation service* ii Proportion offered rehabilitation following discharge from acute or community hospital*
4 Ensuring that people have a positive experience of care	**Improving people's experience of integrated care** *4.9 People's experience of integrated care***
Alignment with Adult Social Care Outcomes Framework and/or Public Health Outcomes Framework * Indicator is shared ** Indicator is complementary Indicators in italics in development	

Table 2 Adult social care outcomes framework 2016–17

Domain	Overarching and outcome measures
2 Delaying and reducing the need for care and support	***Outcome measures*** **Everybody has the opportunity to have the best health and wellbeing throughout their life, and can access support and information to help them manage their care needs** **Earlier diagnosis, intervention and reablement means that people and their carers are less dependent on intensive services** 2B Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services* 2D Outcomes of short-term services: sequel to service *Placeholder 2E The effectiveness of reablement services* **When people develop care needs, the support they receive takes place in the most appropriate setting and enables them to regain their independence** 2C Delayed transfers of care from hospital, and those attributable to adult social care
Alignment with NHS Outcomes Framework and/or Public Health Outcomes Framework * Indicator is shared Indicators in italics in development	

3 Summary of suggestions

3.1 Responses

In total 9 stakeholders responded to the 2-week engagement exercise 02/11/17 to 16/11/17.

Stakeholders were asked to suggest up to 5 areas for quality improvement. Specialist committee members were also invited to provide suggestions. The responses have been merged and summarised in table 3 for further consideration by the Committee.

Full details of all the suggestions provided are given in appendix 2 for information.

Table 3 Summary of suggested quality improvement areas

Suggested area for improvement	Stakeholders
Assessment • Assessment of need for intermediate care • Single assessment process • Referral to other services	 BGS, NCD, RCN, SCMs AUK, NCD, SCMs CRE, NCD, RCN, SCMs
Referral into intermediate care • Types of intermediate care services • Single point of access • Timely access	 AUK, BGS, RCGP, SCMs AUK, NCD, SCMs, RCOT BGS, NCD, SCMs
Delivering intermediate care • Care planning/reviews • Multidisciplinary team • Co-ordination/integration	 AUK, NCD, RCGP, RCOT, RCSLT, SCMs BGS, NCD, RCOT, RCSLT, SCMs AUK, NCD, RCGP, SCMs
Transition from intermediate care	AUK, BGS, RCOT
Information for service users and families	AUK, RCSLT, SCM
Additional areas • Funding	 AUK
AUK, Age UK BGS, British Geriatrics Society CRE, Care and Repair England NCD, National Clinical Director RCGP, Royal College of General Practitioners RCN, Royal College of Nursing RCOT, Royal College of Occupational Therapists RCSLT, Royal College of Speech and Language Therapists SCM, Specialist Committee Member	

3.2 Identification of current practice evidence

Bibliographic databases were searched to identify examples of current practice in UK health and social care settings; 2541 papers were identified for intermediate care. In

addition, 21 papers were suggested by stakeholders at topic engagement and 12 papers internally at project scoping.

Of these papers, 5 have been included in this report and are included in the current practice sections where relevant. Appendix 3 outlines the search process.

4 Suggested improvement areas

4.1 Assessment

4.1.1 Summary of suggestions

Assessment of need for intermediate care

Stakeholders suggested it is important to assess people in order to identify if they may benefit from intermediate care. It was suggested this should include people at risk of hospital admission and those in hospital who are moderately or severely frail and/or who have cognitive impairment. There should be a particular focus on those identified to be at risk of prolonged hospital stay/delayed transfer of care. Stakeholders emphasised that people should not be excluded from intermediate care because they have a particular condition or due to their living situation, for example, people with dementia, those living in residential care or those who are homeless. It was suggested that a comprehensive geriatric assessment should be used.

Single assessment process

Stakeholders highlighted the importance of having a single assessment process at a local level which spans organisational boundaries. This can reduce unnecessary duplication, improve partnership working and reduce delays in transfers of care. It can also improve people's experience of intermediate care and support improved outcomes. It was suggested that ideally this should be supported by electronic access to individual care records across health and social care.

Referral to other services

It was suggested that the assessment process for intermediate care should identify individual needs which may require referral to other services such as housing, mental health and the voluntary and community sector. It is important for intermediate care services to engage with these other services at a local level and to establish clear routes of referral.

4.1.2 Selected recommendations from development source

Table 4 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 4 to help inform the committee's discussion.

Table 4 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Assessment of need for intermediate care	**Assessment of need for intermediate care** NICE NG74 Recommendation 1.3.1 and 1.3.2
Single assessment process	**Supporting infrastructure** NICE NG74 Recommendation 1.2.2
Referral to other services	**Supporting infrastructure** NICE NG74 Recommendation 1.2.6 **Assessment of need for intermediate care** NICE NG74 Recommendation 1.3.3

Assessment of need for intermediate care

NICE NG74 – Recommendation 1.3.1

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 through illness or disability.

NICE NG74 – Recommendation 1.3.2

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.

Single assessment process

Supporting infrastructure

NICE NG74 – Recommendation 1.2.2

Ensure that intermediate care is provided in an integrated way by working towards the following:

- a single assessment process

Referral to other services

Supporting infrastructure

NICE NG74 – Recommendation 1.2.6

Ensure that the intermediate care team has a clear route of referral to and engagement with commonly used services, for example:

- general practice
- podiatry
- pharmacy
- mental health and dementia services
- specialist and longer-term rehabilitation services
- housing services
- voluntary, community and faith services
- specialist advice, for example around cultural or language issues.

Assessment of need for intermediate care

NICE NG74 – Recommendation 1.3.3

During assessment identify the person's abilities, needs and wishes so that they can be referred for the most appropriate support.

4.1.3 Current UK practice

Assessment of need for intermediate care

The 2017 National Audit of Intermediate Care (NAIC)[1] indicated that crisis response (92%) and home-based intermediate care services (96%) were more likely to accept those with cognitive impairment than bed- based services (81%) and reablement (88%).

Single assessment process

NAIC 2017 asked commissioners to indicate the type of shared assessment framework that was incorporated into their contracts. The most common response

[1] NHS Benchmarking Network (2017) 'National Audit of Intermediate Care'

was “No shared assessment framework specified in contracts” at 50%, followed by “locally developed assessment framework” (37%).

The audit also found that 36% of integrated home-based and reablement services and 41% of integrated home and bed-based services had a single assessment process.

Referral to other services

NAIC 2017[2] confirmed that mental health specialists are rarely part of the establishment of integrated teams; 28% of integrated home-based and reablement services and 19% of integrated bed and home-based services include a mental health specialist. The audit asked service providers to note how access to mental health input was managed. For crisis response, home and bed based intermediate care services, the most common method was direct referral to mental health services (more than 35%). In re-ablement services, 34% of services reported having to request a GP to make the referral.

The NAIC 2017 PREM survey open ended responses to the question ‘Do you feel that there is something that could have made your experience of the service better?’ indicated that some intermediate care service-users had concerns about unmet needs for additional services.

A review of reablement services in Wales[3] found that the majority (21 services in total) had close links with the third sector and some had a third sector broker either within the team or one who is readily accessible through a single point of access.

4.1.4 Resource impact

The resource impact report for NG74 did not identify this area as one likely to lead to a significant resource impact.

[2] NHS Benchmarking Network (2017) ‘National Audit of Intermediate Care’
[3] Social Services Improvement Agency (2014) ‘Reablement Services in Wales’

4.2 Referral into intermediate care

4.2.1 Summary of suggestions

Types of intermediate care service

Stakeholders suggested that the full range of intermediate care services (crisis response, home-based, bed-based and reablement) are not always available locally which can mean that people are not able to access the care that best suits their needs. It was suggested that a more standardised approach to intermediate care is needed as currently there is considerable variation in the type, intensity and length of support provided. There was a concern to ensure intermediate care is provided at home wherever possible. It was suggested that a flexible service model is required so that people can access different intermediate care services if their needs change in order to avoid admission or readmission to hospital.

Single point of access

Stakeholders highlighted the importance of having a single point of access for those referring to intermediate care services. This will improve integration and ensure easier access to care for people using health and social care services.

Timely access

Stakeholders suggested that access to bed and home based intermediate care and reablement should be provided within 2 days of assessment and acceptance of the service. This is important in order to improve the effectiveness of rehabilitation and avoid unnecessary admissions to hospital and long term residential care. Response time for crisis response services was also highlighted as a priority.

4.2.2 Selected recommendations from development source

Table 5 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 5 to help inform the committee's discussion.

Table 5 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Types of intermediate care service	**Supporting infrastructure** NICE NG74 Recommendations 1.2.1 and 1.2.3 **Referral into intermediate care** NICE NG74 Recommendation 1.4.1
Single point of access	**Supporting infrastructure** NICE NG74 Recommendation 1.2.2

Timely access	**Entering intermediate care** NICE NG74 Recommendations 1.5.3 and 1.5.4

Types of intermediate care service

Supporting infrastructure

NICE NG74 – Recommendation 1.2.1

Consider making home-based intermediate care, reablement, bed-based intermediate care and crisis response all available locally. Deliver these services in an integrated way so that people can move easily between them, depending on their changing support needs.

NICE NG74 – Recommendation 1.2.3

Contract and monitor intermediate care in a way that allows services to be flexible and person centred. For recommendations on delivering flexible services, see NICE's guideline on home care.

Referral into intermediate care

NICE NG74 – Recommendation 1.4.1

Consider providing intermediate care to people in their own homes wherever practical, making any adjustments, for example equipment or adaptations, needed to enable this to happen.

Single point of access

Supporting infrastructure

NICE NG74 – Recommendation 1.2.2

Ensure that intermediate care is provided in an integrated way by working towards the following:

- a single point of access for those referring to the service

Timely access

Entering intermediate care

NICE NG74 – Recommendation 1.5.3

For bed-based intermediate care, start the 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.

NICE NG74 – Recommendation 1.5.4

Ensure that the crisis response can be started within 2 hours from receipt of a referral when necessary.

4.2.3 Current UK practice

Types of intermediate care service

NAIC 2017[4] asked commissioners if they actively commissioned/funded the four different service category elements of intermediate care. For crisis response services, 89% of commissioners actively commissioned these services. Bed based, home based and reablement services, were commissioned by 96%, 88% and 89% of commissioners for the respective services.

Single point of access

In NAIC 2017, the number of commissioners with a single point of access for their whole intermediate care system, was 41% (35% in NAIC 2015). For integrated home-based and reablement services 53% have a single point of access. Similarly, 45% of integrated home and bed-based integrated services have a single point of access.

Underlining the importance of a consistent approach, a Local Government Association report[5] highlighted how variation in front-line decision-making can have a considerable impact on referral patterns to reablement services. Referral patterns to reablement were examined across two neighbouring localities. In one locality the team referred 10% of individuals to reablement while in the other, 70% were referred. When case notes were exchanged, each team continued to refer to reablement at the same levels. The report concluded that the decision to refer, rather than being based specifically on the individual's needs, appeared to be driven by the culture, practices and habits of the team.

[4] NHS Benchmarking Network (2017) 'National Audit of Intermediate Care'
[5] Local Government Association (2016) 'Efficiency opportunities through health and social care integration: Delivering more sustainable health and care'

Timely access

NAIC 2017[6] reported that although the median target response time for crisis response services was 2 hours, actual performance showed a mean time from referral to assessment of 4.8 hours and a median time of 2 hours. Around 16% of services were taking, on average, more than 8 hours to respond.

The national audit found wide variation (from 0 to 100%) in the % of service users waiting over 2 days from referral to commencement of home-based, bed-based and reablement services with overall results in the table below.

Intermediate care service NAIC 2017	% of services reporting more than half of people are waiting more than 2 days	% of services reporting that no-one is waiting more than two days
Home based	33%	16%
Bed based	13%	26%
Re-ablement	28%	25%

Average waiting times from referral to assessment were as follows;

- 5.8 days for home-based services (compared with 6.3 days in 2015)
- 2.5 days for bed based services (compared to 3.0 days in 2015)
- 3.5 days for reablement services (no comparison with 2015 due to sample changes)

A Healthwatch England special inquiry[7] highlighted that people leaving hospital are experiencing delays and a lack of coordination between different services including intermediate care. The report includes an example of a patient with Parkinson's disease whose health deteriorated while he was kept in hospital waiting for assessment and a place in an intermediate care unit. The report states that 'By the time the rehabilitation place became available his mobility had deteriorated so badly that they could no longer do anything for him.' He was eventually admitted to residential care where his health continued to decline.

4.2.4 Resource impact

The resource impact report for NG74 identified this as an area where a significant resource impact is likely.

The main area quantified was for increasing capacity in bed-based intermediate care to be able to start the service within 2 days of receiving an appropriate referral. At

[6] NHS Benchmarking Network (2017) 'National Audit of Intermediate Care'
[7] Healthwatch England (2015) 'Safely home: What happens when people leave hospital and care settings?'

the time of publication of the guideline, according to the most recent available data, the average wait from referral to care was 3 days. Around 76% of care was provided within 2 days of referral. To provide the 24% of care not being received within 2 days of referral required additional capacity in bed-based IC, incurring additional costs.

Based on the assumptions in the resource impact report, the cost of providing this additional capacity was estimated at around £3.2 million in 2017/8, increasing to around £32.1 million from 2021/22 onwards. Savings from reduced bed-days in other areas, for example, reduced consultant-led bed-days may be achievable as a result of providing this additional capacity. This may lead to improved productivity for providers and additional income from an increased number of admissions and procedures reimbursed. Cash savings as a result of the increased capacity are unlikely though since any beds made available as a result of increased capacity in bed-based intermediate care are likely to be occupied by other patients.

Providing bed-based intermediate care within 2 days of referral is also expected to improve outcomes for people receiving intermediate care earlier than they would have done previously. People are less likely to be re-admitted to hospital following discharge and are also less likely to be discharged into a care home. Long-term savings are therefore likely as a result of implementing this recommendation.

The most recent National Audit of Intermediate Care (2017) states the average wait from referral to care for bed-based IC has been reduced to 2.5 days. The costs provided above are therefore likely to have fallen, but are still likely to be significant.

Several other areas were identified as areas where a resource impact is possible as a result of implementing the recommendations. The size of any potential costs or savings was assessed as likely to vary widely depending on local current arrangements. These were in the following areas:

- integration (recommendations 1.2.1 and 1.2.2)
- considering providing intermediate care to people in their own homes (recommendation 1.4.1)
- ensuring that crisis response can be started within 2 hours from receipt of a referral when necessary (recommendation 1.5.4)

Investing in all these areas alongside other investment where required across the whole patient pathway is likely to lead to the following savings and benefits:

- reduced hospital admissions and re-admissions
- quicker discharge from hospital
- reduced need for home care
- delayed admissions to care homes

4.3 Delivering intermediate care

4.3.1 Summary of suggestions

Care planning/reviews

Stakeholders highlighted the importance of involving people and their family and carers in care planning and reviews in order to identify and monitor progress towards their goals for intermediate care. This will help to ensure that they are engaged in their care. Individual communication needs should be identified so that the person can be involved in care planning. Care plans should embed positive risk taking. It is important that the care plan is shared with everyone involved in providing care to the person.

Multidisciplinary team

It was suggested that having a multidisciplinary team with staff from a broad range of disciplines is advantageous to people using intermediate care as it ensures a holistic approach. Stakeholders indicated that there is currently considerable variation in the range and level of skills of staff delivering intermediate care and reablement and that it would be helpful to identify minimum requirements and competency frameworks. This would improve consistency and outcomes for people using intermediate care. There was a concern that there has been a decline in therapist input in bed based services and reablement.

Co-ordination/integration

Stakeholders highlighted the importance of a co-ordinated and integrated approach to delivering intermediate care across hospital, community health, primary and social care services in order to ensure individual needs are met. It was suggested that this requires: a single management structure with a single accountable person; joint planning; communication between teams including joint meetings; shared records; and standardised performance monitoring. There was concern that commissioners do not always have a strategic plan for intermediate care.

4.3.2 Selected recommendations from development source

Table 6 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 6 to help inform the committee's discussion.

Table 6 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Care planning/reviews	**Core principles of intermediate care, including reablement** NICE NG74 Recommendations 1.1.3 **Entering intermediate care** NICE NG74 Recommendations 1.5.7, 1.5.9, and 1.5.10 **Delivering intermediate care** NICE NG74 Recommendation 1.6.2
Multidisciplinary team	**Supporting infrastructure** NICE NG74 Recommendation 1.2.9
Co-ordination/integration	**Supporting infrastructure** NICE NG74 Recommendation 1.2.2 and 1.2.5 **Delivering intermediate care** NICE NG74 Recommendation 1.6.3 and 1.6.5

Care planning/reviews

Core principles of intermediate care, including reablement

NICE NG74 Recommendation 1.1.3

Intermediate care practitioners should:

- work in partnership with the person to find out what they want to achieve and understand what motivates them
- focus on the person's own strengths and help them realise their potential to regain independence
- build the person's knowledge, skills, resilience and confidence
- learn to observe and guide and not automatically intervene, even when the person is struggling to perform an activity, such as dressing themselves or preparing a snack
- support positive risk taking.

Entering intermediate care

NICE NG74 Recommendation 1.5.7

When planning the person's intermediate care:

- assess and promote the person's ability to self-manage
- tell the person what will be involved
- be aware that the person needs to give consent for their information to be shared
- tell the person that intermediate care is a short-term service and explain what is likely to happen afterwards.

NICE NG74 Recommendation 1.5.9

Complete and document a risk plan with the person (and their family and carers, as appropriate) as part of the intermediate care planning process. Ensure that the risk plan includes:

- strategies to manage risk; for example, specialist equipment, use of verbal prompts and use of support from others
- the implications of taking the risk for the person and the member of staff.

NICE NG74 Recommendation 1.5.10

Discuss and agree intermediate care goals with the person. Make sure these goals:

- are based on specific and measurable outcomes
- take into account the person's health and wellbeing
- reflect what the intermediate care service is designed to achieve
- reflect what the person wants to achieve both during the period in intermediate care, and in the longer term
- take into account how the person is affected by their conditions or experiences
- take into account the best interests and expressed wishes of the person.

Delivering intermediate care

NICE NG74 Recommendation 1.6.2

Review people's goals with them regularly. Adjust the period of intermediate care depending on the progress people are making towards their goals.

Multidisciplinary team

Supporting infrastructure

NICE NG74 Recommendation 1.2.9

Ensure that intermediate care teams include a broad range of disciplines. The core team should include practitioners with skills and competences in the following:

- delivering intermediate care packages
- nursing
- social work
- therapies, for example occupational therapy, physiotherapy and speech and language therapy
- comprehensive geriatric assessment.

Co-ordination/integration

Supporting infrastructure

NICE NG74 Recommendation 1.2.2

Ensure that intermediate care is provided in an integrated way by working towards the following:

- a management structure across all services that includes a single accountable person, such as a team leader
- a shared understanding of what intermediate care aims to do
- an agreed approach to outcome measurement for reporting and benchmarking.

NICE NG74 Recommendation 1.2.5

Ensure that mechanisms are in place to promote good communication within intermediate care teams. These might include:

- regular team meetings to share feedback and review progress
- shared notes
- opportunities for team members to express their views and concerns.

Delivering intermediate care

NICE NG74 Recommendation 1.6.3

Ensure that staff across organisations work together to coordinate review and reassessment, building on current assessment and information. Develop integrated ways of working, for example, joint meetings and training and multidisciplinary team working.

NICE NG74 Recommendation 1.6.5

Ensure that an intermediate care diary (or record) is completed and kept with the person. This should:

- provide a detailed day-to-day log of all the support given, documenting the person's progress towards goals and highlighting their needs, preferences and experiences
- be updated by intermediate care staff at every visit
- be accessible to the person themselves, who should be encouraged to read and contribute to it
- keep the person (and their family and carers, as appropriate) and other staff fully informed about what has been provided and about any incidents or changes.

4.3.3 Current UK practice

Care planning/reviews

NAIC 2017[8] suggests that the majority of service users had a care plan and most had their care plan reviewed weekly by the MDT as shown below.

Service	% of service users with a care plan	% of service users with a care plan reviewed weekly by the MDT
Home-based	85%	79%
Bed-based	96%	96%
Reablement	95%	72%

The NAIC PREM survey of people discharged from intermediate care found that the large majority (96%) indicated they were ‘definitely aware of what we were trying to

[8] NHS Benchmarking Network (2017) ‘National Audit of Intermediate Care’

achieve'. This was consistently high across home- based, bed-based and reablement services and is similar to findings in 2014 and 2015.

A review of reablement services in Wales[9] found that although many services had developed outcome focused care and support plans, some were continuing with time and task based care plans or a combination of both.

Service delivery	Number of local authorities
Outcomes	9
Time and/or task	4
Both	8

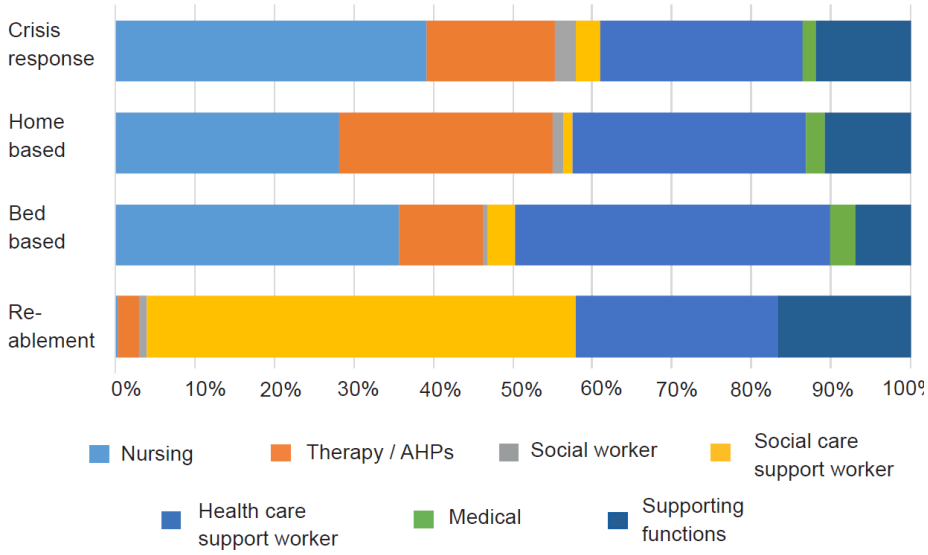
Multidisciplinary team

The NAIC 2017[10] results (see chart below) show that the skill mix within crisis response services, home-based and bed-based intermediate care is dominated by registered nurses and health care support workers whilst the skill mix within reablement services is predominantly social care support workers. The percentage of social care workers in crisis, bed and home based services remains low. Therapy input in bed based services (10%) appears limited and, in reablement services appears to have declined to just 3% of the workforce. The PREM survey found that a consistent, frequent concern for patients in bed-based services was the lack of mobility assessment, physiotherapy and opportunities for exercise & self-care.

The ratio of "nursing" to "unregistered health staff" for intermediate care units in community hospitals and acute settings was 51:49 for NAIC 2017. The ratio is still below the RCN recommended ratio[11] of 65:35 for ideal, good quality care in these settings, although is close to the ratio for basic, safe care, 50:50.

[9] Social Services Improvement Agency (2014) 'Reablement Services in Wales'
[10] NHS Benchmarking Network (2017) 'National Audit of Intermediate Care'
[11] Royal College of Nursing (2012) 'Safe staffing for older people's wards'

Figure 1: Mix of disciplines within intermediate care services NAIC 2017



NAIC 2017[12] also found that intermediate care services are looking at innovative ways of breaking down traditional distinctions between disciplines and developing new ways of working in the form of trans-disciplinary roles for both registered and unregistered staff.

Trans-disciplinary roles in intermediate care services	Crisis response	Home	Bed	Re-ablement
Are you using or developing trans-disciplinary roles for staff?	58%	71%	34%	41%
If yes, do the roles apply to registered staff?	85%	71%	36%	33%
If yes, do the roles apply to unregistered staff?	67%	74%	66%	67%

Co-ordination/integration

The 2017 National Audit of Intermediate Care found that although there has been some progress with integration at a strategic level, there is still some way to go before service models fully support closer working arrangements. Key findings were:

- 95% of commissioners reported joint strategic planning for intermediate care by health and local government compared with 92% in 2015. 59% of

[12] NHS Benchmarking Network (2017) 'National Audit of Intermediate Care'

commissioners indicated there is a local intermediate care strategic plan, compared with 63% in 2015

- 42% stated that there was a joint lead commissioner responsible for commissioning all intermediate care services including reablement compared with 44% in 2015

- 32% indicated there was a single intermediate care manager co-ordinating all intermediate care provision across the CCG or local authority area for which the services are commissioned compared with 43% in 2015

- Overall 25% of services indicated there is a shared, electronic patient record accessed and updated by all intermediate care services compared with 20% in 2015. 29% indicated there was a comprehensive, shared paper patient record accessed and updated by all intermediate care services (same as 2015).

- 39% of integrated home and reablement services and 32% of integrated home and bed-based services have a single performance management framework.

- 71% of integrated home and reablement services and 59% of integrated home and bed-based services have weekly MDT meetings attended by health and social care staff.

The 2017 National Audit PREM survey indicated that 'poor communication, coordination & organisation within and between services' was a common concern among home-based and reablement service users. Some service users were concerned about the lack of consistency of people providing care and found it confusing to have different aspects of care provided by different people and services.

A Healthwatch England special inquiry[13] found that people leaving hospital who received up to 6 weeks of care at home received care from many different carers and found having to explain their situation to each new person distressing.

4.3.4 Resource impact

The resource impact report for NG74 identified 2 recommendations in this area where a resource impact is possible as a result of implementing the recommendations. The size of any potential costs or savings was assessed as likely to vary widely depending on current local arrangements.

[13] Healthwatch England (2015) 'Safely home: What happens when people leave hospital and care settings?'

Investment in intermediate care teams may be needed to ensure they meet the skills and competencies recommended. Similarly, some areas may need to invest resources to ensure that intermediate care is provided in an integrated way.

Investing in both these areas alongside other investment where required across the whole patient pathway is likely to help lead to the following savings and benefits:

- reduced hospital admissions and re-admissions
- quicker discharge from hospital
- reduced need for home care
- delayed admissions to care homes

4.4 Transition from intermediate care

4.4.1 Summary of suggestions

There was a suggestion that there should be clear processes to facilitate transition from intermediate care to other services. It was also suggested that delays in discharge from intermediate care should be monitored.

4.4.2 Selected recommendations from development source

Table 7 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 7 to help inform the committee's discussion.

Table 7 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Transition from intermediate care	**Entering intermediate care** NICE NG74 Recommendation 1.5.5 **Transition from intermediate care** NICE NG74 Recommendation 1.7.2

Entering intermediate care

NICE NG74 Recommendation 1.5.5

As part of the assessment process, ensure that crisis response services identify the person's ongoing support needs and make arrangements for the person's ongoing support.

Transition from intermediate care

NICE NG74 Recommendation 1.7.2

Ensure good communication between intermediate care staff and other agencies. There should be a clear plan for when people transfer between services, or when the intermediate care service ends. This should:

- be documented and agreed with the person and their family or carers
- include contact details for the service
- include a contingency plan should anything go wrong.

4.4.3 Current UK practice

The 2017 NAIC PREM survey[14] highlighted some concerns about forward planning for discharge from home-based services and reablement. Some people experienced difficulties around discharge arrangements and after-care planning. A number of people reported having little or no prior notice that services were going to cease or information about other services being provided.

4.4.4 Resource impact

This area was not included in the resource impact assessment for NG74. It was not identified as an area that would have a significant resource impact.

[14] NHS Benchmarking Network (2017) 'National Audit of Intermediate Care'

4.5 Information for service users and families

4.5.1 Summary of suggestions

The importance of providing information to service users and their families about what intermediate care is and what it can and cannot achieve was highlighted as a priority. This information needs to be consistent and joined up across all services. This will enable people to make informed choices about their care and encourage them and their families and carers to engage with the process. It is important that information is provided in a range of formats to suit individual needs. When they are receiving intermediate care it is important that service users and families know who to contact in case of an emergency and/or have a named contact.

4.5.2 Selected recommendations from development source

Table 8 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 8 to help inform the committee's discussion.

Table 8 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Information for service users and families	**Core principles of intermediate care, including reablement** NICE NG74 Recommendation 1.1.4 and 1.1.5 **Entering intermediate care** NICE NG74 Recommendations 1.5.1 and 1.5.2

Core principles of intermediate care, including reablement

NICE NG74 Recommendation 1.1.4

Ensure that the person using intermediate care and their family and carers know who to speak to if they have any questions or concerns about the service, and how to contact them.

NICE NG74 – Recommendation 1.1.5

Offer the person the information they need to make decisions about their care and support, and to get the most out of the intermediate care service. Offer this information in a range of accessible formats, for example:

- verbally

- in written format (in plain English)
- in other accessible formats, such as braille or Easy Read
- translated into other languages
- provided by a trained, qualified interpreter.

Entering intermediate care

NICE NG74 – Recommendation 1.5.1

Discuss with the person the aims and objectives of intermediate care and record these discussions. In particular, explain clearly:

- that intermediate care is designed to support them to live more independently, achieve their own goals and have a better quality of life
- that intermediate care works with existing support networks, including friends, family and carers
- how working closely together and taking an active part in their support can produce the best outcomes.

NICE NG74 – Recommendation 1.5.2

When a person starts using intermediate care, give their family and carers:

- information about the service's aims, how it works and the support it will and will not provide
- information about resources in the local community that can support them
- opportunities to express their wishes and preferences, alongside those of the person using the service
- opportunities to ask questions about the service and what it involves.

4.5.3 Current UK practice

An Age UK report[15] highlighted that 'what's actually available to older people who are about to be discharged (from hospital) is often very unclear to them and their families.' There was concern that there is considerable local variation in the types of service available, with no comprehensive written information and no one obvious to

[15] Age UK (2016) 'Behind the headlines: are older people and families really to blame when their hospital discharges are delayed?'

ask. In particular, there was concern that it is unclear who is eligible for public funding and a lack of transparency in decision making around this.

The 2017 National Audit of Intermediate Care PREM survey[16] highlighted that a lack of appropriate, consistent information about services or care were a common concern for service users across all intermediate care service types.

4.5.4 Resource impact

This area was not included in the resource impact assessment for NG74. It was not identified as an area that would have a significant resource impact.

[16] NHS Benchmarking Network (2017) 'National Audit of Intermediate Care'

4.6 Additional areas

Summary of suggestions

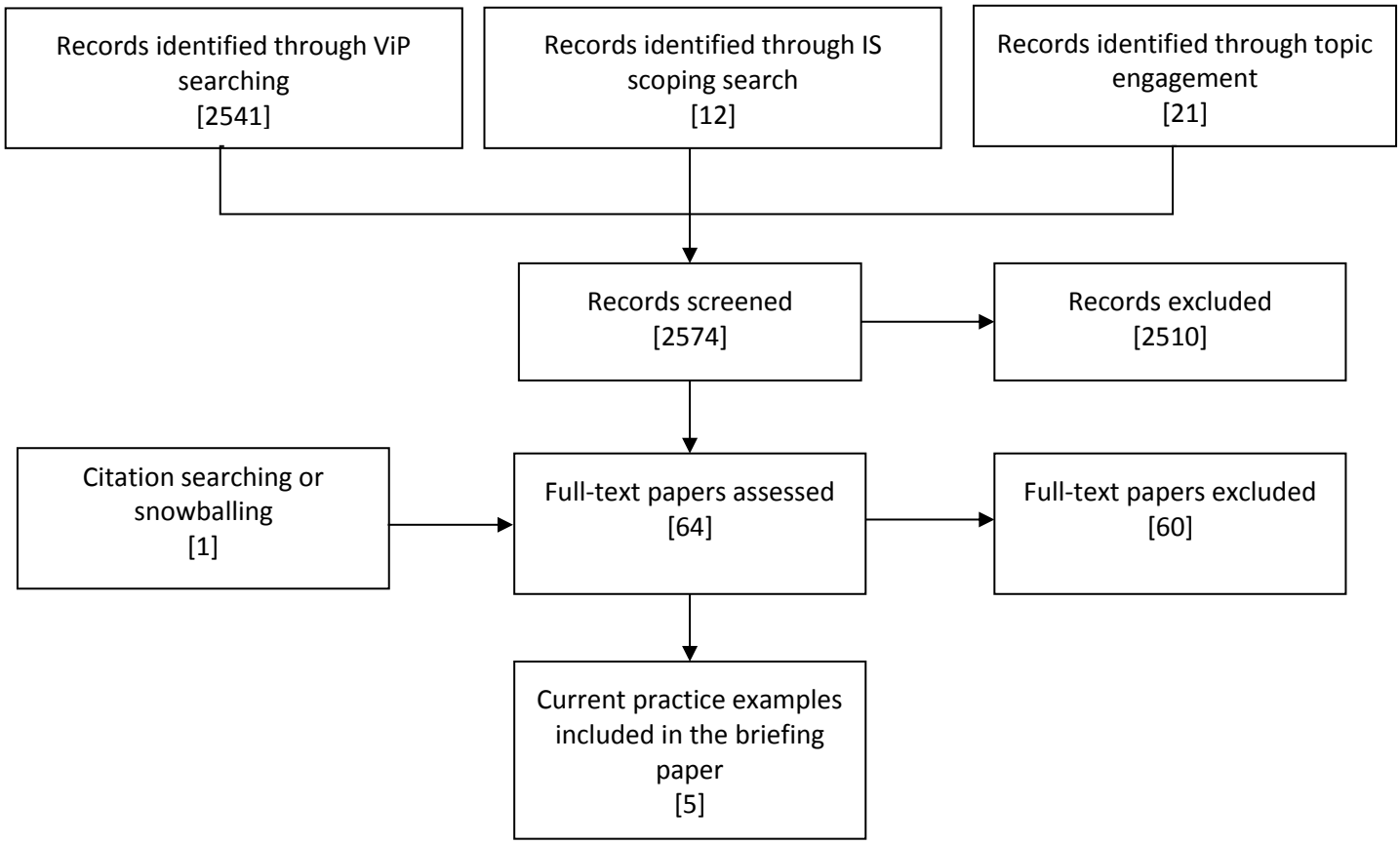
The improvement area below was suggested as part of the stakeholder engagement exercise. However it is felt to be unsuitable for development as a quality statement.

There will be an opportunity for the committee to discuss this area at the end of the session on 9th January 2018.

Funding

It was suggested that current funding for intermediate care is inadequate and leads to long waiting times to access services. It was felt that local areas should plan appropriate funding levels given the evidence of effectiveness and return on investment for intermediate care services. Recommendations about appropriate funding for services are beyond the remit of NICE.

Appendix 1: Review flowchart



Appendix 2: Suggestions from stakeholder engagement exercise – registered stakeholders

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
Assessment – Assessment of need for intermediate care					
1	British Geriatrics Society	Key area for quality improvement 2	All older people who would potentially benefit from reablement or intermediate care are offered it; all moderate or severely frail patients presenting to hospital should be offered CGA in order assess their potential to benefit from intermediate care.		
6	British Geriatrics Society	Key area for quality improvement 4	The needs of people with dementia who would benefit from intermediate care must be met.		
2	National Clinical Director	What 5 national priority areas for quality improvement would you want to see covered by this quality standard?	1) Early access (within 72 hours of presentation) within clearly identified care pathways to comprehensive geriatric assessment (CGA) for older people presenting to urgent and elective care settings who are identified to be most at risk of prolonged hospital admission and subsequent delayed transfer of care and who may benefit from intermediate care. This includes those aged 75 and over with moderate and severe frailty (Clinical Frailty Scale >6), cognitive disorder (delirium and dementia).		
3	Royal College of Nursing	Key area for quality improvement 1 Prevention of Admission	NICE Intermediate care including reablement guidelines set out recommendations for providing support and rehabilitation to people at risk of hospital admission or who have been in hospital. There seems to be a particular emphasis on hospital discharge. Intermediate Care	Many intermediate care service offer home based interventions such as intravenous therapy as well as rehabilitation to prevent admission to hospital. Some also provide treatments and interventions that traditionally are undertaken in outpatients or as inpatients – e.g. occupational therapy and physiotherapy for dealing with exacerbation of multiple sclerosis.	NICE Guideline NG74: Intermediate care including reablement

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			is key in preventing avoidable hospital admission and premature admission to long term care.	It is more difficult to measure prevention of unnecessary admission accurately but there does need to be an indicator for both acute hospital admissions prevention and for residential care homes.	
7	Royal College of Nursing	Key area for quality improvement 2 Mental Health component	NICE Intermediate care including reablement guidelines make clear that we do not exclude people from intermediate care based on whether they have a particular condition.		NICE Guideline NG74: Intermediate care including reablement
8	SCM1	Key area for quality improvement 2	Ensuring that people are not excluded from Intermediate Care services as a result of their diagnosis for example dementia or their living situation for example residential care	Whilst services locally are commissioned to support people with dementia, the numbers who do so do not reflect our population and anecdotally we know that people struggle to access these services	This forms part of the NICE guidance, and the Health and Social Care Act 2012
9	SCM2	Key area for quality improvement 4 Mental health provision within Intermediate Care functions and exclusion of Intermediate Care for those with a known dementia.	Nice guidance on Intermediate Care (2017) states that people should not be excluded from receiving Intermediate Care based on their diagnosis or condition, including people with dementia. It also states consider reablement for people living with dementia, to support them to maintain and improve their independence and wellbeing. Reablement and bed based Intermediate Care are more inclined not to except people with a cognitive impairment, National Audit of Intermediate Care 2017 (only 81% of bed based Intermediate Care and 88% of Reablement services accepted people with a dementia).	National Audit for Intermediate Care (2017) states that Mental Health workers are rare in Intermediate Care services. Currently in the UK there are 850,000 people with dementia; by 2050 this will reach over two million therefore, people with this disease should not be excluded from any Intermediate Care function if assessed as appropriate and having the potential to achieve goals (Dementia Research UK).	
10	SCM3	Key area for quality improvement 5	At present, bed based models may exclude people who have NFA as the outcome of intermediate care is	Attention to inequalities and restricted characteristics and human rights legislation.	

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
		The intermediate care model and its implementation should not perpetuate or create inequalities for people already excluded or vulnerable	uncertain. If the preferred model is home based, those without a home, or chaotic lifestyle or poor home circumstances may be excluded altogether from intermediate care. Homeless people are particularly affected by this. Many older people with intermediate care needs will have levels of dementia and care needs to be taken that this does not exclude them from rehabilitation and intermediate care support. Cultural changes and training might be required.	Social issues are a frequent component of intermediate care. For homeless people, there needs to be more work across LAs, homeless charities, veterans associations in order to address this. The demographics of an ageing population mean that more people who need intermediate care will have dementia.	
Assessment – Single assessment process (also see comments 48, 51, 55)					
4	Age UK	3.Transitions and care planning	Many of the issues described above can also come from poor integrated planning at a local level. The National Audit for Intermediate Care points out that half of commissioners are commissioning integrated services, but many practical elements such as a single point of access and a single assessment process, both recommended by NICE, are not happening. Making sure people have a smooth experience coming onto intermediate care, and transitioning away, is important to achieving good outcomes. One example we were contacted about saw someone refused intermediate care to cover the additional help they required because they already had a package of social care in place. There is an immediate risk, with ongoing pressure on local authority and NHS finances, that transitions like these are impacted by unhelpful territorialism from respective agencies. This further creates challenges		

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			in the care planning process if areas are not cooperating, undermining the known benefits from documented care planning and multi-disciplinary team working. The quality standard must include clear standards for inter-agency working and transitions.		
5	SCM4	Key area for quality improvement 5 Single assessment process and shared patient records	The NICE IC guideline committee recognised that a single assessment process has the potential to improve the quality of care delivered by reducing unnecessary duplication. Currently IC services are not using a single assessment process consistently.	A single assessment process which spans organisational boundaries can help to reduce delays in transfers of care, and can improve partnership working. Ideally, electronic access would be enabled to allow simplified access to all relevant care records for the individual e.g. allowing health staff to access Social Care records, and vice versa.	A recent audit conducted by NHS Providers identified the need to share records about patients and service users transferring between them, while maintaining safeguards and appropriate levels of consent. http://nhsproviders.org/media/1469/nhsp-right-place-short-lr2.pdf These issues were also highlighted by an expert witness during the development of the NICE guideline for IC. https://www.nice.org.uk/guidance/ng74/documents/guideline-appendix
Assessment – Referral to other services (also see comment 23)					
11	Care & Repair England	Key area for quality improvement 1	Most people in hospital want to go home as soon as possible. There is evidence that the homes that people live in significantly impact on their wellbeing. Good housing helps older people to stay warm, safe and healthy. Cold and unsuitable homes lead to further health conditions and often a return to hospital.	One of the areas that have the most impact is collaborative/integrated working across all sectors and while this has proved to be a challenge across health and social care it 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 in intermediate care especially as the guideline promotes home	One key 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 can be obtained from http://www.findmyhia.org.uk/

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			Most older people live in what is called 'mainstream' or 'general needs' housing (as opposed to specialist housing or residential care), and most own their homes. Home adaptations and repairs can improve the quality of life for people helping them to feel more confident and in control of their daily activities, can help to prevent falls, and can prevent or delay a move back to hospital or to residential care.	based intermediate care as a key option that should be available locally. This requires health and care partners 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. Finding clear routes of referral and engagement with housing bodies is an expectation in the guidance and a prerequisite to offering good home based intermediate care yet all too often housing bodies are not engaged in local teams or part of the referral processes.	An example of a project where a local agency offers help in relation to reablement and intermediate care is in Ealing – which 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 rehabilitation and the role of a housing setting in that process There are resources from NHS England aimed at engaging housing. See https://www.england.nhs.uk/commissioning/health-housing/ which refers to the health and housing quick guide and gives a focus to the role of housing in

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
					enabling people to return home from hospital.
12	Care & Repair England		Where intermediate care is being developed to support people at home their physical environment needs to be right to meet their health, care and support needs at home. This means both the need for an assessment and action to be taken to improve the home environment – to make it warm, safe, accessible and well repaired. That is why the role of housing in intermediate care is a key area for improvement	The suitability of the home to intermediate and long-term care at home should be an important part of the assessment process and measures to improve the home environment a key ingredient to offer good quality intermediate care at home. This will include minor repairs, aids and adaptations and equipment to make the home a suitable setting for intermediate care and for long term care in the future. Developing a quality standard in this area would help to further integrate housing as part of the solution.	Further examples of where housing bodies have been engaged in pressure on hospitals including supporting intermediate care and reablement are identified in these case studies https://www.housinglin.org.uk/Topics/type/Home-from-hospital-How-housing-services-are-relieving-pressure-on-the-NHS/ And some specific examples of the use of sheltered and extra care housing for intermediate care are at https://www.housinglin.org.uk/Topics/browse/HousingExtraCare/Commissioning/IntermediateCare/
13	Care & Repair England	Additional developmental areas of emergent practice	We would ask that two reports are added to the list of key policy documents, reports and national audits to the Quality Standards Topic Overview to ensure that housing issues are considered in scope in the quality standard. These are •Memorandum of Understanding on integrating housing with health which has been developed with a range of partners such as DH, DCLG, PHE, ADASS, NHS England, LGA http://careandrepair-		

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			england.org.uk/wp-content/uploads/2014/12/A_Memorandum_of_Understanding_MoU_to_support_joint_action_on_improving_health_through_the_home.pdf •Hospital2home resource pack – a very practical guide to considering older people's housing situation in hospital discharge developed with a range of partners including DH, DCLG, ADASS. LGA, RCN, Age UK http://www.housinglin.org.uk/hospital2home_pack/		
14	National Clinical Director	What 5 national priority areas for quality improvement would you want to see covered by this quality standard?	4) Routine identification of depression and/or anxiety/ and/or loneliness among people who are assessed as eligible for intermediate care services		
15	Royal College of Nursing	Key area for quality improvement 2 Mental Health component	There must be explicit requirement to have access to mental health specialist input as part of an Intermediate Care service.	Many people have physical and mental health needs. Many people with multiple conditions experience depression and anxiety and access to the relevant specialist input to maximise the intermediate care intervention	NICE Guideline NG74: Intermediate care including reablement
16	SCM3	Additional developmental areas of emergent practice 1. The work of voluntary organisations, charities and community groups needs to be factored into intermediate care models:could be crucial for short term effectiveness and longer term sustainability.	The intermediate care model needs to be creative and practical. The results of work may suggest a phased approach to home based approaches. There are training implications for care staff that need to be addressed now. More soundings of carers needs may need to be done.	See previous column.	

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			The capacity of general practice, and shortage of GPs and increasing demands from demography and in general, more health care to take place outside of hospital settings needs to be factored into models of intermediate care.		
Referral into intermediate care – Types of intermediate care services (also see comment 57)					
17	Age UK	4.Availability and flexibility	Local intermediate care services are not always geared up to deliver the different types of service recommended in national guidance, i.e. crisis response; home-based intermediate care; bed-based intermediate care; and reablement. Older people have reported to us that they have been recommended for intermediate care, but the specific type is currently at full capacity. Any subsequent referral can mean the person is not getting the care that is right from them, but also, once again, may open them up to being charged. Likewise, people who are not accepted to intermediate care are not always sign-posted to an alternative, with the National Audit revealing this happened in only around a half of cases. As such, its later finding that over 40% of commissioners did not have a strategic plan for intermediate care suggests that full systems planning to organise services effectively is not happening everywhere. The quality standard should examine how to best organise services to make sure the variety of relevant services are available. Pathways through the system must be built around getting people to the right service for them.		

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
18	British Geriatrics Society	Key area for quality improvement 4	There should a range of different types of intermediate care offered including intermediate care at home and those provided in other places such as suitable residential homes and community hospital.		
19	Royal College of General Practitioners	Key area for quality improvement	General	General	• Reablement should be as close to home as possible
20	SCM3	Key area for quality improvement 2 A flexible model and approach to intermediate care which provides a continuum of care coordinated across all delivery agencies, including 'step up' care, with single point of access	Patients tend to be referred to either bed based intermediate care or intermediate care at home, at the point of their discharge from hospital. However, people's conditions frequently fluctuate in that 4-6 weeks, with high levels of readmissions within 28 days. For some people who are having intermediate care at home, a short episode in a bed based facility, could avoid a break down of intermediate care and a hospital admission. Patients and families need this to be easily navigable as handing over from one service to another often creates lapses in a continuity of service.	Remaining in hospital after an acute episode of poor health or an accident has been demonstrated to result in overall deterioration of patients health, especially in older frail people. More creativity and better use of resources might be achieved when people are admitted to a bed based facility because of the need to use equipment, by looking a day care or shared care.	•
21	SCM3	Key area for quality improvement 4 A presumption that intermediate care (both to avoid hospitalisation and on discharge) should take place within the patient's own home unless the patient's assessed need or home and support	Most people want go home after hospitalisation and want to avoid hospitalisation by having support and care in their own homes. Most people who need intermediate care are older or have longer term conditions and already need considerable support from carers. With the home based intermediate care model, we need to	There are not enough beds in hospital for people who do not need hospital care and people's health can deteriorate (as above); they can catch an infection, be moved to a ward that does not specialise in their care (medical outlier), not have active medical intervention, and so on. A small amount of intermediate care has been demonstrated to avoid the need to go into hospital	•

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
		services circumstances suggest otherwise	ensure that carers are not overloaded and taken for granted and can cope, as many are quite aged themselves.	and aid recovery, especially when provided quickly in a crisis.	
22	SCM3	Additional developmental areas of emergent practice 1. Work needs to be done on the potential impact of a significant extension of home based intermediate care: in particular, the capacity and willingness of unpaid carers to be able assist; the availability of paid carers with appropriate training (including dementia); and general practice support.	The intermediate care model needs to be creative and practical. The results of work may suggest a phased approach to home based approaches. There are training implications for care staff that need to be addressed now. More soundings of carers needs may need to be done. The capacity of general practice, and shortage of GPs and increasing demands from demography and in general, more health care to take place outside of hospital settings needs to be factored into models of intermediate care.	See previous column.	•
23	SCM4	Key area for quality improvement 4 Standardisation of IC service delivery with respect to the type, intensity, frequency and length of input	As identified through the NAIC 2015, the scale and nature of IC provision varies considerably across services nationally. In addition, research conducted by Ariss 2015, identifies that the complexity of people accessing IC services has increased. As a result of increasing complexity, services are now required to deliver a broader range of support. However there are still obvious gaps, particularly in terms of providing adequate support for people with mental health needs.	Identifying the components of an effective intermediate care service would benefit patients by reducing the variability and improving effectiveness of care delivered. Standardisation would also make accessing IC support more equitable.	The NAIC 2015 identified a lack of involvement of mental health services. 'The proportion of mental health trained staff in any of the service models audited was miniscule, and training in dementia care had only been provided to about half the staff'. https://academic.oup.com/ageing/article/44/2/182/93813/The-second-national-audit-of-intermediate-care

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
					•
24	SCM5	Additional developmental areas of emergent practice **Transitions between hospital community or care home settings**	There is evidence that well organised Intermediate Care and Reablement Services can facilitate better/ more seamless transitions between hospital/ community or Care home settings for adults with social care needs, by focusing on these needs and or some of the wider determinants of health and wellbeing, (i.e MECC) Intermediate Care Services can drive both improvements in quality of life and reductions in Urgent and Emergency care/ Crisis presentations of people with multimorbidity and/ or social care needs. Intermediate care and reablement services are often used to ensure care is closer to home and that patients with social care needs get to see the right person at the right time every time, the current system focus on interventions such as Discharge to Assess, and the Getting It Right First Time Methodology mean that intermediate Care and Reablement services need to consistently show how they contribute to facilitating discharge and reducing delayed transfers of care	Several health, social care and other services are involved when adults with care and support needs move into or out of hospital from the community or a care home. Families and carers also play an important part. Problems can occur if services and support are not integrated, resulting in delayed transfers of care, readmissions and poor care, examples of poor transitions include discharge problems (such as when people are kept waiting for further non-acute NHS care or for their home care package to be finalised), uncoordinated hospital admissions and avoidable admissions to residential or nursing care from hospital. NHS England's Delayed transfers of care statistics show that, in 2014/15, every day an average of 3.7 adults per 100,000 population had their transfer of care delayed. This is equivalent to over 1,500 delayed transfers a day throughout England. This is up from 3.1 per 100,000 in 2013/14. Healthwatch England's Safely home: what happens when people leave hospital and care settings report (2015) highlighted that poor hospital discharge practice leads to unnecessary problems for patients and wasted resources. In 2012/13 there were more than a million emergency readmissions within 30 days of discharge in England. This cost more than £2.4 billion (Emergency admissions to hospital: managing the demand National Audit Office)	Transition between inpatient hospital settings and community or care home settings for adults with social care needs (QS136) Identifying reasons for delays in acute hospitals using the day of care survey method. Clinical Medicine. 2015; 15(2) 117-120 Reid, E., King, A., Mathieson, A., Woodcock, T & Watkin, S
Referral into intermediate care - Single point of access (also see comments 4, 20, 48, 51, 57)					
25	Royal College of Occupational Therapists	2. People should be able to access intermediate care services via a single access point and have a single named			

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
		practitioner throughout their time in intermediate care.			
Referral into intermediate care – Timely access					
26	British Geriatrics Society	Key area for quality improvement 1	Delay in transfers of care to Intermediate care should be minimised and in all cases transfer should be offered within two days of assessment and acceptance		1) National audit for Intermediate Care (NAIC) to be published November 2017 2) National audit for in patient falls (NAIF) to be published November 2017 3) National Hip fracture data base (NHFD) http://www.nhfd.co.uk/ 4) Fracture Liaison Service database(FLS-DB) https://www.rcplondon.ac.uk/projects/fracture-liaison-service-database-fls-db 5) NAO Discharging Older Patients (2016) https://www.nao.org.uk/wp-content/uploads/2015/12/Discharging-older-patients-from-hospital.pdf 6) NHS benchmarking Older People in Acute Care settings Audit 2016 https://www.nhsbenchmarking.nhs.uk/news/older-peoples-care-in-acute-settings-

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
					benchmarking-2016-findings-published 7) National audit of dementia 2017 http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/nationalclinicalaudits/dementia/nationalauditofdementia.aspx 8) Kings Fund Social Care for Older People 2016 9) 10) https://www.kingsfund.org.uk/publications/social-care-older-people BGS & RCGP Integrated Care for Older People 2016
27	National Clinical Director	What 5 national priority areas for quality improvement would you want to see covered by this quality standard?	2) Delivery of bed and home based rehabilitation and recovery services within 2 days of assessment and acceptance for these services. 3) Delivery of reablement service within 2 days of assessment and acceptance of this service.		
28	SCM1	Key area for quality improvement 1	Timescale for commencing bed based intermediate care	We know from National Audit of Intermediate care data that this is an area of concern, which is likely to impact on the effectiveness of Intermediate Care and that locally we find this challenging.	• Recommendation of two days within the guidance
29	SCM2	Key area for quality improvement 1 Accessibility into Intermediate Care Services.	Discharge planning should be started at admission whilst the person is in an acute setting to ensure timely planning into Intermediate Care services if this is assessed as appropriate (Kingsfund 2014). National Audit Office “Discharging	National Audit Office estimated in 2015, 2.7million bed days were occupied by older people no longer requiring acute care which approximately cost £820 million. It results in poor health outcomes and increasing financial strain.	

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			Older People from hospital ” (2016) states a 5% muscle reduction can be lost per day in the older person whilst waiting unnecessarily in an acute hospital bed. National Audit of Intermediate Care (2015) states that effective response times into Intermediate Care plays a major role in reducing admissions into secondary care and maintaining people within their own home environment. Kingsfund states that a lack of capacity is a key factor why people go straight from hospital to long term care home.	The National Audit of Intermediate Care (2015) states that a third of people waiting for Home based Intermediate Care or Reablement in their own homes are waiting unnecessarily in an acute bed, with increasing lengths of stays which impacts on the effectiveness of rehabilitation. Nice guideline on Intermediate Care (2017) has recommended a 2 day waiting time from referral to transfer when transferring from acute to bed based Intermediate Care.	
30	SCM4	Key area for quality improvement 2 Waiting/access times	Evidence from research carried out by Prof John Young demonstrated that long waits for IC are highly damaging for older people, as their optimum rehabilitation window may be missed. John Young, then NCD for Integration and Frail Elderly, in his forward to NAIC 2015 Summary Report, recommended a target maximum two day waiting time for IC services. His suggestion was that the percentage of people waiting more than two days for IC access, should be regularly reported.	As NAIC 2015 points out, the national IC capacity is estimated to be around half of that required impacting on waiting times. According to NAIC 2015, the average waiting time reported at the service level showed a deteriorating trend over the last three years across all service categories which may be a symptom of demand continuing to outstrip capacity. Average waiting times were at 6.3 days for home based, 3.0 days for bed based and 8.7 days for re-ablement services. However, whilst the majority of service users are waiting between 0 and 3 days, there are still some service users waiting for considerable periods for services to commence. At the time of drafting recommendations for the NICE guideline for IC, the guideline committee were in consensus there was a real opportunity to improve the quality of services by reducing waiting times.	Literature reviewed during development of the NICE guideline demonstrated that timely referral into the service is key to improving outcomes for people. Reference for John Young’s research: • An estimate of post-acute intermediate care need in an elderly care department for older people, Young J, Forster A, Green J (2003)
31	SCM5	Key area for quality improvement 2	One of the strands of intermediate is the crisis response service, the IC &R Crisis response service purpose is to prevent	There is significant variation in the response times for intermediate care with 31 % of IC users in community settings experiencing greater than 2 day waits for	Young et al 2007 NAIC 2014

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
		Demand Capacity and Responsiveness	risk of further deterioration and reduced independence. To do this response times are a critical factor in ascertaining efficacy as well as the ability to establish close links between crisis response and diagnostics (for example, GP,X-ray or blood tests) so that people can be diagnosed quickly if needed. IC&R Crisis response services also need to identify ongoing support needs and make arrangements to meet these needs	assessment with 16 % waiting longer than 2 days for service commencement. This delay in service negate the better independence outcomes associated with IC&R intervention	
Delivering intermediate care – Care planning/reviews (also see comment 55)					
32	National Clinical Director	What 5 national priority areas for quality improvement would you want to see covered by this quality standard?	5) Routine and consistent communication of care and support plans which clearly describe person centred ('what matters to me') care goals and outcomes, for patients in receipt of intermediate care services among all service elements both assessing for and delivering intermediate care.		
33	Royal College of General Practitioners	Key area for quality improvement	General	General	•Putting the person interest first (this can create tensions when there is pressure within a system such as delayed discharges)
34	Royal College of Occupational Therapists	1. Intermediate care teams should ensure people in receipt of services are fully involved in setting their own goals, and practitioners take and embed positive risk taking in their practice.			
35	Royal College of Speech and Language Therapists	Key area for quality improvement 2		During assessment and care planning, people's communication needs should be identified and responded to appropriately with access to a speech	

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				and language therapy to support decision-making and choice. People's communication needs should be identified and responded to appropriately during assessment and care planning, including through having access to speech and language therapy where necessary	
36	Royal College of Speech and Language Therapists	Key area for quality improvement 4		Approaches to delivering intermediate care should be tailored to the person's communication needs and abilities and decisions should involve the individual and carers, with appropriate communication support provided where necessary	
37	SCM1	Key area for quality improvement 4	Training and development around positive risk taking and person centred goals	Anecdotally it is reported that there are a range of approaches to risk taking across our services and we know that individuals are not involved in the reviews of their goals as often or effectively as they should be	Supporting NICE guidance
38	SCM3	Key area for quality improvement 3 Active involvement of patients and carers in their assessment (and care plan) for intermediate care undertaken in the environment in which it will be delivered, with a shared single document of the plan, risks and contingencies and a named person to guide them	If people are involved and understand what is happening to them and why the intermediate care recommended is important, they are more likely to cooperate; and families should be fully engaged so they can support the programme. This is even more important when intermediate care takes place at home, when there will be less supervision and more reliance on carers. One of the main complaints of patients and families is that services are not joined app and they do not know who is in charge and who to contact in an emergency.	At present, because of the pressure on hospital beds, there is an imperative to discharge patients when they are deemed 'medically fit'. Because of timescales , this is often done without meaningful discussion with the patient or carer. The possibility of intermediate care along with any other services that might be needed on discharge, needs to be raised with patients at an early stage in their hospitalisation, where appropriate.	
Delivering intermediate care – Multidisciplinary team (also see comment 35)					
39	British Geriatrics Society	Key area for quality improvement 5	Multidisciplinary rehabilitation in intermediate care should be suitably funded with appropriate number of trained		

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			therapists and supported by social care and medical care		
40	National Clinical Director	What 5 national priority areas for quality improvement would you want to see covered by this quality standard?	Ensure the intermediate care service has critical mass and resilience achieved by: an ability to always accept patients into service delivered by a competency based workforce with appropriate skill mix		
41	Royal College of Occupational Therapists	4. All intermediate care teams should be led by a qualified allied health professional grounded in the enabling ethos.	There is evidence on the importance of establishing, maintaining and supporting an enablement ethos through leadership within a reablement service. An occupational therapist's role also involves reviewing complex cases and ensuring review of outcomes. This would also be applicable within intermediate care.		• College of Occupational Therapists (2016) *Reducing the pressure on hospitals*. (recommendation 6) http://3clw1r2j0esn1tg2ng3xziww.wpengine.netdna-cdn.com/wp-content/uploads/2017/03/ILSM-Report-ENGLAND-28pp.pdf • College of Occupational Therapists (2013) Reablement: the added value of occupational therapists. (COT Position Statement). London: College of Occupational Therapists. Available at: *https://www.cot.co.uk/position-statements/reablement-added-value-occupational-therapists*

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
					• Social Care Institute for Excellence; College of Occupational Therapists (2011) Reablement: a key role for occupational therapists. (At a Glance Briefing 46). London: Social Care Institute for Excellence. Available at: *http://www.scie.org.uk/publications/ataglance/ataglance46.asp* • Social Services Improvement Agency (2013) Position statement on reablement services in Wales. Cardiff: Social Services Improvement Agency. Available at: *http://www.ssiacymru.org.uk/home.php?page_id=7912* • Winkel A, Langberg H, Wæhrens EE (2015) Reablement in a community setting. Disability and Rehabilitation, 37(15), 1347-1352. doi:10.3109/09638288.2014.963707

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
42	Royal College of Occupational Therapists	5. Every staff member working in an intermediate care team should receive regular and appropriate training, as well as regular mentoring from a qualified allied health professional.			Position Statement on Reablement Services in Wales https://socialcare.wales/resources/position-statement-on-reablement-services-in-wales 5
43	Royal College of Speech and Language Therapists	Key area for quality improvement 1		Intermediate care teams should include a broad range of disciplines. The core team should include speech and language therapists to support both the identification and appropriate response to communication and swallowing needs and to provide direct therapy to those with more complex needs	
44	Royal College of Speech and Language Therapists	Key area for quality improvement 5		Ensure that intermediate care staff are able to recognise and respond to eating, drinking and swallowing needs to promote patient safety and reduce risk	
45	SCM2	Key area for quality improvement 3 Skill mix of Intermediate Care workforce	Nice guidance on Intermediate Care (2017) recommended a broad range of professionals/disciplines. The National Audit of Intermediate Care (2017) states that the more types of staff a person comes into contact with whilst receiving Intermediate Care the more improved service user outcome.	The National Audit of Intermediate care (2017) states that therapy input has declined since the last audit in 2015. Therapy input has reduced to 10% of the workforce in bed based Intermediate Care and to 3% in Reablement services. SCIE (2010) and the Royal College of Occupational therapists state that occupational therapists (OTs) can contribute to the effective delivery of reablement services by leading and coordinating Reablement teams and by working as a core member. OT's contribute to successful Reablement teams.	
46	SCM4	Key area for quality improvement 3 Development of the IC workforce	Where new models of IC service are evolving locally, the workforce has developed to deliver more interdisciplinary working which better meets the holistic needs of the complex patient cohort.	Whilst quality statements on staff training and competency are not usually included in quality standards, there are some specific types of training which the IC workforce would benefit from which exceeds professional standards. Professionals in IC settings often work outside the traditional remit of their roles, and there is little	The NHS five year forward reinforces the need for the NHS to make efficiencies in order to achieve financial balance. Well developed generalist roles for IC are one strategy to support efficiency savings. However, there is currently little recognition

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			The development of more generalist roles, and 'care navigation' roles for both professional and non-professional staff requires development of an appropriate competency framework and tailored education and training programme which is challenging to deliver locally with constrained resources.	recognition of the value and benefit that this brings to the care delivered. This lack of recognition negatively impacts on recruitment and retention in the IC setting. Improving the profile of such roles through structured training and education, and standardised outcomes frameworks could address these workforce issues. The IC workforce would benefit from cross organisational training in case-management skills, assessment skills, identification and management of the deteriorating patient, trusted assessor training, complex manual handling training etc.	or support/training for these important roles. An example of a competency framework is as follows: http://www.nes.scot.nhs.uk/media/511724/nhs_final.pdf
47	SCM5	Key area for quality improvement 1 **Composition of Intermediate Care and Reablement Services** **Quality Standards for workforce**	The available evidence suggests that having a multidisciplinary team with a broad range of disciplines can be advantageous for service users however there is significant variation in what disciplines make up the core intermediate care and reablement workforce, having some minimum standards / workforce dataset (including staffing levels) for IC&R can help standardise outputs and outcomes that can be expected from the service depending on locality needs	There is significant variation in interpretation on what the minimum ICR workforce should consist as well as the level of skill they should have, this variation may drive poor outcomes for service users and increased spend with uncertain outcomes for commissioners. Clinicians and commissioners will need to collaboratively work to determine the minimum number of staff, and the knowledge and skill levels required to provision the needs of their users	OECD Reviews of healthcare quality 2014
Delivering intermediate care – Co-ordination/integration (also see comments 4 and 38)					
48	National Clinical Director	What 5 national priority areas for quality improvement would you want to see covered by this quality standard?	Ensure that intermediate care is provided in an integrated way by working towards the following: • a single point of access for those referring to the service • a management structure across all services that includes a single accountable person such as a team leader • a single assessment process		

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			Ensure the intermediate care service has critical mass and resilience achieved by: • all constituent services working together an escalation plan when capacity is becoming critical		
49	Royal College of General Practitioners	Key area for quality improvement	General	General	As a practitioner working on frailty pathway locally I would make the following points: •Information sharing •Communication between teams • System leadership •Integration between hospital, community, social and primary care Please ensure all of the above points are covered
50	SCM1	Key area for quality improvement 3	Development of an Intermediate Care Diary	A number of separate organisations deliver intermediate care in partnership across this economy, and although it has been discussed a shared record has never been achieved.	Guidance recommendation, feedback from people who have used the service, will be helpful to support shared KPI's
51	SCM2	Key area for quality improvement 2 Joined up and integrated Intermediate Care services to ease transition through the range of Intermediate care functions.	National Audit of Intermediate Care (2015) states that many Intermediate care services across the country are yet to develop a truly integrated service, which have a single management structure, single assessment process, single shared patient record or weekly mulit-disciplinary meetings. This is important as people may have to step up/step down within the Intermediate Care functions during their period of ill health and this would allow for a seamless service and achieve the best outcomes for the person(NICE guideline on Intermediate Care 2017). A person	Intermediate Care Half way Home (2009) states keys factor in successful implementation of Intermediate Care is good co-ordination of services and a single point of access to the service. A shared framework also prevents the person from undergoing multiple assessments from different people in different settings. National Audit Office "Discharging older patients from hospital" (2016) that health and social care organisations have a statutory duty of care to share patient information.	

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			may be transitioning across health and social care organisations whilst receiving Intermediate Care services.	NICE guideline for Intermediate Care (2017) states "Ensure that staff across organisations work together to coordinate review and reassessment, building on current assessment and information. Ensure that intermediate care is provided in an integrated way by working towards the following: •a single point of access for those referring to the service •a management structure across all services that includes a single accountable person, such as a team leader •a single assessment process	
52	SCM4	Key area for quality improvement 1 Standardised outcome measures and patient reported outcome measures (PROMs)	A set of clinical and patient reported outcome measures would enable the robust measurement of services to demonstrate their quality and value.	This is a key area for quality improvement as an accepted set of outcome measures could help to monitor, standardise and improve the care delivered nationally, and to ensure that outcomes are aligned across organisations which is particularly important for integrated health and social care services. In addition, a set of standardised outcome measures will enable analysis of the quality and value/cost-effectiveness of the care delivered. Currently there are major gaps in the evidence for IC to allow cost effective analysis to be performed. In addition the use PROMs will support patient engagement, activation and satisfaction with treatment.	As the NICE guideline for IC points out, there is a lack of evidence pertaining to the effectiveness and cost effectiveness of intermediate care services, particularly crisis response services. Recently a standardised patient reported outcome measure was created for MSK conditions, the MSK-HQ. It may be possible to develop a similar tool for IC which takes account of both the health and social care needs of the individual. https://www.keele.ac.uk/media/keeleuniversity/ri/primarycare/implementation/musculoskeletal-health-questionnaire-briefing-june-2016.pdf

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
Transition from intermediate care (also see comment 4)					
53	British Geriatrics Society	Key area for quality improvement 3	The effectiveness of intermediate care as an essential component of the whole system of care should be monitored: for example, by the percentage of older people transferred to intermediate care or reablement are living in their own home by 91 days. Delays in discharge from intermediate care services should be measured.		
54	Royal College of Occupational Therapists	3. Intermediate care services should have clear policies and procedures with aligned services around people's transitions.			NICE guideline [NG27]
Information for people and families (also see comment 38)					
55	Age UK	2.Information and choice	Older people frequently report to us that information and guidance on intermediate care is poorly handled by health and care staff. Some people are simply not told it is available and could be expected to pay for a stay in a residential care home. Others may be told they are eligible for intermediate care by NHS but subsequently told they are not by local authority staff and are thus liable for services already delivered. Still more are told that there are strict time-limits on the period people can receive intermediate care and often significantly below the six weeks set out in guidance. Not only does this lack of clarity impact on someone's future care planning, it has significant implications for a person's ability to choose the services right for them. Older people and their families		

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			report to us they are not given the chance to fully engage with the assessment process or make an informed choice on the location of care. This can again impact on financial commitments in cases, for example, where people who choose to subsequently move to a different care home are told funding will be withdrawn. All local areas should be expected to maintain staff competences in understanding intermediate care and communicating with people and their families. All conversations must be driven by shared decision-making principles and working towards goals set by the person being supported.		
56	Royal College of Speech and Language Therapists	Key area for quality improvement 3		All information should reflect the communication needs of people using the service and should be offered in a range of formats to support their needs and individual preferences; including verbal, written, sign, Alternative and Augmentative Communication (AAC), accessible formats, easy read and others.	
57	SCM3	Key area for quality improvement 1 Transparent and understandable information about intermediate care for patients and families/carers coordinated and consistent across all those delivering intermediate care, with a single models and point of contact on a devilry.	Patients and families need to understand what intermediate care is and what it can and cannot achieve, in general and for them, so they can make informed choices about their care and understand what it entails and actively engage in their improvement. All agencies need to be speaking the same language and be coordinated their approaches to provide an integrated seamless service for patients, which is simple for patients (and practitioners) to understand.	There's confusion and complexity about what constitutes intermediate care. It embraces convalescence, recuperation, rehabilitation, re-ablement, retraining, therapy, social care, confidence building, crisis support, short term care - and more; it is variously provided by the local authority, the NHS and the independent sector; it sometimes has general practice medical cover and sometimes not; it has different models and levels of investment and availability across the country and sometimes within local areas.	

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			People get confused and concerned about the number of people and service visiting them, which can lead to contradictory information and the patient or carer unrealistically managing/orchestrating intermediate care.		
Additional area - Funding					
58	Age UK	Funding	The overall funding picture for intermediate care is not adequate to meet older people's needs. The National Audit for Intermediate Care has recently found an overall increase in spending, but this has had little impact on capacity with the costs of running services increasing in tandem. It is likely that this is impacting on waiting times being below what NICE recommends in their guideline (no more than 2 days) with average waiting times for an assessment at 5.8 days for home-based care. This is despite good evidence for overall effectiveness and strong return on investment, particularly where long stays in acute care are avoided. In following the quality standard, local areas must take full account of the benefits of intermediate care and plan funding levels appropriately, taking full account of the need for continuous improvement and any pressures brought about by national policy such as changes to the national living wage.		
General					
59	Royal College of Paediatrics and Child Health	Thank you for inviting the Royal College of Paediatrics and Child Health to comment			

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
		on the intermediate care including reablement consultation. We have not received any responses for this consultation.			
60	Royal College of Physicians	The RCP is grateful for the opportunity to respond to the above consultation. We would like to endorse the response submitted by the British Geriatrics Society (BGS)			