
Intermediate Care, Reablement or Something Else? A Research Note about the Challenges of Defining Services

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Introduction

There is substantial confusion about and overlap between health and social care services labelled as 'intermediate care' and those labelled as 'reablement'. In this brief research note, we explore the policy and practice background to the development of reablement and intermediate care in order to help explain some of this definitional confusion. We then propose a classification of the operational or functional objectives of the two types of care that may assist when trying to evaluate one or the other or both.

Policy and practice

Attempts to bring about a shift to community-based care and avoid unnecessary and/or lengthy hospital admissions have long dominated health and social care policies and strategies, especially in relation to older people. Community hospitals, community nursing services and community-based therapists have always promoted the achievement of independence as well as prevention of admission to and facilitation of timely discharge from hospital. In the late 1990s, however, there was an increase in specially designed, usually multi-disciplinary, models of care targeted specifically at achieving early discharge and avoiding hospital admission (Parker *et al.*, 1999). These initiatives were often in response to the need to reduce hospital waiting times and 'bed blocking' and were developed or expanded with 'winter pressures' funding (Parker *et al.*, 1999).

While such care models might include elements of rehabilitation, their main purpose was to provide clinical oversight in settings other than acute hospitals, and predominantly in people's own homes. At the same time, however, community-based rehabilitation services were also expanding their remit and including social care staff in teams, again often in response to 'winter pressures' (Parker *et al.*, 1999).

Together, these services came to be designated, in the UK context, as 'intermediate care' (Steiner, 1997; Parker and Peet, 2001).

The National Service Framework for Older People (DH, 2001a) subsequently formalised and extended the definition of intermediate care, describing it as 'a new layer of care, between primary and specialist services ... to help prevent unnecessary hospital admission, support early discharge and *reduce or delay the need for long-term residential care*' (p.13, our emphasis). It envisaged services

providing comprehensive, multi-disciplinary assessment and cross-professional working to maximise independence and enable people to remain in or return to their own homes.

In response to this wider definition, coupled with the £900m promised in the NHS Plan for expanding intermediate care by 2004 (DH, 2000, p.13), NHS providers put in place or expanded care models that covered admission avoidance at the point of referral for acute care and supported early discharge for people with continuing clinical need after an acute admission. At the same time, 'reablement' services for people who were not acutely ill were also developed within the health service and within local authorities - see Lovett (1999) for one of the first descriptions and evaluations of an English reablement service.

Even within a single geographical area (and one that was at the forefront of development of these new models of care), the nature of reablement services varied substantially (Peet *et al.*, 2002). They were sometimes NHS funded, sometimes local authority funded, and sometimes jointly funded. Largely, the funding paralleled the objectives of the services; the greater the involvement of the NHS, the more likely that the objectives were admission avoidance and early discharge, while LA-funded and/or -led schemes were more likely to focus on wider rehabilitative goals and preventing or delaying admission to long-term care. Referral routes and skill mix in teams also differed depending on the source of funding, and some services were delivered in people's own homes while others were based in community hospitals or care homes. Despite these differences, 'before and after' evaluation showed improvements in functional abilities and health-related quality of life and positive feedback from service users across the different schemes (Peet *et al.*, 2002).

By 2009, when the Department of Health's 2001 guidance on intermediate care (DH, 2001b) was updated, the definition had widened to include aspects of organisational structure (integration) and again emphasised the outcome of maximising independent living. Intermediate care was defined there as:

A range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living.

(DH, 2009)

Additional criteria for defining services as intermediate care included the need for comprehensive assessment and a structured individual care plan, time-limited input (normally no more than six weeks) and cross-professional working with a single assessment framework, single professional record and shared protocols.

However, later and in an attempt to define reablement as something distinct from intermediate care, the Department of Health Care Services Efficiency Delivery

Programme (CSED), stated that 'homecare re-ablement' was about supporting people and maximising their independence 'so that we can appropriately *minimise their need for ongoing homecare support*' (CSED, 2010, p.2, our emphasis). Yet, the National Service Framework (DH, 2001a) had claimed something similar for intermediate care nine years earlier, stating that it:

... should be used as an opportunity to maximise people's physical functioning, build confidence,[and] re-equip them with the skills they need to live safely and independently at home ...

(p.45)

Although not stated specifically, there is surely an implicit assumption here of a reduced need for home care support if function and skills are restored.

CSED then went on, in the same document, to attempt to separate intermediate care from homecare reablement, but included in their definition of the latter, hospital discharge support (p.5).

Further development and further confusion

Partly in response to further substantial resources made available nationally for service development and partly in response to a modernisation agenda in local authority home care services (Glendinning *et al.*, 2010) reablement services, so defined, have grown in number and distribution across English local authorities. £70 million extra funding was made available to the NHS in 2010 to support hospital discharge (DH, 2010a), followed by £300 million/year over 2012-15 for 'reablement spending' (DH, 2010b). More recently, the government announced an investment of £91.6 billion in local NHS services in 2012/3, including £150 million for reablement (DH, 2011a). The promotion of reablement services within the Care and Support 2012 White Paper also firmly establishes it as a priority for local authorities (HMG, 2012).

Thus, in 2006, 24 per cent of councils in England reported that they had home care reablement services, 16 per cent that they were planning to expand a currently more limited service and 26 per cent that they were planning to establish a service (CSED, 2007). At the same time, the NHS continued to develop reablement services, often overlapping with or being delivered in the same 'package' as supported early discharge and, more rarely, admission avoidance (Martin *et al.*, 2004, 2006) and sometimes in partnership with local authorities. Very few health and social care communities are now without something described by them as a reablement service.

However, the overlap between intermediate care and reablement remains. This was acknowledged in a DH Circular (2010c), which argued that, for the purposes of understanding funding and charging streams, 'Whether or not the re-ablement

services provided to a person do in fact fall within the definition of intermediate services will need to be examined on a case by case basis.’ (para.3). The circular perhaps muddied the definitional waters further by referring to regulations that define intermediate care as ‘a qualifying [under the regulations] service which consists of a structured programme of care provided for a limited period of time to assist a person to maintain or regain the ability to live in his (sic) home’ (p.2).

Distinguishing between reablement and other services for evaluation purposes

This fuzziness of the definition of reablement (where objectives, interventions and service delivery and organisational issues are often conflated), and the overlap in service delivery with intermediate care poses challenges for evaluation. A possible response to this is to identify key characteristics that distinguish intermediate care and reablement from other health and social care services, and from each other.

We feel that recent evaluative literature (see, for example, Lewin *et al.*, 2013, 2014) and policy documents identify two key characteristics that distinguish intermediate care/reablement from other health and social care services

The first characteristic is the generally agreed **objectives** of intermediate care/reablement. These are: acute admission avoidance at the point of clinical need for acute care; early supported discharge after acute admission; longer-term avoidance of unplanned hospital admission; reduction in the use of home care services; avoidance of admission to long-term care.

Secondly, there is the **time-limited nature** of the service offered (usually up to a maximum of six weeks). This is the key defining characteristic that distinguishes intermediate care or reablement from, say, generic rehabilitation services.

A third characteristic then distinguishes intermediate care from reablement; this is **the restorative, self-care element** included in the service. In other words, a reablement service is about enabling people to regain or retain self-care function for themselves, rather than providing input that *replaces* that function (for example, reablement teaches people how to cook for themselves again, rather than providing meals on wheels).

Table 1: Distinguishing between intermediate care and reablement.

| <i>Objective</i> | <i>Time-limited?</i> | <i>Restorative of self-care?</i> | <i>Intermediate care or reablement?</i> |
|--|----------------------|----------------------------------|--|
| Acute admission avoidance at the point of clinical need for acute care | Yes | Not usually | Intermediate care |
| Early supported discharge after acute admission | Yes | Sometimes | Reablement if it includes a restorative element, otherwise intermediate care |
| Longer-term avoidance of unplanned hospital admission | Yes | Yes | Reablement |
| Reduction in the use of home care services | Yes | Yes | Reablement |
| Avoidance of admission to long-term care | Yes | Yes | Reablement |

Putting these three characteristics together, as in Table 1, gives us working definitions of intermediate care and reablement that can be used to separate services into those we want to evaluate and those that fall outside our range of interest. However, as is clear from this, simply asking service providers about their objectives, without other contextual information, would not allow us securely to identify the services of interest. Further, we know that some services attempt to meet more than one of the objectives and sometimes all of them via a single service. All this points to the need for careful questioning of service providers, before defining their service as reablement, in part or in whole.

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