NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Intermediate care including reablement

NICE quality standard

Draft for consultation

March 2018

This quality standard covers referral and assessment for intermediate care and how to deliver the service. It describes high-quality care in priority areas for improvement. It does not cover rehabilitation for specific conditions.

It is for commissioners, service providers, health, public health and social care practitioners, and the public.

This is the draft quality standard for consultation (from 12 March to 11 April 2018). The final quality standard is expected to publish in August 2018.

Quality statements

Statement 1 Adults being assessed for intermediate care have a discussion about the support the service will and will not provide.

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

Statement 3 Adults starting intermediate care discuss and agree personal goals.

Statement 4 Adults using intermediate care discuss and agree a plan for when the service ends.

NICE has developed guidance and a quality standard on patient experience in adult NHS services (see the NICE pathway on patient experience in adult NHS services), which should be considered alongside these quality statements.

Other quality standards that should be considered when commissioning or providing intermediate care include:

- People's experience using adult social care services Publication expected December 2018
- Multimorbidity (2017) NICE quality standard 153
- Transition between inpatient hospital settings and community or care home settings for adults with social care needs (2016) NICE quality standard 136
- Social care for older people with multiple long-term conditions (2016) NICE quality standard 132
- Home care for older people (2016) NICE quality standard 123

A full list of NICE quality standards is available from the quality standards topic library.

Questions for consultation

Questions about the quality standard

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

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

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? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.

Questions about the individual quality statements

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?

Local practice case studies

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

Quality statement 1: Discussion about intermediate care

Quality statement

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

Rationale

Adults who are being assessed for intermediate care (and their family and carers as appropriate) should understand what intermediate care is and what it can and cannot achieve. This will enable them to make informed decisions about their care and encourage them to engage with the rehabilitation process. It will also enable them to consider any further support they may need in addition to intermediate care.

Quality measures

Structure

a) Evidence that information about the support provided by the local intermediate care service is available.

Data source: Local data collection, for example locally tailored booklets or pamphlets.

b) Evidence of local processes to ensure that adults being assessed for intermediate care have a documented discussion about the support the service will and will not provide.

Data source: Local data collection, for example service protocol.

Process

Proportion of adults being assessed for intermediate care who have a documented discussion about the support the service will and will not provide.

Numerator – the number in the denominator who have a documented discussion about the support the service will and will not provide.

Denominator – the number of adults being assessed for intermediate care.

Data source: Local data collection, for example audit of electronic case records.

Outcome

a) Level of satisfaction among adults assessed for intermediate care with information provided about the service.

Data source: Local data collection, for example survey of adults assessed for intermediate care.

b) Level of awareness of the support the service provides among families and carers of adults assessed for intermediate care.

Data source: Local data collection, for example carer survey.

What the quality statement means for different audiences

Service providers (such as hospitals, community services, care homes, home care agencies and voluntary sector organisations) ensure that staff have the knowledge and information they need to have a discussion with adults who are being assessed for intermediate care about the support the service will and will not provide. Service providers ensure that processes are in place for staff to record that the discussion took place.

Health and social care practitioners (such as nurses, discharge coordinators, social workers and allied health professionals) ensure that, when they carry out an assessment for intermediate care, they give information and have a discussion with the person about the support it will and will not provide. They also ensure that family and carers are given information and included in the discussion as appropriate. They should provide information in a suitable format to meet individual needs and record that the discussion took place.

Commissioners (such as clinical commissioning groups and local authorities) ensure that services assessing adults for intermediate care have processes in place so that staff give information and have a discussion with the person (and their family and carers as appropriate) about the support that will and will not be provided. Commissioners may want to ensure that information is available about the full range

of local intermediate care services, because people may move between services if their support needs change.

Adults being assessed for intermediate care have a discussion with their care team about the type of support that this service will and will not provide. Their family and carers should also be involved in the discussion if appropriate. Clear information (such as a booklet or leaflet) should be provided about what care is available. This discussion will help the person to make decisions about their care and to work with the intermediate care service so that they can benefit as much as possible.

Source guidance

Intermediate care including reablement (2017) NICE guideline NG74, recommendations 1.1.5, 1.5.1 and 1.5.2.

Definitions of terms used in this quality statement

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. [NICE's guideline on intermediate care including reablement, 'terms used in this guideline' section]

Equality and diversity considerations

Service providers should 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.

Discussions about the support provided by intermediate care may need to be adapted to meet the needs of people living with cognitive impairment, including dementia, and their family and carers.

Quality statement 2: Starting bed-based intermediate care

Quality statement

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

Rationale

Delays in starting bed-based intermediate care can increase the risk of further deterioration in the person's condition and lead to reduced independence. If the move to bed-based intermediate care takes longer than 2 days it is likely to be less successful and could lead to unnecessary admissions to hospital or residential care.

Quality measures

Structure

Evidence of local arrangements to ensure that bed-based intermediate care can be started within 2 days of referral.

Data source: Local data collection, for example referral pathways and service protocol.

Process

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

Numerator – the number in the denominator who start the service within 2 days of referral.

Denominator – the number of adults accepted for bed-based intermediate care.

Data source: Local data collection, for example audit of electronic case records. The NHS Benchmarking Network National Audit of Intermediate Care includes data on waiting times for bed-based intermediate care.

Outcome

a) Rate of delayed transfer of care from hospital for adults.

Data source: Data on average number of delayed transfers of care from hospital per 100,000 population are available from NHS Digital's Clinical Indicators as part of the clinical adult social care outcomes framework – indicator 2c.

b) Proportion of discharges from bed-based intermediate care to acute hospital.

Data source: Local data collection, for example audit of electronic case records. The NHS Benchmarking Network National Audit of Intermediate Care includes destination on discharge for adults admitted to bed-based intermediate care.

c) Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement or rehabilitation services.

Data source: Data on the proportion of older people (aged 65 and over) who, after a period of reablement or rehabilitation, maintain their independence by remaining or returning to their home or previous residence 91 days after leaving hospital are available from the NHS Digital's Clinical Indicators as part of the NHS outcomes framework – indicator 3.6.i.

What the quality statement means for different audiences

Service providers (such as hospitals, community services, care homes and voluntary sector organisations) ensure that processes are in place for adults to start bed-based intermediate care within 2 days of referral. This may require a coordinated approach to demand management across local hospital and intermediate care services, for example through a single point of access for referrals.

Healthcare professionals (such as nurses and allied health professionals) ensure that adults accepted for bed-based intermediate care start the service within 2 days of referral.

Commissioners (such as clinical commissioning groups and local authorities) commission bed-based intermediate care services with sufficient capacity to ensure that adults can start the service within 2 days of referral. Commissioners also ensure that there is an efficient approach to demand management for intermediate care services, for example through a single point of access for referrals. Commissioners monitor waiting times for bed-based intermediate care.

Adults who are having bed-based intermediate care to help their recovery are able to start this within 2 days of being referred. This will help them to regain their independence as soon as possible.

Source guidance

Intermediate care including reablement (2017) NICE guideline NG74, recommendation 1.5.3.

Definitions of terms used in this quality statement

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. 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). [NICE's guideline on intermediate care including reablement, 'terms used in this guideline' section]

Equality and diversity considerations

Bed-based intermediate care service providers should not exclude people based on whether they have a particular condition, such as dementia, or live in particular circumstances, such as prison, residential care or temporary accommodation.

Question for consultation

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?

Quality statement 3: Personal goals

Quality statement

Adults starting intermediate care discuss and agree personal goals.

Rationale

Involving people in identifying and agreeing their goals for intermediate care will help to ensure that the care is person-centred and focused on their individual strengths and preferences. Setting personal goals will also encourage the person to be engaged in their care and promote independence.

Quality measures

Structure

a) Evidence of local arrangements to ensure that staff carrying out assessments for intermediate care are trained to discuss and agree personal goals with adults starting the service.

Data source: Local data collection, for example competency assessments.

b) Evidence of local processes to ensure personal goals are documented and shared with the person starting intermediate care, their family and carers if appropriate, and care staff.

Data source: Local data collection, for example service protocol.

Process

Proportion of adults starting intermediate care who have documented personal goals.

Numerator – the number in the denominator who have documented personal goals.

Denominator – the number of adults starting to use intermediate care.

Data source: Local data collection, for example audit of electronic case records.

Outcome

a) Proportion of adults discharged from intermediate care who achieved their personal goals.

Data source: Local data collection, for example audit of electronic case records. The NHS Benchmarking Network National Audit of Intermediate Care asks if the intermediate care goals set on admission for the person using the service were achieved.

b) Proportion of adults discharged from intermediate care with an improved level of independence.

Data source: Local data collection, for example audit of electronic case records. The NHS Benchmarking Network National Audit of Intermediate Care collects data on dependency levels based on the Modified Barthel Index for bed-based services and the Sunderland Community Scheme for home-based and reablement services.

What the quality statement means for different audiences

Service providers (such as hospitals, community services, care homes, home care agencies and voluntary sector organisations) ensure that processes are in place to discuss and agree personal goals with adults starting intermediate care, and their family and carers as appropriate. Providers ensure that personal goals are documented and shared with the person, their family and carers as appropriate, and staff providing care. Providers ensure that the care provided supports people to achieve their goals.

Health and social care practitioners (such as nurses, social workers, allied health professionals, and care staff) ensure that they discuss and agree personal goals with adults starting intermediate care, and their family and carers as appropriate. They give a copy of the agreed personal goals, in a suitable format, to the person, their family and carers as appropriate, and staff providing care. Care staff ensure that they provide care to support people to achieve their goals.

Commissioners (such as clinical commissioning groups and local authorities) commission intermediate care services that have processes in place to discuss, agree, document and share personal goals for adults starting to use the service.

Commissioners ensure that providers monitor whether personal goals are achieved and levels of dependency both at the start of the service and on discharge.

Adults starting intermediate care are supported by the care team to plan what they want to achieve – their personal goals. They are given a copy of their agreed goals in a format that suits them. Agreeing clear goals will help them to work towards improving their independence. Their family and carers may also be involved in helping them to agree goals and supporting them to achieve these goals.

Source guidance

Intermediate care including reablement (2017) NICE guideline NG74, recommendation 1.5.10.

Definitions of terms used in this quality statement

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. [NICE's guideline on intermediate care including reablement, 'terms used in this guideline' section]

Personal goals

Personal goals to optimise independence and wellbeing should:

- be 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.

[NICE's guideline on intermediate care including reablement, recommendations 1.1.1 and 1.5.10]

Quality statement 4: A plan for when the service ends

Quality statement

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

Rationale

An agreed plan for when the intermediate care service ends will help to ensure that the person's specific needs are met, facilitate successful transfers to other services and reduce the likelihood of hospital admission. Planning for discharge from intermediate care should begin as soon as the person starts using the service and the plan should be reviewed before discharge to reflect the progress made.

Quality measures

Structure

a) Evidence of local referral pathways between intermediate care and statutory, independent and voluntary services.

Data source: Local data collection, for example a directory of services that includes referral criteria and processes.

b) Evidence of local information about where adults leaving intermediate care can get support.

Data source: Local data collection, for example locally tailored booklet, pamphlet or website.

c) Evidence of local processes to ensure that adults using intermediate care discuss and agree a plan for when the service ends.

Data source: Local data collection, for example service protocol.

Process

a) Proportion of adults using intermediate care who have a documented agreed plan for when the service ends.

Numerator – the number in the denominator who have a documented agreed plan for when the service ends.

Denominator – the number of adults using intermediate care.

Data source: Local data collection, for example audit of electronic case records.

b) Proportion of adults using intermediate care whose plan for when the service ends was reviewed before discharge.

Numerator – the number in the denominator whose plan for when the service ends was reviewed before discharge.

Denominator – the number of adults using intermediate care.

Data source: Local data collection, for example audit of electronic case records.

Outcome

a) Rate of emergency readmissions to hospital within 30 days of discharge from hospital into reablement or rehabilitation services

Data source: Local data collection, for example audit of service user records. Data on all emergency readmissions within 30 days of discharge from hospital are available from the NHS Digital's Clinical Indicators as part of the clinical commissioning group outcomes indicator set – indicator 3.2.

b) Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement or rehabilitation services.

Data source: Data on the proportion of older people (aged 65 and over) who, after a period of reablement or rehabilitation, maintain their independence by remaining or returning to their home or previous residence 91 days after leaving hospital are available from the NHS Digital's Clinical Indicators as part of the NHS outcomes framework – indicator 3.6.i.

c) Satisfaction of adults with their discharge from intermediate care.

Data source: Local data collection, for example survey of people discharged from intermediate care.

What the quality statement means for different audiences

Service providers (such as hospitals, community services and care homes) ensure that processes are in place so that adults using intermediate care, and their family and carers as appropriate, are involved in developing and agreeing a clear plan for when the service ends. Providers ensure that staff are aware of local referral pathways to other statutory, independent and voluntary services, and have access to information about local sources of support for adults leaving intermediate care. Providers ensure that the agreed plan is documented and shared with the person (and their family and carers as appropriate) and that it is reviewed before discharge to reflect the progress made.

Health and social care practitioners (such as nurses, social workers and allied health professionals) involve adults using intermediate care, and their family and carers as appropriate, in developing a plan for when the service ends, and ensure that the plan is agreed and documented. They provide a copy of the plan in a suitable format to the person (and their family and carers as appropriate). They review the plan before the person is discharged to reflect the progress made.

Commissioners (such as clinical commissioning groups and local authorities) ensure that specifications for intermediate care services include agreeing a clear plan for when the service ends with adults using the service (and their family and carers as appropriate), documenting and sharing the plan, and reviewing the plan before discharge. Commissioners ensure that there is coordinated information about local services that can provide support after intermediate care ends, and that clear referral pathways are in place.

Adults using intermediate care are involved in developing and agreeing a plan for any support they may need once the service ends. Their family and carers may also be involved in developing the plan if appropriate. The plan might include moving to another service if they need to, information about other types of support available locally, and information about how to ask for intermediate care in the future if they need help again. The plan should be clear and easy to understand, and should be

agreed and a copy given to them. It should be checked to make sure it is still relevant before they are discharged. This plan will help to ensure that they can remain as independent as possible once intermediate care ends.

Source guidance

Intermediate care including reablement (2017) NICE guideline NG74, recommendation 1.7.2.

Definitions of terms used in this quality statement

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. [NICE's guideline on intermediate care including reablement glossary]

Plan for when the service ends

The plan for when the intermediate care service ends should be documented, and include:

- information about how the person can refer themselves back into the service if their needs or circumstances change
- contact details for the service they are being referred to (if appropriate)
- a contingency plan should anything go wrong
- information about other sources of support available, including support for carers.

[NICE's guideline on intermediate care including reablement, recommendations 1.7.1, 1.7.2 and 1.7.3]

Equality and diversity considerations

Individual cultural and religious needs should be taken into account when identifying options for ongoing support services following intermediate care.

About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision-making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about how NICE quality standards are developed is available from the NICE website.

See quality standard advisory committees on the website for details of standing committee 2 members who advised on this quality standard. Information about the topic experts invited to join the standing members is available on the quality standard's webpage.

This quality standard will be included in the NICE Pathway on intermediate care including reablement, which brings together everything we have said on intermediate care including reablement in an interactive flowchart.

NICE has produced a quality standard service improvement template to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and

Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Improving outcomes

This quality standard is expected to contribute to improvements in the following outcomes:

- health-related quality of life
- social care-related quality of life
- length of hospital stay
- delayed transfer of care from hospital
- hospital readmissions
- admissions to residential care.

It is also expected to support delivery of the Department of Health and Social Care outcome frameworks:

- Adult social care outcomes framework 2016–17
- NHS outcomes framework 2016–17
- Public health outcomes framework for England, 2016–19.

Resource impact

NICE quality standards should be achievable by local services. The potential resource impact is considered by the quality standards advisory committee, drawing on resource impact work for the source guidance. Organisations are encouraged to use the resource impact report and template for the NICE guideline on intermediate care including reablement to help estimate local costs.

Diversity, equality and language

During the development of this quality standard, equality issues were considered and equality assessments are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

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