

HEALTHWATCH TRAFFORD'S REVIEW OF BED BASED INTERMEDIATE CARE



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SUMMARY

This review of bed based care at Ascot House was our starting point on this topic; the other elements of intermediate care being crisis care, rehabilitation and home based care which we plan to review in 2018.

We need to point out that HWT has no access to any data sources and, therefore, this report is aimed at providing a rich source of opinion and qualitative feedback from the groups surveyed to inform current and future developments of intermediate care.

The average age of service users nationally in bed based intermediate care is 83 years of age. We know that Trafford's elderly population is set to rise both in terms of numbers (an estimated additional 10,000 by 2030) in complexity and in longevity.

We have, therefore, also looked at the National Audit of Intermediate Care to see if we can provide some indications of the future model of care for Trafford's care complex currently under review by Trafford Clinical Commissioning Group.

Our starting point for the current service was to develop a series of 3 questionnaires for GPs, referring hospital therapists and relatives of people using Ascot House, the current bed based intermediate care facility in Trafford. All responses were anonymised. The only exception to this was that we asked GPs to identify which locality they were part of so that we could see if there was any geographical bias in the responses received.

The GP survey was answered by 20 GPs. In total there were 10 question choices. Excluding yes/no answers we received 94 specific comments. 9 questions were skipped, of which 5 related to the question asking about the benefits of Ascot House.

The hospital Occupational Therapist survey was answered by 5 individuals. There were 35 question choices. Again, excluding yes/no answers we received 98 specific comments. There were 6 skipped comments.

The relatives' questionnaire survey comprised 17 questions. This was only completed by 2 relatives and 1 answer was skipped. This disappointing result is discussed within the main body of this report.

KEY CONSIDERATIONS FOR TRAFFORD'S REVIEW OF INTERMEDIATE CARE

Trafford is one of the 85 out of 154 organisations who took part in the NAIC audit and so will be well placed, on receipt of their individual entries (due in December 2017) to benchmark itself against the current provision and future model under the proposed care complex.

1. 85% of patients' dependence was maintained or improved
2. Mental health workers and social workers need to be well represented
3. There has been no step change in investment and capacity needed to meet demand over the past 4 years nationally
4. Total investment in intermediate care is around £2.8million per 100,000 weighted population (Trafford's current population 233,300 (estimated in 2015) of which there were 38,000 people over the age of 65 which is estimated to rise to 48,300 in 2030.
5. 69% of people in bed based care return home, 12% were returned to acute care reflecting the age and frailty of the service user cohort and increasing dependency.
6. Discharge to assess models have been recognised as effective where service users deemed to be 'clinically optimised' and no longer require an acute bed but may require some short term care and support.
7. A new NICE guideline (NG74) has been published recently. This recommends that intermediate care teams contain a broad range of disciplines including nursing, social work and therapy professions. The guideline also introduces an important aim for bed based services to start within two days of receiving an appropriate referral.
8. There should be a single point of access, a single management structure and a single assessment process as recommended by NICE.
9. It is estimated that 59% of capacity is being used for step up (last local figure is 17.5%) with 41% for step down.
10. The direct cost per service user of intermediate care services (excluding indirect costs and overheads) is £982 with an average length of stay of 26.8 days.
11. Therapy-led intermediate care services are very much in the minority - estimated at 10%.

The NAIC, having looked at the evidence, suggests that intermediate care is an effective component of the modern health and social care system and Healthwatch Trafford strongly supports that belief. We also believe that commissioning an effective intermediate care service will ameliorate delayed transfers of care.

RECOMMENDATIONS FOR CONSIDERATION

Planning for the proposed Care Complex

1. Trafford CCG should benchmark its intermediate care return (submitted to the National Audit of Intermediate Care in early 2017) against the overall NAIC results published in November 2017 and use this information as the basis for planning the proposed care complex. This should include the overall financial benefit to the soon to be established integrated health and social care organisation (see Appendix 1).
2. Health and Social Care should determine the preferred model encompassing capacity required for the period up to 2030, having regard to the standards required in the recently published NICE guideline (see Appendix 2).
3. The main consideration should be whether intermediate care services can provide an integrated nurse-led model (as opposed to the current therapy-led model) supported by the full range of practitioners advocated in the NAIC audit within the available resource set against savings in acute sector activity as a consequence of shorter lengths of stay or hospital avoidance.
4. The health and wellbeing benefits for patients should be uppermost and routinely evaluated.

Short term measures

5. In the short term, the admission criteria to Ascot House should be reviewed to include people with cognitive impairment, physical and learning disabilities.
6. There should be efforts to encourage and enable people from ethnic minorities to use Ascot House.
7. There should be organised activities for residents of Ascot House.
8. A list of conditions that would be suitable for step-up to avoid hospital admission should be agreed between GPs and the acute sector and performance managed to ensure change in behaviour to effect hospital avoidance.
9. The use of the Trafford Coordination Centre as the single point of access and information and advice to referrers in terms of bed availability, access criteria etc. should be explored.
10. The 'trusted assessor' pilot to ensure that patients are only assessed for intermediate care once, should be implemented as quickly as possible.

11. The role and function of Ascot House should be widely communicated and, where possible, acute and community staff exchange visits should be encouraged.

12. Efforts should be made to improve connectivity between IT systems.

PURPOSE AND RATIONALE FOR THE REVIEW

In October 2016, Healthwatch Trafford (HWT) decided to prioritise intermediate care within its work plan. This work plan was shared with TMBC and the CCG.

There are four components to intermediate care - as set out by the National Audit of Intermediate Care (NAIC). These comprise crisis care, home based care, reablement and bed based care. We selected Ascot House as the first of these four areas to review.

Our rationale for focussing on intermediate care beds was

- The need to provide patient experience qualitative information to enrich the range of quantitative data currently available to commissioners and providers but not available to HWT.
- To hear at first hand what patients/residents and relatives' views are in relation to the care they receive and whether they feel it enables them to regain their independence
- To seek the views of professionals as to how services could be improved
- To contribute to the understanding of how patients flow through the health and social care system and identify barriers
- To contribute to the understanding of how well services are being integrated.

Since HWT's review began, the CCG has initiated its own review of Ascot House and the CQC, on behalf of the Department of Health, is undertaking a local system review on Delayed Transfers of Care in Trafford (DTOCS) which will be reported back to the Health and Wellbeing Board in January 2018. HWT was invited to provide both verbal and written evidence to the CQC.

We were also asked to provide written evidence to the CQC's 'new style' review of Ascot House and we were able to provide feedback from the questionnaires we sent out but not this report.

ASCOT HOUSE

Ascot House is managed by Pennine Care under a Section 75 agreement with Trafford Metropolitan Borough Council and commissioned by Trafford Clinical Commissioning Group.

Ascot House was formerly a residential care home and is currently registered with the CQC as a residential facility providing 36 beds for the assessment of older adults. It provides rehabilitation for both step up and step down patients from hospital and is a therapy-led model with nursing input as required by district nurses. A local GP practice provides medical input. Ascot House is located in Sale and serves all Trafford GPs.

The current website states that 'Ascot House is an assessment centre for older adults. It also provides rehabilitation and has two beds available for regular respite users. Ascot House provides short term care and accommodation for up to 36 adults. The building is divided into four units, three of which provide assessment while the fourth unit provides intermediate care and rehabilitation to people recovering from illness'.

Recently, the top floor at Ascot House has been turned into a 9 bed 'home to assess' unit, giving a total capacity of 45 beds. A multi-disciplinary team provides physiotherapy, occupational therapy and social work support as required. Community services such as nursing, podiatry, dietetics and speech and language therapy support the unit when necessary.

Ascot House is described as 'supporting people of old age, with mental health conditions, dementia, physical impairment'. We can find no evidence that people with these conditions are admitted; rather that it is a service for the frail elderly who are assessed as being able to benefit from intermediate care therapy to enable them to return to their usual place of residence. The majority of patients are those that are stepped down from a hospital setting with only 17.5% stepped up to avoid hospital care.

HEALTHWATCH TRAFFORD METHODOLOGY FOR THE REVIEW

We set up task and finish groups to develop questionnaires for referrers in the main acute hospitals we use. Our volunteers developed three questionnaires with the help and support of the CCG (our particular thanks to Paul Fleming, Tracy Cartmell and Sarah Morton for their support). We also held meetings with Pennine Care and TMBC around the scope of the work.

Two questionnaires were one-off surveys where we sought the views of GPs, and referring practitioners (principally hospital therapists involved in discharge). In relation to relatives our intention was to have this given out on an 8 weekly basis by Ascot House staff to get an acceptable response level. Relatives were able to use a paper return or an on-line response. Regrettably, we only received two returns. Healthwatch has now decided to visit Ascot House periodically, with the agreement of management, to collect relatives' feedback.

We approached the respective Chief Executives of our acute trusts for their help and support in encouraging their staff to complete these surveys. We approached them on two separate occasions. We also sent out the GP questionnaire twice (with the support of the LMC Chief Executive).

We also visited Ascot House on the 9 August 2017. This was not a formal enter and view by HWT, rather it was a walk round for the HWT Chair and Chief Officer.

We were guided to various parts of Ascot House. Whilst this is a dated building it was, nevertheless, well maintained and meticulously clean. The staff we met appeared caring and friendly.

On the day of the visit the top floor (home to assess) was empty. The only patient who was appropriate for this service had been transferred to the ground floor.

We spoke to several patients, all of whom were elderly. They said that they had therapy in the mornings and then in the afternoons they conversed, had tea, watched TV or read. They were very complimentary about the food with three cooked meals each day.

We noted that in order to get residents ambulant and climbing stairs, they had to use the main staircase from the first to the second floor. These stairs are steep and are wholly inappropriate and, even with staff present, could be dangerous. A chair was sited on the landing but, even so, there were numerous stairs to climb to reach it.

HWT - as mentioned previously - has no access to occupancy rates, lengths of stay, nor have we seen admission or discharge criteria. Our observations on the day were that all the residents were frail elderly. We saw nobody with dementia, mental illness or physical disabilities.

Our impression on the day was that Ascot House was 50% occupied.

We noted that the community nursing team is called in overnight in case of need to support unqualified care staff. On the day of the visit the community rehabilitation team was being re-located to Ascot House.

On discharge from Ascot House, referral was made to each of the four localities in Trafford. Staff wondered if this might lead to differential responses depending on home care, therapist and voluntary sector availability.

A major barrier to more effective functioning was cited by staff as the need to use two different computer systems.

FINDINGS FROM HEALTHWATCH TRAFFORD SURVEYS

The GP Questionnaire

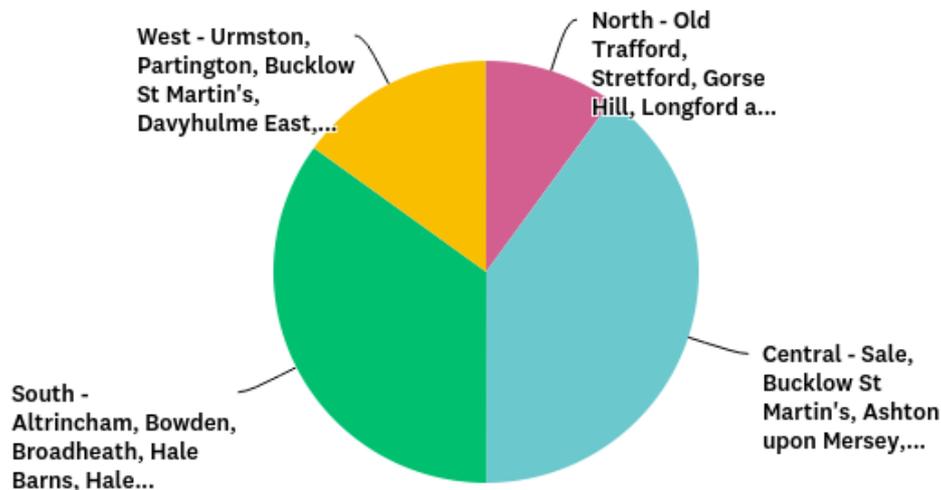


Figure 1. Location of GP surgeries we received responses from

80% of GPs said they were aware of what intermediate care services (step up or step down) can be provided at Ascot House, yet 80% had not used the service.

The reason for not using Ascot House were: 20 out of 20 responded and 16 commented as follows:

- No need to
- Not had appropriate patient
- Too much hassle to get in, in the end - an old lady with UTI almost 'off her legs'
- Both referrals declined, very narrow referral criteria, receiving staff not very helpful or available
- Not had appropriate patient
- I am a practice manager and would expect the GPs to do the referral
- Not required - usually step down from hospital
- Not had the opportunity, not had appropriate patients
- Not easy to access
- Don't know what they do or how to refer or what sort of patients they will see
- Unaware
- Not fully aware of what they do
- Did satisfy admission criteria
- No suitable patients

- Difficult to find patients which fit the criteria most a bit too sick or else don't really need it - is a very narrow window since it opened for step up. I have not come across a suitable patient.
- Too far from south locality

37% of GPs felt that Ascot House was simple to access but 63% found it difficult. 19 out of 20 responses were received. 12 GPs commented as follows:

- Would be easier if one number to someone who knew what they were talking about to talk through and help direct to the different options for step up care available.
- Hard to track down the right form, very hard to speak to someone directly, referrals declined
- Very complicated - reluctance to take patients - not helpful administration at all
- Not easily available
- Know nothing about it really
- My patient did not meet the criteria. However, she fell in her own home a few weeks later and was admitted to hospital. She was then discharged to Ascot House from hospital
- Not accessed
- Not used
- Don't use
- Don't know
- Don't know
- Don't know

85% of GPs felt that the geographical location of Ascot House was NOT a factor in referring patients to Ascot House. 20 out of 20 responded and 3 commented as follows:

- Geographical distance
- It is outside practice boundary
- Trafford

When asked whether Ascot House could be considered as an alternative to hospital admission 60% said YES and 40% said NO. 20 out of 20 responded.

When questioned as to whether there were any groups of patients reluctant to use Ascot House, the majority of GPs did not think so. One exception was potentially younger patients. 19 out of 20 responded and commented as follows:

- No
- Not applicable
- Younger patients
- Not sure they know about it - up to us to offer
- No
- Not to my knowledge
- Not known to me
- Nil particular

- Not known
- Not really. I use the enhanced care team to help the process for me
- No
- No
- Not applicable - never tried to refer anybody there
- Unsure
- None that I am aware of
- ?
- no
- no

‘Any patient requiring hospital admission will not meet the criteria for Ascot House. It is, therefore, not an alternative to hospital admission. Ascot House is a therapy led service for well patients - step up is for this cohort e.g., fall but not unwell. The care package offered by Ascot House does not offer the diagnostic resource or treatment package needed for an unwell patient requiring hospital admission e.g. 24 hour nursing care, chest x-ray, intravenous antibiotics, diuretics or fluids. As a Sale GP my patients find Ascot House convenient.’

There was an even split of GPs who would refer to the Trafford Coordination Centre (TCC) for those patients that need any type of intermediate care (in crisis, in the community or in the patient’s own home, including Ascot House.

Feedback on TCC was as follows: 20 out of 20 responded and 11 commented as follows:

- Too slow to respond, don’t do anything
- Have rarely found the TCC of any help or value
- Not overly impressed by response
- With varying degrees of success
- Have not found it helpful
- I refer directly to the service I need using the single point of access
- Not convinced that TCC performs any useful function - not seen any evidence of this
- I didn’t know TCC would act in a crisis
- Did not know they provide the role
- Hopeless service - completely ineffectual
- Intermediate care referral do not go via TCC they go to the single point of access for Pennine Care - this should be amalgamated into one gateway.

GPs were asked whether they had any suggestions that would lead to more efficient and effective use of Ascot House or any other form of intermediate care. 18 out of 20 responded as follows:

Responses were:

- Need additional facility within south locality

- Avoiding inappropriate admissions from hospital. It is a therapy led service e.g., ideal for rehabilitation of post op fracture. Patients have been sent to Ascot House very ill - e.g. with rigors and have had to be sent back to hospital
- Yes - can there be a service provision for patients who are frail, elderly and waiting for a nursing home to have a 'holding' service to prevent hospital admissions for social reasons? A criterion for Ascot House is 'patients will return to their home address' - prevents referring this group of patients.
- Ascot House is a therapy led service for the provision of rehabilitation. It is NOT an alternative to hospital admission for medically unwell patients and should not be seen as such. The majority of GPs have a good understanding of this fact. Unfortunately, pressure from Wythenshawe to 'step down' patients to free up beds frequently results in patients who are ill and need hospital treatment being discharged to Ascot House inappropriately. Admission of these inappropriate patients prevents admission of step up patients from the community.
- Single phone number to call, with knowledgeable person answering who is also aware of availability and can help direct as we as GPs not always aware of what options may be available/best for our patients.
- I found their refusal to accept patients with a dementia diagnosis ridiculous - we have an ageing population and increasing number of patients are being diagnosed with dementia but live independently with care at home - they need rehab too at times!
- Make it simpler - they must trust the GP's judgement for their patient care needs and the needs of the families - expansion of intermediate care will be a lot more cost efficient and better to be expanded.
- Needs relocating. Needs full review of function. Needs integrating
- More information and publicity on how to refer and what services are provided e.g., IVs.
- Continue to use the enhanced care team to organise through TCC as we struggle to keep up to date with beds, etc.
- Easier access and ALL beds to have in-house GP cover
- No
- Yes, clarity re what they do, easy referral process and not some long form. Let allied health professionals, district nurses and McMillan refer easily.
- To change the model from a therapy led service to a nurse led model as was originally proposed together with specifically commissioned allied health professional access i.e., speech and language therapists, dieticians and phlebotomy services
- No
- I think a facility such as Ascot House has limited ability to impact on stopping hospital admissions. It is an intensive physiotherapy resource in essence. If the aim is to prevent medical admissions by step up to intermediate care, Ascot House would have to offer a different service - 24- hour nursing - if, in addition to this, it was co-located on a hospital site, patients at Ascot House could be easily access diagnostics across the car park and then more patients could be managed in this facility. Also if they deteriorated, transfer would be easier - similarly step down would also be easier - then it would look something like Opal House at Wythenshawe (the problem is if this facility is run by secondary care it attracts a different tariff than if run by community services. The second problem is if different organisations run adjacent

services, the transfer criteria between the two becomes very bureaucratic and introduces time delays.

From your experience of using Ascot House, what do you consider to be the benefits? 15 of 20 responded as follows:

- Effective rehabilitation for post operative patients which can be done intensively before they return home.
- Therapy-led multidisciplinary approach in a local facility with experienced and dedicated staff
- No experience
- Very little, waste of time referring from primary care, unwieldy referral criteria
- Saving, good care of the patients and help to the families
- I don't
- Rehabilitative post hospital discharge
- Alternative to a busy expensive hospital. More holistic care
- Minimal
- Good way of getting frail elderly back on their feet
- Not applicable
- Not applicable
- Helpful for physical rehabilitation which currently is its commissioned purpose
- Patients like the rehabilitation closer to home that Ascot House provides
- Very good for step down and good for step up if the correct patient is referred in for rehabilitation.

The Hospital Questionnaire

We canvassed Chief Executive support from Wythenshawe, Salford Royal and Manchester Royal Infirmary and had five Occupational Therapist replies as the main referrers to Ascot House

3 OTs aware of Ascot House, whilst 2 were not. Similarly, 3 had referred, 2 of which were in the last 3 months and 1 in the last 6 months.

2 OT' said it was simple to access, whilst 1 did not. 4 said that Ascot House was their preferred option. 4 OTs said that as far as possible they fell in with patients, relatives and carers' influence in the decision to use Ascot House and 1 said 'where appropriate'.

In answer to the question 'do you collect or receive feedback from Ascot House, 1 agreed and 4 disagreed and made the following comments

- They don't send us feedback and the patient is already discharged from us in the hospital
- Never referred anybody there
- Wasn't aware of the service

- Feedback may come to our organisation, but does not necessarily get fed back to individual therapists who had referred.

Of the 5 referring Occupational Therapists, none had ever visited Ascot House in the past 6 months.

In terms of suggestions that would lead to more efficient and effective intermediate care, the following responses were received from 4 of the 5 therapists.

- Accepting the referrals from physiotherapists who have completed assessments and treatments of the patients in hospital, would be more efficient than spending therapists' time from intermediate care therapists coming into the hospital when already assessed and agreement between hospital multi disciplinary team, patients and their family agree to referral and then difficulty if not accepted to intermediate care therapy. Also intermediate care therapy assessors are coming in to see a patient for the first time and basing their acceptance/declining of referrals if they don't know them so can be difficult to build rapport or trust with a patient that is nervous or hard of hearing on first meeting someone new in their care.
- Being aware of this service that our patients are able to access
- Review the ever-changing criteria. For example, patients with cognitive impairment. The acute therapists have already begun rehabilitation and have to continue to rehabilitate this criteria of patient. If they were not able to progress they would not be referred. All deserve a chance.
- It is helpful to be able to discuss directly with Ascot House therapists' individual patients and their suitability. Feedback on how patients do and how we can improve referrals and their appropriateness would be helpful.

In response to the question 'do health and social care assessments take place on admission' 3 said 'yes' and 2 said 'no'.

Who undertakes assessments?

- Patients are assessed depending on their needs, may be a combination of nursing, physiotherapy and OT assessment
- The multi-disciplinary team (social worker, nurses, doctors and occupational therapist)
- Various staff and only when they are nearing the end of their stay in preparation for discharge planning. Minimum stay on the unit is 3 months (unit not identified).
- Therapists
- Uncertain how and if this happens

What do these assessments comprise?

- Depends on the patient's needs, will discuss home circumstances and how they are managing at home. Discuss mobility, transfers, aids, activities of daily living.

- Full nursing assessment. Family meetings, multi-disciplinary meetings and social work input
- Nursing needs assessment, capacity around discharge. Best interest meetings if required around discharge destination, continuing health care screen and meeting.
- Intermediate care therapists review referrals sent, contact therapists or visit the patient on the ward
- Not sure

In response to the question as to whether there was a specified time in the hospital's policy as to when initial assessment is undertaken, 3 responded 'yes' and 2 'no'. The next question asked whether this timescale was met and 1 person responded 'often' and 4 'routinely'.

OTs were then asked what the assessments comprised.

- Dependent on patient need and who they need treatment from e.g., physiotherapist, occupational therapist, social worker etc.
- Nursing needs assessment - continuing health care
- Social worker or district nurse visit to patient and family
- Uncertain

This was followed up by a question on whether there is a set time that assessments happen prior to discharge, and 4 OTs responded 'no' and 1 'yes'. 1 OT said that this timescale was met often and 4 routinely. These all took place on the ward.

Who is involved in the care of the patient during their stay in hospital was cited as health professionals but 4 of the 5 OTs said that social care was involved, 2 that voluntary organisations were involved and that district nurses, Macmillan, orthotics, RAID, psychiatry, and community services could also be called upon.

We then moved on to how quickly GPs were informed of discharge and 2 said same day, 1 next day, 2 next week. The next question was when was the patient's summary sent to the GP. 4 of the 5 said that this was sent on the same day as discharge take place, with 1 saying more than 1 week.

Occupational therapists were then asked if they used the Trafford Coordination Centre. 2 replied that they did and 3 that they did not.

In answer to 'what benefits do you see from TCC', the answers were as follows:

- Unknown service. I am not aware of this. GPs are informed of discharge by the medical team on discharge.
- Advice and liaison of services
- Not applicable
- Referrals are emailed to the single point of access

How are patients, relatives and carers informed of processes within the organisation?

- Open communication
- We arrange an early family meeting and have ongoing meetings as required. The last few around discharge
- Verbally
- Usually met by the professionals caring for the patient. Patient flow, discharged teams etc.
- Patients will be included in the process and informed of referrals and will have given consent.

We asked how often patients' discharges were delayed because their medication was not ready to go with them and the response from all respondents was 'sometimes'. The choices here were very often, often, sometimes or never.

We asked how patients, relatives and carers were enabled to make comments, compliments and complaints.

- Comments cards available, PALS service, friends and family test
- Friend and family test, questionnaire
- Yes
- Wards and departments are aware of PALS. There are notices around departments highlighting how to make complaints or compliments. Some have suggestion boxes to give opportunity for anonymity.
- Encouragement is given to provide feedback.

What out-of-hospital obstacles do you encounter in discharging patients to their chosen destination?

- Availability of onward referral places e.g. nowhere available to send them for rehabilitation, waiting social care at home or placement in nursing home not available. Big delays in getting carers at home. Lack of patients accepted by intermediate care..
- Availability of care packages. Continuing health care screening. Lack of nursing home placements. Complexity of discharges i.e., peg feeding, medication. Family dynamics and expectations.
- Placement availability specialist equipment. Specific placement wheelchair needs if the choice is not appropriate.
- Lack of places at nursing homes and residential homes. Awaiting social worker assessment. Family decision making. Intermediate care criteria. Lack of hospice placements. Not enough community or carer support for patients to return home.
Unsuitable properties.
- Awaiting rehabilitation beds, packages of care, crisis cleans, provision of essential equipment.

In response to the question of how often patients are admitted/readmitted to hospital from intermediate care (past 6 months), 1 answered 'often' 3 'sometimes' and 1 'never'.

We then asked how services are adapted to account for patients' cultural needs.

- Treatments are completed with sensitivity to cultural or religious requirements e.g. treatment by same sex staff, single sex wards.
- Preferences noted on admission. If requiring a nursing home of their own culture for example. Interpreter services. Help with dietary choices. Give patient and family time to discuss the individual needs whilst in hospital
- Needs are asked and met as much as possible within available resources
- Acute hospital staff are very adaptable and always attempt to meet the needs of patients with cultural needs.
- Often try to look at getting patients directly home rather than to intermediate care beds if language is likely to be difficult to engage them in rehabilitation.
- Uncertainty about what intermediate care beds will have on offer for those with cultural needs.

How are care and services adapted to those patients with complex communication needs?

- Use of communication tools, e.g., written tools, interpreters, encouraging joint working with family and patients and the multi-disciplinary team
- We have a high number of patients with complex communication needs, mainly due to Aphasia due to stroke, cognitive impairment and hearing and visually impaired patients. We have speech and language therapists, rehabilitation assistants and activity coordinator to offer support.
- All our patients have complex needs
- Be aware of the communication difficulties and liaise with the appropriate services. Speech and language therapists, communication cards, translation services, adapting communication to the patient or carers form of communication.
- Use of interpreters and family.

From your experience of using Ascot House, what do you consider to be the benefits?

- A place to go for rehabilitation which is required for patients to aid return of function, but can be difficult to get patients accepted there and would benefit from coordination with ward therapists when they attend to assess the patient's need on the ward.
- I have little knowledge of Ascot House recently as stroke patients were deemed too complex to go there from the stroke pathway, the patient should remain in a stroke specialty environment for the whole of their journey. I feel it would, however, be beneficial if the care the individual receives at Ascot House could be tailored to meet the needs of stroke patients.
- When Ascot House accepted patients we were able to give the patient the opportunity to improve their function to enable them to have a better quality of life.
- More recently, with the extra beds, transfer to Ascot House has been quicker and communication better.

The Relatives' Questionnaire

It was extremely disappointing to have only received two responses from relatives of people in Ascot House. One person admitted from home, whilst the other person was referred by Salford Royal. In one instance the response was made in 3 days, whilst the other was approximately 4 weeks. In both cases the care plan had been explained and both carers had been involved in the development of the care plan. When asked if the staff at Ascot House regularly update on their relative's progress, both said that this did not happen. However, both felt that their relative was receiving appropriate care and that they were listened to. 1 person said they were kept fully aware of the support their relative was receiving, whilst one said they were not. When asked whether their relative had plenty to occupy them, one said they thought that they did but the other felt that although the staff were kind and engaged, more activities could be provided other than TV. Neither respondent felt that their relative was lonely at Ascot House.

WHAT DOES THE FUTURE HOLD FOR INTERMEDIATE CARE IN TRAFFORD?

HWT is absolutely committed to the idea of having a fully integrated intermediate care service. All the evidence points to the fact that, if well organised and properly resourced, this can have a dramatic impact on DTOCs. Furthermore, and as important if not more so, Trafford patients will benefit hugely by not having to stay in hospital one more day than necessary. This will help with re-ablement and reduce the chances of acquiring hospital infections as well as building resilience in the community and enabling people to return to their choice of destination.

However, what does concern HWT are future plans for this service in terms of its size and make-up. As plans proceed to develop Trafford's care complex, we must use the evidence to right-size the intermediate care element.

In order to do this, data NAIC has collected is the average - with a clear acknowledgement that current services across England only account for 50% of potential demand.

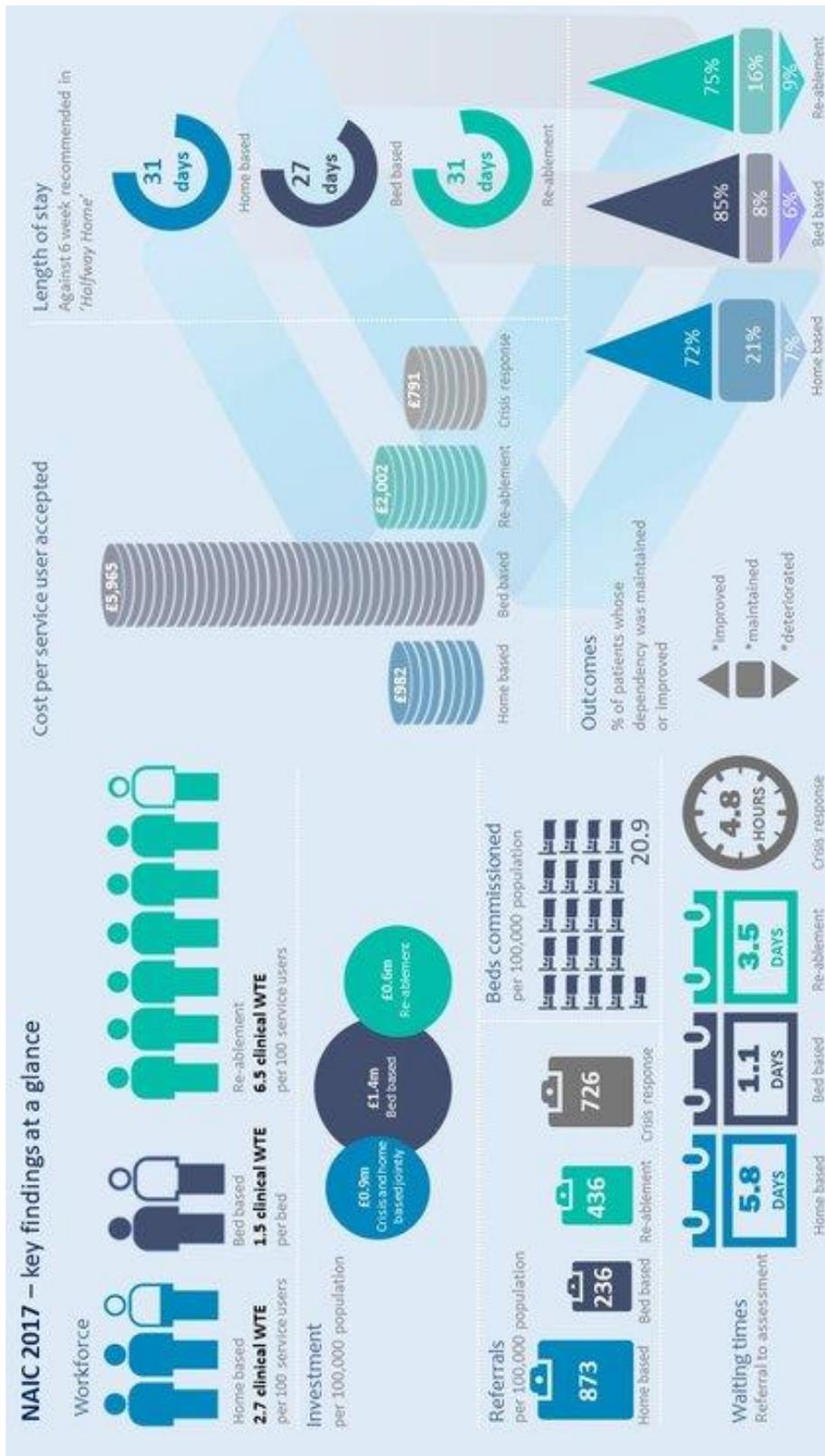
We make no apology for including key findings from the NAIC (published in mid-November 2017) in support of our belief that intermediate care will significantly improve the health and wellbeing of Trafford's residents.

END

27 November 2017.

Appendix 1: NAIC Key Findings At A Glance

National Audit of Intermediate Care 2017 (published November 2017)



Summary report available at <https://www.nhsbenchmarking.nhs.uk/projects/naic>

Appendix 2: NICE Guidelines on Intermediate Care

Full details and download of National Institute for Health and Care Excellence guidelines (September 2017) can be found here:

<https://www.nice.org.uk/guidance/ng74>



Intermediate care including reablement NICE guideline

Published: 22 September 2017

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Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should **assess and reduce the environmental impact of implementing NICE recommendations** wherever possible.

Overview

This guideline covers referral and assessment for intermediate care and how to deliver the service. 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.

Who is it for?

- Health and social care practitioners who deliver intermediate care and reablement in the community and in bed-based settings
- Other practitioners who work in voluntary and community services, including home care, general practice and housing
- Health and social care practitioners in acute inpatient settings
- Commissioners and providers
- Adults using intermediate care and reablement services, and their families and carers

Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in **your care**.

Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of our recommendations, and has information about professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

The term 'intermediate care' in this guideline refers to all 4 service models of intermediate care described in **terms used in this guideline**.

1.1 Core principles of intermediate care, including reablement

1.1.1 Ensure that **intermediate care** practitioners:

- develop goals in a collaborative way that optimises independence and wellbeing
- adopt a **person-centred** approach, taking into account cultural differences and preferences.

1.1.2 At all stages of assessment and delivery, ensure good communication between intermediate care practitioners and:

- other agencies
- people using the service and their families and carers.

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**.

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.

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.

1.2 Supporting infrastructure

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.

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

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**.

1.2.4 Ensure that intermediate care teams work proactively with practitioners referring into the service so they understand:

- the service and what it involves

- how it differs from other services
- the ethos of intermediate care, specifically that it aims to support people to build independence and improve their quality of life
- that intermediate care is free for the period of delivery.

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.

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.

1.2.7 Consider deploying staff flexibly across intermediate care, where possible following the person from hospital to a community bed-based service or directly to their home.

1.2.8 Ensure that the composition of intermediate care teams reflects the different needs and circumstances of people using the service.

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.

1.3 Assessment of need for intermediate care

This section relates to the assessment of a person's support needs. It could be undertaken by a range of professionals, for example therapists, nursing staff or social workers, working in various locations. It aims to ensure that the type of intermediate care support is appropriate for the person's needs and circumstances.

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.

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.

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

1.3.4 Actively involve people using services (and their families and carers, as appropriate) in assessments for intermediate care and in decisions such as the setting in which it is provided.

1.3.5 When assessing people for intermediate care, explain to them (and their families and carers, as appropriate) about advocacy services and how to contact them if they wish.

1.4 Referral into intermediate care

People may be referred into the services described in this section by either health or social care practitioners. The location of intermediate care will vary depending on how different areas configure the service to meet local circumstances and needs. Intermediate care could be commissioned by either health or social care commissioners, or jointly as part of an integrated working approach.

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.

1.4.2 Offer **reablement** as a first option to people being considered for **home care**, if it has been assessed that reablement could improve their independence.

1.4.3 For people already using home care, consider reablement as part of the review or reassessment process. Be aware that this may mean providing reablement alongside home care. Take into account the person's needs and preferences when considering reablement and work closely with the home care provider.

1.4.4 Consider reablement for people living with dementia, to support them to maintain and improve their independence and wellbeing.

1.4.5 Consider **bed-based intermediate care** for people who are in an acute but stable condition but not fit for safe transfer home. Be aware that if the move to bed-based intermediate care takes longer than 2 days it is likely to be less successful.

1.4.6 Refer people to **crisis response** if they have experienced an urgent increase in health or social care needs and:

- the cause of the deterioration has been identified
- their support can be safely managed in their own home or care home
- the need for more detailed medical assessments has been addressed.

1.4.7 The crisis response service should raise awareness of its purpose and function among other local services such as housing and the voluntary sector. This means making sure they understand:

- the service and what it involves
- how it differs from other types of intermediate care
- how to refer to the service.

1.5 Entering intermediate care

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.

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.

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.

Crisis response

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

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.

1.5.6 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.

Person-centred planning

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.

1.5.8 Carry out a risk assessment as part of planning for intermediate care and then regularly afterwards, as well as when something significant changes. This should include:

- assessing the risks associated with the person carrying out particular activities, including taking and looking after their own medicines
- assessing the risks associated with their environment
- balancing the risk of a particular activity with the person's wishes, wellbeing, independence and quality of life.

For recommendations on supporting people in residential care to take and look after their medicines themselves, see NICE's guidelines on **managing medicines in care homes** and **medicines optimisation**.

[This recommendation is adapted from NICE's guideline on **home care**]

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.

[This recommendation is adapted from NICE's guideline on **home care**]

Agreeing goals

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.

1.5.11 Recognise that participation in social and leisure activities are legitimate goals of intermediate care.

1.5.12 Document the intermediate care goals in an accessible format and give a copy to the person, and to their family and carers if the person agrees to this.

1.6 Delivering intermediate care

1.6.1 Take a flexible, outcomes-focused approach to delivering intermediate care that is tailored to the person's social, emotional and cognitive and communication needs and abilities.

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.

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.

1.6.4 Ensure that specialist support is available to people who need it (for example, in response to complex health conditions), either by training intermediate care staff or by working with specialist organisations. [This recommendation is adapted from NICE's guideline on **home care**]

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.

1.6.6 Ensure that intermediate care staff avoid missing visits to people's homes. Be aware that missing visits can have serious implications for the person's health or wellbeing, particularly if they live alone or lack mental capacity. [This recommendation is adapted from NICE's guideline on **home care**]

1.6.7 Contact the person (or their family or carer) if intermediate care staff are going to be late or unable to visit. [This recommendation is adapted from NICE's guideline on **home care**]

1.7 Transition from intermediate care

1.7.1 Before the person finishes intermediate care, providers of intermediate care should give them information about how they can refer themselves back into the service, should their needs or circumstances change.

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.

For recommendations on communication during transition between services, see NICE's guideline on **transition between inpatient hospital settings and community or care home settings for adults with social care needs**.

1.7.3 Give people information about other sources of support available at the end of intermediate care, including support for carers.

1.8 Training and development

1.8.1 Ensure that all staff delivering intermediate care understand:

- the service and what it involves
- the roles and responsibilities of all team members
- how it differs from other services
- the ethos of intermediate care, specifically that it aims to support people to build independence
- how to work collaboratively with people to agree person-centred goals
- positive risk taking.

1.8.2 Ensure that intermediate care staff are able to recognise and respond to:

- common conditions, such as diabetes; mental health and neurological conditions, including dementia; frailty; stroke; physical and learning disabilities; sensory loss; and multi-morbidity
- common support needs, such as nutrition, hydration, continence, and issues related to overall skin integrity
- common support needs, such as dealing with bereavement and end of life
- deterioration in the person's health or circumstances.

[This recommendation is adapted from NICE's guideline on **home care**]

1.8.3 Provide intermediate care staff with opportunities for:

- observing the work of another member of staff
- enhancing their knowledge and skills in relation to delivering intermediate care
- reflecting on their practice together.

Document these development activities and record that people have achieved the required level of competence.

1.8.4 Ensure that intermediate care staff have the skills to support people to:

- optimise recovery
- take control of their lives
- regain as much independence as possible.

Terms used in this guideline

Bed-based intermediate care

Assessment and interventions provided in a bed-based setting, such as an acute hospital, community hospital, residential care home, nursing home, stand-alone intermediate care

facility, independent sector facility, local authority facility or other bed-based setting. Bed-based intermediate care aims to prevent unnecessary admissions to acute hospitals and premature admissions to long-term care, and to support timely discharge from hospital. For most people, interventions last up to 6 weeks. Services are usually delivered by a multidisciplinary team but most commonly by healthcare professionals or care staff (in care homes).

Crisis response

Community-based services provided to people in their own home or a care home. These services aim to avoid hospital admissions. Crisis response usually involves an assessment, and may provide short-term interventions (usually up to 48 hours). Crisis response is delivered by a multidisciplinary team but most commonly by healthcare professionals.

Home-based intermediate care

Community-based services that provide assessment and interventions to people in their own home or a care home. These services aim to prevent hospital admissions, support faster recovery from illness, support timely discharge from hospital, and maximise independent living. For most people interventions last up to 6 weeks. Services are delivered by a multidisciplinary team but most commonly by healthcare professionals or care staff (in care homes).

Home care

Care provided in a person's own home by paid care workers which helps them with their daily life. It is also known as domiciliary care. Home care workers are usually employed by an independent agency, and the service may be arranged by the local council or by the person receiving home care (or someone acting on their behalf).

Intermediate care

A range of integrated services that: promote faster recovery from illness; prevent unnecessary acute hospital admissions and premature admissions to long-term care; support timely discharge from hospital; and maximise independent living. Intermediate care services are usually delivered for no longer than 6 weeks and often for as little as 1 to 2 weeks. Four service models of intermediate care are available: bed-based intermediate care, crisis response, home-based intermediate care, and reablement.

Person-centred approach

An approach that puts the person at the centre of their support and goal planning. It is based around the person's strengths, needs, preferences and priorities. It involves treating them as an equal partner and considering whether they may benefit from intermediate care, regardless of their living arrangements, socioeconomic status or health conditions.

Positive risk taking

This involves balancing the positive benefits gained from taking risks against the negative effects of attempting to avoid risk altogether.

Reablement

Assessment and interventions provided to people in their home (or care home) aiming to help them recover skills and confidence and maximise their independence. For most people interventions last up to 6 weeks. Reablement is delivered by a multidisciplinary team but most commonly by social care practitioners.

For other social care terms see the Think Local, Act Personal [Care and Support Jargon Buster](#).

Putting this guideline into practice

NICE has produced [tools and resources](#) to help you put this guideline into practice.

Some issues were highlighted that might need specific thought when implementing the recommendations. These were raised during the development of this guideline. They are:

- Ensuring an integrated approach to intermediate care. Currently, the 4 service models of intermediate care tend to operate separately, delivered by different staff and funded from different budgets. Moving to a more integrated approach for planning, funding and delivery of all 4 models, including transferable assessments that are accepted across all services, would improve the experience for people using the services. However, such changes may be difficult to achieve.
- Starting bed-based intermediate care services within 2 days (and crisis response within 2 hours) of receiving an appropriate referral. Rapid provision of the right intermediate care service will benefit people using the services, and may help reduce pressure on hospital beds. However, this approach will prove challenging in light of the current financial pressures and demands on the services.
- Making sure the aims, objectives and purpose of intermediate care are understood by people using the services, their families, and professionals from the wider health and social care system. There is currently a lack of understanding that the term 'intermediate care' includes intermediate care services funded by the healthcare system and reablement services funded by social care. In addition, there is low awareness that active rehabilitation or reablement is quite different from ongoing care and support.
- Developing leadership that promotes clarity of purpose and good communication within each service, and provides guidance and support to staff. This leadership will help staff working in intermediate care services to deliver a service focused on enabling and supporting independence, and optimising wellbeing.

Putting recommendations into practice can take time. How long may vary from guideline to guideline, and depends on how much change in practice or services is needed. Implementing change is most effective when aligned with local priorities.

Changes should be implemented as soon as possible, unless there is a good reason for not doing so (for example, if it would be better value for money if a package of recommendations were all implemented at once).

Different organisations may need different approaches to implementation, depending on their size and function. Sometimes individual practitioners may be able to respond to recommendations to improve their practice more quickly than large organisations.

Here are some pointers to help organisations put NICE guidelines into practice:

1. **Raise awareness** through routine communication channels, such as email or newsletters, regular meetings, internal staff briefings and other communications with all relevant partner organisations. Identify things staff can include in their own practice straight away.
2. **Identify a lead** with an interest in the topic to champion the guideline and motivate others to support its use and make service changes, and to find out any significant issues locally.
3. **Carry out a baseline assessment** against the recommendations to find out whether there are gaps in current service provision.
4. **Think about what data you need to measure improvement** and plan how you will collect it. You may want to work with other health and social care organisations and specialist groups to compare current practice with the recommendations. This may also help identify local issues that will slow or prevent implementation.
5. **Develop an action plan**, with the steps needed to put the guideline into practice, and make sure it is ready as soon as possible. Big, complex changes may take longer to implement, but some may be quick and easy to do. An action plan will help in both cases.
6. **For very big changes** include milestones and a business case, which will set out additional costs, savings and possible areas for disinvestment. A small project group could develop the action plan. The group might include the guideline champion, a senior organisational sponsor, staff involved in the associated services, finance and information professionals.
7. **Implement the action plan** with oversight from the lead and the project group. Big projects may also need project management support.
8. **Review and monitor** how well the guideline is being implemented through the project group. Share progress with those involved in making improvements, as well as relevant boards and local partners. Taking part in the National Audit of Intermediate Care (NAIC) will help to provide a benchmark for measuring progress and will add to the national data on intermediate care.

NICE provides a comprehensive programme of support and resources to maximise uptake and use of evidence and guidance. See our [into practice](#) pages for more information.

Also see Leng G, Moore V, Abraham S, editors (2014) *Achieving high quality care – practical experience from NICE*. Chichester: Wiley.

Context

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.

Intermediate care uses a range of service models to help people be as independent as possible. It can prevent hospital admissions, facilitate an earlier, smoother discharge, or be an alternative to residential care. It can also offer people living at home who experience difficulties with daily activities a means to maintain their independence.

This guideline focuses on the 4 service models included in the **National Audit of Intermediate Care summary report 2014** (NHS Benchmarking Network):

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

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.

The concept of intermediate care was developed by the Department of Health in 2000 in their **NHS Plan** and implemented in England through their **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. Most recently, NHS commissioners and local authorities have been required, via the **Better Care Fund** and the **NHS Five Year Forward View**, to take a more integrated approach to planning by pooling budgets to support models of integrated care and support, including reablement and intermediate care. The **Care Act 2014** requires that services, including intermediate care, should consider how person-centred support is planned to promote individual wellbeing.

This guideline covers intermediate care services provided by the NHS and social care, and how these are best planned and delivered alongside services provided by the voluntary and independent sector. It identifies the key components of the intermediate care pathway (see below), and how services can work together with the person and their support networks to deliver effective intermediate care. The guideline draws on the evidence base to highlight best practice, making recommendations that aim to provide equity of access and a more integrated approach to provision. It also aims to bring greater coherence, parity and

responsiveness to service delivery, reducing duplication of effort and clarifying responsibilities for service providers.

The intermediate care pathway

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 the following functions (described in more detail in the recommendations):

- **Assessing the need for intermediate care** – this includes gathering information about the person and deciding which intermediate care setting is most appropriate. If the person is in hospital, their assessment may include developing goals to include in the referral to the intermediate care team. If the person is at home the assessment may be completed by a social worker, community nurse, crisis response team, or community social care occupational therapist.
- **Acceptance by the intermediate care service** – an individual plan is then developed by the intermediate care team, based on the person's assessment. Goals are agreed with the person and then reviewed regularly. The plan should contain enough information so that staff visiting the person and providing their rehabilitation know what needs to be done.
- **Delivery of the service** – this should always be based on the agreed plan, and if problems arise then support staff should be able to contact the assessing practitioner in the intermediate care team.
- **A formal review** – this should be undertaken as the person approaches achieving their goals with a clear plan for transition from the intermediate care service. If the person has ongoing support needs there may be a handover to a new home care provider or day service. If the person has achieved their desired level of independence the plan may include information about how to refer themselves back into the service if they need to, and links to community services that can support them.

More information

To find out what NICE has said on topics related to this guideline, see our web page on [**adult social care**](#).

Recommendations for research

The guideline committee has made the following recommendations for research.

1 Optimal time between referral and starting intermediate care

What is the optimal time between referral to and starting intermediate care in terms of effectiveness and cost effectiveness and in terms of people's experiences?

Why this is important

Recommendation 1.4.3 states that for bed-based intermediate care, the service should start within 2 days of a referral being received. There is moderate-quality evidence to suggest that if the referral is made from acute care then the person's condition will begin to deteriorate if intermediate care does not start within 2 days. There is no clear evidence about the most effective timescale for people whose referral is being made in different circumstances, for example if they are at home and being referred for home-based intermediate care or reablement to prevent hospital admission or improve independence.

A comparative evaluation is needed to assess outcomes associated with different lengths of time between referral and starting the 4 intermediate care service models. Also, to assess the resource impact and overall cost effectiveness of different waiting times. Effectiveness and cost-effectiveness research should be complemented by qualitative data from people receiving and delivering the service to investigate their views and experiences and the perceived impact on the person's level of independence and quality of life.

2 Team composition for home-based intermediate care

How effective and cost effective are different approaches, in terms of team structure and composition, to providing home-based intermediate care for adults?

Why this is important

The skill mix and competency of a home-based intermediate care team can influence the quality of care and outcomes. The evidence on views and experiences of home-based intermediate care is exclusively from health and social care practitioners, with no evidence from other care and support practitioners from the community.

Comparative studies are needed to determine the effectiveness and cost effectiveness of different approaches to delivering home-based care and support, in terms of team skills, structure and composition. A better understanding of how these factors influence quality of care could improve outcomes for people who use home-based intermediate care.

Qualitative studies are also needed to explore the views and experiences of a wider range of care and support practitioners. This will help practitioners learn about and understand each other's roles, which will improve their delivery and quality of care.

3 Crisis response

What are the barriers and facilitators to providing an effective and cost effective crisis response service, with particular reference to different models for structuring delivery of this service?

Why this is important

There is no evidence on the effectiveness and cost effectiveness of crisis response services. The evidence that is available shows that practitioners and people using this service found the short-term support provided (up to 48 hours) too limited to address the needs of older people. It is also unclear if health and social care practitioners fully understand the purpose of the crisis response service when making referrals.

Comparative studies are needed to evaluate the different approaches to structuring the delivery of crisis response services to improve outcomes.

Cost information is also needed. This needs to be supplemented by qualitative data to explore how well the crisis response service is understood among practitioners.

4 Dementia care

How effective and cost effective is intermediate care including reablement for supporting people living with dementia?

Why this is important

Some intermediate care and reablement services support people living with dementia. However, others specifically exclude people with a dementia diagnosis, because they are perceived as being unlikely to benefit. There is limited evidence on the effectiveness and cost effectiveness of using intermediate care and reablement to support people with dementia.

There is no evidence on the views and experiences of people living with dementia, their family and carers, or health, social care and housing practitioners, in relation to the support they receive from intermediate care and reablement services.

Comparative effectiveness and cost-effectiveness studies are needed to evaluate the different approaches to delivering support to people with dementia. This will help to ensure that both a person's specialist dementia needs and their intermediate care and reablement needs are accommodated in the most effective way. The studies should include a comparison of care provided by a specialist dementia team with that provided by a generalist team; and access versus no access to memory services. These need to be supplemented with qualitative studies that report the views and experiences of people living with dementia, their family and carers, and practitioners.

5 Reablement

How effective and cost effective are repeated periods of reablement, and reablement that lasts longer than 6 weeks?

Why this is important

The evidence that reablement is more effective than home care at improving people's outcomes is based on data from 1 period of reablement. In current practice, people can use reablement repeatedly. There is no evidence on the outcomes and costs for people who use reablement more than once.

In addition, there is no peer-reviewed study that measures the impact of different durations of reablement for different population groups. This is important because in practice, reablement is funded for up to 6 weeks only. However, some people are offered reablement for a period of more than 6 weeks based on their identified needs. At present there is very limited knowledge about the costs and outcomes of reablement as provided to different population groups, and the optimal duration for these groups.

Longitudinal studies of a naturalistic design with a control group are needed to follow up people who have received reablement several times or over a longer period than 6 weeks, or both.

Comparative studies are also needed to understand the long-term impact of duration on costs and patient outcomes, by comparing 6-week reablement services with services that last longer than 6 weeks.

6 A single point of access for intermediate care

How effective and cost effective is introducing a single point of access to intermediate care?

Why this is important

There is evidence that poor integration between health and social care is a barrier to successfully implementing intermediate care. A management structure that has a single point of access can help to improve communication between teams and speed up referral and access to services.

Comparative studies are needed to evaluate the effectiveness and cost effectiveness of introducing a management structure that has a single point of access versus a structure with no single point of access. This will help to reduce the length of time from referral to receipt of intermediate care.

7 Duration and intensity of home-based intermediate care

How effective and cost effective are different approaches, in terms of duration and intensity, to providing home-based intermediate care for adults?

Why this is important

There is some evidence that people who used home-based intermediate care found their care ended too suddenly at 6 weeks, and poor communication compounded this negative perception. The optimal time limit can differ depending on people's health and care and support needs.

Studies of comparative designs are needed to assess the effectiveness and cost effectiveness of different intensities and durations of home-based intermediate care for people with a range of care needs.

8 Support for black and minority ethnic groups

How effective and cost effective are different approaches to supporting people from black and minority ethnic groups using intermediate care?

Why this is important

Addressing the cultural, language and religious needs of black and minority ethnic groups can remove some of the barriers to accessing support services. There is no evidence on the effectiveness and cost effectiveness of intermediate care in supporting people from black or minority ethnic groups to access intermediate care and reablement.

Comparative effectiveness and cost-effectiveness studies are needed to evaluate 'what works' in terms of planning and delivering intermediate care for minority groups. This includes all 4 service models of intermediate care. Qualitative data are needed on the views and experiences of people from black and minority ethnic groups, their family, carers, practitioners and voluntary support groups to inform the development of a service that meets the needs of this population.

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07480 615 47



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