Intermediate Care -"A Whole System Approach"

Jan Allwood

Reference Group member

Health and Social Care Change Agent Team – D.O.H

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Facts and Figures

- Since the 1930s, over 65s has more than doubled.
- Now, one fifth of the population is over 60
- Between 1995-2025:
  - over 80s will increase by almost a half
  - Numbers of people over 90 will double

Issues around acute hospital admission & discharge

- Older people occupy 65% of acute sector beds
- Transfers from acute wards account for:
  - 63% of nursing home admissions
  - 43% of residential home admissions

  <3000 beds / day are occupied by people awaiting discharge
- Majority of those beds are occupied by people with Mental Health needs

What is Intermediate Care?

- An emerging concept in health care
- May offer attractive alternatives to hospital care
- Care that is "in between"
- Arises out of a policy imperative
- Intermediate Care is delivered by those health (***and social care***) services that do not require the resources of a general hospital but are beyond the scope of the traditional primary care team (BGS)

Intermediate Care – The National Perspective

Builds on the National Guidance (Jan 2001)

Intermediate care should focus on three key points in the pathway of care:

- responding to or averting a crisis
- active rehabilitation following acute hospital stay
- where long term care is being considered

NSF for Older People (Standard 3)

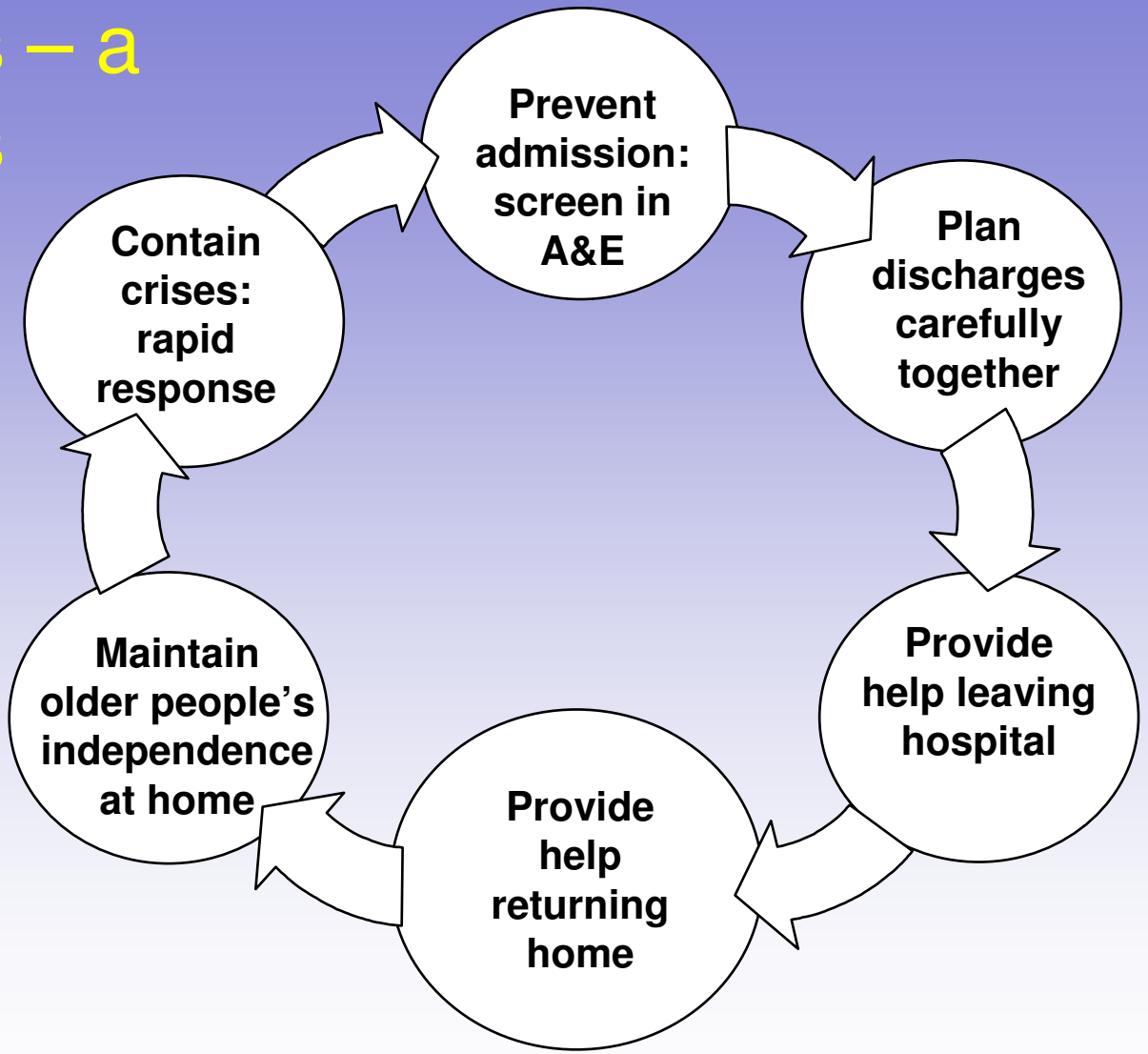
To provide integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admissions, support timely discharge & maximise independent living.

(***This includes adults with complex needs and older people with mental health needs***)

A Whole Systems Approach

- Self Care – Advice and Carer Support
- Multi-agency prevention
- Voluntary Sector
  - Primary Care
  - Housing
  - Health and Social Services
- Community Nursing / Therapy / Social Care Support
- Intermediate / Interim / Transitional Care
- Secondary Care
  - Fast Track Medical Assessment and Treatment
  - Specialist Nursing and Therapy

Integrated services – a Virtuous Circle



Key Deliverables - Intermediate Care

- Improving discharge and transfers from hospital and promoting rehabilitation
- Reducing avoidable admissions
- Avoiding premature/ avoidable dependence on long-term care

Who is eligible ?

Targeted at people who would otherwise face:

- unnecessarily prolonged hospital stay
- inappropriate admission to acute in-patient care , long term residential or continuing NHS in-patient care
- Provided on the basis of a comprehensive assessment, individualised care plan, active therapy, treatment *or* opportunity for recovery.

Essential components of I.C.

- In reach to secondary care to encourage timely referral
- Single point of referral to Intermediate Care
- Free at the point of delivery
- 24 hour, 7 day access to integrated services
- Fast response, flexible and adaptable. Ready access to equipment
- Person/carer centred, not service driven
- Time limited service, individualised
- Speedy access to medical assessment/support
- Settings: own home, day hospital, day care, extra care step-up/step-down, beds in a variety of settings

Cont.

- Empowered, highly skilled professionals
- Generic, well trained support workers
- Clear aims, objectives, outcomes
- SAP which links up all care sector
- Access to technology
- Ability to offer end of life care
- Evaluation, ongoing development
- Marketing, communication, joint training
- Leadership, champions
- Pooled budget

What needs to be done?

- Research : Evaluate : Monitor : Feedback
  - Listen to older people's and carer's views
  - GP Practice profiles – IC referrals
  - Delayed transfers – quantity & quality
- Culture Change – "hearts and minds"
  - Multi-agency Training
  - Involve all acute wards
  - Communication / Feedback Loop / Newsletter
  - Publicity Campaign for consumers

How is it done?

- Requires Health and Social Care colleagues to work ***in partnership*** to further develop responsive innovative solutions to current challenges

- Requires a ***shared vision***, which involves all involved being clear about the national agenda.

Intermediate Care in the future

- Joint assessment and joint management of risk
- The assessment and decision making about the longer term care needs of older people including older people with mental health needs should take place within an Intermediate Care setting rather than an acute general hospital