Intermediate care including reablement

NICE guideline

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Your responsibility

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

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

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

Contents

Overview

This guideline covers referral and assessment for intermediate care and how to deliver the service. Intermediate care is a multidisciplinary service that helps people to be as independent as possible. It provides support and rehabilitation to people at risk of hospital admission or who have been in hospital. It aims to ensure people transfer from hospital to the community in a timely way and to prevent unnecessary admissions to hospitals and residential care.

Who is it for?

- Health and social care practitioners who deliver intermediate care and reablement in the community and in bed-based settings

- Other practitioners who work in voluntary and community services, including home care, general practice and housing

- Health and social care practitioners in acute inpatient settings

- Commissioners and providers

- Adults using intermediate care and reablement services, and their families and carers

Recommendations

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

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

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

1.1 Core principles of intermediate care, including reablement

1.1.1 Ensure that intermediate care practitioners:

- develop goals in a collaborative way that optimises independence and wellbeing

- adopt a person-centred approach, taking into account cultural differences and preferences.

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

- other agencies

- people using the service and their families and carers.

1.1.3 Intermediate care practitioners should:

- work in partnership with the person to find out what they want to achieve and understand what motivates them

- focus on the person's own strengths and help them realise their potential to regain independence

- build the person's knowledge, skills, resilience and confidence

- learn to observe and guide and not automatically intervene, even when the person is struggling to perform an activity, such as dressing themselves or preparing a snack

- support positive risk taking.

1.1.4   Ensure that the person using intermediate care and their family and carers know who to speak to if they have any questions or concerns about the service, and how to contact them.

1.1.5   Offer the person the information they need to make decisions about their care and support, and to get the most out of the intermediate care service. Offer this information in a range of accessible formats, for example:

- verbally

- in written format (in plain English)

- in other accessible formats, such as braille or Easy Read

- translated into other languages

- provided by a trained, qualified interpreter.

1.2   Supporting infrastructure

1.2.1   Consider making home-based intermediate care, reablement, bed-based intermediate care and crisis response all available locally. Deliver these services in an integrated way so that people can move easily between them, depending on their changing support needs.

1.2.2   Ensure that intermediate care is provided in an integrated way by working towards the following:

- a single point of access for those referring to the service

- a management structure across all services that includes a single accountable person, such as a team leader

- a single assessment process

- a shared understanding of what intermediate care aims to do

- an agreed approach to outcome measurement for reporting and benchmarking.

1.2.3   Contract and monitor intermediate care in a way that allows services to be flexible and person centred. For recommendations on delivering flexible services, see NICE's guideline on home care.

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

- the service and what it involves

- how it differs from other services

- the ethos of intermediate care, specifically that it aims to support people to build independence and improve their quality of life

- that intermediate care is free for the period of delivery.

1.2.5   Ensure that mechanisms are in place to promote good communication within intermediate care teams. These might include:

- regular team meetings to share feedback and review progress

- shared notes

- opportunities for team members to express their views and concerns.

1.2.6   Ensure that the intermediate care team has a clear route of referral to and engagement with commonly used services, for example:

- general practice

- podiatry

- pharmacy

- mental health and dementia services

- specialist and longer-term rehabilitation services

- housing services

- voluntary, community and faith services

- specialist advice, for example around cultural or language issues.

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

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

1.2.9   Ensure that intermediate care teams include a broad range of disciplines. The
core team should include practitioners with skills and competences in the
following:

- delivering intermediate care packages

- nursing

- social work

- therapies, for example occupational therapy, physiotherapy and speech and language
therapy

- comprehensive geriatric assessment.

1.3   Assessment of need for intermediate care

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

1.3.1   Assess people for intermediate care if it is likely that specific support and
rehabilitation would improve their ability to live independently and they:

- are at risk of hospital admission or have been in hospital and need help to regain
independence **or**

- are living at home and having increasing difficulty with daily life through illness or
disability.

1.3.2   Do not exclude people from intermediate care based on whether they have a
particular condition, such as dementia, or live in particular circumstances, such
as prison, residential care or temporary accommodation.

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

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

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

1.4   Referral into intermediate care

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

1.4.1   Consider providing intermediate care to people in their own homes wherever practical, making any adjustments, for example equipment or adaptations, needed to enable this to happen.

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

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

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

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

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

- the cause of the deterioration has been identified

- their support can be safely managed in their own home or care home

- the need for more detailed medical assessments has been addressed.

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

- the service and what it involves

- how it differs from other types of intermediate care

- how to refer to the service.

1.5   *Entering intermediate care*

1.5.1   Discuss with the person the aims and objectives of intermediate care and record
         these discussions. In particular, explain clearly:

- that intermediate care is designed to support them to live more independently, achieve
  their own goals and have a better quality of life

- that intermediate care works with existing support networks, including friends, family
  and carers

- how working closely together and taking an active part in their support can produce
  the best outcomes.

1.5.2   When a person starts using intermediate care, give their family and carers:

- information about the service's aims, how it works and the support it will and will not
  provide

- information about resources in the local community that can support them

- opportunities to express their wishes and preferences, alongside those of the person
  using the service

- opportunities to ask questions about the service and what it involves.

1.5.3   For bed-based intermediate care, start the service within 2 days of receiving an appropriate referral. Be aware that delays in starting intermediate care increase the risk of further deterioration and reduced independence.

Crisis response

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

1.5.5   As part of the assessment process, ensure that crisis response services identify the person's ongoing support needs and make arrangements for the person's ongoing support.

1.5.6   Establish close links between crisis response and diagnostics (for example, GP, X-ray or blood tests) so that people can be diagnosed quickly if needed.

Person-centred planning

1.5.7   When planning the person's intermediate care:

- assess and promote the person's ability to self-manage

- tell the person what will be involved

- be aware that the person needs to give consent for their information to be shared

- tell the person that intermediate care is a short-term service and explain what is likely to happen afterwards.

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

- assessing the risks associated with the person carrying out particular activities, including taking and looking after their own medicines

- assessing the risks associated with their environment

- balancing the risk of a particular activity with the person's wishes, wellbeing, independence and quality of life.

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

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

1.5.9   Complete and document a risk plan with the person (and their family and carers, as appropriate) as part of the intermediate care planning process. Ensure that the risk plan includes:

- strategies to manage risk; for example, specialist equipment, use of verbal prompts and use of support from others

- the implications of taking the risk for the person and the member of staff.

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

Agreeing goals

1.5.10   Discuss and agree intermediate care goals with the person. Make sure these goals:

- are based on specific and measurable outcomes

- take into account the person's health and wellbeing

- reflect what the intermediate care service is designed to achieve

- reflect what the person wants to achieve both during the period in intermediate care, and in the longer term

- take into account how the person is affected by their conditions or experiences

- take into account the best interests and expressed wishes of the person.

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

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

1.6   Delivering intermediate care

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

1.6.2   Review people's goals with them regularly. Adjust the period of intermediate care depending on the progress people are making towards their goals.

1.6.3   Ensure that staff across organisations work together to coordinate review and reassessment, building on current assessment and information. Develop integrated ways of working, for example, joint meetings and training and multidisciplinary team working.

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

1.6.5   Ensure that an intermediate care diary (or record) is completed and kept with the person. This should:

- provide a detailed day-to-day log of all the support given, documenting the person's progress towards goals and highlighting their needs, preferences and experiences

- be updated by intermediate care staff at every visit

- be accessible to the person themselves, who should be encouraged to read and contribute to it

- keep the person (and their family and carers, as appropriate) and other staff fully informed about what has been provided and about any incidents or changes.

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

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

1.7   Transition from intermediate care

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

1.7.2   Ensure good communication between intermediate care staff and other agencies. There should be a clear plan for when people transfer between services, or when the intermediate care service ends. This should:

- be documented and agreed with the person and their family or carers

- include contact details for the service

- include a contingency plan should anything go wrong.

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

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

1.8   Training and development

1.8.1   Ensure that all staff delivering intermediate care understand:

- the service and what it involves

- the roles and responsibilities of all team members

- how it differs from other services

- the ethos of intermediate care, specifically that it aims to support people to build independence

- how to work collaboratively with people to agree person-centred goals

- positive risk taking.

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

- common conditions, such as diabetes; mental health and neurological conditions, including dementia; frailty; stroke; physical and learning disabilities; sensory loss; and multi-morbidity

- common support needs, such as nutrition, hydration, continence, and issues related to overall skin integrity

- common support needs, such as dealing with bereavement and end of life

- deterioration in the person's health or circumstances.

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

1.8.3   Provide intermediate care staff with opportunities for:

- observing the work of another member of staff

- enhancing their knowledge and skills in relation to delivering intermediate care

- reflecting on their practice together.

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

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

- optimise recovery

- take control of their lives

- regain as much independence as possible.

Terms used in this guideline

Bed-based intermediate care

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

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

Crisis response

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

Home-based intermediate care

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

Home care

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

Intermediate care

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

Person-centred approach

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

Positive risk taking

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

Reablement

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

For other social care terms see the Think Local, Act Personal Care and Support Jargon Buster.

Putting this guideline into practice

NICE has produced <u>tools and resources</u> to help you put this guideline into practice.

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

- Ensuring an integrated approach to intermediate care. Currently, the 4 service models of intermediate care tend to operate separately, delivered by different staff and funded from different budgets. Moving to a more integrated approach for planning, funding and delivery of all 4 models, including transferable assessments that are accepted across all services, would improve the experience for people using the services. However, such changes may be difficult to achieve.

- Starting bed-based intermediate care services within 2 days (and crisis response within 2 hours) of receiving an appropriate referral. Rapid provision of the right intermediate care service will benefit people using the services, and may help reduce pressure on hospital beds. However, this approach will prove challenging in light of the current financial pressures and demands on the services.

- Making sure the aims, objectives and purpose of intermediate care are understood by people using the services, their families, and professionals from the wider health and social care system. There is currently a lack of understanding that the term 'intermediate care' includes intermediate care services funded by the healthcare system and reablement services funded by social care. In addition, there is low awareness that active rehabilitation or reablement is quite different from ongoing care and support.

- Developing leadership that promotes clarity of purpose and good communication within each service, and provides guidance and support to staff. This leadership will help staff working in intermediate care services to deliver a service focused on enabling and supporting independence, and optimising wellbeing.

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

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

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

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

1. **Raise awareness** through routine communication channels, such as email or newsletters, regular meetings, internal staff briefings and other communications with all relevant partner organisations. Identify things staff can include in their own practice straight away.

2. **Identify a lead** with an interest in the topic to champion the guideline and motivate others to support its use and make service changes, and to find out any significant issues locally.

3. **Carry out a baseline assessment** against the recommendations to find out whether there are gaps in current service provision.

4. **Think about what data you need to measure improvement** and plan how you will collect it. You may want to work with other health and social care organisations and specialist groups to compare current practice with the recommendations. This may also help identify local issues that will slow or prevent implementation.

5. **Develop an action plan**, with the steps needed to put the guideline into practice, and make sure it is ready as soon as possible. Big, complex changes may take longer to implement, but some may be quick and easy to do. An action plan will help in both cases.

6. **For very big changes** include milestones and a business case, which will set out additional costs, savings and possible areas for disinvestment. A small project group could develop the action plan. The group might include the guideline champion, a senior organisational sponsor, staff involved in the associated services, finance and information professionals.

7. **Implement the action plan** with oversight from the lead and the project group. Big projects may also need project management support.

8. **Review and monitor** how well the guideline is being implemented through the project group. Share progress with those involved in making improvements, as well as relevant boards and local partners. Taking part in the National Audit of Intermediate Care (NAIC) will help to provide a benchmark for measuring progress and will add to the national data on intermediate care.

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

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

Context

The NHS and social care sectors are experiencing unprecedented pressure due to increasing demand from people living longer, often with complex needs or impairments and 1 or more long-term conditions. Admission to hospital and delays in hospital discharge can create significant anxiety, physical and psychological deterioration, and increased dependence. Multidisciplinary services that focus on rehabilitation and enablement can support people and their families to recover, regain independence, and return or remain at home.

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

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

- bed-based intermediate care

- home-based intermediate care

- crisis response

- reablement.

These services are for adults aged 18 years or over and are delivered in a range of settings, such as:

- community settings, including:

  - people's own homes

  - temporary accommodation

  - specialist housing, such as sheltered, warden-supported or extra care housing

  - supported living housing (including shared lives schemes)

  - day centres

- residential and nursing care homes

- dedicated intermediate care and reablement facilities

- acute, community and day hospitals

- prisons.

The concept of intermediate care was developed by the Department of Health in 2000 in their NHS Plan and implemented in England through their National Service Framework for Older People. Reablement specifically received policy support in 2010 when it was recognised as a means of prolonging or regaining independence.

The Care and Support White Paper subsequently announced the transfer of funds from the NHS Commissioning Board to local councils in 2013–14. Most recently, NHS commissioners and local authorities have been required, via the Better Care Fund and the NHS Five Year Forward View, to take a more integrated approach to planning by pooling budgets to support models of integrated care and support, including reablement and intermediate care. The Care Act 2014 requires that services, including intermediate care, should consider how person-centred support is planned to promote individual wellbeing.

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

The intermediate care pathway

Local areas may take different approaches to configuring their intermediate care service depending on existing resources and team structures, but the pathway should always include the following functions (described in more detail in the recommendations):

- **Assessing the need for intermediate care** – this includes gathering information about the person and deciding which intermediate care setting is most appropriate. If the person is in hospital, their assessment may include developing goals to include in the referral to the intermediate care team. If the person is at home the assessment may be completed by a social worker, community nurse, crisis response team, or community social care occupational therapist.

- **Acceptance by the intermediate care service** – an individual plan is then developed by the intermediate care team, based on the person's assessment. Goals are agreed with the person and then reviewed regularly. The plan should contain enough information so that staff visiting the person and providing their rehabilitation know what needs to be done.

- **Delivery of the service** – this should always be based on the agreed plan, and if problems arise then support staff should be able to contact the assessing practitioner in the intermediate care team.

- **A formal review** – this should be undertaken as the person approaches achieving their goals with a clear plan for transition from the intermediate care service. If the person has ongoing support needs there may be a handover to a new home care provider or day service. If the person has achieved their desired level of independence the plan may include information about how to refer themselves back into the service if they need to, and links to community services that can support them.

More information

To find out what NICE has said on topics related to this guideline, see our web page on adult social care.

Recommendations for research

The guideline committee has made the following recommendations for research.

1 Optimal time between referral and starting intermediate care

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

Why this is important

Recommendation 1.5.3 states that for bed-based intermediate care, the service should start within 2 days of a referral being received. There is moderate-quality evidence to suggest that if the referral is made from acute care then the person's condition will begin to deteriorate if intermediate care does not start within 2 days. There is no clear evidence about the most effective timescale for people whose referral is being made in different circumstances, for example if they are at home and being referred for home-based intermediate care or reablement to prevent hospital admission or improve independence.

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

2 Team composition for home-based intermediate care

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

Why this is important

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

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

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

3 Crisis response

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

Why this is important

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

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

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

4 Dementia care

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

Why this is important

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

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

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

5 Reablement

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

Why this is important

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

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

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

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

6 A single point of access for intermediate care

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

Why this is important

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

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

7 Duration and intensity of home-based intermediate care

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

Why this is important

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

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

8 Support for black and minority ethnic groups

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

Why this is important

Addressing the cultural, language and religious needs of black and minority ethnic groups can remove some of the barriers to accessing support services. There is no evidence on the

effectiveness and cost effectiveness of intermediate care in supporting people from black or minority ethnic groups to access intermediate care and reablement.

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

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