

## Factsheet 76

# Intermediate care and reablement

May 2018

### About this factsheet

This factsheet explains the referral and assessment process for intermediate care including reablement. These terms describe short-term NHS and social care support that aims to help you:

- avoid unnecessary admission to hospital
- be as independent as possible after an unplanned hospital stay or illness
- remain living at home if due illness or disability, you are having increasing difficulty with daily life
- avoid moving permanently into a care home before you really need to.

This type of support is free for up to six weeks.

The information in this factsheet is correct for the period May 2018 to April 2019.

The information in this factsheet is applicable in England. Please contact Age Cymru, Age Scotland or Age NI for their version of this factsheet. Contact details can be found at the back of this factsheet.

# Contents

<b>1</b>	<b>What is intermediate care?</b>	<b>3</b>
<b>2</b>	<b>What types of support may be available?</b>	<b>3</b>
2.1	Intermediate care offers free, time-limited support	3
<b>3</b>	<b>Referral into intermediate care</b>	<b>4</b>
<b>4</b>	<b>When might intermediate care be appropriate?</b>	<b>5</b>
4.1	Alternative to hospital admission	5
4.2	Support timely discharge from hospital	5
4.3	Facing a permanent move into residential care	5
4.4	End of life care	6
<b>5</b>	<b>Access to intermediate care and reablement</b>	<b>6</b>
<b>6</b>	<b>Relevant legislation and guidance</b>	<b>7</b>
	Age UK	8
	Support our work	8

## 1 What is intermediate care?

Intermediate care is a specific type of *short term* care, usually involving collaboration between health and social care, to help you realise your potential to be as independent as possible. It is available to anyone aged 18 or over but more usually offered to older people, with the aim of:

- avoiding unnecessary hospital admission, or
- helping you become as independent as possible after a hospital stay, or
- helping you remain living at home if due to illness or disability, you are having increasing difficulty with daily life, or
- preventing a premature, permanent move into residential care.

## 2 What types of support may be available?

There are four types of intermediate care:

**Crisis response** – offers an assessment and possibly short-term care (typically less than 48 hours) if there is an urgent increase in your needs that can be safely managed at home or by a short stay in a care home.

**Home-based intermediate care** – provides services at home, or in a care home if that is where you normally live, delivered by a multidisciplinary team but most commonly by health professionals, such as nurses and therapists.

**Bed-based intermediate care** – offers support mainly from health professionals in a community hospital or care home.

**Reablement** – offers services at home from specially trained social care staff. Rather than undertaking tasks for you, staff work with you to enable you to do things yourself and re-learn skills you may have lost while unwell, and so recover your ability to live safely at home. To meet all your needs, it may mean reablement runs alongside home care.

### 2.1 Intermediate care offers free, time-limited support

Support is time-limited and may involve moving from one type of intermediate care to another. It normally lasts no longer than six weeks and can be as little as 1-2 weeks, if staff believe that is what you need to reach agreed goals. It is expected local authorities will be flexible with time frames as in some cases, it may take a bit longer than six weeks to reach your goals. Intermediate care services must be free for the first six weeks or if the agreed timescale is less than six weeks, for that period. While a local authority has the power to charge if it extends beyond six weeks, it has discretion to extend provision of free services.

Before the end of the agreed period, staff should carry out assessments to see if you are likely to make further progress. If this is unlikely, they will carry out a needs assessment to identify if you need long term support. For information see factsheet 41, *How to get care and support*.

### 3 Referral into intermediate care

At the outset, staff must consider your physical and mental health needs and assess whether, with this type of support now, you have potential to improve your ability to live independently. If staff have concerns about your ability to give consent or work towards goals, they must act in your best interests. They should talk to you and where appropriate your family and explain their findings. If they have doubts about your ability to benefit, they should give reasons. If unhappy with their decision, you could consider asking for a second opinion.

#### People living with dementia

An admission to hospital or prolonged stay in the emergency department can be traumatic if you have dementia, due to the noisy environment and stress of separation from familiar people, places and routines.

If staff are considering whether you would benefit from intermediate care, it is important they involve professionals with experience of people living with dementia. They can help clarify how dementia affects you and how well you would understand and remember techniques to, for example, improve your mobility or help you safely carry out tasks of daily living.

#### Developing and working towards goals

If the assessment shows you have potential to live more independently, which may mean you are able to continue to live in your preferred place, staff decide on the most appropriate care setting and refer you to the intermediate care team.

Their staff work in partnership with you to develop goals based on assessment information - taking account of what you can do, what you have difficulty with and things that matter to you and would make a difference to your independence and quality of life. You can involve your family or those significant to you, if you want to, or seek support from an advocate. Goal setting will:

- Be specific, measurable and realistic. Goals may relate to improving your mobility, changing safely from a sitting to a standing position, using stairs or carrying out *activities of daily living* such as washing and dressing, preparing a simple meal or may relate to leisure or social engagement.
- Consider what input or services would help you achieve your goals and manage any identified risks. It might involve providing equipment, support from a physiotherapist and help with personal care. You then agree a time frame within which you would hope to reach your goals.

Staff should draw up a care and support plan, regularly review your goals and progress with you, making written adjustments to your support package or the time frame, as appropriate. They should give you contact details of a named person to speak to with any questions or concerns. Before being discharged from intermediate care, you should have an assessment to find out if you need long term support.

## 4 When might intermediate care be appropriate?

Staff may consider intermediate care as a stage in your overall care. As well as helping you maximise your independence, they may use it to identify your need for longer term support after an accident or illness.

### 4.1 Alternative to hospital admission

#### Crisis response

This aims to prevent unnecessary hospital admission and may be considered if you become ill at home or a fall results only in minor injury.

It requires there to be a dedicated team for the GP, out-of-hours doctor, district nurse, ambulance crew or emergency department staff to contact. The team - made up of nurses, occupational therapists and other specialist staff - can promptly assess your needs and if they can be safely managed outside hospital, can arrange appropriate services at short notice. Typically this is at home for less than 48 hours but possibly up to 72 hours. If necessary, it can be a temporary stay in a care home. During this time, health and social care staff can follow up and decide what further support you need.

### 4.2 Support timely discharge from hospital

Having assessed your needs as part of the discharge process, staff can refer you to the intermediate care team if they believe you have the potential to benefit, once you no longer need to be on an acute hospital ward. This could mean reablement, home-based or bed-based intermediate care.

### 4.3 Facing a permanent move into residential care

If a permanent move into residential care looks likely and you have not spent time on a ward dedicated to providing rehabilitation services, staff should consider referring you to the intermediate care team. Having an assessment away from a busy acute hospital ward is likely to give a more realistic picture of your needs and potential to return home.

It is not generally recommended that patients move directly from an acute hospital ward to a permanent place in a care home unless there are exceptional circumstances.

Exceptional circumstances can include:

- completion of specialist rehabilitation, such as that offered on a stroke unit
- sufficient attempts have been tried to support you at home (with or without an intermediate care package) in the past
- judgement that a short period of intermediate care in a residential setting followed by a move to a different care home is likely to be distressing.

## Note

If you have significant or complex needs, or staff are proposing a permanent place in a nursing home as the best option, they should consider your eligibility for NHS continuing healthcare (NHS CHC).

Ask if they have completed, or intend to complete, the NHS CHC Checklist tool. This indicates whether you should have a full assessment to decide NHS CHC eligibility. They should only consider a full assessment once your longer-term needs are clear, so intermediate care may be appropriate after a positive Checklist.

If you are eligible for NHS CHC, the NHS is responsible for agreeing and funding your on-going care package. See factsheet 20, *NHS continuing healthcare and NHS-funded nursing care*.

## 4.4 End of life care

Intermediate care can be appropriate if there are specific goals that you or your carer could meet in a limited time. This might be to establish a suitable home environment and routine or for your partner to develop specific skills that mean you can be cared for at home.

## 5 Access to intermediate care and reablement

If you, or a relative, are in one of the situations described in section 4 and believe you or they could benefit from intermediate care, speak to the person responsible for your care.

This could be paramedics who attend you at home, your GP or an out-of-hours doctor, social worker, emergency department staff or hospital discharge staff. They should know the services available, criteria for making a referral and how to make one.

If you are in hospital, you may wish to discuss this type of support as early as possible, with staff responsible for your discharge.

Availability of the four types of intermediate care varies across England and in many areas, demand can outstrip supply. There may be an overall lack of supply or waits of several days before reablement and home-based and bed-based intermediate care can start.

If you believe you or a family member would benefit from intermediate care and it is not on offer, speak to the person responsible for your care. If after further discussion, you are unhappy with the support being offered, you could consider making a complaint. Staff can tell you how to complain, who to complain to and how to get independent practical support and advice to make your complaint.

For information see factsheet 66, *Resolving problems and making a complaint about NHS care* or factsheet 59, *How to resolve problems and making a complaint about social care* (if it relates to reablement).

## 6 Relevant legislation and guidance

The following documents support information in this factsheet.

**NICE guidance NG74 *Intermediate care including reablement*  
September 2017**

[www.nice.org.uk/guidance/ng74](http://www.nice.org.uk/guidance/ng74)

**The Care Act 2014**

[www.legislation.gov.uk/ukpga/2014/23/contents/enacted](http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted)

**The Care and Support (*Preventing Needs for Care and Support*)  
Regulations 2014**

[www.legislation.gov.uk/uksi/2014/2673/pdfs/uksi\\_20142673\\_en.pdf](http://www.legislation.gov.uk/uksi/2014/2673/pdfs/uksi_20142673_en.pdf)

**The Care and Support (*Charging and Assessment of Resources*)  
Regulations 2014**

[www.legislation.gov.uk/uksi/2014/2672/contents/made](http://www.legislation.gov.uk/uksi/2014/2672/contents/made)

**Care and Support Statutory Guidance issued under the Care Act  
2014**

[www.gov.uk/guidance/care-and-support-statutory-guidance](http://www.gov.uk/guidance/care-and-support-statutory-guidance)

***Intermediate Care: Halfway Home: Updated Guidance for the NHS  
and Local Authorities. DH, 2009.***

[http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/@pg/documents/digitalasset/dh\\_103154.pdf](http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@pg/documents/digitalasset/dh_103154.pdf)

**The National Audit for Intermediate Care Summary Report 2017**

<https://www.nhsbenchmarking.nhs.uk/news/2017-national-audit-of-intermediate-care-conference-review>

***NICE Guidance NG27: Transition between inpatient hospital  
settings and community or care home settings for adults with  
social care needs December 2015***

[www.nice.org.uk/guidance/ng27/resources/transition-between-inpatient-hospital-settings-and-community-or-care-home-settings-for-adults-with-social-care-needs-1837336935877](http://www.nice.org.uk/guidance/ng27/resources/transition-between-inpatient-hospital-settings-and-community-or-care-home-settings-for-adults-with-social-care-needs-1837336935877)

## Age UK

Age UK provides advice and information for people in later life through our Age UK Advice line, publications and online. Call Age UK Advice or Age Cymru Advice to find out whether there is a local Age UK near you, and to order free copies of our information guides and factsheets.

### Age UK Advice

[www.ageuk.org.uk](http://www.ageuk.org.uk)

0800 169 65 65

Lines are open seven days a week from 8.00am to 7.00pm

### In Wales contact

#### Age Cymru Advice

[www.agecymru.org.uk](http://www.agecymru.org.uk)

0800 022 3444

### In Northern Ireland contact

#### Age NI

[www.ageni.org](http://www.ageni.org)

0808 808 7575

### In Scotland contact

#### Age Scotland

[www.agescotland.org.uk](http://www.agescotland.org.uk)

0800 124 4222

## Support our work

We rely on donations from our supporters to provide our guides and factsheets for free. If you would like to help us continue to provide vital services, support, information and advice, please make a donation today by visiting [www.ageuk.org.uk/donate](http://www.ageuk.org.uk/donate) or by calling 0800 169 87 87.



## Our publications are available in large print and audio formats



### Next update May 2019

The evidence sources used to create this factsheet are available on request. Contact [resources@ageuk.org.uk](mailto:resources@ageuk.org.uk)

This factsheet has been prepared by Age UK and contains general advice only, which we hope will be of use to you. Nothing in this factsheet should be construed as the giving of specific advice and it should not be relied on as a basis for any decision or action. Neither Age UK nor any of its subsidiary companies or charities accepts any liability arising from its use. We aim to ensure that the information is as up to date and accurate as possible, but please be warned that certain areas are subject to change from time to time. Please note that the inclusion of named agencies, websites, companies, products, services or publications in this factsheet does not constitute a recommendation or endorsement by Age UK or any of its subsidiary companies or charities.

Every effort has been made to ensure that the information contained in this factsheet is correct. However, things do change, so it is always a good idea to seek expert advice on your personal situation.

Age UK is a charitable company limited by guarantee and registered in England and Wales (registered charity number 1128267 and registered company number 6825798). The registered address is Tavis House, 1–6 Tavistock Square, London WC1H 9NA. Age UK and its subsidiary companies and charities form the Age UK Group, dedicated to improving later life.