

Intermediate care including reablement

Consultation on NICE Guideline (SCWAVE0709)

Ref: 1417

Date: May 2017

All rights reserved. Third parties may only reproduce this paper or parts of it for academic, educational or research purposes or where the prior consent of Age UK has been obtained for influencing or developing policy and practice.

Name: Jake Beech
Email: jake.beech@ageuk.org.uk

Age UK
Tavis House
1-6 Tavistock Square
London WC1H 9NA
T 0800 169 80 80 **F** 020 3033 1000
E policy@ageuk.org.uk
www.ageuk.org.uk

Age UK is a charitable company limited by guarantee and registered in England (registered charity number 1128267 and registered company number 6825798). The registered address is Tavis House 1-6 Tavistock Square, London WC1H 9NA.

The National Institute for Health and Care Excellence (NICE) is currently developing a guideline on 'Intermediate care and reablement'. Intermediate care is split into several areas and this guideline covers the topics of crisis response, home-based intermediate care, bed-based intermediate care and reablement. These collectively aim to help people:

- Safely return home from hospital.
- Effectively recover after their stay.
- Regain their independence.
- Avoid future readmissions.
- Avoid the need for residential or nursing care.

The finished guideline is due to be published in October 2017 and as part of the development process, stakeholders have been invited to comment on the draft (available online [here](#)). Age UK welcomes this guideline as a positive contribution to improving older people's recovery and reablement outside of hospital and in raising the standard of support available to them in the community.

Key points and recommendations

Age UK's detailed comments can be seen in the NICE proforma below. Key points from our response include:

- Recognising the importance of the third sector in providing and complementing intermediate care services.
- Acknowledging how the transition home from hospital can be a useful point for assessing a broad spectrum of needs to not just promote better outcomes in care but in wellbeing, financial security and independence as well.
- Reiterating the different types of outcomes and goals older people might have regarding intermediate care and how service providers can support these most effectively.
- Stressing how vital the 'two day waiting standard' is for older people in achieving good care outcomes and the efficient use of healthcare resources.
- Reiterating the importance of striking the right balance mitigating risk with encouraging self-management and promoting independence.

Age UK's comments

Comment number	Document (full version, short version or the appendices)	Page number Or ' general ' for comments on the whole document	Line number Or ' general ' for comments on the whole document	Comments
1	Short	General	General	Age UK welcomes the opportunity to comment on this draft guideline. We believe that good intermediate care and related care strategies are essential to enabling many older people to improve their health and wellbeing, and to maintain or regain their independence.
2	Short	2	Information Box	In the bulleted list outlining who the guidance is for, we would encourage the explicit inclusion of the community

				<p>and voluntary sector. In our joint report <i>Untapped Potential</i> (Richmond Group of Charities, 2015), we outlined the evidence behind the growing role for the voluntary sector in health and care. Age UK and others in the sector are offering more and more in the way of services and support to our communities. For example, the 'Home from Hospital' programmes delivered by some of our local Age UKs provide support for older people in settling back in to their homes and readjusting after a trip to hospital. The service takes the form of support with day to day tasks that a person might initially struggle with such as shopping or picking up prescriptions. It also involves some elements of informal social activity and very light-touch supervision with the aim of improving confidence and wellbeing. Having this available after a hospital discharge can make a difference to an older person during the early stages of the reablement process, complementing the intermediate care frameworks outlined in this guidance. We therefore feel this type of contribution can be acknowledged at this point in the guidance.</p>
3	Short	4	7	<p>We recommend adding a third bullet in this section that reads 'builds on existing support structures around the patient including families, friends and carers'. This expands upon the collaborative aspects of the previous bullet point and reflects the different groups involved in a person's care and with a shared interest in achieving their outcomes and goals.</p>
4	Short	5	6	<p>We would like to amend this line to read 'focus on building the person's confidence, resilience and emotional reserves'. Building confidence is an important aspect of reablement but it must occur alongside the development of emotional resilience and similar types of emotional reserve. These characteristics broadly speak to a person's ability to adapt and manage in the face of adverse circumstances. This might be the initial crisis that began the process leading to intermediate care or it may be the many smaller challenges associated with recovery. Having the right support in developing emotional resilience can be an important factor in sustaining independence and avoiding relapse. Guidelines NG32 and PH16 are relevant to this aspect of intermediate care. NG32 for example recommends guidelines users be aware of the signs of declining mental wellbeing and be proactive in helping combat when it occurs. This could either be through signposting or by commissioning social wellbeing services depending on who is using the guideline.</p> <p>For some older people, more psychologically-based approaches may be required to build the resilience needed for recovery. The report, <i>Investing in emotional and psychological wellbeing for patients with long-term conditions</i> (2012) produced by the NHS Confederation Mental Health Network presents the case for commissioning services to address the secondary effects of living with physical impairments. Through a series of case studies and their evaluations, it outlines the beneficial results mental health support strategies can have in improving physical health outcomes across a range of conditions. Many of the lessons and good practice, particularly, related to CBT, are applicable to intermediate care and reablement.</p>

5	Short	6	1-4	Within the bulleted list on page 6, we would like to see 'Ensure benefits of care are sustainable' added. It is vital that recovery and reablement is achieved in a lasting way for an older person. This prompt should encourage guideline users to consider how their delivery of intermediate care can guarantee stable, lasting recovery beyond the care period. This might include signposting to other services or promoting self-care. These points are covered in more detail in our other comments.
6	Short	6	20-22	Regarding point 1.2.4, we would recommend including examples of the types of 'advocacy service' that are relevant as a prompt for those using the guideline. For example, many older people may find that they or their carers are newly entitled to certain welfare benefits in light of their changed care needs. Attendance and Carers' allowance very often go unclaimed (<i>Agenda for Later Life</i> , Age UK, 2015) and have the potential to make a large difference to a person's life during the intermediate care period and beyond. Voluntary sector organisations like Age UK and many others in the field can provide support and advice in accessing these entitlements. More generally, around £3.7 billion of benefits go unclaimed by people of state pension age each year (<i>Agenda for Later Life</i> , Age UK, 2015). This is especially important given the fact that ONS <i>Households Below Average Income</i> data for 2015/16 suggests that 1.9 million pensioners are now living below the poverty line. Having intermediate care professionals signpost to advocacy services can be important in making every contact count. This may help unlock historically unclaimed financial support as well as new entitlements. Additional health and care costs can make it very difficult for an older person to cope if they are already struggling financially so it is vital to maximise the support available.
7	Short	6	5	Regarding section 1.2 and related to the point above, we feel that assessment for intermediate care is a natural point at which a person's other needs can be assessed. For example, if there are no current social care arrangements (either formal or informal) in place, then an assessment should determine whether they are now needed. If care is in place, the assessment should aim to decide if existing arrangements are adequate in light of changing circumstances. For many older people, recovery can only happen if there is good carer support in place, with opportunities for respite breaks. Incorporating a recommendation encouraging users (commissioners, healthcare practitioners) to develop or enable holistic assessments would help ensure intermediate care follows a more person-centred approach that cuts across needs.
8	Short	7	27	1.3.1 should state 48 hours rather than 'two working days '. If a two day standard is to be implemented, then it must be equally valid at weekends and during holidays as it is during work days. The <i>2015 National Audit of Intermediate Care</i> highlights the importance of the absolute two day standard at all times, both in terms of patient wellbeing and cost effectiveness. It finds that, 'seven day services are essential if intermediate care is to make an impact on admission avoidance'. Similarly, we agree with the authors of the audit on their conclusion that 'waiting times are a key measure of

				accessibility and are particularly important for older people who may deteriorate rapidly whilst waiting for an intermediate care service in an acute bed'. We therefore firmly believe that this guideline should recommend that providers seek to secure consistent two day standards at all times.
9	Short	8	1	Regarding the section on 'planning the person's intermediate care', we feel there should be greater acknowledgement of the need to strike the right balance between risk mitigation and independence, i.e. maximising people's autonomy and wellbeing while also supporting their health and recovery. This balance will obviously vary based on the wishes and needs of the individual. As such, we would like to echo the recommendation in NICE Guideline NG27, <i>Transition between inpatient hospital settings and community or care home settings for adults with social care needs</i> , that all staff involved in the hospital discharge process (and, in the case of this guideline, those involved in intermediate care) receive training in 'helping people to manage risks effectively so that they can still do things they want to do' and learn to develop a 'risk enablement' mindset.
10	Short	8	5	<p>Line 5 here should be changed to read 'assess and promote the person's ability to self-manage'. This clarifies the point that intermediate care should work to support self-management as one of its objectives. Similar to the third point of recommendation 1.1.5, we agree that enabling personally fulfilling self-management, even if sometimes challenging, can support the wellbeing and recovery of older people. In addition to this, there is evidence that self-management, if correctly supported, can also reduce overall reliance on services (Panagioti et al, <i>Self-management support interventions to reduce health care utilisation without compromising outcomes: a systematic review and meta-analysis</i>, BMC Health Services Research 2014;14:356, 2014).</p> <p>In our 2010 report with the Richmond Group, <i>How to deliver high-quality, patient-centred, cost-effective care: Consensus solutions from the voluntary sector</i>, we outlined what we believe to be some of the core pillars for support that enables effective self-management. This includes personalised action plans, structured education or information, access to trained specialist advice and emotional, psychological or practical support. When planning intermediate care, services that work through these principles should be factored in and made available to promote and enable self-management and care. As we state in the report, these can increasingly be delivered by joining up health, care and voluntary sector organisations.</p> <p>However, we stress that supporting 'self-management' should not be used as a justification to withhold services or care that a person may need.</p>
11	Short	10	3	We are concerned about the point which advises intermediate care goals 'are aligned with the remit of the service'. This runs contrary to the idea of person-centred care. We feel there is a danger of creating a 'one-size fits all' mentality where the person must fit the service and not vice versa. This is especially noticeable

				given the following recommendation (1.3.13) which states that 'participation in social and leisure activities are legitimate goals of intermediate care' which we fully support and will often go beyond what most services offer by default. A person's goals must be the starting point for a person's care plan and the latter should take account of, but not be dictated by, what is available.
12	Short	10	1-17	Add 'Update and refer back to care goals regularly and as circumstances change' as an additional recommendation.
13	Short	12	14-20	<p>Add final bullet 'shared values for care'. These values should reflect those contained within the <i>NHS Constitution for England</i>, including:</p> <ul style="list-style-type: none"> 1. Working together for patients. 2. Respect and dignity. 3. Commitment to quality of care. 4. Compassion. 5. Improving lives. 6. Everyone counts. <p>We feel the addition of a bullet point about 'shared values' would again reiterate the importance of values-based approaches when providing services.</p>
14	Short	14	1	<p>Amend this statement to 'Common conditions, such as diabetes; complications arising from multimorbidity; mental health and neurological conditions, including dementia; loss of personal reserves such as frailty; physical and learning disabilities; and sensory loss'. Regarding frailty, we recommend the definition and arrangements we outlined with the British Geriatrics Society in <i>Fit for Frailty</i> (2014) which we do not consider covered by default in the statement <i>as is</i>. The definition has been included in NICE Guideline NG16, <i>Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset</i>, as follows:</p> <p>'Frailty typically means a person is at a higher risk of a sudden deterioration in their physical and mental health. Frailty is distinct from living with 1 or more long-term conditions or disabilities, although there may be overlaps in their management.'</p>
15	Short	14	1-9	Add bullet 'obligations around mental capacity, consent and compliance, including decisions to be made under the Mental Capacity Act 2005'.