NICE National Institute for Health and Care Excellence

NICE Pathways

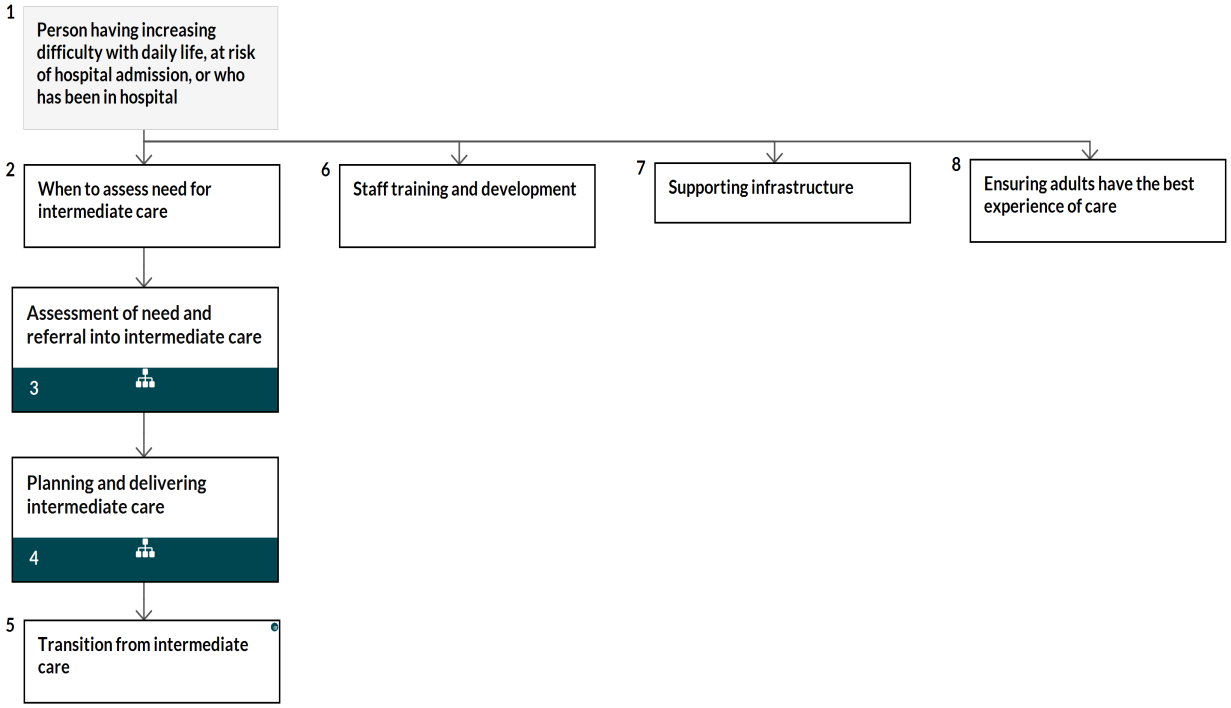
Intermediate care including reablement overview

NICE Pathways bring together everything NICE says on a topic in an interactive flowchart. NICE Pathways are interactive and designed to be used online.

They are updated regularly as new NICE guidance is published. To view the latest version of this NICE Pathway see:

http://pathways.nice.org.uk/pathways/intermediate-care-including-reablement
NICE Pathway last updated: 03 November 2020

This document contains a single flowchart and uses numbering to link the boxes to the associated recommendations.



1 Person having increasing difficulty with daily life, at risk of hospital admission, or who has been in hospital

No additional information

2 When to assess need for intermediate care

Assess people for intermediate care [See page 8] 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.

3 Assessment of need and referral into intermediate care

See Intermediate care including reablement / Assessment of need and referral into intermediate care

4 Planning and delivering intermediate care

See Intermediate care including reablement / Planning and delivering intermediate care

5 Transition from intermediate care

Before the person finishes intermediate care [See page 8], providers of intermediate care should give them information about how they can refer themselves back into the service, should their needs or circumstances change.

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 what NICE says on transition between inpatient hospital settings and community or care home settings for adults with social care needs.

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

Quality standards

The following quality statement is relevant to this part of the interactive flowchart.

4. Transition plan

6 Staff training and development

Ensure that all staff delivering intermediate care [See page 8] 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 [See page 8] goals
- positive risk taking [See page 8].

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.

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.

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.

7 Supporting infrastructure

Flexible person-centred services

Consider making home-based intermediate care [See page 8], reablement [See page 8], bed-based intermediate care [See page 8] and crisis response [See page 8] all available locally. Deliver these services in an integrated way so that people can move easily between them, depending on their changing support needs.

Ensure that intermediate care [See page 8] 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.

Contract and monitor intermediate care in a way that allows services to be flexible and person centred. For recommendations on delivering flexible services, see what NICE says on home care for older people.

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.

Intermediate care team composition and integrated working

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

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.

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.

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.

Referral into intermediate care and to other services

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.

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.

8 Experience of care

Use these recommendations with NICE's recommendations on:

- patient experience in adult NHS services
- people's experience in adult social care services
- service user experience in adult mental health services.

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).

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.

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 usually delivered by a multidisciplinary team but most commonly by healthcare professionals or care staff (in care homes).

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.

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.

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

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.

Sources

Intermediate care including reablement (2017) NICE guideline NG74

Your responsibility

Guidelines

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.

Technology appraisals

The recommendations in this interactive flowchart represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, health professionals are expected to take these recommendations fully into account, alongside the individual needs, preferences and values of their patients. The application of the

recommendations in this interactive flowchart is at the discretion of health professionals and their individual patients and do not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian.

Commissioners and/or providers have a responsibility to provide the funding required to enable the recommendations to be applied when individual health professionals and their patients wish to use it, in accordance with the NHS Constitution. They should do so 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.

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.

Medical technologies guidance, diagnostics guidance and interventional procedures guidance

The recommendations in this interactive flowchart represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, healthcare professionals are expected to take these recommendations fully into account. However, the interactive flowchart does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

Commissioners and/or providers have a responsibility to implement the recommendations, in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity, and foster good relations. Nothing in this interactive flowchart should be interpreted in a way that would be inconsistent with compliance 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.