Factsheet 76

Intermediate care and reablement

May 2017

About this factsheet

This factsheet explains intermediate care and 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
- avoid moving permanently into a care home before you really need to.

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

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 is a specific type of *short term* support involving NHS and social care services. It may be provided to anyone aged 18 or over but is more usually offered to older people.

Intermediate care has three main aims:

- avoid unnecessary hospital admission
- help you become as independent as possible after a hospital stay
- prevent you having to move prematurely into permanent 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 health or social care needs that can be safely managed at home or by a stay in a care home. This means you avoid a trip to or admission to hospital.

Home-based intermediate care – services are provided in your own home, or a care home if that is where you normally live, by a team with different specialities but mainly health professionals such as nurses and therapists. You may also need help with personal care.

Bed-based intermediate care – services are delivered in a community hospital or care home, mainly by health professionals.

Reablement – services are provided in your own home, mainly by social care professionals and specially trained social care staff. Rather than undertaking tasks for you, staff show you techniques to help you do things yourself, enabling you to re-learn skills and recover your confidence to live at home.

2.1 Intermediate care offers free, time-limited support

Intermediate care support is time-limited and may involve moving from one type of intermediate care to another. It is normally no longer than six weeks and frequently as little as 1-2 weeks, if staff believe you are unlikely to need six weeks to reach agreed goals. Local authorities should not impose strict time limits as in some cases staff can expect it to take longer than six weeks to reach your goals.

Intermediate care services must be free for up to and including six weeks. While a local authority has the power to charge for intermediate care if it extends beyond six weeks, it also has the discretion to extend provision of free services.

Once it is agreed you have maximised your independence and are unlikely to make further progress, staff carry out a needs assessment to find out if you need long term support. For more information see factsheet 41, *How to get care and support.*

3 Developing an intermediate care package

Staff, including those with skills relating to your physical and mental health needs, must first carry out an assessment to judge whether you would benefit from intermediate care.

If staff have concerns about your mental capacity to give consent or your ability to work towards goals, they must act in your best interests. They should communicate with you and where appropriate your family or significant people in your life and explain their thinking around your potential to make further progress and become more independent.

Developing and working towards goals

If the assessment shows you have potential to live more independently, which may also mean you avoid going into permanent residential care, you are referred to the intermediate care team. They work with you to identify what you can do, what you have difficulty doing, what you would like to do and could realistically achieve. You can involve your family or those significant to you in such discussions if you want or seek support from an advocate.

Taking your health into account, you and staff then agree:

- Specific, measurable, realistic goals. These might relate to improving your mobility, changing safely from a sitting to a standing position, moving confidently around your home, using stairs safely, carrying out *activities of daily living* such as washing and dressing, preparing a simple snack or meal or may relate to leisure or social engagement.
- Services to help you achieve these goals and a time frame within which you hope to achieve them. This might involve providing equipment, support from a physiotherapist and help with personal care.
- An appropriate location to receive this support.

Staff should draw up a care and support plan and review your goals and progress regularly, making appropriate adjustments to your support package or the time frame. They should give you contact details of a named person to speak to with any questions or concerns.

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.

People living with dementia

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

If you suddenly become ill or suffer a fall and an assessment by a crisis response team shows you could be safely supported at home, it is likely to be better for your wellbeing and potential for recovery if you can avoid an unnecessary trip to A&E or hospital admission.

When deciding if intermediate care is appropriate after a hospital stay, it is important to involve health professionals who understand the needs of people living with dementia or have experience of working with them. They can help identify how your dementia affects you and how well you would understand and remember techniques staff suggest, for example to improve your mobility or help you safely carry out tasks of daily living. Their input can help decide whether you are likely to benefit from intermediate care support.

Availability of intermediate care for people living with dementia varies across England.

4.1 Alternative to hospital admission

Crisis response

Crisis response aims to prevent an unnecessary hospital admission and may be appropriate if you become ill at home or a have a fall causing only a minor injury. It addresses your immediate needs, typically for less than 48 hours but possibly up to 72 hours.

There must be a dedicated crisis team for a GP, out-of-hours doctor, district nurse, ambulance crew or staff in the accident and emergency (A&E) department to contact. The team made up of nurses, occupational therapists and other specialist staff assess your needs and if these can be safely managed outside hospital, they are able to arrange services at short notice usually at home but if necessary as a temporary stay in a care home. This allows health and social care staff time to follow up and decide what further support you need and means you avoid the stress of a busy A&E department or unnecessary hospital admission.

4.2 Support timely discharge from hospital

Having assessed your needs as part of the discharge process, staff may agree you have the potential to benefit from services to help you recover further and maximise your independence and refer you to the intermediate care team. This could mean setting goals to be achieved by reablement at home or by home-based or bed-based intermediate care.

4.3 Facing a permanent move into residential care

If you have not spent time on a ward dedicated to providing rehabilitation services and face a permanent move into residential care, staff should consider whether you would benefit from home or bed based intermediate care or reablement, once hospital treatment finishes.

Staff are likely to get a more realistic picture of your needs when an assessment takes place in a location other than a busy hospital ward. Your potential to return home may become more apparent once away from the hospital environment.

It is not generally recommended that patients move directly from a busy 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 is offered in a stroke unit
- sufficient attempts have been tried to support you at home (with or without an intermediate care package)
- 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 if staff propose 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. A full assessment should only be considered once your longer term needs are clear, so intermediate care may be appropriate before or after completing the 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.*

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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 period of 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

Ask about the possibility of intermediate care with the person responsible for your care if you, or a relative, are in one of the situations in section 4.

This could be paramedics who attend you at home, your GP or out-of-hours doctor, A&E staff or the team responsible for your hospital discharge. They should know the services available, the criteria for making a referral to the intermediate care team and how to make one.

If in 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 intermediate care varies across England and in many areas, demand outstrips 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, consider making a complaint. Staff can tell you how to complain, who you should make it to and how to get independent practical support and advice to make it.

For more information see factsheet 66, *Resolving problems and making a complaint about NHS care* (if it relates to home or bed-based intermediate 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.

The *Care Act 2014*
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

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

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

The National Audit for Intermediate Care 2015
http://www.nhsbenchmarking.nhs.uk/CubeCore/.uploads/NAIC/Reports/NAICReport2015FINALA4printableversion.pdf

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

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.

Age UK Advice
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
www.agecymru.org.uk
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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