

Factsheet 76 November 2009

Intermediate care

About this factsheet

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

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 7 for details.

For details on how to order other Age Concern Factsheets and information materials go to section 7.

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1 Recent developments

- Best practice guidance, updating the original 2001 guidance, was issued in July 2009. It is aimed at those who commission local intermediate care services but may also interest those providing health and social care services, those who receive them and their carers.
- This update 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 mental health needs).
- The guidance is part of the Department of Health's prevention package for older people. It reflects the current focus on prevention, early intervention and personalising care services so that people are helped to live independently for as long as possible.

2 What is intermediate care?

Intermediate care is a term used to represent a range of integrated health and/or social care services that as part of an agreed care plan aim to:

- promote faster recovery from illness
- prevent unnecessary admission to hospital
- support timely discharge following an acute hospital admission
- prevent premature admission to long-term residential care
- maximise your chances of living independently.

Note: The term 'acute hospital admission' means admission to a general hospital, often via accident and emergency (A&E), where you are treated on a medical or surgical ward. Where an 'acute hospital ward' is referred to in section 3.3 it means a medical or surgical ward in a general hospital, rather than a ward designed to provide predominantly rehabilitation or a ward in a community hospital.

The 2001 guidance requires intermediate care to describe services that meet the following criteria:

- services provided on the basis of a comprehensive assessment, resulting in a structured, individual, care plan that involves active therapy, treatment or opportunity for recovery
- services that have a planned outcome of maximising independence and typically enable those receiving support to resume living at home
- services that are time-limited, normally no longer than six weeks and frequently as little as one to two weeks or less (see section 6)
- services that involve cross-professional working, with a single assessment framework, single professional records and shared protocols.

Intermediate care should help you regain your health and confidence, and be an opportunity for you to realise your full potential. It should be integrated with other mainstream health and social services and contribute to the portfolio of services that can be called on to meet your short term needs and/or help determine your longer term needs.

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

The 2009 Guidance can be found at:
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_103146

3 **Who could benefit from intermediate care?**

Older people who could benefit from the opportunity for further assessment and subsequent rehabilitation or services to re-build their confidence and support their recovery and rehabilitation are a key target group for intermediate care but it 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.

The types of service that may be available are outlined in section 4.

3.1 **An alternative to hospital admission**

If you become ill at home or have a fall but only have a minor injury, it may be possible for you to avoid admission to hospital and be cared for at home.

If appropriate specialised health and/or social care support services are available through the intermediate care service, your GP, district nurse, social care staff, out-of-hours staff, ambulance service paramedics, staff working in A&E or a hospital medical assessment unit may identify you as a potential candidate for intermediate care and refer you to the intermediate care team for an assessment by the rapid response team. See section 4.

3.2 **Early supported discharge from hospital**

Following treatment as a hospital in-patient, early discharge may be possible if short-term nursing support and/or practical/personal care support are available for you at home together with rehabilitation at home or in a community setting such as a day centre.

3.3 **When facing admission to residential care**

The updated guidance stresses that anyone facing admission to long-term residential care should have the opportunity to benefit from rehabilitation and recuperation and the opportunity 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.

3.4 Older people with dementia or other mental health needs

The updated guidance specifically mentions that intermediate care should include older people with dementia or mental health needs, if there is a goal that could be addressed within a limited period of weeks as part of your 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 goals to be reached, it is important to involve health professionals who understand the needs of people with dementia, such as a community psychiatric nurse, old age psychiatrist or geriatrician.

A stay in hospital is often traumatic for people with dementia as they are separated from familiar people and places. Intermediate care support could make it possible for them to avoid admission to hospital or enable early discharge home, significantly affecting recovery and wellbeing.

3.5 End of life care

Intermediate care could form part of your care pathway if there are specific goals for you or your carer that could be addressed in a limited period of time. Using a period of intermediate care to establish a suitable environment and routine or helping carers to develop skills to enable their partner remain at home are examples given in the updated guidance.

4 What types of service may be available?

The types of services available across the country will vary but in principle, services may be provided in your own home, in a day centre or day hospital or a residential setting, although the preference is to provide support in a community setting rather than in residential care.

Intermediate care services may involve a wide range of health and social care professionals including doctors, nurses, psychiatrists, community mental health nurses, physiotherapists, occupational therapists, speech therapists, social workers and care assistants.

Services that form part of an integrated intermediate care portfolio might include the following:

- **Rapid response teams** – their main aim is to prevent unnecessary admission to hospital. They may be based in the community and have links with local GP practices, out-of-hours services, the ambulance service or the hospital accident and emergency department. They comprise a mix of health and social care professionals and offer rapid assessment of your needs and, if necessary, initiate rapid access to short-term nursing support, equipment and personal care support at home.
- **Acute care at home** – this is support from specialist teams, including some specialist 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** – this is attendance at a day hospital or day centre for physiotherapy or other rehabilitation services.

Note: As specified in the 2001 Guidance, services that are arranged by social services and form part of an intermediate care package are free to the user. These services may be home care, day care or residential care.

5 Access to intermediate care

Intermediate care and how you access it will vary according to where you live. If you, or a relative, are in one of the situations outlined in section 3, the team responsible for hospital discharge at your local hospital, your GP or the adult social care team in your local authority should be able to explain local options. Ideally there will be one team co-ordinating intermediate care within your area.

Your needs should be assessed, an intermediate care plan discussed and agreed with you, and where appropriate your carers, and a named person appointed to ensure that your care plan is implemented.

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

The 2001 guidance suggests intermediate care should be no longer than six weeks although this may be extended in individual cases if a further short-term goal is identified at the end of the agreed period. Your progress should be reviewed at regular intervals within the time frame specified in your care plan. If your intermediate care needs last longer than six weeks, further reviews should take place regularly, for example every two weeks.

While acknowledging the short-term nature of intermediate care, the 2009 update 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.

7 **Further information from Age Concern**

Visit the Age Concern website, www.ageconcern.org.uk, or call our national Information Line on 0800 00 99 66 (free call) if you would like:

- to order copies of any of the Age Concern information materials mentioned in this factsheet
- to request information in large print
- further information about our full range of information products
- contact details for your nearest local Age Concern.

Books from Age Concern

Age Concern publishes a wide range of books for older people and those who care for and work with them. The following title may be of particular interest:

Your rights to money benefits 2009/10. All you need to know about the full range of benefits for the over 60s. £5.99

To order this book, or to view our full range of books, please visit our website www.ageconcern.org.uk/bookshop or call our book order line 0870 442 2120.

Age Concern and Help the Aged

Age Concern England and Help the Aged have joined together to form Age UK, a single charity dedicated to improving the lives of older people.

Age Concern and Help the Aged across the UK

To find out more about Age Concern and Help the Aged's work in Northern Ireland, Scotland and Wales, contact:

Age Concern Northern Ireland

Tel: 028 9032 5055

Website: www.ageconcernni.org

Scottish Helpline for Older People (Age Concern Scotland)

Tel: 0845 125 9732

Websites: www.olderpeoplescotland.org.uk

www.ageconcernscotland.org.uk

Age Concern Cymru & Help the Aged in Wales

Tel: 029 2043 1555

Website: www.accymru.org.uk

Support our work

Age Concern is the largest provider of services to older people in the UK after the NHS. We make a difference to the lives of thousands of older people through local resources such as our befriending schemes, day centres and lunch clubs; by distributing free information materials; and through our national freephone helpline – the Age Concern Information Line 0800 00 99 66.

If you would like to support our work by making a donation please call Supporter Services on 020 8765 7527 (national call rate, Monday to Friday 9.15am–5pm) or visit www.ageconcern.org.uk

Legal statement

Age Concern England (charity number 261794) has merged with Help the Aged (charity number 272786) to form Age UK, a charitable company limited by guarantee and registered in England: registered office address 207-221 Pentonville Road, London, N1 9UZ, company number 6825798, registered charity number 1128267.

Age Concern and Help the Aged are brands of Age UK. The three national Age Concerns in Scotland, Northern Ireland and Wales have also merged with Help the Aged in these nations to form three registered charities: Age Scotland, Age Northern Ireland, Age Cymru.

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