NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION

SUMMARY REPORT

1 Quality standard title

Intermediate care including reablement

Date of quality standards advisory committee post-consultation meeting:
8 May 2018.

2 Introduction

The draft quality standard for intermediate care including reablement was made available on the NICE website for a 4-week public consultation period between 12 March and 11 April 2018. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 22 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the quality standards advisory committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the committee as part of the final meeting where the committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the committee should read this summary alongside the full set of consultation comments, which are provided in appendix 1.

3 Questions for consultation

Stakeholders were invited to respond to the following questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be to be for these to be put in place?

3. Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.

4. For draft quality statement 2: We have focussed the statement on adults who have already been accepted for bed-based intermediate care. This ensures we are only promoting and measuring speed of access to the service in adults where the initial referral is appropriate. However, is there a risk this potentially results in services not accepting people for bed-based intermediate care if they cannot start the service within 2 days of referral?

Local practice case studies

5. Do you have an example from practice of implementing the NICE guideline(s) that underpins this quality standard? If so, please submit your example to the NICE local practice collection on the NICE website. Examples of using NICE quality standards can also be submitted.

4 General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

- There was general support for the quality standard and the areas identified for quality improvement although some additional areas were also highlighted as a priority.
- Definitions of intermediate care and reablement
  - Clear definitions are needed as there is local variation in the type of services identified as intermediate care and reablement and therefore still some misunderstanding about what is included.
  - The definitions should emphasise that intermediate care is a multidisciplinary service.
- There was some confusion about whether the quality standard includes all intermediate care services or just bed-based services.
- Some statements reflect basic practice and should already be achieved.
- Statements should include carers.
- Outcome measures should include people under 65 years.
- The quality standard should recognise how primary care services will be provided e.g. in care homes or if the person is still a mental health hospital patient.
- All statements should acknowledge that support should be adapted to meet the person’s individual circumstances e.g. culture, religion.

Consultation comments on data collection

- It was confirmed that the National Audit of Intermediate Care will remain as the main data source until the Community Services Data Set (CSDS) can be

developed to capture relevant data. It may not be possible to include all the required data in the CSDS.

- Currently local systems may not be in place to record the data for all statements but provided resources are available solutions could be developed to do this.
- As intermediate care may be embedded within wider health and social care services local work may be required to disentangle data for intermediate care from other functions.

Consultation comments on resource impact

- There was a general concern about a lack of sustainable funding for intermediate care services and the ability of providers to provide the level of service required.

5 Summary of consultation feedback by draft statement

5.1 Draft statement 1

Adults being assessed for intermediate care have a discussion about the support the service will and will not provide.

Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

- Statement
  - Written information should be included.
  - Make it clearer who is responsible - the referrer or the intermediate care service.
  - Wording should be more collaborative and emphasise that the person is an equal partner, for example: *"Adults being assessed for intermediate care are given clear information verbally and in writing as to what they can expect from the intermediate care / re-ablement service, and how this will support them to live the life they want for themselves."*
  - Should include more detail on the content of the discussion.
- Measures
  - A measure of satisfaction with the discussion should be included.
  - Include a measure of whether the person felt they had choice and control over the decision to enter the service.
  - A reduction in inappropriate referrals to intermediate care could be an outcome.
- Audience descriptors
  - Service providers list should include local authorities (as they directly provide reablement services in some areas).
  - Specify that information about other local services that could provide additional support should also be provided.
- Equality and diversity considerations

- People who are terminally ill should not be excluded from the service if they would benefit.
- Specify that the discussion should include a relative or carer if the person is living with cognitive impairment.

5.2 Draft statement 2

Adults accepted for bed-based intermediate care start the service within 2 days of referral.

Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

- General
  - Many areas do not have bed-based services or commission them from the private sector.
  - Statement may be challenging to achieve given the current capacity of bed-based services and will have resource implications as 7 day working is not currently the norm in many areas.
- Statement
  - It is important to specify ‘appropriate’ referrals.
  - Emphasise that the statement includes referrals for step down and step up care.
  - Should be extended to all types of intermediate care service - it is unclear why it does not apply to all intermediate care services if a person is assessed as suitable for this type of support.
- Measures
  - Data on referral and delivery times is not routinely collected in hospital or community data sets.
  - An outcome measure is needed for step up referrals e.g. hospital admissions avoided.
  - There was some uncertainty about whether delayed transfers of care from hospital is an appropriate measure as the reason codes are not subdivided by type of intermediate care service. There is local variation in the approach to measurement in different hospitals.

Consultation question 4

We have focussed the statement on adults who have already been accepted for bed-based intermediate care. This ensures we are only promoting and measuring speed

of access to the service in adults where the initial referral is appropriate. However, is there a risk this potentially results in services not accepting people for bed-based intermediate care if they cannot start the service within 2 days of referral?

Stakeholders made the following comments in relation to consultation question 4:

- Some stakeholders agreed there is a risk that people will not be accepted for bed-based intermediate care if they cannot start the service within 2 days in order to ensure services can meet the target. Others felt the risk is low.
- It was suggested that it may be helpful to include a measure of the number of referrals turned away due to being at capacity.

5.3 Draft statement 3

Adults starting intermediate care discuss and agree personal goals.

Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

- Statement
  - Goal setting begins at initial assessment so timing needs to be clear.
  - Should include reviewing goals and measurement of progress and outcomes.
  - Alternative wording suggested: *"Adults starting intermediate care have their care and support planned with them, focussing on their personal goals and what matters to them (as they describe it), and these are clearly documented and reviewed as appropriate."*
- Measures
  - A measure for staff training and competency would be helpful.
  - Data source for the process measure could be audit of care plans.
  - Include a measure of satisfaction for people using the service and their family and carers.
  - Consider including measures of the need for ongoing services such as home care and residential care following intermediate care.
  - Consider including a satisfaction measure for 'care staff provide care to support people to achieve their goals'.
- Definitions
  - The definition of personal goals should specify that goal setting is realistic, SMART and person-centred. It should include nutrition and hydration needs.

5.4 Draft statement 4

Adults using intermediate care discuss and agree a plan for when the service ends.

Consultation comments

Stakeholders made the following comments in relation to draft statement 4:

- General
  - A lack of resources in social care can make it difficult to arrange timely discharge planning meetings.
- Statement
  - Ensure the statement does not tie providers to a rigid timeframe so that the service can be extended if progress is slower or faster than expected. Alternative wording suggested: *"A clear plan should be documented and agreed with the person before they leave the intermediate care service. This should be flexible, and period adjusted (shortened or extended) according to the person's progression towards their personal goals."*
- Rationale
  - Emphasise the need for a flexible approach to discharge planning taking into account the person's progress.
- Measures
  - Consider having different measures for different types of intermediate care and reablement service and also step up and step down care because timescales differ.
- Descriptors
  - Emphasise the importance of recognising ongoing care needs as early as possible so that a co-ordinated multidisciplinary approach can be put in place.
  - Change 'to reflect **the** progress made' to 'to reflect **any** progress made' as there is no guarantee that the person will make progress.
  - Practitioners should be required to make any referrals for ongoing care before the intermediate care service ends so that the person is not left without the services they need.

6 Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements.

- Ensuring primary and secondary care practitioners are aware of intermediate care
- Holistic assessment of needs
- Response times for all intermediate care and reablement services
- Access to a multidisciplinary team
- Assigning a case manager
- How to work with the person receiving care
- Measuring outcomes of intermediate care on discharge
- Staff training and development – ability to respond to common support needs such as nutrition

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Appendix 1: Quality standard consultation comments table – registered stakeholders

ID	Stakeholder	Statement number	Comments[1]
1	Department of Health and Social Care	General	Thank you for the opportunity to comment on the draft for the above quality standard. I wish to confirm that the Department of Health and Social Care has no substantive comments to make, regarding this consultation.
2	Gerald Pilkington Associates	General	Whilst I mostly agree with four statements I feel that this standard has missed an opportunity to be relevant to all reablement services. This document appears to only 'apply' to reablement services that foirm part of an integrated service with health, yet the vast majority of reablement services are stand alone and actually provided or at least commissioned by local authorities I note that no local authority or their representative body were included in the advisory group despite the fact that they deliver or commission virtually very service across England. Even in integrated services the reablement service element is provided or funded by the local authority. The omission of input from local authorities is clearly obvious throughout the document in terms of its content, coverage and perspective.
3	Gerald Pilkington Associates	General	The briefing paper refers to various sources including SCIE and the College of OT for justification that OTs in particular must be involved in reablement services. This is a topic that I have pursued for a number of years and have raised directly with the College both directly and whilst speaking at two of their conferences. Whilst I had expected to see an added value in terms of improved outcomes and duration of benefits from services that had OTs in their team AND providing a hands-on role, there is no evidence from studies that this is the case. Two studies completed by SPRU, University of York indicate that whilst access is important for those people who need therapy input, there is no evidence that therapists need to be members of the team. Having completed operational reviews of a number of 'integrated' services, it is apparent that in many cases OTs in the team do not have sight of clients, but merely review paper referrals. I have just completed the review of two services, both of which have OTs. In the first the OTs are in a central single point of access and work with health colleagues to determine whether referrals should pass to the intermediate care team or the reablement team. Their

[1]PLEASE NOTE: Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how quality standards are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its staff or its advisory committees.

ID	Stakeholder	Statement number	Comments[1]
			involvement is purely based on referral details received and after that stage the OTs have no involvement with the clients at all unless they need community equipment or adaptations. In the second service, an OT manages some of the case managers who are the ones that actually visit the clients. The OT has no direct contact with the client at any stage. The paper from the College of OT includes a number of superstitions based on logic but no real study based evidence. The SCIE reference provided in the briefing paper refers to now out of date 'evidence' from Professor Lewin in W Australia. In April 2015 she and her team published the results of a study in which they compared the outcomes of people whose assessors were professionally qualified (nurse, therapist etc) and those who were not but trained in assessment. (HOME INDEPENDENCE PROGRAM CO-ORDINATOR (HIPC) EVALUATION FINAL REPORT, Silver Chain, Apl 2015) The outcome of that study is that the "results were found to be as good as the outcomes achieved in the HIP RCT when the service was delivered by health professionals"
4	Gerald Pilkington Associates	General	At various points throughout the briefing paper there are statements about the effectiveness and cost effectiveness of intermediate care. However, almost without exception the document uses words like "may lead to", "is likely to lead to", etc. There does not appear to be any real hard study based evidence. In fact, the studies completed by the Dept of Health back in 2005 into intermediate care showed that they often result in additional costs. This is not surprising given the basis for funding of acute care. Whilst transfer to an intermediate care setting may well be the most appropriate clinical / medical support, safest in terms of minimising hospital acquired infections, welcomed by people, etc. it can only create additional costs. Under the current systems, unless the transfer avoids charges for additional days over and above those included within the HRG, a shorter than expected length of stay does not result in a lower charge since this is a fixed price. Further, the 'released' capacity is often used by another person (quite rightly) but this generates a further charge by the hospital. Thus, if acute care manage to discharge people early by utilising intermediate care it does not result in any savings for the CCG, and without any real measures of outcomes and effectiveness, there is no evidence that this helps avoid downstream demand and costs.
5	Hull City Council	General	I have reviewed the NICE guideline published 22nd September 2017 Intermediate Care including Reablement. The document itself is clear and comprehensive in terms of what these services should aim to achieve for people it also covers how organisations and practitioners should interface with each other. It is clear to ascertain from this document the ways in which partnership working could be further integrated and embedded within practise in Hull and the advantages this would give to the citizens of Hull by operating in such a way. We are getting there but there isn't a seamless transfer of people into the community from bedded units. Presently there is a lack of therapy (Physio) for

ID	Stakeholder	Statement number	Comments[1]
			people who are already receiving long term care and support as this mainly happens at the start of the service but is not considered if someone is already receiving service. It indicates about working in a Person Centred Way which does cover empowering people to identify goals however there is nothing regarding the solution focused approach in terms of how the practitioner themselves would work with the person.
6	Royal College of Physicians	General	The RCP is grateful for the opportunity to respond to the above consultation. We would like to endorse the response submitted by the British Geriatric Society (BGS).
7	Royal College of Speech and Language Therapists	General	The RCSLT note that in the briefing paper intermediate care is defined as: ‘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.’ However, we also note that the quality standards do not include any reference to ensuring that it is a multidisciplinary service. There is research evidence that an increased number of disciplines involved in intermediate care services is associated with better patient outcomes. Furthermore, this definition is associated with all types of intermediate care service and not just those that are bed based. Quality statement 2 only applies to bed based - and we believe should be broadened to all intermediate care community services.
8	Royal College of Speech and Language Therapists	General	briefing paper 2.4 - The RCSLT believe that this paragraph should include a bullet point that states the pathway should include ‘processes for discharge or transition to other services’.
9	Royal College of Speech and Language Therapists	General	We also observe that none of the quality standards as stated include consideration of the carers of service users.
10	Royal College of Speech and Language Therapists	General	Briefing paper 4.3.1 -While we fully support the statement under ‘Multidisciplinary team’, we believe this should be further highlighted given the evidence available to support the importance of multidisciplinary teams on patient outcomes. However, we do question why is there not a quality statement associated with the above?
11	The Society for Research in Rehabilitation	General	In the briefing paper Intermediate care is defined as ‘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.’

ID	Stakeholder	Statement number	Comments[1]
			However, the quality standards do not include any reference to ensuring that it is a multidisciplinary service. There is research evidence that an increased number of disciplines involved in intermediate care services is associated with better patient outcomes. Furthermore, this definition is associated with all types of intermediate care service and not just those that are bed based. Quality statement number 2 only applies to bed based--- and should be broadened to all intermediate care community services.
12	The Society for Research in Rehabilitation	General	Briefing paper paragraph 2.4 - Should include processes for discharge or transition to other services. None of the quality standards as stated include consideration of the carers of service users.
13	The Society for Research in Rehabilitation	General	Briefing paper Section 4.3.1 I positively support the following statement: 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. This needs to be highlighted further given the evidence available to support the importance of multidisciplinary teams on patient outcomes. Why is there not a quality statement associated with the above It is not clear whether this quality statement is only applicable to those being referred for intermediate care in bed based services-- if that is the case it should be reflected in the title. If it is not then the statements should clarify why some quality statements are only applicable to those entering bed based services.
14	British Geriatrics Society	Question 1	Question 1: Does this draft quality standard accurately reflect the key areas for quality improvement? Accurate, yes. Sufficient: no. I note no standard for responsiveness of non-bed-based services has been stated. Rapid response services that do not respond rapidly are a misnomer and are unacceptable. Similarly, admission avoidance (home or bed based) intermediate care need to be accessed rapidly otherwise the patient is admitted (after all, that is what the services are there to prevent). I think the response time targets are the most important ones to specify. Reablement (by which I mean the use of home care to promote independence and hence reduce the need for long term home care (using a rehabilitation style of practice) rather than simply routine home care delivery probably just needs to have a response time target that matches the response time for home care in general.
15	British HIV Association (BHIVA)	Question 1	Q. 1 - Key areas for improvement reasonably reflected in the standard

ID	Stakeholder	Statement number	Comments[1]
16	Durham County Council	Question 1	With regards to Intermediate Care Beds it is felt that the quality standard generally reflects the key areas for quality improvement.
17	Gerald Pilkington Associates	Question 1	These standards cover issues that are more about how an effective service should operate rather than focus on quality improvement. Based on my work with integrated intermediate care services the biggest issue has been the absence of any real measures of outcomes. Services tend to measure inputs (visits, initial consultations, follow-ups, etc) but they rarely measure what difference the service has made and whether or to what extent it has achieved its objectives. In one service they purported to measure the number of cases for whom their intervention had avoided the need for hospital admission. In fact, on closer examination of their own data it became clear that something like 35% of all such cases had completed only one visit by a member of the team and that visit had lasted approximately 20 minutes to 1 hour. A joint discussion identified that these visits were to provide information and, in their absence, the person would not have been admitted to hospital – but that was the only 'measure' available on their system for people who did not require any further input.
18	NHS England	Question 1	No. A key area for quality improvement to prevent deconditioning and unwarranted hospital admission and extended hospital stay is timely access to all 4 service elements. For crisis response we believe this should be delivered within 2 hours of acceptance; for home based, bed based intermediate care and reablement delivery of service should be within 2 days of acceptance for service. Measurement of both process performance and outcome against this standard could lead to significant improvements in both avoidance of unwarranted hospital admissions and extended lengths of stay leading to reduced numbers of 7 and 21 day stranded patients and delayed transfers of care. In addition DHSC are currently seeking to ensure that a seven day service offer is available- this is not reflected explicitly in these statements.
19	Nutricia Advanced Medical Nutrition	Question 1	Is there any scope to include recommendations from supporting NICE guidelines about the holistic assessment of patients for intermediate care services (including nutritional screening)?
20	Nutricia Advanced Medical Nutrition	Question 1	In the NG74 under 1.8.2 training and development of staff – it specifically calls out nutrition training, are there plans to include training standards within this QS which are aligned with what is written in the NG74?
21	Royal College of General Practitioners	Question 1	There is no mention of who or how primary care services will be provided. If the person is still a hospital patient then they cannot register with a GP. This is often an issue with mental health patients who are moved to intermediate care and have physical health issues.

ID	Stakeholder	Statement number	Comments[1]
22	Royal College of Nursing	Question 1	We welcome the quality standard and feel that if Health and Social care services are able to implement it that it would have a significant impact on individual patient outcomes, prevent avoidable admission to secondary care and reduce the numbers of people remaining unnecessarily in hospital. We do however, have major concerns in the ability of organisations to provide the level of service required in light of the reduced numbers of community services and lack of robust sustainable funding to provide them. This is particularly relevant to question 2 in terms of numbers of beds. Many areas do not have bed based facilities or commission them from the private sector and therefore there are delays. A question that might be considered is why do the individuals need bed based facilities and could they be offered intensive intermediate care in their own place of residence, particularly if this is a care home? Commissioners need to commission for outcomes both short, medium and long to ensure that the efficacy of services can be measured effectively and this will include robust matrix to measure this. Often false expectations are raised or services are not accessed by primary and secondary practitioners because of the lack of understanding of what they provide and a fixation on 6 weeks.
23	Salford City Council	Question 1	The statements are process and output measures and don't cover outcomes. Given the purpose and nature of Intermediate Care I think there needs to be a statement/standard that reflects outcome measurement. Statement 3 around Goal setting might be useful in this context as Goals should be monitoring with changes measured. So I would ask that you consider a standard that relates to Goal Progress measurement on discharge from Intermediate Care
24	British Geriatrics Society	Question 2	Question 2 Are local systems and structures in place to collect data for the proposed quality measures? No. The discussions referred to in Statements 1, 3 & 4 are likely to be handwritten and, even if electronic, in several different recording systems. At present, this would require manual searching of these records for evidence of these discussions. At present the content of a discussion may not be recorded, but the decisions may be reported (for example a hospital record may say that a patient is being moved to an intermediate care setting, but this may not record whether there was a discussion). Oddly to outsider eyes, goals setting is surprisingly frequently not recorded but service objectives (e.g. discharge) are. In general, discussions may not be recorded. Another issue is that health and social services differ in what they call intermediate care. For example, many community hospitals were in place for decades before the term intermediate care was introduced, and so is not applied to them. A plethora of rehabilitation services arise, develop and are closed, often fulfilling the definition of intermediate care but not called this. There is widespread mis-understanding of terms such as respite care and short term care, such that defining intermediate care (and hence in whom the standards should be applied) is still problematic. Reablement is another term which seems to be rarely used in the ways in which it was originally defined. If not, how feasible would it be for these to be put in place?

ID	Stakeholder	Statement number	Comments[1]
			It should be largely possible for local communities to define which services are and are not intermediate care, although there may well be functional units (especially with integration and single points of access) where it is hard to disentangle the intermediate care functions from other functions. It will therefore require carefully thought-out local work to pick out the intermediate care from other functions of services. Again, local solutions are likely to be required to determine how and where discussions are to be recorded, and hence how they can be collated for analysis. It should be possible for each locality to agree procedures with their local IT providers for these standards to be recorded in a standard way. If the two points can be dealt with (both the numerator and the denominator) then these standard can be applied. Standard 2, entry into service is relatively easy to determine so long as the date and time of referral is recorded and the date and time of the transfer (to a bed). This can be done by the intermediate care administration team, provided there is such a thing (see above point, services providing intermediate care functions may be embedded within systems delivering wider community health and social care provision and function) and provided intermediate care functions can be defined and distinguished from other functions (respite, short term care pending ongoing care).
25	British HIV Association (BHIVA)	Question 2	Q. 2 - As far as we are aware, local data collection systems are in place
26	NHS England	Question 2	No. As suggested above the Community Services data set currently does not contain adequate data for the proposed measures. In addition there is no in hospital easily accessible data set for these measures. While the CSDS is developed measurement will at best only occur via the NAIC annually
27	British Geriatrics Society	Question 3	Q3. Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment. Yes, for 1,3 and 4 these standards reflect basic practice and should be present in 100% already. For 2, it is not yet clear. My presumption that the results of the NAIC will apply and it will not be met in many areas, and times of the year. Whether they can be met by greater efficiency and flow within bed based intermediate care (which may not require investment) or greater provision (of beds or staff or both) is not clear. My hunch is that there are efficiency gains to be had in most areas.
28	British HIV Association (BHIVA)	Question 3	Q. 3 - The draft Quality Standards are achievable by a satisfactorily-funded service
29	Durham County Council	Question 3	Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them?

ID	Stakeholder	Statement number	Comments[1]
			• Further resources would be required to deliver, manage and report on key local and strategic data required for each of the four statements in the Quality Standard. Including development of further systems, processes and protocols. • Further staffing resources may also be required to collect, manage and present the data and management information which would be required to evidence compliance with the standard. • In addition to this, compliance with the standard would potentially require further investment in service monitoring of Intermediate Care, particularly around the areas such as the agreement of personal goals, and audit of care plans / case records to evidence discussion and agreement (and review) of plans for when the service ends.
30	NHS England	Question 3	No. There is considerable variation across England evidenced in the NAIC 2017 suggesting that some areas will be significantly challenged in dehttps://www.nao.org.uk/report/reducing-emergency-admissions/livering access to services together with appropriate documentation of activity and outcomes. NAO 2018 https://www.nao.org.uk/report/reducing-emergency-admissions/ suggested that there is a requirement to double the current capacity of intermediate care services. We also estimate significant investment is required to deliver a 7 day service with access for bed, home and reablement service delivered in 2 days of acceptance.
31	British Geriatrics Society	Question 5	Question 5 Do you have an example from practice of implementing the NICE guideline that underpins this quality standard? If so, please submit your example to NICE local practice case studies on the NICE website. Examples of using NICE quality standards can also be submitted No
32	British HIV Association (BHIVA)	Statement 1	Outcome - The number or proportion of adults who have a discussion about support provided by a service is not the same as a satisfaction indicator. Satisfaction with the discussion must be measured separately
33	Durham County Council	Statement 1	Question 2 - Are local systems and structures in place to collect data for the proposed quality measures? If not how feasible would it be to put them in place? • Key data can be collected from regular quality surveys following discharge from the care home. • It would undoubtedly be useful if locally focused information on Intermediate Care Beds can be made available prior to and during the period of the Intermediate Care Bed placement. • Development of procedures and protocols would be required to highlight and underpin the importance of discussions with service users and families about the support which can and cannot be provided.
34	Gerald Pilkington Associates	Statement 1	Quality Statement - This statement should be a given but is an area that is often ignored by ICTs. Without it the people passing through and their relatives, etc will have no clear understanding of the purpose of the service and, therefore, what they can reasonably expect and NOT expect

ID	Stakeholder	Statement number	Comments[1]
35	Gerald Pilkington Associates	Statement 1	Service providers - This section ignores the operation of reablement services which are virtually all provided by or at least commissioned by local authorities and NOT health partners. Even in 'integrated' services this element is provided by or at least funded by local authorities.
36	HC-One	Statement 1	(descriptor) - Should include adults receive written information (in a suitable/accessible format)or leaflet to support discussion
37	Lancashire County Council	Statement 1	This will require some changes to process (to support the data collection), and although leaflets may be given, this does not necessarily offer assurance that a conversation took place with the person. Not necessarily a priority for us locally
38	Manchester Health and Care Commissioning	Statement 1	Adults being assessed for intermediate care have a discussion about the support the service will and will not provide. This statement would be relatively easy to measure if it is the service that collects this information not the referrer e.g. hospital discharge teams. Although there is evidence that the service produces information about what the service can and can't do hospital staff still refer people who are not appropriate for intermediate care and may not be managing expectations. Information needs to be produced to show the whole offer home based reablement and intermediate care not just bed based intermediate care. The information needs to be in clear language and shared with Adults being assessed and their carer or family. The information needs to focus on the purpose of the service and how it can assist to regain independence and focus on personal goals that are important to them and will help them to live at home avoiding hospital admission and/or residential carer admission. The service would be able to add to the existing survey a question around satisfaction of the information provided.
39	NHS Benchmarking Network on behalf of the NAIC Steering Group	Statement 1	This statement was felt to be slightly negative and paternalistic in nature. It was felt that the statement should be more collaborative in nature, with the focus being on the person and them as an equal partner on the process. Clear communication between the person, family and clinician is essential so there is clarity re expectations. An alternative statement is suggested as follows: - "Adults being assessed for intermediate care are given clear information verbally and in writing as to what they can expect from the intermediate care / re-ablement service, and how this will support them to live the life they want for themselves."
40	NHS England	Statement 1	The process for documentation of the discussion and satisfaction in the Community Services Data set may prove challenging which may in turn present difficulty in assessing the delivery of care at scale in line with this statement.
41	Royal College of Nursing	Statement 1	Adults being assessed for intermediate care have a discussion about the support the service will and will not provide: We welcome this statement and feel that as long as the criteria are clearly understood then appropriate services will

ID	Stakeholder	Statement number	Comments[1]
			be offered. They should not exclude people with dementia or people who are terminally ill if they would benefit from reablement. If people are cognitively impaired then the discussion must include a relative and or carer.
42	Royal College of Occupational Therapists	Statement 1	Clear communication between service user, family and clinician is essential so there is clarity re: expectations.
43	Royal College of Speech and Language Therapists	Statement 1	We believe it may be useful to add that it is good practice to inform those receiving intermediate care of other services (health, social and voluntary), in the locality, of which ones will provide additional assistance.
44	South West Yorkshire Foundation Partnership Trust	Statement 1	Question 2 - Feel as though this statement is achievable- we are going to be collecting to see whether patients and families/carers (if applicable) have been involved in care planning within 24 hours
45	The 25% ME Group	Statement 1	Rationale - We welcome the rationale set out in respect of discussion i.e. providing an understanding of intermediate care so that the prospective client can make an informed decision about their care. However, as regards one form of intermediate care - reablement - we are increasingly aware that local authority social services departments are not in fact acting in keeping with this principle. Far from providing prospective clients with scope to make an informed choice, many local authorities are insisting on a period of 'observation' by reablement workers as a necessary precondition before any community care will be provided. Indeed, our experience strongly suggests that this is routinely viewed as part and parcel of a 'community care assessment' - without which the person can and will be denied care. This insistence is doubly misplaced when the person concerned is not at an intermediate stage in their life situation. (Neither as defined in the briefing paper - i.e. people at risk of hospital admission or who have been in hospital - nor in terms of the slightly wider definition set out in the draft Quality Standard). In other words, the person may well not be a candidate for a reablement approach in the first place.
46	The 25% ME Group	Statement 1	Quality Measures - We note that no proposed quality measure addresses the issue of client choice and control over the decision that is reached about entering the service. Focus is simply on having a discussion and the provision of information about the service - which is no guarantee of client autonomy. This is a serious omission.
47	The Society for Research in Rehabilitation	Statement 1	It may be useful to add that it is good practice to inform those receiving intermediate care of other services (health, social and voluntary) in the locality which provide additional assistance.
48	University Hospital Birmingham NHS Foundation Trust	Statement 1	A measure of up to date information would be helpful. Paper information dates quickly and current versions are sometimes not available. Web information can also be outdated or not dated.

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49	Durham County Council	Statement 2	Quality Statement 2 stipulates a reasonable period within which the service should commence (within 2 days of referral). However, consideration needs to be given to 'surges' in demand which may lead to a shortfall in available beds, together with a potential shortfall in MDT operational staff to support the process.
50	Durham County Council	Statement 2	Are local systems and structures in place to collect data for the proposed quality measures? If not how feasible would it be to put them in place? • Key data regarding commencement within 2 days can be collected via Single Point of Access Teams or via Intermediate Care / MDT Teams based in local areas • However, the collection of further performance data could have an effect on limited staffing resources available.
51	Gerald Pilkington Associates	Statement 2	Quality Statement - Within this section and subsequent sections it refers to acceptance within 2 days of referral. However, within the briefing paper it refers to acceptance with 2 days of an 'appropriate' referral. The addition of the word is essential and it needs to be consistently used throughout the standard. However, a target of 2 days between referral and starting is high and for operational reasons may be difficult to achieve. From my work it is clear that referrals are often vague and do not include sufficient information for the receiving body to make a decision. In a recent operational review it was stated that referrers often 'cut and paste' generic phrases rather than provided specific details. This results in the need to request for further specific information.
52	Gerald Pilkington Associates	Statement 2	It would seem highly likely that there is a risk that services will not accept a case if they cannot accommodate them within 2 days as a way of 'achieving' the standard. Unfortunately services across health and social care have a history of perverse behaviour so that they appear to meet 'targets'
53	HC-One	Statement 2	(descriptor) - Will have resource implications as 7 day working is not the norm in many areas to support 2 day referral to admission to bed based IC. There are key interdependancies that also require the right level of resourcing – resourcing to care homes to ensure adequate nursing supply/and access to GP or Geriatrician expertise for care homes (for bed based care, given increasingly frailty of adults being referred. In many cases GP support is not readily available due to Primary Care being thinly spread or lacking expertise in complex ageing /community medicine. Increasingly care homes are picking up the costs of equipment (both standard and bespoke) without this being reflected in the real costs of care / this has a bigger impact in intermediate care, where the need to timely and appropriate equipment can incur additional charges based upon the lead time. In order to meet the 2 day response time , a higher turnaround charge from equipment supplier is probable , so needs to be factored into costs and benefits.
54	Lancashire County Council	Statement 2	We will need to think about how DTOC is recorded as LCC covers five acute hospitals, all of whom record DTOC differently, so data will be flawed, we will need to agree how this figure will be measured across the economy. The

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			approach is one we would support, but that will be a challenge, as the number of beds in relation to the population varies across the County, and the length of stay within these beds also varies, which will challenge us. This is the most challenging of the quality statements, for our economy, but probably the one that if achieved will have the most impact
55	Manchester Health and Care Commissioning	Statement 2	Adults accepted for bed-based intermediate care start the service within 2 days of referral. This would need additional reporting from the service. There are often delays out of Intermediate Care onto the next setting and this is being reported to commissioners which enables us to see where there might be additional pressures within the system. Commissioners will need to ensure there is sufficient capacity across the whole home based reablement and intermediate care and bed based. This would need to be included in the service specification.
56	NHS Benchmarking Network on behalf of the NAIC Steering Group	Statement 2	Agree with the aim of admission into bedded unit within 48 hours of assessment is very important given the evidence base. It is unfortunate that the statement does not also include commencement of home based and re-ablement services. The optimum window for rehabilitation surely applies to all 3 of these services (bed, home and re-ablement).
57	NHS England	Statement 2	This statement is supported and helpful to the expedient delivery of service. It is suggested that the statement includes explicit reference to step down and step up care. The recent NAIC 2017 https://www.nhsbenchmarking.nhs.uk/naic/ suggested that there has been a shift more towards use of step down care since 2015. It is important that timely access for step up care as well as step down care is emphasised to support people who might otherwise be admitted unnecessarily to hospital. Measurement of performance may prove challenging at scale and currently the NAIC only provides an annual assessment of the waiting times for intermediate care services. It is also suggested that delayed transfers of care are only a global indicator and the reason codes within this data set are not subdivided by type of intermediate care service. In addition the use of the DTOC indicator as a measure of outcome for this statement does not capture performance for step up intermediate care refer to delivery of bed based service. In addition, while acknowledging there is refer to deliver timescale recommended for reablement or home based care in NG74, it is suggested that this statement represents a missed opportunity to provide timely care for both home based and reablement care both of which also deliver positive outcomes as evidence in NAIC 2017 https://www.nhsbenchmarking.nhs.uk/naic/ in line with the stated rationale of wishing to achieve successful outcomes of reducing unnecessary hospital and care homes admission. Currently this statement may prove challenging to measure because data which captures referral and delivery times is not routinely collected in either hospitals or community data sets.

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58	Royal College of General Practitioners	Statement 2	As a GP, it is virtually impossible to access home based intermediate care, or access bed-based intermediate care for patients in the community. These standards are optimistic and do not reflect the current state of provision. Many patients are placed in bed-based intermediate care on discharge from hospital, but it is not possible to avoid the admissions in the first place as the intermediate care is usually at complete capacity. There is potential for gaming by providers, as the providers need to accept the patients for bed-based intermediate care in order to record and measure if the start of the service is within 2 days of referral. An additional or alternative outcome measure would be related to the number of referrals that are accepted as opposed to the number that are turned away due to the scheme being at capacity.
59	Royal College of Nursing	Statement 2	Adults accepted for bed-based intermediate care start the service within 2 days of referral: We welcome this statement and think its ambition is laudable, however, this standard is likely to be difficult to achieve in light of the lack of community beds and the inability of such facilities to access ongoing domiciliary care in order for people who have achieved their goals to return to their usual place of residence so resulting in delays in transfer. The lack of robust community and social care funding and resource may impact on this standard being met.
60	Royal College of Occupational Therapists	Statement 2	We agree with the aim of admission into bedded unit within 48 hours of assessment. It is unfortunate that the statement does not also include commencement of home-based and reablement services. The optimum window for rehabilitation surely applies to all 3 of these services (bed, home and reablement)?
61	Royal College of Speech and Language Therapists	Statement 2	We are unsure why this is limited to bed based services only. All intermediate care services should be available within 2 days of referral if the individual is assessed as being appropriate for this type of support.
62	Salford City Council	Statement 2	The vast majority of Intermediate Care activity takes place in the community - in peoples own home. To only have a focus on time to treatment for bed based service detracts from the main focus of Intermediate Care. So I would ask that you consider introducing a time to treatment for community based services on the basis that evidence shows delays to starting of therapy interventions leads to poorer outcome for patients.
63	The Society for Research in Rehabilitation	Statement 2	It is very unclear why this is limited to bed based services only. All intermediate care services should be available within 2 days of referral if the individual is assessed as being appropriate for this type of support.
64	University Hospital Birmingham NHS Foundation Trust	Statement 2	Specify if this is 2 calendar or working days. Relevant for service delivery at the weekend which may prevent transfer to intermediate care.

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65	British Geriatrics Society	Statement 2 - Question 4	Question 4 For draft quality statement 2: We have focussed the statement on adults who have already been accepted for bed-based intermediate care. This ensures we are only promoting and measuring speed of access to the service in adults where the initial referral is appropriate. However, is there a risk this potentially results in services not accepting people for bed-based intermediate care if they cannot start the service within 2 days of referral? I would have thought the risk is low, and only in poorly managed settings. Most likely the target will not be met. The NHS has a strong culture of rationing by waiting lists. There is another point. We know from the research studies where response was optimised for trial purposes to be rapid that hospital–at-home / early discharge forms of intermediate care reduced the number of acute bed days by perhaps 7 days on average. Thus, every day of waiting reduces the efficiency (to the point that a wait of >7 days for an “early discharge” service does the reverse). Aware of this, clinicians will tend to use alternative provision when there is a substantial waiting list if at all possible. But this would only be helped by having a standard for transfer, so as to make the great British NHS waiting list unacceptable in this instance.
66	British HIV Association (BHIVA)	Statement 2 - Question 4	Q4 - Any instances of not accepting people for bed-based care should enter the data for appropriate scrutiny
67	British HIV Association (BHIVA)	Statement 2 - Question 4	As for Q. 4, any instances of not accepting people for bed-based care should enter the data for appropriate scrutiny and subsequent service revision
68	NHS England	Statement 2 - Question 4	We believe that there is a risk of patients being delayed in referral and other measure need to be in place to ensure that timely referral is prompted. This provides opportunity for an additional quality statement to mitigate the anticipated effect of statement 2 as written. In addition we also believe that there is a risk this will be interpreted to mean only service delivery for step down care and suggest that the statement be worded to reflect the need also to deliver to this time scale for step up care.
69	British HIV Association (BHIVA)	Statement 3	Satisfactory as currently worded
70	Durham County Council	Statement 3	Are local systems and structures in place to collect data for the proposed quality measures? If not how feasible would it be to put them in place? • Under IC Beds Contract in County Durham, service users are encouraged to be as self-managing as possible, whilst working towards goals set and agreed with the service user / family on the initial goal setting form. However, it is clear that more structured systems need to be implemented to consistently collect and monitor this data

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			• This data could be collected and monitored by regular audit of care plans / case records • Audits around staff training and competency assessments may also be useful to evidence compliance and improvements in this area. • Feedback from service users and families from regular quality surveys could also be beneficial in evidencing compliance with the quality measure
71	Gerald Pilkington Associates	Statement 3	Quality Statement - This should go without saying, and the goals should be those of the person participating and not merely those of the health professional. This particularly applies within reablement but should also apply within intermediate care. How else can services fulfil their objectives which include ‘maximising independent living’
72	Lancashire County Council	Statement 3	It’s person centred – the emphasis on personal goals, moves services away from a one size fits all approach – whilst we can count the measure in the way suggested, however one of the challenges with this is how information can be aggregated up to understand if a service is successful in supporting people to meet their needs
73	Manchester Health and Care Commissioning	Statement 3	Adults starting intermediate care discuss and agree personal goals. This would require additional reporting from the service but something we expect the service to be doing already. Service protocol will be updated to include agreeing this across the 3 localities in the city. Staff will need to be trained to have the strength based conversation to ensure the plans are person centred and personal outcomes are agreed. The approach should be standard practice across the whole reablement and intermediate care offer. The measures should be outcome focused and show a reduction in Adults requiring less home care and improved independence,reduction in residential care admissions.
74	NHS Benchmarking Network on behalf of the NAIC Steering Group	Statement 3	It was felt that this was a variation on statement 1 but was presumably necessary because not everyone assessed for intermediate care is offered or accepts intermediate care / re-ablement. A person-centred approach is essential – using clear SMART goals, which are relevant to the client and therefore more likely to be achieved. One member of the NAIC Steering Group suggested that an alternative statement might be “Adults starting intermediate care have an assigned case manager and have their care discussed at a multi-disciplinary team meeting with the professionals involved in their care (before completion/ discharge from the service).” However, the NAIC currently does not ask about the assignment of case managers to patients, simply about the multi-disciplinary team that delivers the agreed care package. An alternative statement was suggested as follows: -

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			"Adults starting intermediate care have their care and support planned with them, focussing on their personal goals and what matters to them (as they describe it), and these are clearly documented and reviewed as appropriate."
75	NHS England	Statement 3	This statement is supported. However it is again suggested that the statement will prove challenging to measure except via the National Audit because of the lack of data to support measurement of the process or outcomes. It is also suggested that demonstration of achievement of personal goals may be difficult to measure unless there is direct assessment of this at patient level. In addition there are currently a range of standard outcome measures in use but these may not be directly comparable at scale were they to be included in the community services data set in due course.
76	Nutricia Advanced Medical Nutrition	Statement 3	It would be good as part of goal setting to include nutrition and hydration needs being met and built into the individual's care plan and goal setting – this is not mentioned in the draft yet
77	Royal College of Nursing	Statement 3	Adults starting intermediate care discuss and agree personal goals: We agree with this statement. No service should be commenced without a robust assessment and a realistic discussion about what the individual needs and wants to achieve and the timeframe for these goals, including their responsibility to work with the team on achieving them. An honest discussion needs to also take place if progress is slow due to lack of motivation and engagement or a deterioration in the individual's cognitive ability.
78	Royal College of Occupational Therapists	Statement 3	A person-centred approach is essential – goals are more likely to be achieved if the team starts with the person's priorities, and sets SMART goals to achieve these.
79	South West Yorkshire Foundation Partnership Trust	Statement 3	Question 2 -Going to be implementing the goal scoring system developed by Derby Hospital. Goals are also used for care planning at initial assessment.
80	The 25% ME Group	Statement 3	Definitions - We welcome many of the features set out in the definition of personal goals, notably: 'take into account the person's health and wellbeing'; 'take into account how the person is affected by their conditions or experiences'; and 'take into account the best interests and expressed wishes of the person'. However it is important that these principles are adhered to in practice.
81	The 25% ME Group	Statement 3	Quality Measures - We note that none of the proposed 'Quality Measures' gets to grips with the qualitative aspects of identifying and agreeing personal goals. Merely calculating the proportion of people who have documented personal goals [process] and the proportion who have achieved said goals [outcome], says nothing about the framing of goals in person-centred terms in the first place.
82	The 25% ME Group	Statement 3	What Statement Means – Practitioners: We agree that it is important that "Care staff ensure that they provide care to support people to achieve their goals."

ID	Stakeholder	Statement number	Comments[1]
			However none of the proposed quality measures directly addresses this feature of service delivery.
83	The 25% ME Group	Statement 3	What Statement Means - Adults starting intermediate care: Bearing in mind the ethos of goal setting provided in the definition, it is important that goals set are realistic and appropriate. Failure to recognise that ill health can and commonly does limit what a person can feasibly achieve is far from liberating, or fostering 'independence'. Such an approach may be perceived by the service user exhibiting as a lack of understanding, or even simple bullying. Therefore in our view framing this quality statement in terms of clients being supported "to plan what they want to achieve" requires to be tempered with a degree of recognition that what a person would ideally want to achieve and what they can achieve in their circumstances. Otherwise this approach can be counterproductive and emotionally damaging to the person concerned.
84	University Hospital Birmingham NHS Foundation Trust	Statement 3	Personal goals section (p12) Description of goals is very general with nothing specific about independence, return of functional skills etc. Would benefit from strengthening of language about reablement.
85	British HIV Association (BHIVA)	Statement 4	Satisfactory as currently worded. The Equality and Diversity considerations should apply to the whole standard and its different parts, not only to Statement 4
86	Durham County Council	Statement 4	Are local systems and structures in place to collect data for the proposed quality measures? If not how feasible would it be to put them in place? • There is a clear requirement for planning for discharge to be commence (in conjunction) with the service user as soon as the service commences. • However, to ensure compliance with this quality standard, it is likely that further investment in systems and processes (and staff) may be required. • Key data regarding the development and ongoing review of discharge plans could be monitored via the development of structured protocols and procedures between commissioners, operational staff and service providers, together with assessment of outcomes either directly through audit of care plans, or indirectly via feedback from quality surveys following discharge.
87	Gerald Pilkington Associates	Statement 4	Quality Statement - Again, this should go without saying. This particularly applies within reablement but should also apply within intermediate care.
88	HC-One	Statement 4	(measure and descriptor) - This is already being effected by the lack of social care staff working in pathways to have timely and regular discharge planning meetings. Where there is need for ongoing care , this need flagging and managing early on so requires a social care response even when families are trying to be proactive.

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89	Lancashire County Council	Statement 4	we can count this relatively easily, but whether it will impact, as we would be counting leaflets not conversations
90	Manchester Health and Care Commissioning	Statement 4	A plan for when the service ends This would require an agreed audit with the service which could be combined with statement 3. Currently collect discharge destination only. This would have resource implications so would need to have agreed timescales with the service such as a 6 monthly audit. Co-ordinated integrated approach across the sectors where Adults need further support. Information is made available where Adults may access support within their local community.
91	NHS Benchmarking Network on behalf of the NAIC Steering Group	Statement 4	The NAIC Steering Group felt that this was essential – often there is a time pressure to assess the person and commence service provision (taking time to clarify goals and expectations) but discharge is often rushed due to pressure for hospital discharge. Concluding service provision needs to be viewed as important as the initial assessment and service commencement. However, the NAIC Steering Group wanted to ensure that the wording of this quality statement wouldn't tie people into a rigid timeframe and prevent intermediate care from being extended if there was slower progress than expected, but still good progress towards personal goals. An alternative wording of the statement was suggested as follows: - "A clear plan should be documented and agreed with the person before they leave the intermediate care service. This should be flexible, and period adjusted (shortened or extended) according to the person's progression towards their personal goals."
92	NHS England	Statement 4	This statement is supported. Again it may currently prove challenging to measure because of lack of suitable data within the community services data set. It is also suggested that measurement of this statement should be differentiated between the 4 key service elements and by step up and step down care, as the timescales for completion of services differ and the consequences of not competing services on time are different between each element. Using a single denominator of all users of intermediate care will therefore make it difficult to assess process performance among separate elements and similarly for outcomes. It should also be noted that depending on local demography intermediate care services are used by people under the age of 65 and the outcome data source in this statement and Statement 2 may exclude younger people receiving the service
93	Royal College of Nursing	Statement 4	Adults using intermediate care discuss and agree a plan for when the service ends: We agree with this statement. An estimated date for the discharge should be identified from the start in order to manage expectations. Should the goals be achieved in advance of this date, then discharge should take pace earlier. If progress is still being made then the

ID	Stakeholder	Statement number	Comments[1]
			date could be extended. If it is anticipated that ongoing needs are likely then local arrangements must be in place for an assessment of probable needs at the earliest possible time to reduce the possibility of a delay in discharge from reablement services.
94	Royal College of Occupational Therapists	Statement 4	Discussing and agreeing a plan for when the service ends is essential. Often there is a time pressure to assess a person and commence service provision (taking time to clarify goals and expectations) but discharge is often rushed due to pressure for hospital discharge. Concluding service provision needs to be viewed as important as initial assessment and service commencement.
95	Royal College of Speech and Language Therapists	Statement 4	We believe it is essential that this is addressed at an early point in intermediate care provision. It is important that information about other services (health social and voluntary) in the locality, are provided to the service user.
96	South West Yorkshire Foundation Partnership Trust	Statement 4	Question 2 - Yes, discharge planning is completed during care plans
97	The 25% ME Group	Statement 4	Outcome Measures - We agree that client satisfaction with discharge from intermediate care should be gauged. We note that getting to grips with this requires a survey or similar mechanism, as proposed in the draft. We are concerned that meaningful evaluation on such a qualitative issue has cost implications which may prove to present a barrier to implementation of this measure.
98	The 25% ME Group	Statement 4	What Statement Means – Practitioners: The final sentence assumes that the person will have progressed. Clearly making progress is to be desired, but it is not a foregone conclusion. Please modify to read: “They review the plan before the person is discharged to reflect any progress made and/or any setbacks.”
99	The 25% ME Group	Statement 4	What Statement Means – Practitioners: We note that commissioners are asked to ensure that clear referral pathways are in place. In this regard, we strongly suggest that practitioners be required to take steps to make any referrals regarding future care and support before the period of intermediate treatment ends, and to ensure that such service is in place timeously i.e. the person is not left for a period without a necessary service on cessation on intermediate care.
100	The Society for Research in Rehabilitation	Statement 4	It is essential that this is addressed at an early point in intermediate care provision. It is important that information about other services (health social and voluntary) in the locality are provided to the service user.
101	University Hospital Birmingham NHS Foundation Trust	Statement 4	b) measure for up to date-ness of local information would be helpful

Registered stakeholders who submitted comments at consultation

- British Geriatrics Society
- British HIV Association (BHIVA)
- Department of Health and Social Care
- Durham County Council
- Gerald Pilkington Associates
- Hull City Council
- HC-One
- Lancashire County Council
- Manchester Health and Care Commissioning
- NHS Benchmarking Network on behalf of the National Audit of Intermediate Care Steering
- NHS England
- Nutricia Advanced Medical Nutrition
- Royal College of General Practitioners
- Royal College of Nursing
- Royal College of Occupational Therapists
- Royal College of Physicians
- Royal College of Speech and Language Therapists
- Salford City Council

- South West Yorkshire Foundation Partnership Trust
- The Society for Research in Rehabilitation
- The 25% ME Group
- University Hospital Birmingham NHS Foundation Trust