Age UK
Let's change how we age

Factsheet 76

Intermediate care and reablement

May 2025

About this factsheet

This factsheet explains intermediate care, which also 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 a hospital stay or illness
- remain living at home if due to illness or disability, you are having increasing difficulty with daily activities
- 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 2025 to April 2026.

The information in this factsheet is applicable in England. If you are in Wales, Scotland or Northern Ireland, please contact Age Cymru, Age Scotland or Age NI for their advice on the rules in these countries. 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 this if they believe that with specialist support, you have potential to improve and live more independently.

It is important to know that IC is *not* a period of free care that you are always entitled to following a hospital stay.

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 activities 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 staff trained to observe, encourage and guide you, so you can do things yourself, rather than relying on them to 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 of this factsheet describes each type.

IC normally lasts no longer than six weeks but can be as little as one or two weeks, if staff believe that is what you need to reach your goals. Staff 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 may be funded, arranged, and provided by the NHS or by the local authority. Arrangements vary locally and can involve the NHS or the local authority individually, or both working together in partnership.

Where a local authority provides intermediate care or reablement, it must be provided free for **up to** six weeks, so if the timescale agreed with you is less than six weeks, it would be funded for that period. While a local authority has the power to charge if the provision of IC extends beyond six weeks, it also has discretion to extend provision of free services.

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

Dementia

People with dementia can receive IC services like everyone else, see section 3.5 for more information.

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 available, 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 support staff will visit you, usually daily. Their focus is on observing, guiding and encouraging you to do things yourself, so you rebuild confidence and skills that 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, as well as 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. You receive support similar to home-based IC to help reach your goals. The sooner bed-based IC starts, ideally within two days of referral, 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.

Referrals

Who makes a referral depends on the reason IC is being considered. If it is to support your discharge from hospital, the discharge team will discuss whether this may be suitable for you. If you are outside of hospital in your own home or a care home, you may be referred by a member of the health or social care team, such as your GP, a paramedic, social worker, or NHS 111.

You may also be able to self-refer to the service. Contact your local adult social services team for further information.

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 you are 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

The hospital discharge team may discuss the suitability of IC with you.

Depending on your needs and what your goals are, any one of reablement or home-based or bed-based intermediate care may be suitable.

Bed-based IC is often offered if you are well enough to leave hospital, have potential to improve, but are not well enough to go home.

If you have a new or increased need for support upon discharge, you are likely to be referred to a *care transfer hub*, where a multidisciplinary team will determine your discharge pathway including whether you would benefit from IC.

See section 5.1 of factsheet 37, *Hospital discharge and recovery*, for further information about discharge pathways.

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 when a fall results in only minor injury. To deliver a crisis response, there must be a dedicated team available 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 then arrange appropriate services at short notice.

Support at home is usually up to 48 hours but may be offered for a longer period of time. 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 IC.

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 means-tested home care.

3.4 Facing a permanent move into residential care

If you are on an acute hospital ward and a permanent move into residential care looks likely, you should be referred to the care transfer hub or similar team.

If it is thought you are likely to benefit from IC, you should be discharged to a more appropriate location to receive it. A subsequent assessment of your long-term needs is likely to give a more realistic picture of your abilities, and whether a care home place is best for you.

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 you are found eligible for CHC funding, the NHS is responsible for agreeing and funding your on-going care package. See factsheet 20, *NHS Continuing Healthcare and NHS-funded nursing care.*

3.5 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 cooperate and engage with the process. It is important to take into account whether you can understand, remember and follow instructions to improve your mobility or carry out daily living tasks, when considering if you would benefit.

4 Intermediate care and goal setting

Developing personal goals, agreeing support and time frames

Once staff agree you are able to engage with IC and have potential to live more independently - where possible continuing to live in your preferred place - they 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 involves:

- **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 *activities of daily living* 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 an Individual rehabilitation plan***,* reflecting points agreed above
- **recording your progress and regularly reviewing your plan**, making written adjustments to your support package or the time frame, as appropriate
- **planning** for the end of IC support, may include moving to another service and options for ongoing support if needed.

Whether it is the NHS or local authority providing your intermediate care services, you should not be charged for the first six weeks, or if the agreed timescale is less than six weeks, for that period.

You should be provided with the details of who to contact if you have any questions or concerns about your care and support.

Before discharge from intermediate care, you should have a care and support assessment from the local authority social services department to find out if you need long term support.

5 Accessing intermediate care and reablement

If you or a relative are in a situation described in section 3 and you believe that you or they could benefit from IC, speak to the person responsible for your care, such as your GP, or contact your local adult social services team.

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.

There may not be more than one option of where you can receive 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* and factsheet 59, *How to resolve problems and making a complaint about social care.*

6 Relevant legislation and guidance

The following documents support information in this factsheet.

NICE guidance NG74 ***Intermediate care including reablement September 2017*** Link includes 'information for the public' tab, explaining purpose of intermediate care.
www.nice.org.uk/guidance/ng74

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

The ***Care Act 2014 (Section 2)***
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/contents/made

The ***Care and Support (Charging and Assessment of Resources) Regulations 2014 Section 3(3)***
www.legislation.gov.uk/uksi/2014/2672/contents

Care and Support Statutory Guidance issued under the Care Act 2014
www.gov.uk/guidance/care-and-support-statutory-guidance

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/

A new community rehabilitation and reablement model – Good practice guidance for integrated care boards (commissioners and providers) 2023
www.england.nhs.uk/wp-content/uploads/2023/09/PRN00761ii-a-new-community-rehabilitation-and-reablement-model.pdf

Hospital discharge and community support guidance. Updated January 2024
www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-discharge-and-community-support-guidance

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 Advice
www.agecymru.wales
0300 303 44 98

In Northern Ireland contact

Age NI
www.ageni.org
0808 808 75 75

In Scotland contact

Age Scotland
www.agescotland.org.uk
0800 124 42 22

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Next update May 2026

The evidence sources used to create this factsheet are available on request.

Contact *resources@ageuk.org.uk*

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