

Intermediate care including reablement

Quality standard

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This standard is based on NG74.

This standard should be read in conjunction with QS153, QS136, QS132, QS123, QS174 and QS182.

Quality statements

The quality statements cover all intermediate care service models unless a specific type of service is identified.

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 personalised goals.

Statement 4 Adults using intermediate care services discuss and agree a transition plan for when their support 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. NICE quality standard 182](#)
- [Multimorbidity. NICE quality standard 153](#)
- [Transition between inpatient hospital settings and community or care home settings for adults with social care needs. NICE quality standard 136](#)
- [Social care for older people with multiple long-term conditions. NICE quality standard 132](#)
- [Home care for older people. NICE quality standard 123](#)

A full list of NICE quality standards is available from the [quality standards topic library](#).

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

Healthcare professionals in hospitals or the community who are assessing people for intermediate care should have a discussion, provide information and ensure that the person (and their family and carers, as appropriate) understand what intermediate care is and what it can and cannot achieve. This will ensure that people are involved in making decisions about their care and encouraged 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, leaflets or booklets or pamphlets tailored to local services.

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

Numerator – the number in the denominator who have a record of a 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 records.

Outcome

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

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

What the quality statement means for different audiences

Service providers (such as hospitals, community providers, local authorities, care homes, home care agencies and not-for-profit social enterprises) ensure that staff carrying out assessments for intermediate care have the knowledge and materials to provide information and have a discussion with the person (and their family and carers, as appropriate) 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, trusted assessors, social workers and allied health professionals) ensure that, when they carry out an assessment for intermediate care, they give up-to-date information and have a discussion with the person (and their family and carers, as appropriate) about the support the service will and will not provide. 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 for staff to give information and have a discussion with the person (and their family and carers as appropriate) about the support the service will and will not provide. Commissioners should ensure that information is available about the full range of local intermediate care services, so that people know what options they have.

Adults being assessed for intermediate care discuss with their care team the type of support the service will and will not provide. Their family and carers should be involved if appropriate. Clear information (such as a leaflet or booklet) 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 to gain as much benefit from the service as possible.

Source guidance

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

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

Discussion about the support the service will and will not provide

The discussion should include:

- the aims and objectives of intermediate care, in particular, that it is designed to support them to live more independently, achieve their own goals and have a better quality of life
- any options for intermediate care services in different settings locally
- how the intermediate care service works and the support it will and will not provide
- information about other resources in the local community that can provide support
- how to get further information.

[[NICE's guideline on intermediate care including reablement](#), recommendations 1.3.4, 1.5.1 and 1.5.2]

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. Healthcare professionals should ensure that the person living with cognitive impairment is supported by a relative or carer or an advocate (as appropriate) to ensure involvement in the discussion.

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 from hospital or the community takes longer than 2 days it is likely to be less successful and could lead to admissions to hospital or residential care that could have been avoided.

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 from hospital and the community and service protocols.

Process

a) Proportion of adults accepted for bed-based intermediate care from hospital 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 from hospital.

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

b) Proportion of adults accepted for bed-based intermediate care from the community 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 from the community.

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

c) Proportion of referrals for bed-based intermediate care that were not accepted due to insufficient capacity.

Numerator – the number in the denominator that were not accepted due to insufficient capacity.

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

Data source: Local data collection, for example, audit of referral records. The [NHS Benchmarking Network National Audit of Intermediate Care](#) includes data on reasons for not being accepted onto the scheme including a lack of capacity.

Outcome

a) Rate of unplanned hospital admissions for chronic ambulatory care sensitive conditions.

Data source: Data on unplanned hospital admissions for chronic ambulatory care sensitive conditions are available from [NHS Digital's Clinical Indicators](#) as part of the NHS outcomes framework – indicator 2.3i.

b) 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 adult social care outcomes framework – indicator 2c.

c) Proportion of discharges from bed-based intermediate care to acute hospital or residential care.

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

d) Proportion of people who were still at home 91 days after discharge from hospital into reablement or rehabilitation services.

Data source:Local data collection, for example, audit of case records. 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 [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 providers, care homes and not-for-profit social enterprises) have processes in place to ensure that adults start bed-based intermediate care within 2 days of referral from hospital or the community. This may require a coordinated approach to manage demand for intermediate care across local hospital and intermediate care services, for example, through a single point of access for referrals.

Health and social care practitioners (such as nurses and allied health professionals) ensure that adults accepted for bed-based intermediate care start the service within 2 days of referral from hospital or the community.

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 from hospital or the community. Commissioners ensure that they manage demand for intermediate care services efficiently, 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. NICE guideline NG74 (2017), 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 healthcare professionals or care staff (in care homes) as part of a multidisciplinary team. [[NICE's guideline on intermediate care including reablement, terms used in this guideline section](#)]

Within 2 days of referral

Within 48 hours of receipt of the referral. [[NICE's guideline on intermediate care including reablement, recommendation 1.5.3](#)]

Equality and diversity considerations

Providers of bed-based intermediate care 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.

Quality statement 3: Personalised goals

Quality statement

Adults starting intermediate care discuss and agree personalised 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 personalised goals will also encourage the person to be engaged in their care and promote independence. Personalised goals should be reviewed regularly.

Quality measures

Structure

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

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

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

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

Process

a) Proportion of adults starting intermediate care who have a record of a discussion to agree personalised goals.

Numerator – the number in the denominator who have a record of a discussion to agree personalised goals.

Denominator – the number of adults starting intermediate care.

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

b) Proportion of adults starting intermediate care who have documented personalised goals.

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

Denominator – the number of adults starting intermediate care.

Data source: Local data collection, for example, audit of care plans.

Outcome

a) Satisfaction of adults discharged from intermediate care that the service supported them to achieve their personalised goals.

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

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

Data source: Local data collection, for example, audit of electronic 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 providers, local authorities, care homes, home care agencies and not-for-profit social enterprises) ensure that processes are in

place to discuss and agree personalised goals with adults starting intermediate care, and their family and carers as appropriate. Providers ensure that personalised 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 and that their personalised goals are reviewed regularly.

Health and social care practitioners (such as nurses, social workers, allied health professionals, and care staff) ensure that they discuss and agree personalised goals with adults starting intermediate care, and their family and carers as appropriate. They give a copy of the agreed personalised goals, in a suitable format, to the person, their family and carers as appropriate, and staff providing care. Health and social care practitioners ensure that personalised goals are reviewed regularly and 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 personalised goals for adults starting to use the service. Commissioners ensure that providers review personalised goals regularly and monitor whether goals are achieved, including 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 personalised 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. Personalised goals should be regularly reviewed.

Source guidance

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

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

Personalised goals

Personalised 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]

Equality and diversity considerations

Individual cultural and religious needs should be taken into account when discussing and agreeing personalised goals for intermediate care.

Discussions about personalised goals for intermediate care may need to be adapted to meet the needs of people living with cognitive impairment, including dementia, and their family and carers. Healthcare professionals should ensure that the person living with cognitive impairment is supported by a relative or carer or an advocate as appropriate.

Quality statement 4: Transition plan

Quality statement

Adults using intermediate care services discuss and agree a transition plan for when their support ends.

Rationale

An agreed transition plan for when support from the intermediate care service ends will help to ensure that a person's specific needs are met, transfers to other services are successful and the likelihood of hospital admission is reduced. Transition planning should begin as soon as a person starts using the intermediate care service. The transition plan should be reviewed before discharge to reflect any 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, a booklet or website with information about local services.

c) Evidence of local processes to ensure that adults using intermediate care services discuss and agree a transition plan for when their support ends.

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

Process

a) Proportion of adults starting to use intermediate care services who have a record of a discussion to agree a transition plan for when their support ends.

Numerator – the number in the denominator who have a record of a discussion to agree a transition plan for when their support ends.

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

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

b) Proportion of adults starting to use intermediate care services who have a documented transition plan for when their support ends.

Numerator – the number in the denominator who have a documented transition plan for when their support ends.

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

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

c) Proportion of adults discharged from intermediate care whose transition plan for when their support ends was reviewed before discharge.

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

Denominator – the number of adults discharged from intermediate care.

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

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

Data source:Local data collection, for example, audit of case records. 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 [NHS Digital's Clinical Indicators](#) as part of the NHS outcomes framework – indicator 3.6.i.

c) Satisfaction of adults with their transition 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 providers, local authorities, care homes, home care agencies and not-for-profit social enterprises) ensure that processes are in place for adults starting to use intermediate care services, and their family and carers as appropriate, to be involved in developing and agreeing a clear transition plan for when their support ends. Providers ensure that staff are aware of local referral pathways to other statutory, independent and voluntary services, and can access information about local sources of support for adults leaving intermediate care. Providers ensure that the agreed transition plan is documented and shared with the person (and their family and carers as appropriate) and that it is reviewed before discharge to reflect any progress made.

Health and social care practitioners (such as nurses, social workers and allied health professionals) involve adults starting to use intermediate care services, and their family and carers as appropriate, in developing a transition plan for when their support ends. They 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) and review the plan before the person is discharged to reflect any progress made.

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

Adults starting to use intermediate care services are involved in developing and agreeing a plan for any support they may need once their support ends. Their family and carers may also be involved if this is appropriate. The transition plan might include moving to another service, and should include information about other types of support available locally and how to ask for intermediate care in the future. The plan should be clear and easy to understand, and a copy should be given to the person. It should be checked before they are discharged to make sure it is still relevant. The transition plan should help to ensure that they can remain as independent as possible after intermediate care.

Source guidance

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

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

Transition plan

The transition plan should be documented, and include:

- information about how the person can refer themselves back into the intermediate care service if their needs or circumstances change
- contact details for the service they are being referred to or any services that are restarting (if appropriate)
- information about potential costs of any ongoing social care services
- 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, and expert opinion]

Equality and diversity considerations

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

Discussions about a transition plan for when support from the intermediate care service ends may need to be adapted to meet the needs of people living with cognitive impairment, including dementia, and their family and carers. Healthcare professionals

should ensure that the person living with cognitive impairment is supported by a relative or carer or an advocate as appropriate.

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 our [webpage on quality standard advisory committees](#) 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 from the [webpage for this quality standard](#).

This quality standard has been included in the [NICE Pathway on intermediate care including reablement](#), which brings together everything we have said on a topic 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
- carer quality of life
- independence, choice and control over daily 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](#)
- [NHS outcomes framework](#)
- [Public health outcomes framework for England](#)
- [Quality framework for public health.](#)

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 for this quality standard](#) 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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Endorsing organisation

This quality standard has been endorsed by The Department of Health and Social Care, as required by the Health and Social Care Act (2012)

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- [British Geriatrics Society](#)
- [NHS Benchmarking](#)
- [Royal College of Occupational Therapists \(RCOT\)](#)
- [Association of Directors of Adult Social Services](#)
- [Royal College of General Practitioners \(RCGP\)](#)