In CSED’s work to date, we have tried to differentiate homecare re-ablement from other forms of care and support, including intermediate care, by using the definitions applied by the DeMontfort University in their evaluation of the HART service in Leicestershire.

It is important to be clear about the differences between intermediate care and homecare re-ablement because in some ways they appear to duplicate each other. The confusion is increased because there is no single model for either homecare re-ablement or intermediate care. In addition, as this document seeks to illustrate, the term ‘intermediate care’ is often used to refer to a function or to a service, and specific services can and do take a number of different purposes and forms.

It remains our view that homecare re-ablement complements the work of intermediate care services (as defined by DH in its June 2009 publication, *Intermediate Care – Halfway Home*, Updated Guidance for the NHS and Local Authorities) rather than replaces it. Re-ablement seeks to support a different phase on the continuum of care, whether that be different groups of people or the same people at a different stage of their ‘recovery’. In reality, the intermediate care and homecare re-ablement phases for specific individuals may overlap.

**Definition**

The latest guidance (*Intermediate Care – Halfway Home*, Updated Guidance for the NHS and Local Authorities, July 2009) seeks to provide an update to the previous guidance issued in 2001 (Department of Health Intermediate Care 2001 Health service/local authority circular HSC 2001/001) and incorporate all of the subsequent policy changes.

‘Intermediate Care – Halfway Home’ defines intermediate care 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.” (see page 3).
It goes on to re-affirm the defined criteria for service models as including those that meet the following criteria:

- "They are targeted at people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute inpatient care, long term residential care or continuing NHS in-patient care.
- They are provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment or opportunity for recovery.
- They have a planned outcome of maximising independence and typically enabling patients and service users to resume living at home.
- They are time-limited, normally no longer than six weeks and frequently as little as one to two weeks or less.
- They involve cross-professional working, with a single assessment framework, single professional records and shared protocols”

So having defined intermediate care as a function that encompasses a range of services, the document goes on to provide guidance on the principle focus:

“The key target groups for intermediate care identified in the initial guidance – people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute inpatient care, long-term residential care or continuing NHS in-patient care – remain the priorities. However, those who might be facing admission to long-term residential care should be considered to be equally, if not more, important than the other two groups. All older people at risk of entering care homes, either residential or nursing, should be given the opportunity to benefit from rehabilitation and recuperation and for their needs to be assessed in a setting other than an acute hospital ward”

So in most cases, intermediate care services seek to address one or more of three main priorities:

1. Prevent admission to hospital
2. Speed up hospital discharge, and
3. Prevent or delay admission to long-term residential care

In comparison, homecare re-ablement seeks to support people and maximise their level of independence so that we can appropriately minimise their need for ongoing homecare support. Its clients therefore include those who may have undergone a phase of intermediate care but also people who remain within the community requiring support to live at home and have not ‘gone near’ a hospital or long-term care placement. In many services community referrals are 50%+ of their caseload.
Forms of intermediate care

Accepting that intermediate care, as a function, can take a number of forms, the guidance provides examples (see Section 4, page 8)

“The services that might contribute to the intermediate care function include:

- rapid response teams to prevent avoidable admission to hospital for patients referred from GPs, A&E or other sources, with short-term care and support in their own home
- acute care at home from specialist teams, including some treatment such as administration of intravenous antibiotics
- residential rehabilitation in a setting such as a residential care home or community hospital, for people who do not need 24-hour consultant-led medical care but need a short period of therapy and rehabilitation, ranging from one to about six weeks
- supported discharge in a patient’s own home, with nursing and/or therapeutic support, and home care support and community equipment where necessary, to allow rehabilitation and recovery at home. The arrangements may work well in specialist accommodation such as extra care housing
- day rehabilitation for a limited period in a day hospital or day centre, possibly in conjunction with other forms of intermediate care support.”

Commonly the residential rehabilitation settings take one of two forms:

- Step-up: to prevent admission to acute care by taking referrals from the community or care home settings
- Step-down: to facilitate a stepped pathway out of hospital by taking referrals from acute hospitals and to facilitate return home or to a care home setting

In addition, as illustrated in the intermediate care academic studies completed for DH in 2005, these services or residential settings often, but not always, focus on specific client groups or conditions e.g. post stroke, etc. rather than on supporting all people discharging from hospital.

Intermediate care teams

The recently published guidance in Section 4, page 8 provides information on the skill sets required within an intermediate care service:

“A core intermediate care team is likely to include support workers, nurses, physiotherapists, occupational therapists, social workers and community psychiatric nurses. It should be led by a senior clinician, who should ensure that the team’s competence and knowledge of good practice and research are kept up to date. Nursing skills are likely to be needed for those with complex
or long-term conditions and for short-term treatments, such as the provision of intravenous antibiotics at home”

**Charge for service**

The legal definition for intermediate care, as set out in the Community Care (Delayed Discharges) Act 2003, is as follows:

“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”.

Local Authority Circular (DH) (2010)6 says “Regulation 4(2) of the 2003 Regulations requires that intermediate care is provided free of charge for the first six weeks. Accordingly, re-ablement services are likely to fall within the definition of intermediate care services and should not be charged for the first six weeks”.

For more information, see http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/LocalAuthorityCirculars/DH_120994

**Summary**

A problem with any comparison of such disparate services is that similar services are often called different things, and different services are often called the same thing.

Table 1 summarises the generic features and highlights the differences between intermediate care services and homecare re-ablement services.

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**Table 1: Generic Features of Intermediate Care and Homecare Re-ablement**

Care Services Efficiency Delivery (CSED): Homecare Re-ablement Toolkit 2010 4
<table>
<thead>
<tr>
<th>INTERMEDIATE CARE</th>
<th>HOMECARE RE-ABLEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PURPOSE</strong></td>
<td>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</td>
</tr>
<tr>
<td><strong>MODEL OF CARE / SUPPORT</strong></td>
<td>Patient has a defined clinical need Normally adopt a health model of care</td>
</tr>
<tr>
<td><strong>SKILL SET</strong></td>
<td>Clinician led with multi-professional teams including nurses, therapists, etc.</td>
</tr>
<tr>
<td><strong>FORM</strong></td>
<td>Bed based: as in specific intermediate care centres or in care homes Community: as in people's homes or day rehab</td>
</tr>
<tr>
<td><strong>CLIENT GROUP</strong></td>
<td>All adults that fall within the purpose of the service as defined above. Some services focus on clients with specific medical conditions only.</td>
</tr>
<tr>
<td><strong>LOCATION OF SERVICE DELIVERY</strong></td>
<td>Residential as in step up and step down Community: as in hospital at home or supported discharge at home Daycare: as in day rehabilitation</td>
</tr>
<tr>
<td><strong>SELECTION / DESELECTION</strong></td>
<td>Operate on a selective basis</td>
</tr>
<tr>
<td><strong>ELIGIBILITY</strong></td>
<td>Not subject to FACS</td>
</tr>
<tr>
<td><strong>CHARGE</strong></td>
<td>Not subject to charge for the first six weeks</td>
</tr>
</tbody>
</table>