Intermediate care

About this factsheet

This factsheet explains intermediate care – a range of health and social care services that can be offered in order to avoid unnecessary admission to hospital, to support timely discharge from hospital, to avoid premature admission to long-term residential care and to promote faster recovery from illness.

The information given in this factsheet is applicable in England. Different rules may apply in Wales, Northern Ireland and Scotland. Readers in these nations should contact their respective national Age Concern organisations for information specific to where they live – see section 9 for details.

For details on how to order other Age Concern Factsheets and information materials go to section 9.

Note: Many local Age Concerns are changing their name to Age UK.
Inside this factsheet

<table>
<thead>
<tr>
<th></th>
<th>Recent developments</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>What is intermediate care?</td>
<td>3</td>
</tr>
<tr>
<td>3</td>
<td>Who could benefit from intermediate care?</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>3.1 An alternative to hospital admission</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>3.2 Early supported discharge from hospital</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>3.3 When facing admission to residential care</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>3.4 Older people with dementia or other mental health needs</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>3.5 End of life care</td>
<td>6</td>
</tr>
<tr>
<td>4</td>
<td>What types of service may be available?</td>
<td>6</td>
</tr>
<tr>
<td>5</td>
<td>Access to intermediate care</td>
<td>7</td>
</tr>
<tr>
<td>6</td>
<td>Is there a time limit for an intermediate care package?</td>
<td>8</td>
</tr>
<tr>
<td>7</td>
<td>Re-ablement</td>
<td>8</td>
</tr>
<tr>
<td>8</td>
<td>Relevant legislation, guidance and circulars</td>
<td>9</td>
</tr>
<tr>
<td>9</td>
<td>Further information from Age UK</td>
<td>9</td>
</tr>
</tbody>
</table>
1 Recent developments

- A Local Authority Circular was published on 28 October 2010. It asks local authorities - in view of the potential for similarities between intermediate care and ‘re-ablement’ - to review their charging arrangements for re-ablement services, with a view to repaying to clients any amounts that were wrongly charged and received for services that met the intermediate care definition. This definition can be found in the 2003 Regulations below.

- ‘Intermediate Care – Halfway Home’ is best practice guidance issued in July 2009 to update the original 2001 guidance. It is aimed at those who arrange and manage local intermediate care services. However it may be of interest if you provide health and social care services, receive them or are a relative or friend of someone who receives them.

- ‘Intermediate Care – Halfway Home’ clarifies some areas of the original guidance (such as how long intermediate care might last) and expands on the range of individuals who could be considered for intermediate care (such as people with dementia or who have mental health needs).

You can find full titles and links to the Legislation, Guidance and Circulars mentioned in this factsheet in section 8.

2 What is intermediate care?

The Community Care (Delayed Discharges etc) Act (Qualifying Services) (England) Regulations 2003 say:

- “intermediate care” means ‘a qualifying 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 home.’

- a period of intermediate care which begins on or after these regulations come into force is required to be provided free of charge to any person to whom it is provided for any period up to and including six weeks.

Health and/or social care services that meet this definition of intermediate care may be provided to:

- prevent unnecessary admission to hospital
● prevent unnecessarily prolonged stays in hospital following an ‘acute hospital admission’
● prevent or delay premature admission to long-term residential care
● maximise your health and self confidence and chances of living independently.

An ‘acute hospital admission’ is admission to a general hospital, often via accident and emergency (A&E), where you are treated on a medical or surgical ward.

Intermediate care is not meant to be viewed in isolation but to be seen as having a key role to play in supporting you to stay independent for as long as possible and in identifying your future support needs.

3 Who could benefit from intermediate care?

Intermediate care should be available to help all adults over the age of 18 who might need it. No one should be excluded on the basis of age, ethnic or cultural group, or health condition.

Older people are a key target group for intermediate care, as many can benefit from:
● services to support their recovery and rehabilitation and re-build their confidence
● being given the opportunity for further recovery before deciding on their longer term care needs, particularly if admission to a care home looks likely.

Below are occasions when intermediate care could be an option if the appropriate services, outlined in section 4, are available.

3.1 An alternative to hospital admission

If you become ill at home or have a fall that results in only a minor injury, it may be possible to avoid admitting you to hospital and to care for you at home if appropriate services can be put in place at short notice. This has the added advantage of avoiding the stress of going into hospital and means that at a later date, you can have your longer term needs reviewed in familiar surroundings.
It is important that all staff you could come in contact with in this context - this could be your GP or an out-of-hours doctor, district nurse, social care staff, ambulance service paramedics, A&E department or hospital medical assessment unit staff - are aware of the health and/or social care services available through the local intermediate care service. If they believe you are a potential candidate for intermediate care and there is a rapid response team, you can be referred to them for an assessment. See section 4.

3.2 Early supported discharge from hospital

You may be able to leave early after hospital in-patient treatment, if the following were available to you at home - short-term nursing support and/or practical or personal care support as well as rehabilitation support at home or at a day centre/hospital.

3.3 When facing admission to residential care

Section 2 of the 2009 intermediate care guidance stresses that anyone facing admission to long-term residential care should have the opportunity to benefit from rehabilitation and recuperation and to have their needs assessed in a location other than an acute hospital ward.

It also discourages transferring patients directly to long-term residential care from an ‘acute hospital ward’ unless there are exceptional circumstances. Exceptional circumstances might include:

- completion of specialist rehabilitation – such as is offered in a stroke unit
- sufficient previous attempts to be supported at home having been tried (with or without an intermediate care package)
- judgement that a short period of intermediate care in a residential setting followed by another move is likely to be distressing.

The term ‘acute hospital ward’ means a medical or surgical ward in a general hospital. It does not refer to a ward in a general or community hospital that is dedicated to providing rehabilitation services.
3.4 Older people with dementia or other mental health needs

The 2009 guidance specifically mentions that intermediate care should be considered as an option for older people with mental health needs, if there is a goal that could be addressed within a limited period of weeks as part of their recovery from an episode of mental or physical ill health.

When deciding if intermediate care would be appropriate and agreeing how long to allow for specific goals to be reached, it is important to involve health professionals who understand the needs of people with conditions such as dementia. This might be a community psychiatric nurse or old age psychiatrist.

A stay in hospital can be traumatic when you have dementia as you are separated from familiar people and places. Access to suitable intermediate care support means you can either avoid admission to hospital or leave hospital early, significantly affecting your recovery and wellbeing.

3.5 End of life care

Intermediate care could be appropriate if there are specific goals for you or your carer that can be addressed in a limited period of time. These might be to establish a suitable home environment and routine or to help your partner to develop skills to enable you to remain at home.

4 What types of service may be available?

The range of services that form part of an intermediate care package can vary across the country. Where possible the preference is for core services to be provided in your own home rather than a residential setting, but services may be provided in your own home, in a day centre, in a day hospital, community hospital or other residential setting.

A wide range of health and social care professionals is likely to be involved. This could include doctors, nurses, psychiatrists, community mental health nurses, physiotherapists, occupational therapists, speech therapists, social workers and care assistants.
Services that might be available include:

- **Rapid response teams** – who can offer rapid assessment of your needs either at home or in the A&E department. Their main aim is to prevent unnecessary admission to hospital. These teams may be community based. Where appropriate, they can initiate rapid access to short-term nursing support, equipment and personal care at home. Local GP practices, out-of-hours services, the ambulance service or the hospital accident and emergency department should be aware of when and how to access their local teams.

- **Acute care at home** – this is support from specialist teams and could include treatment such as administration of intravenous antibiotics.

- **Supported discharge from hospital** – this is a short-term programme of nursing care and/or therapeutic support, with personal care and community equipment where necessary to allow rehabilitation and recovery at home.

- **Residential rehabilitation** – this is a short-term period of care in a community hospital or residential care home for people who need rehabilitation services but no longer need 24-hour access to consultant-led medical care.

- **Day rehabilitation** – in addition to services that allow you to live at home, you may attend a day hospital or day centre for physiotherapy or other rehabilitation services.

5 **Access to intermediate care**

If you, or a relative, are in one of the situations outlined in section 3, you should raise the question of intermediate care with the person responsible for your future care.

This could be paramedics who attend you at home, the team responsible for your hospital discharge, your GP or out-of-hours doctor or the adult social care team in your local authority. They should be able to explain local options and criteria for referring to the intermediate care team. Ideally there will be one team co-ordinating intermediate care within your area.
If you are referred to this team, your needs should be assessed and if intermediate care is appropriate, a care plan and time frame should be discussed and agreed with you, and where appropriate your carers. The care plan is likely to include active therapy or treatment and support that helps you realise your potential for any further recovery.

A named person should be appointed to ensure that your care plan is implemented and your progress monitored and reviewed at regular agreed intervals. Your needs should be reassessed at the end of this period to allow any future care needs to be identified and addressed once you are discharged from intermediate care.

6 Is there a time limit for an intermediate care package?

While acknowledging the short-term nature of intermediate care, the 2009 guidance supports the need for flexibility and avoidance of unrealistic expectations. It says that individuals with dementia may need an extended period of intermediate care while a physical condition stabilises. Intermediate care is provided free of charge for any period up to and including six weeks.

7 Re-ablement

‘Re-ablement’ services may also fall within the definition of intermediate care.

Re-ablement services are usually time-limited and most frequently delivered in your own home using specially trained carers. The aim is to support and encourage you, particularly after a stay in hospital, to learn or relearn skills necessary for daily living and for you to discover what you are capable of doing for yourself. The ultimate aim is for you become more confident when moving around your home and with tasks such as washing, dressing and preparing meals and so regain your independence.

If your re-ablement package meets the definition of intermediate care in section 2, you should not be charged for up to six weeks of such care.
At the end of an agreed period, your ability to manage daily living tasks will be reviewed. If this assessment identifies the need for longer term support, appropriate steps can be taken to meet those needs. For further information see Age UK’s factsheet 41 *Local authority assessment for community care services*.

8 **Relevant legislation, guidance and circulars**

*The Community Care (Delayed Discharges etc) Act (Qualifying Services) (England) Regulations 2003* can be found at:

*The 2001 Intermediate Care Guidance* can be found at:
www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Healthservicecirculars/DH_4003694

*The 2009 Intermediate Care Guidance* can be found at:

*Local Authority Circular LAC (DH) (2010) Personal Care at Home Act 2010* can be found at:
www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/LocalAuthorityCirculars/DH_120994

9 **Further information from Age UK**

*Age UK Information Materials*

Age UK publishes a large number of free Information Guides and Factsheets on a range of subjects including money and benefits, health, social care, consumer issues, end of life, legal, issues employment and equality issues.

Whether you need information for yourself, a relative or a client our information guides will help you find the answers you are looking for and useful organisations who may be able to help. You can order as many copies of guides as you need and organisations can place bulk orders.

Our factsheets provide detailed information if you are an adviser or you have a specific problem.
Age UK Advice

Visit the Age UK website, www.ageuk.org.uk, or call Age UK Advice free on 0800 169 65 65 if you would like:

- further information about our full range of information products
- to order copies of any of our information materials
- to request information in large print and audio
- expert advice if you cannot find the information you need in this factsheet
- contact details for your nearest local Age UK/Age Concern

Age UK

Age UK is the new force combining Age Concern and Help the Aged. We provide advice and information for people in later life through our, publications, online or by calling Age UK Advice.

Age UK Advice: 0800 169 65 65
Website: www.ageuk.org.uk

In Wales, contact:
Age Cymru: 0800 169 65 65
Website: www.agecymru.org.uk

In Scotland, contact:
Age Scotland: 0845 125 9732
Website: www.agescotland.org.uk

In Northern Ireland, contact:
Age NI: 0808 808 7575
Website: www.ageni.org.uk
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If you would like to support our work by making a donation please call Supporter Services on 0800 169 80 80 (8.30 am–5.30 pm) or visit www.ageuk.org.uk/donate

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