Factsheet 76

Intermediate care and reablement

May 2019

About this factsheet

This factsheet explains intermediate care, a term that includes reablement. It describes its characteristics and the referral and assessment process for this 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 to 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 2019 to April 2020.

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.

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1 What is intermediate care?

Intermediate care (IC) is non means-tested, time-limited, *short term* support. Staff can offer it they believe that, with specialist support, you have potential to improve and live more independently. Intermediate care can be misunderstood, so it important to know it is *not* a period of free care that you are always entitled to following a stay in hospital.

There is a particular type of IC with the aim of avoiding unnecessary hospital admission but in the main, it is a form of *active rehabilitation* to:

- help you become as independent as possible after a hospital stay, or
- help you to continue to live at home if you are having increasing difficulty with daily life due to illness or disability, or
- prevent a premature, permanent move into residential care.

Based on your current health, abilities and wishes, you agree and work towards personal goals. You are supported by health and care staff trained to maximise your mobility and observe, encourage and guide you to do things yourself, rather than intervene or carry out tasks for you.

Free, time-limited support

Support is time-limited and where appropriate, may involve moving from one of the four types of intermediate care to another. Section 2 describes each type. It normally lasts no longer than six weeks but can be as little as 1-2 weeks, if staff believe that is what you need to reach your goals. Local authorities are expected to be flexible with time frames, as in some cases it may take a bit longer than six weeks to reach your goals.

IC 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 IC extends beyond six weeks, it has discretion to extend provision of free services.

Staff should review your progress at intervals and towards the end, to see if further progress is likely. If it is not, even with a bit more time, they should complete a needs assessment to see if you need *long term* support. For information, see factsheet 41, *How to get care and support.*

People living with dementia

If you are living with dementia, a prolonged stay in hospital can be traumatic, due to its noisy environment and separation from familiar people, places and routines. When considering if you could benefit from IC, staff should aim to involve professionals with experience of people living with dementia. They can contribute to a risk assessment, clarify how dementia affects you and judge how well you could understand, remember and follow instructions for example, to improve your mobility or carry out daily living tasks and cooperate and engage with the process. It is important to take these things into account, when considering if you would benefit from IC.

2 What types of support may be available?

There are four types of intermediate care but staff may use other terminology. Your needs and the range of local services, which varies across the country, affect the type of IC you are offered.

- **Reablement** – provides support in your own home to improve your confidence and ability to live as independently as possible. Your goals are likely to relate to daily living tasks such as getting washed and dressed, preparing a drink or light snack, moving safely around your home or enabling you to participate in social activities.

  Specially trained social care support staff visit daily. Their focus is on observing, guiding and encouraging you to do things yourself, so you re-build confidence and skills you may have lost while unwell.

- **Home-based intermediate care** – provides support in your own home, or a care home if that is where you normally live. You work with a multidisciplinary team of health professionals and possibly a social worker to agree goals and the type of support you need.

  It is predominantly delivered by health professionals and might involve nurses; physiotherapists who can provide tailor-made exercises to help you become stronger and move safely from place to place and any aids to help mobility; and an occupational therapist who can help you find ways to continue to do daily living tasks more easily and safely.

- **Bed-based intermediate care** – involves a temporary stay in a care home, community hospital or standalone IC facility, where you receive support similar to home-based IC, to help you reach your goals. The sooner after referral bed-based IC starts, ideally within 2 days, the better the chance of success.

- **Crisis response** – offers a prompt assessment at home or on arrival at the emergency department. This is to decide if your needs can be safely managed by providing short-term care at home (typically less than 48 hours) or if more appropriate, by arranging a short stay in a care home.

  If they can, you avoid an unnecessary hospital admission and your recovery and a fuller assessment can take place in a calmer, more familiar environment. Staff may decide you would benefit by moving on to another type of IC.

3 When might intermediate care be appropriate?

Having considered if you could benefit from IC, the IC team should explain their findings and reasons for their decision to you, and where appropriate your family. If unhappy with their decision, you can seek clarification of the decision or request a second opinion.

If staff believe you could benefit, IC may be offered to help maximise your independence after an accident, hospital stay or illness, and be considered part of the process to identify your long-term support needs.

3.1 To support timely discharge from hospital

Staff can refer you to the IC team if they believe you no longer need to be in hospital but have the potential for further improvement and to become more independent.

Having agreed your goals, reablement, home-based or bed-based intermediate care may be suitable. Bed-based is often offered if you are well enough to leave hospital, have potential to improve but are not well enough to go home.

Rehabilitation offered by health professionals after a stroke or heart attack is not time limited and is not a type of IC.

3.2 An alternative to hospital admission

Crisis response

Crisis response may be considered if you become ill at home or a fall results in only minor injury. To deliver crisis response, there must be a dedicated team for a GP, out-of-hours doctor, district nurse, ambulance paramedics or emergency department staff to contact.

The team of nurses, occupational therapists and other specialist staff can promptly assess your needs, decide if they can be safely managed outside hospital, and arrange appropriate services at short notice.

Support at home is typically for less than 48 hours but may be up to 72 hours. If more appropriate, staff may propose 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, which may involve referring you for another type of intermediate care.

Crisis response is not available in all areas but if you are taken ill at home and seen by a doctor or attended by paramedics, they may be able to access and refer you to such a service, if they believe hospital admission is not necessary. Similarly, if you are seen by emergency department staff, they may have access to a crisis response team.

3.3 If finding it difficult to live at home

If you are at home and already receive home care, staff may propose reablement as part of a review or reassessment of your needs. It may be an option if you are struggling at home or after an illness not requiring a stay in hospital. It may mean receiving reablement alongside home care.

3.4 To support 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 to enable your partner to develop specific skills that mean you can be cared for at home.

3.5 Facing a permanent move into residential care

If you are in an acute hospital bed and a permanent move into residential care looks likely, staff should consider referring you to the IC team. If you are suitable for and receive IC and you then have an assessment away from a busy hospital ward, it is likely to give a more realistic picture of your needs and whether a care home is necessary.

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

Exceptional circumstances can include:

- completion of specialist rehabilitation, such as on a stroke unit and you have discussed and agreed a stroke rehabilitation plan
- 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 another move 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 IC may be appropriate after a positive Checklist.

If found eligible, 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 Referral into intermediate care

Developing personal goals, agreeing support and time frames

If staff consider you are able to engage with IC and have potential to live more independently - where possible continuing to live in your preferred place - staff conduct a full assessment and work with you to develop personal goals.

They take account of what you can do and what you have difficulty with, as well as 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 and follow up will involve:

- Setting measurable and realistic goals. These may relate to improving your mobility, changing safely from a sitting to a standing position, using stairs or carrying out *daily living activities* such as washing, dressing, preparing a simple meal or engaging in social or leisure activities
- Considering what input or services would help you achieve your goals and manage any identified risks. It might involve providing equipment, support from health professionals and with personal care
- Agreeing a time frame within which you would hope to reach your goals and the type of intermediate care you need
- Drawing up a care and support plan, in a format that suits you, reflecting points agreed above, and giving contact details of a named person who can address any questions or concerns
- Recording your progress in the equivalent of a diary, with entries added by staff and by you, if you wish
- Regularly reviewing your goals and progress, making written adjustments to your support package or the time frame, as appropriate.

Before discharge from intermediate care, you should have a care and support assessment to find out if you need long term support.

5 Accessing intermediate care and reablement

If you, or a relative, are in one of the situations described in section 3 and believe you or they could benefit from IC, speak to the person responsible for your care. This could be hospital discharge staff, paramedics who attend you at home, your GP or an out-of-hours doctor, a social worker or emergency department staff. They should know the services available, criteria for making a referral and how to make one.

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

Availability of the four types of IC 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 starting reablement, home-based and bed-based intermediate care.

If you believe you or a family member have the potential to benefit from IC 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

Understanding intermediate care including reablement – a quick guide for people using intermediate care services. 2018
www.nice.org.uk/Media/Default/About/NICE-Communities/Social-care/quick-guides/understanding-intermediate-care-quick-guide.pdf

The *Care Act 2014*
www.legislation.gov.uk/ukpga/2014/23/contents

The *Care and Support (Preventing Needs for Care and Support) Regulations 2014*
www.legislation.gov.uk/uksi/2014/2673/made

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

The National Audit of Intermediate Care Summary Report 2017
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

Intermediate Care: Halfway Home: Updated Guidance for the NHS and Local Authorities. DH, 2009.
https://webarchive.nationalarchives.gov.uk/20130124050747/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@pg/documents/digitalasset/dh_103154.pdf

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 to find out whether there is a local Age UK near you, and to order free copies of our information guides and factsheets.

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

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0800 022 3444

In Northern Ireland contact

Age NI
www.ageni.org
0808 808 7575

In Scotland contact

Age Scotland
www.agescotland.org.uk
0800 124 4222

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