

# Intermediate care including reablement

## NICE guideline: short version

### Draft for consultation, April 2017

This guideline covers referral and assessment for, and delivery of intermediate care, which uses a range of multidisciplinary service models to help people be as independent as possible and to improve their wellbeing. The guideline covers how to support people at risk of hospital admission or who have been in hospital, to help them recover and regain independence. It aims to ensure people transfer from hospital to the community in a timely way and prevent unnecessary admissions to hospitals and residential care. It also includes supporting people who are having increasing difficulty with daily life, and where specific support and rehabilitation is likely to improve their ability to live independently or avoid a hospital admission.

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.

#### Who is the guideline for?

- Health and social care practitioners who deliver intermediate care and reablement in the community
- Other practitioners who work in community services, including:
  - home care
  - general practice

– 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

This version of the guideline contains the draft recommendations, context and recommendations for research. Information about how the guideline was developed is on the [guideline's page](#) on the NICE website. This includes the guideline committee's discussion and the evidence reviews (in the [full guideline](#)), the scope, and details of the committee and any declarations of interest.

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## 1 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.

2

3 Definitions of the 4 service models on which the recommendations are based are  
4 given in [terms used in this guideline](#), while the [context](#) section provides more  
5 information about the core functions of an intermediate care service.

### 6 1.1 ***Core principles of intermediate care***

7 1.1.1 Ensure that [intermediate care](#):

- 8
- develops goals in a collaborative way that optimises independence and wellbeing
  - is person centred, taking into account cultural differences and preferences.
- 10
- 11

12 1.1.2 Discuss with the person (and their family and carers if relevant) the aims  
13 and objectives of intermediate care. In particular, explain clearly:

- why working closely together and taking an active part in their support can produce the best outcomes
  - that intermediate care is designed to support them to live more independently and have a better quality of life.
- 14
- 15
- 16
- 17

18 1.1.3 Support people to recognise their own strengths and realise their potential  
19 to regain independence. Explain to the person how intermediate care will  
20 support them to achieve those things.

- 1 1.1.4 Address people's social, emotional, communication and cognitive needs,  
2 as well as their physical needs as part of intermediate care.
- 3 1.1.5 Staff providing intermediate care should:
- 4 • work in partnership with the person to find out what they want to
  - 5 achieve and understand what motivates them
  - 6 • focus on building the person's confidence
  - 7 • learn to observe and not automatically intervene, even when the person
  - 8 is struggling to perform an activity, such as dressing themselves or
  - 9 preparing a snack.
- 10 1.1.6 Do not exclude people from intermediate care based on whether they  
11 have a particular condition, such as dementia, or live in particular  
12 circumstances, such as prison or temporary accommodation.
- 13 1.1.7 Consider making all 4 intermediate care service models available locally.  
14 Services should be designed in a way that referrals can easily be made  
15 between them, depending on people's changing support needs.
- 16 1.1.8 Consider deploying staff flexibly across the different service models,  
17 where possible following the person from hospital to a community  
18 bed-based service or directly to their home.
- 19 1.1.9 Ensure that intermediate care teams include staff from a broad range of  
20 disciplines. Core practitioners include:
- 21 • support staff
  - 22 • nurses
  - 23 • social workers
  - 24 • physiotherapists
  - 25 • occupational therapists
  - 26 • speech and language therapists
  - 27 • pharmacists.
- 28 1.1.10 Ensure that the composition of intermediate care teams reflects the  
29 different needs and circumstances of people using the service.

1 1.1.11 Ensure that intermediate care staff have the skills to support people to:

- 2 • optimise recovery  
3 • take control of their lives  
4 • regain as much independence as possible.

5 1.2 ***Assessment of need for intermediate care***

6 1.2.1 Undertake an assessment identifying the person's abilities, needs and  
7 wishes so that they can be referred to the most appropriate model of  
8 intermediate care, avoiding wherever possible the need for acute hospital  
9 admission.

10 1.2.2 Actively involve people using services and their families and carers in  
11 assessments for intermediate care and in decisions such as the setting in  
12 which it is provided. Make any reasonable adjustments and provide  
13 support to help people understand the options and make informed  
14 choices, for example, use clear, straightforward language or different  
15 formats for communication.

16 1.2.3 Through all stages of assessment and delivery, ensure good  
17 communication between intermediate care staff and other agencies and  
18 between intermediate care staff and people using the services and their  
19 families.

20 1.2.4 When assessing people for intermediate care, explain to them and their  
21 family and carers about advocacy services and how to contact them if  
22 they wish.

23 1.2.5 Talk to the person's family and carers, if the person agrees to this, about  
24 the aims of intermediate care and what it will achieve. Record these  
25 discussions.

26 **Home-based intermediate care**

27 1.2.6 Consider providing intermediate care to people in their own homes  
28 wherever practical, making reasonable adjustments as required to enable  
29 this to happen.

1 **Bed-based intermediate care**

2 1.2.7 If transfer from acute care takes no longer than 2 days, consider [bed-](#)  
3 [based intermediate care](#) for people who are in an acute but stable  
4 condition but not fit for safe transfer home.

5 **Reablement**

6 1.2.8 Offer [reablement](#) as a first option to people being considered for [home](#)  
7 [care](#), if it is judged that reablement could improve their independence.

8 1.2.9 Consider reablement for people already using home care, as part of the  
9 review or reassessment process. This may mean providing reablement  
10 alongside home care. Take into account the person's needs and  
11 preferences when considering reablement.

12 1.2.10 Consider reablement for people living with dementia, to support them to  
13 maintain and improve their independence and wellbeing.

14 **Crisis response**

15 1.2.11 Refer people to [crisis response](#) if they have experienced an urgent  
16 increase in health or social care needs and:

- 17
- their support can be safely managed in their own home or care home
- 18 **and**
- they are likely to benefit from the service.
- 19

20 1.2.12 Raise awareness of the crisis response service among practitioners  
21 working in other local teams and organisations (such as housing and  
22 voluntary services) and make sure they understand:

- 23
- the service and what it involves
- 24
- how it differs from other types of intermediate care
- 25
- how to refer to the service.

26 1.3 ***Entering intermediate care***

27 1.3.1 Start the intermediate care service within 2 working days of receiving an  
28 appropriate referral.

1 **Assessment by the intermediate care service**

2 1.3.2 When planning the person's intermediate care:

- 3
- 4 • tell the person how long the service will last, what will be involved and  
5 what is likely to happen afterwards
  - 6 • assess the person's ability to self-manage
  - 7 • involve the person in setting goals, and their family or carers if the  
8 person agrees to this
  - 9 • take into account the person's:
    - 10 – cultural preferences
    - 11 – mental capacity
  - 12 • think about whether the person needs to give consent for their  
13 information to be shared.

13 1.3.3 When a person starts using a [home-based intermediate care](#) service,  
14 make sure their family and carers are also given information about the  
15 service and how it works, including:

- 16
- 17 • the service's aims and the support it will and will not provide
  - 18 • resources in the local community that can support families and carers.

18 1.3.4 Ensure that the person has opportunities to ask questions about the  
19 service and what it involves.

20 1.3.5 Carry out a risk assessment as part of planning for intermediate care and  
21 then regularly afterwards, as well as when something significant changes  
22 This should include:

- 23
- 24 • assessing the risks associated with the person carrying out particular  
25 activities
  - 26 • assessing the risks associated with their environment
  - 27 • balancing the risk of a particular activity with the person's wishes,  
28 wellbeing, independence and quality of life.

(This recommendation is adapted from NICE's guideline on [home care](#).)



1 1.3.6 Complete and document a risk plan with the person and their family and  
2 carers as part of the intermediate care planning process. Ensure that the  
3 risk plan includes:

- 4 • strategies to manage risk; for example, specialist equipment, use of  
5 verbal prompts and use of support from others
- 6 • the implications of taking the risk for the person and the member of  
7 staff.

8 (This recommendation is adapted from NICE's guideline on [home care](#).)

9 1.3.7 Assume that people using bed-based intermediate care can take and look  
10 after their medicines themselves unless a risk assessment has indicated  
11 otherwise. For recommendations on supporting people in residential care  
12 to take and look after their medicines themselves, see NICE's guidelines  
13 on [managing medicines in care homes](#) and [medicines optimisation](#).

14 1.3.8 Ensure that staff across organisations work together to coordinate review  
15 and reassessment, building on current assessment and information. Joint  
16 meetings and training can improve integrated working.

### 17 ***Crisis response***

18 1.3.9 As part of the assessment process, ensure that crisis response services  
19 identify the person's ongoing support needs and make arrangements for  
20 the person's ongoing support.

21 1.3.10 Ensure that the crisis response can be initiated within 2 hours from receipt  
22 of a referral.

23 1.3.11 Ensure close links between crisis response and diagnostics (for example,  
24 GP, X-ray or blood tests) so that people can be diagnosed quickly if  
25 needed.

### 26 **Goal planning**

27 1.3.12 Discuss and agree intermediate care goals with the person. Make sure  
28 these goals:

- 1           • are specific, measurable, achievable, realistic and time bound  
2           • take into account the person’s health and wellbeing  
3           • are aligned with the remit of the service  
4           • reflect what the person wants to achieve both during the period in  
5           intermediate care, and in the longer term  
6           • take into account how the person is affected by their conditions or  
7           experiences  
8           • take into account the best interests and expressed wishes of the  
9           person.
- 10   1.3.13   Recognise that participation in social and leisure activities are legitimate  
11           goals of intermediate care.
- 12   1.3.14   Include the person’s family and carers in planning intermediate care, if the  
13           person agrees to this. Take into account their wishes and preferences  
14           alongside those of the person using the service.
- 15   1.3.15   Document the intermediate care goals in an accessible format and give a  
16           copy to the person and their family and carers, if the person agrees to  
17           this.
- 18   1.4       ***Delivering intermediate care***
- 19   1.4.1    Take a flexible, outcomes-focused approach to delivering intermediate  
20           care that is tailored to the person’s needs and abilities.
- 21   1.4.2    Review goals regularly with the person. Subject to progress toward the  
22           goals the service might need to last longer than 6 weeks.
- 23   1.4.3    Ensure that more specialist support is available to people who need it (for  
24           example, in response to complex health conditions), either by training  
25           intermediate care staff or by working with specialist organisations. (This  
26           recommendation is adapted from NICE’s guideline on [home care](#).)
- 27   1.4.4    Ensure that the person using intermediate care and their family and carers  
28           know who to speak to if they have any questions or concerns about the  
29           service, and how to contact them.

- 1 1.4.5 Offer the person the information they need to enable them to meet their  
2 intermediate care goals. Offer this information in a range of accessible  
3 formats; for example:
- 4 • verbally
  - 5 • in written format (in plain English)
  - 6 • in other formats that are easy for the person to understand, such as  
7 braille or Easy Read
  - 8 • translated into other languages or provided by a trained, qualified  
9 interpreter.
- 10 1.4.6 Ensure that an intermediate care diary (or record) is completed and kept  
11 with the person. This should:
- 12 • provide a detailed day-to-day log of all the support given, documenting  
13 the person's progress towards goals and highlighting their needs,  
14 preferences and experiences
  - 15 • be updated by intermediate care staff at every visit
  - 16 • be accessible to the person themselves, who should be encouraged to  
17 read and contribute to the document
  - 18 • be detailed enough to keep the person, their families, carers and other  
19 staff fully informed about what has been provided and about any  
20 incidents or changes.
- 21 1.4.7 Ensure that intermediate care staff avoid missing visits to people's homes.  
22 Be aware that missing visits can have serious implications for the person's  
23 health or wellbeing, particularly if they live alone or lack mental capacity.  
24 (This recommendation is adapted from NICE's guideline on [home care](#).)
- 25 1.4.8 Contact the person (or their family or carer) if intermediate care staff are  
26 going to be late or unable to visit. (This recommendation is adapted from  
27 NICE's guideline on [home care](#).)

1 1.5 ***Transition from intermediate care***

2 1.5.1 Before the person finishes intermediate care, give them information about  
3 how they can refer themselves back into the service.

4 1.5.2 Ensure good communication between intermediate care staff and other  
5 agencies, and with people using intermediate care and their families,  
6 when people are transferring between services or when the intermediate  
7 care ends. For recommendations on communication during transition  
8 between services, see NICE's guideline on [transition between inpatient  
9 hospital settings and community or care home settings for adults with  
10 social care needs](#).

11 1.5.3 Give people information about other sources of support available at the  
12 end of intermediate care, including support for carers.

13 1.6 ***Supporting infrastructure***

14 1.6.1 Ensure that intermediate care is provided in an integrated way by working  
15 towards the following:

- 16
- 17 • a single point of access for those referring to the service
  - 18 • a management structure across all services that includes a single  
19 accountable person, such as a team leader
  - 20 • a single assessment process
  - shared goals that everyone in the team works towards.

21 1.6.2 Consider contracting and monitoring intermediate care in a way that  
22 allows services to be flexible and person centred. For recommendations  
23 on delivering flexible services, see NICE's guideline on [home care](#).

24 1.6.3 Ensure that intermediate care teams work proactively with practitioners  
25 referring into the service so they understand:

- 26
- 27 • the service and what it involves
  - 28 • how it differs from other services
  - 29 • the ethos of intermediate care, specifically that it aims to support  
people to build independence

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

2   1.6.4    Ensure that mechanisms are in place to promote good communication  
3           within intermediate care teams. These might include:

- 4           • regular team meetings to share feedback and review progress  
5           • shared notes  
6           • opportunities for team members to express their views and concerns.

7   1.6.5    Ensure that the intermediate care team has a clear route of referral to and  
8           engagement with commonly used services; for example:

- 9           • general practice  
10          • podiatry  
11          • nutrition services  
12          • pharmacy  
13          • mental health and dementia services  
14          • social work and social care services  
15          • housing services  
16          • continence services  
17          • audiology  
18          • voluntary, community and faith services  
19          • specialist advice; for example, around cultural or language issues.

20   1.7        ***Training and development***

21   1.7.1    Ensure that all staff delivering intermediate care understand:

- 22          • the service and what it involves  
23          • the roles and responsibilities of all team members  
24          • how it differs from other services  
25          • the ethos of intermediate care, specifically that it aims to support  
26             people to build independence.

27   1.7.2    Ensure that intermediate care staff are able to recognise and respond to:

- 1           • common conditions, such as diabetes; mental health and neurological
- 2           conditions, including dementia; physical and learning disabilities; and
- 3           sensory loss
- 4           • common support needs, such as nutrition; hydration; and issues related
- 5           to overall skin integrity
- 6           • common support needs, such as dealing with bereavement and end of
- 7           life
- 8           • deterioration in the person's health or circumstances.

9           (This recommendation is adapted from NICE's guideline on [home care](#).)

10   1.7.3   Provide intermediate care staff with opportunities for:

- 11           • observing the work of another member of staff
- 12           • enhancing their knowledge and skills in relation to delivering
- 13           intermediate care
- 14           • reflecting on their practice together.

15           Document these development activities and record that people have

16           achieved the required level of competence.

## 17   ***Terms used in this guideline***

### 18   **Bed-based intermediate care**

19   Services that provide assessment and interventions to people in a bed-based

20   setting, such as an acute hospital, community hospital, residential care home,

21   nursing home, stand-alone intermediate care facility, independent sector facility,

22   local authority facility or other bed-based setting. These services also receive people

23   from acute hospital settings and provide rehabilitation. Bed-based intermediate care

24   aims to prevent unnecessary admissions to acute hospitals and premature

25   admissions to long-term care, and to support timely transfer from hospital.

26   Interventions last up to 6 weeks for the majority of people. Services are usually

27   delivered by a multidisciplinary team, but predominantly by healthcare professionals

28   and carers (in care homes).

1 **Crisis response**

2 Community-based services provided to people in their own home or a care home.  
3 These services aim to avoid hospital admissions.

4 Services usually involve an assessment, and some may provide short-term  
5 interventions (usually up to 48 hours). Services are usually delivered by a  
6 multidisciplinary team, but predominantly by healthcare professionals.

7 **Home-based intermediate care**

8 Community-based services that provide assessment and interventions to people in  
9 their own home or a care home. These services aim to prevent hospital admissions,  
10 support faster recovery from illness, support timely discharge from hospital, and  
11 maximise independent living.

12 Interventions last up to 6 weeks for the majority of people. Services are usually  
13 delivered by a multidisciplinary team, but predominantly by healthcare professionals  
14 and care staff (in care homes).

15 **Home care**

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

20 **Intermediate care**

21 A range of integrated services that: promote faster recovery from illness; prevent  
22 unnecessary acute hospital admissions and premature admissions to long-term care;  
23 support timely discharge from hospital; and maximise independent living.

24 Intermediate care services are usually delivered for no longer than 6 weeks and  
25 often for as little as 1 to 2 weeks or less. Intermediate care should be available to  
26 adults aged 18 years or over.

27 Four service models of intermediate care are available: bed-based intermediate  
28 care, crisis response, home-based intermediate care, and reablement. Where the

1 term 'intermediate care' is used in this guideline, the recommendation refers to all 4  
2 service models of intermediate care.

### 3 **Reablement**

4 Community-based services that provide assessment and interventions to people in  
5 their own home or a care home. These services aim to help people recover skills and  
6 confidence to live at home and maximise their independence.

7 Interventions last up to 6 weeks for the majority of people. Services are usually  
8 delivered by a multidisciplinary team, but predominantly by social care professionals.

9 For other social care terms see the Think Local, Act Personal [Care and Support](#)  
10 [Jargon Buster](#).

## 11 **Putting this guideline into practice**

12 **[This section will be finalised after consultation]**

13 NICE has produced **tools and resources** [\[link to tools and resources tab\]](#) to help  
14 you put this guideline into practice.

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

- 18 • Ensuring an integrated approach to intermediate care. Currently, the 4 service  
19 models of intermediate care tend to operate separately, delivered by different staff  
20 and funded from different budgets. Moving to a more integrated approach for  
21 planning, funding and delivery of all 4 models, including transferable assessments  
22 that are accepted across all services, would improve the experience for people  
23 using the services. However, such changes may be difficult to achieve.
- 24 • Starting intermediate care services within 2 working days (2 hours for crisis  
25 response) of receiving an appropriate referral. Rapid provision of the right  
26 intermediate care service will benefit people using the services, and may help  
27 reduce pressure on hospital beds. However, this approach will prove challenging  
28 in light of the current financial pressures and the demands on the services.



- 1 • Making sure the aims, objectives and purpose of intermediate care are  
2 understood by people using the services, their families, and professionals from the  
3 wider health and social care system. There is currently a lack of understanding  
4 that the term 'intermediate care' includes intermediate care services funded by the  
5 healthcare system and reablement services funded by social care. In addition,  
6 there is low awareness that active rehabilitation or reablement is quite different to  
7 care.
- 8 • Developing leadership that promotes a clarity of purpose and good  
9 communication within each service, and provides the guidance and support that  
10 staff require. This leadership will help staff working in intermediate care services  
11 to deliver a service focused on enabling and supporting independence, and  
12 optimising wellbeing.

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

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

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

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

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

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

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

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

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

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

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

18 **8. Review and monitor** how well the guideline is being implemented through the  
19 project group. Share progress with those involved in making improvements, as well  
20 as relevant boards and local partners.

21 NICE provides a comprehensive programme of support and resources to maximise  
22 uptake and use of evidence and guidance. See our [into practice](#) pages for more  
23 information.

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

## 26 **Context**

27 The NHS and social care sectors are experiencing unprecedented pressure due to  
28 increasing demand from people living longer, often with complex needs or

1 impairments and one or more long-term conditions. Admission to hospital and delays  
2 in hospital discharge can create significant anxiety, physical and psychological  
3 deterioration, and increased dependence. Multidisciplinary services that focus on  
4 rehabilitation and enablement can support people and their families to recover,  
5 regain independence, and return or remain at home.

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

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

- 13 • bed-based intermediate care
- 14 • home-based intermediate care
- 15 • crisis response
- 16 • reablement.

17 These services are for people aged 18 years or over. The services are delivered in a  
18 range of settings, such as:

- 19 • Community settings, including:
  - 20 – people's own homes
  - 21 – temporary accommodation
  - 22 – specialist housing, such as sheltered, warden-supported or extra care housing
  - 23 – supported living housing (including shared lives schemes)
  - 24 – day centres
- 25 • residential and nursing care homes
- 26 • dedicated intermediate care and reablement facilities
- 27 • acute, community and day hospitals
- 28 • prisons.

29 The concept of intermediate care was developed in by the Department of Health in  
30 2000 in their [NHS Plan](#) and implemented in England through their [National Service](#)

1 [Framework for Older People](#). Reablement specifically received policy support in  
2 2010 when it was recognised as a means of prolonging or regaining independence.

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

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

### 21 ***The intermediate care pathway***

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

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

- 1 • **Acceptance by the intermediate care service** – an individual plan is then  
2 developed by the intermediate care team, based on the person’s assessment.  
3 Goals will be agreed with the person and then reviewed regularly. The plan should  
4 contain enough information so that staff visiting the person and providing their  
5 rehabilitation know what needs to be done.
- 6 • **Delivery of the service** – this should always be based on the agreed plan, and if  
7 problems arise then support staff should be able to contact the assessing  
8 practitioner in the intermediate care team.
- 9 • **A formal review** – this should be undertaken as the person approaches achieving  
10 their goals with a clear plan for transition from the intermediate care service. If the  
11 person has ongoing support needs there may be a handover to a new home care  
12 provider or day service. If the person has achieved their desired level of  
13 independence the plan may include information about how to refer themselves  
14 back into the service if they need to, and links to community services that can  
15 support them.

## 16 ***More information***

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

17

## 18 **Recommendations for research**

19 The guideline committee has made the following recommendations for research. The  
20 committee’s full set of research recommendations is detailed in the [full guideline](#).

### 21 ***1 Team composition for home-based intermediate care***

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

#### 24 **Why this is important**

25 The skill mix and competency a home-based intermediate care team can influence  
26 the quality of care and outcomes. The evidence on views and experiences of home-

1 based intermediate care is exclusively from health and social care practitioners, with  
2 no evidence from other care and support practitioners from the community.

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

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

## 11 **2 Crisis response**

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

### 15 **Why this is important**

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

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

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

## 26 **3 Dementia care**

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

1 **Why this is important**

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

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

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

19 **4 Reablement**

20 How effective and cost effective are repeated periods of reablement and reablement  
21 that last longer than 6 weeks?

22 **Why this is important**

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

27 In addition, there is no peer-reviewed study that measures the impact of different  
28 durations of reablement for different population groups. This is important because in  
29 practice, reablement is funded for up to 6 weeks only. However, some people are  
30 offered reablement for a period of more than 6 weeks based on their identified

1 needs. At present there is very limited knowledge about the costs and outcomes of  
2 reablement as provided to different population groups, and the optimal duration for  
3 these groups.

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

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

## 10 ***5 Single point access for intermediate care***

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

### 13 **Why this is important**

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

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

## 22 ***6 Duration and intensity of home-based intermediate care***

### 23 **Research question**

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

### 26 **Why this is important**

27 There is some evidence that people who used home-based intermediate care found  
28 their care ended too suddenly at 6 weeks, and poor communication compounded



1 this negative perception. The optimal time limit can differ depending on people's  
2 health and care and support needs.

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

## 6 ***7 Support for black and minority ethnic groups***

### 7 **Research question**

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

### 10 **Why this is important**

11 Addressing the cultural, language and religious needs of black and minority ethnic  
12 groups can remove some of the barriers to accessing support services. There is no  
13 evidence on the effectiveness and cost effectiveness of intermediate care in  
14 supporting people from black or minority ethnic groups to access intermediate care  
15 and reablement.

16 Comparative effectiveness and cost-effectiveness studies are needed to evaluate  
17 'what works' in terms of planning and delivering intermediate care for minority  
18 groups. This includes all 4 service models of intermediate care. Qualitative data are  
19 needed from views and experiences of people from black and minority ethnic groups,  
20 their family, carers, practitioners and voluntary support groups to inform the  
21 development of a service that can meet the needs and the intermediate care  
22 requirement of people from black and minority ethnic groups, and which is culturally  
23 sensitive and acceptable to this population.

24 **ISBN:**