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INTERMEDIATE CARE

Executive summary arising from the

Kings Fund seminar

held on 30th October 1996

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Introduction

This paper has been prepared as a summary of the discussion at a seminar held at the King's Fund on 30th October 1996. It seeks to clarify the purpose and function of intermediate care and incorporates the range of views held in relation to a number of key issues. It concludes with recommendations for future work

What is intermediate care?

Intermediate care is seen as a specific service aimed at meeting the needs of those people who are physiologically stable but who could improve the quality of their lives, increase their ability to live independently and minimise their longer term dependence on health care services through timely, intensive therapeutic input. Examples would include people with learning and rehabilitative needs following acute illness, those with health problems which are amenable to nursing and therapist rather than medical intervention, and those sometimes known as 'off their legs' who are at risk of moving to physiological breakdown unless they receive rapid support. The service can be provided in a range of different settings spanning the continuum from home to hospital. Thus:-

- Intermediate care is a **function** concerned with **transition** from medical dependency to personal independence and **restoration** of self care abilities.
- The need arises from a combination of medical and social factors occurring after physiological stability has been achieved (or when physiological breakdown is threatened) and when there is a clear end goal in sight of increasing independence and quality of life.
- The setting in which intermediate care can be offered may range from home to hospital but is of secondary importance provided that the function is clear.

Why consider intermediate care now?

- Factors external to the NHS, such as demographic changes and technological changes, require and allow consideration of new ways of working.
- Central policies encourage consideration of intermediate care as a possible way of dealing with the interface between acute, primary and social services.
- Budgeting constraints require a stringent review of current services, opening up options for alternative (less costly) approaches.

What is the evidence on intermediate care?

- The published literature on intermediate care emphasises nurse-led in-patient units and post-hospital supported discharge schemes which range in orientation from medical to social or multi-professional.
- Nursing unit evidence is mostly qualitative and suggests it is feasible and effective to introduce this type of intermediate care. However policy implications remain unclear owing to methodological difficulties of comparison with conventional approaches.
- Supported discharge schemes can be cost effective with equal or improved patient outcomes, provided that interventions are targeted at patients with defined needs and good potential for recovery.
- Clear specification of care components and service users is required to demonstrate effectiveness. The importance of this arises most evidently in evaluations of intermediate care for elderly people

Points for Debate

This section of the paper has been presented as a series of questions which were debated at the conference, reporting on the range of views offered and summarising the key issues raised.

1. Why, given intermediate care services' existence and successes over many years, are they not already an acknowledged component of NHS care?

- There is a variety of opinion about what intermediate care does, or does not encompass, for example:

> *patients with good prospects for regaining maximum health vs those with a poor prognosis for recovery*
>
> *a specific targeted service vs a repository for bridging services or substitution for the setting in which services take place*

- This lack of clarity has hampered effective evaluation
- Intermediate care crosses traditional boundaries between acute, primary and social care as well as occupational groups and hence its introduction is very complex.
- It potentially threatens traditional patterns of care since it overlaps with, and bridges between, medical and social health.
- There is lack of information about cost implications and a variation of opinion about the relationship between cost and quality indicators.

2. Is intermediate care a new layer in the system, or the glue that holds existing layers together?

- There is some concern that intermediate care would introduce a new 'layer' in the service but this perspective can be rejected in favour of it being integrated into current acute, primary and social services.
- Similarly concern about excessive moves for patients can be countered by the benefits of providing a service specifically targeted at their needs rather than having to vie for attention in an environment which is, by necessity, dominated by acute medical emergencies.
- In the wake of a high degree of specialisation in medical treatment intermediate care can provide the 'glue' in the service which helps patients integrate new levels of health into their day to day lives.

3. Where is the proper locus of intermediate care?

- The setting in which intermediate care services arise is a contentious one which appears to be driven from either a community perspective, as a step up option, an acute perspective, as a step down option, or as an entire care system.
- In any of these options there are financial disincentives related to contracting processes but the threats and opportunities engendered by disinvestment may encourage development in this area of care.
- Examples of exploratory approaches/views being taken to intermediate care include:-

> A hospital based nurse led unit (currently being subjected to an RCT)
>
> The Lambeth Community Care Centre model of a community based inpatient and day care service
>
> A flexible multi-professional community team (within a primary care total purchasing practice) offering either pre or post acute care with access to community hospital beds
>
> Collaboration between acute and community Trusts to provide focused but flexible use of community hospitals with admission primarily related to care categories.
>
> A view that all developments should start from the premise that home care is best.
>
> The use of 'tracer conditions' (at this stage primarily related to a medical diagnosis) to assess what is or could happen to patients and their service arrangements

4. Does intermediate care pose a threat?

- Sectorisation of health care can lead to perceived marginalisation in mixed groups which can hamper free debate about intermediate care.

- If this perspective prevails there is a risk that intermediate care may be seen as either a hospital dominated medically driven service or the exclusive domain of chronically ill people, missing aspects of restoration or enablement.

- The shift in therapeutic model (from cure to enablement) can be seen as problematic as it alters the balance between acute medical interventions and non-technical restorative activities.

- The introduction of 'between services' can create professional uncertainty, lack of ownership by traditional occupational groups and hence lack of a peer support group, and shifts in power relationships, all of which must be addressed if services are to be successfully introduced.

5. Who should lead care provision?

- Although nursing may be seen as a natural candidate, the variation of emphasis in training among different health care workers brings to question whether any current occupational group has all the skills required to deliver intermediate care.

- Opinions vary about the wisdom of blurring traditional occupational boundaries but shared learning is highly valued.

- A potential starting point is to define the competencies required to deliver intermediate care, match this to the core competencies of current occupational groups, and 'top up' skills according to local need.

- Since some intermediate care services already exist information is available about related competencies. The Royal Colleges may have an important function in disseminating this information and assessing the implications for medical (and other) education.

6. Does intermediate care cost too much to be a realistic option?

- The potential for cost savings with the introduction of intermediate care is unclear and may relate to shifting the burden of responsibility either to informal carers or less well paid occupational groups.

- Current contracting systems may act as a disincentive to the introduction of these services because of difficulties in sharing or moving budgets.

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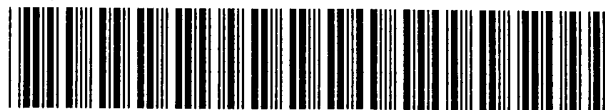
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- Creative ways of using what we already have (such as creating community hospitals within the current acute care setting) need to be considered with an emphasis on maximising value as opposed to simply minimising cost.

What next? How to Proceed

- There is general agreement that the transitional restorative function of intermediate care is crucial to patient care.
- There are important contractual disincentives to providing intermediate care which need to be addressed.
- Practitioners in all sectors must learn to work across boundaries, with shared use of terms, clarification of assumptions, and willingness to develop cross-discipline competencies.
- There is a call for pilot projects and evaluation, using both case study and quantitative approaches to assess intermediate care in relation to existing options.
- A range of options in both community and acute care sectors should be incorporated into this work.

Further details are provided in:

Steiner A, Vaughan B (1997) *Intermediate Care : a discussion paper arising from the King's Fund seminar held on 30th October 1996* London King's Fund. Price £5.00

Steiner A (1997) *Intermediate Care : a conceptual framework and review of the literature* London King's Fund. Price £5.00

Available from the George Godber Bookshop at the King's Fund, 11-13 Cavendish Square, London W1M 0AN, telephone 0171 307 2591.

Information is also available from Philip Hadridge, Intermediate Care Project at Anglia and Oxford NHS Executive, 6-12 Capital Drive, Linford Wood, Milton Keynes MK14 6QP. Telephone 01908844489, fax 01908844477.