King's Fund

Intermediate Care

The Shape of the Team

Barbara Vaughan, Andrea Steiner and
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Intermediate Care Series - Five

INTERMEDIATE CARE

The Shape of the Team

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Section One: Introduction

Box 1.1

Highlights of this Section

- While professionals in acute, primary and social care feel they can recognise people who are likely to benefit from intermediate care, confusion persists about the basic concept.
- Intermediate care is not convalescence, hotel or long stay beds, a movement of services to a new setting or sector, or a new layer in the system.
- Intermediate care targets patients' transitional, therapeutic needs in either the post acute phase or as a means of preventing admission to acute care. It offers a goal directed, time-limited service.
- Many factors are converging to generate a high interest in intermediate care including: pressure on acute beds; increasing demands on primary care; an ageing population with more social care needs; an ageing workforce with different expectations of work responsibilities; a need to balance more sophisticated medical technology with a range of supportive services; a policy interest in integrated services.
- There is debate about whether intermediate care is 'nothing special' and a service that 'anyone can do' or whether it requires special training and particular qualifications
- Health professionals, used to working at a single point in the health services continuum, may not be used to playing a facilitative role that is about tailoring responses to a potentially wide range of health and social needs which cross traditional boundaries.
- Examining the issues and attitudes towards intermediate care which exist within and between professional groups can help to identify key factors in shaping an appropriately skilled team.

"If we could start again would we reinvent doctors, nurses or therapists or would a different type of health care worker be better suited to the needs of patients within an intermediate care environment?" This was the question posed at the outset of the fourth in a series of seminars held at the King's Fund to explore different aspects of intermediate care. Previous seminars, and resultant papers, have considered the nature of intermediate

care[1], how it may be evaluated[2], and implications for funding[3]. The focus in this instance was to explore some of the inter- and intra-professional issues related to the development of intermediate care in order to: gain insight into the way in which professional groups work together; clarify what is in the realm of the possible; seek examples of good practice; and share these experiences with a wider audience. Issues such as managing the shift in responsibility between different care settings and occupational groups were raised, as were the factors which both enhance and inhibit developments in this area.

1.1 Understanding intermediate care

Even though the seminar was directed to issues of staffing and teamwork, it rapidly became clear that many participants felt an ongoing need to clarify just what is meant by intermediate care. Thus throughout the day views on this broader subject were raised. Few people had trouble in recognising the patients who could benefit by intermediate care services, whether they came from an acute, primary or social care background. However confusion remained about both the type of services under discussion and the rationale behind their introduction. As one participant from the acute sector said *"We cannot see it ...therefore how can we define it?"*

There was a view that intermediate care is associated with facilities rather than services; that the focus is a shift of medical services, rather than people, from one setting to another; that it is only concerned with dealing with 'bed blockers' (however unacceptable this term may be to many of us); or, with an air of cynicism, that it is just a passing fashion. From a community perspective views were expressed that *"...the eyes glaze over [at the mention of intermediate care] since it is so much easier to relate to specific services rather than a broad conceptual issue."* Indeed some felt that its promotion is seen with a degree of suspicion; that it is more to do with people seeking to regain territory or turf than about patient need; that it may be financially rather than clinically driven; that it will lead to insurmountable changes in workload, particularly for GPs; and that problems will arise in deciding where responsibility for clinical care should lie at different points in a patient's clinical career trajectory.

It is critical that such issues continue to be discussed in order to reach a point of conceptual clarity about the nature and purpose of intermediate care, albeit in a framework which can

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[1] 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

[2] Steiner A, Vaughan B, Hanford L (1998) *Intermediate Care : Approaches to Evaluation* London King's Fund

[3] Steiner A, Vaughan B, Hanford L (1998) *Intermediate Care : Shifting the Money* London King's Fund

be flexible and responsive to local need. All the questions and anxieties raised above are legitimate. Yet somewhere throughout the country there are already teams who have overcome the difficulties expressed by colleagues; are clear about the service they provide; have sorted out both funding and responsibility for care; and are breaking new ground in redrawing professional roles and relationships.

1.2 Why the confusion

Reasons varied about what lies behind this lack of clarity over the 'what, why and where' of intermediate care. One suggestion was that it is neither new nor complex. Participants felt that they had all, over time, developed their own understanding and could see no reason for the current debate. Indeed it has been described as '*spectacularly ordinary*' and simple in its purpose, with many people able to offer examples of long standing services. However, many, by their very ordinariness, have gone unrecorded and unevaluated. Thus while most people can recognise the need for intermediate care, through lack of clear definition and haphazard development, services have not become strategically embedded as part of mainstream. Couple this with the rising costs of technology and pharmacology which, in a competitive world, are weighed against less easily quantifiable services, and it is understandable that progress has been slow.

1.3 A working definition

The definition we have offered previously suggests:

> Intermediate care encompasses a range of services aimed at meeting the needs of those 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.[4]

Over time we have broadened this statement to encompass those people who are 'physiologically predictable', since it could be argued that medical stability is not realistic. Furthermore, as time moves on and confidence is gained in services, there is a greater level of trust about the degree of clinical stability which can be managed in an intermediate care facility. Our experience of the range and breadth of services which are developing has also led us to encompass:

> Those people who, through timely therapeutic intervention may be diverted from acute physiological crisis and hence admission to an acute care bed.

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[4] Steiner A (1997) *Intermediate Care : a conceptual framework and review of the literature* London King's Fund

Thus while intermediate care may facilitate early discharge from an acute hospital bed it may also be seen as a service which reduces the need for admission to these facilities, thus offering the opportunity for better use of resources.

1.4 What it is not

We have also, over time, found it helpful to clarify what intermediate care is not[5]. In this way it can be differentiated from a range of health care services, all of which have a role to play but which are not encompassed by the relatively specific definitions offered above. Box 1.2 summarises these alternative services.

Box 1.2 What Intermediate Care is Not

- convalescence - which allows time for people to heal but has no active therapeutic input
- hotel beds - which bring people near services but again offer no therapy
- long stay beds - where it is unlikely that there will be sufficient recovery for people to regain independent living
- movement of services - from one setting to another e.g. the shift in treatment of deep vein thrombosis from acute to primary care
- another layer in the service - rather it is being developed in response to what has become known as the 'black hole', where no targeted services have been available to help the transition between acute and primary care

The features which are distinctive to intermediate care relate to the developmental needs of the patients or clients concerned and the goal directed and time limited nature of the service. The setting in which such services are offered is secondary to these considerations. For many this shift from a service defined around an acute medical diagnosis and readily placed in either an acute or primary setting challenges the traditional way in which health care has evolved and, more importantly, been commissioned. Hence there is an ever greater need to open up the debate and clarify the concepts.

[5] Vaughan B (1998) 'Caring Differently' *International Journal of Nursing Practice*

1.5 Why now?

A second recurring theme in any debate around intermediate care is 'why now?' That intermediate care is not a new concept has been discussed elsewhere[6]. Yet it is only in recent times that it has raised such interest. Participants held a range of views about why this should be the case. Increasing pressure on acute hospital beds, accompanied by a perceived pressure to shift the emphasis of in-patient service from rehabilitation and continuing care to elderly acute medicine was seen as one factor. The shift by many general practitioners away from covering night calls may have had a part to play, as continuity of care can get lost. Lack of knowledge of a patient's medical and social needs may lead to a more cautious approach and an earlier admission than might otherwise have been the case. Conversely concerns were also raised around the degree of clinical need. It was suggested that general practitioners are managing people with a much higher level of need in the community than previously and are reluctant to admit through accident and emergency departments, where their patients may be seen by junior doctors with considerably less experience than they have.

From a wider perspective, demographic changes have led not only to an ageing population but also to an older work force who bring both their professional skills and a wealth of life experience to their work. This raises interesting questions about how to make best use of their skills. In a 'cost conscious' era there is a serious need to review the manner in which work is distributed and to question whether there are ways in which we can minimise duplication of effort and maximise use of resources. It can be argued that there is a proportion of the work force who are over qualified, both formally and experientially, for the level of responsibility which they have traditionally exercised in practice. While there is undoubtedly a need to differentiate between academic qualification and clinical competence, the degree of clinical autonomy and accountability which non-medical practitioners can exercise must be open to review when an increasing number are being educated to masters level and beyond. Thus, as new roles are emerging, options for a new way of managing workload, and redefining the boundaries of responsibility, must also be reviewed.

Paradoxically there is also a view that intermediate care is 'nothing special'; that anyone can do it; and that no special training is required. Yet care that is first and foremost based on individualised support and a range of possible health and social needs does not come naturally to many health professionals, who primarily focus on their own section of the

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[6] 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

continuum. Thus a case can be made for a new approach which can be differentiated from the traditional practice of either acute or primary care givers [7].

The context in which intermediate care services are being developed would not be complete without giving some consideration to the current pressure on social services. As the population ages and needs change, so the demands for nursing and residential care have increased to a level where, in many authorities, need can no longer be met. Thus the drive to explore options which may prevent an untimely or inappropriate admission to some form of care setting is a shared concern of health and social care.

Finally, in a world driven by technology, seeking security in decision making and certainty of outcome, there is a growing recognition that the high tech of acute care must be balanced by a range of supporting services in order that need and care can be matched. With the advent of ambulatory services, telemedicine, expanding and developing clinical roles and shifting concerns of the public, it would seem that the time is ripe to review the way in which health care is packaged. As was said by one participant, concern over the 'black hole' between acute and primary care is real and "*..even if there were ample empty beds [in acute care] we would still need intermediate care.*"

1.6 Structure of this report

This report is divided into three further sections. Section Two deals with intra-professional issues related to the introduction of intermediate care. Section Three deals with inter-professional issues and implications for consideration when developing services. Section Four offers examples of ways in which people have 'made it work', and briefly highlights implications at an organisational, policy and professional education level for consideration in the future.

[7] Vaughan B, Hanford L (1997) 'Time of Transition - intermediate care' *Nursing Times* 93 36-39

Section Two: Intra-disciplinary concerns

Box 2.1

Highlights of this Section

- Each occupational group has its own professional concerns and will view intermediate care - or any innovation – through lenses coloured by different sets of values, needs and preferences.
- Nurses may view intermediate care as an ideal opportunity to gain autonomy and expand their roles, particularly as growing numbers gain higher academic qualifications. But internal tribalism and increasing specialisation can block acceptance within the profession of the flexible, cross-boundary role which intermediate care requires.
- Therapists, like nurses, face an 'upward drift of skills'. Many are well qualified to play a leading role in the provision of intermediate care. Limited posts in the NHS and social services mean that the professions must balance their contribution to new posts with the need to provide basic care. Therapists are also frustrated by their lack of visibility and status outside their profession, especially in policy debates about the future.
- Doctors are cautious about patient safety, medical responsibility, workload and remuneration. Consultant views vary between a concern that intermediate care will deprive patients of access to expert knowledge and facilities, or that it is merely a safety valve to relieve pressure on acute beds. Some GPs are worried that patients will be 'dumped' inappropriately into their care while others are at the leading edge of new schemes.
- Social services may see intermediate care as a way to manage increased demand and diminishing budgets. However, closer links with the health service may be seen as a threat to the social sector, with fear of being over ridden by a medical model of care, and erosion of their professional base of practice. Debates about whether assessment is about meeting needs or managing allocation of limited resources may also hamper a multi-professional approach to the development of intermediate care.

A key feature of intermediate care is that the right person is available to offer the right care at the right time. Implicit in this understanding is a recognition of the need for a multi-disciplinary effort. However, before addressing the manner in which the whole team works, it is important to acknowledge that there are also intra-disciplinary issues to be discussed. For the sake of this report these have been broken down into those concerning doctors, nurses, therapists and social workers. It must be stressed at the outset that there are many excellent examples at a local level of cross-discipline and intra-disciplinary sharing and

working. Many have achieved harmony despite, rather than because of, the circumstances in which they work, drawing on mutual respect and an intense focus on patient need rather than occupational gain. However this is not universally the case at operational, strategic or national levels.

2.1 The world of nursing

For many nurses, the introduction of intermediate care offers an ideal opportunity for them to expand their roles, refine their clinical skills and gain greater autonomy in the manner in which they practice. It can be, and is, argued that there is a major disparity between the level of education of many nurses and the degree of clinical discretion which they customarily take. At a minimum all nurses now study to diploma level to obtain qualification but, in reality, many are undertaking first and second level degrees. This begs the question '*Are nurses over trained for the work they do*?' or '*Should we review the way in which health care is managed in order to make better use of resources*?' Link this to a situation where there is a shortage of junior doctors; it is predicted that the GP population will be insufficient to meet need over the next decade as there are insufficient numbers of trainees to replace those approaching retirement; and we are losing nurses and therapists as they become bored and frustrated by their lack of clinical career options. The need to seek alternative solutions then becomes an imperative.

2.1.1 Tribalism

Nurses, however, have their own internal problems to face. That tribalism is rife within their occupational group is a truism of life, with marked evidence of their resistance to share across internal boundaries of practice. Specialisation has become so narrow that there is a real danger of deskilling some practitioners to the point at which they have lost the ability to transfer skills across structural or clinical boundaries. As one participant said "*We are the only health care workers who need a different preparation to work in a different setting. [Such segregation] can be seen as a relic from the past.*" What really matters are the core skills and knowledge of nursing, with the setting in which they work taken as a secondary issue. There is, however, anecdotal evidence of community nurses displaying anxiety about anyone without additional training entering a patient's home. Similarly many nurses working in acute settings have little knowledge of the skills or expertise of their community colleagues. Some new teams, established specifically to offer intermediate care, also report that they are initially viewed with caution by colleagues in both acute and primary care settings.

2.1.2 Employment

Employment restrictions can, in some instances, create difficulties for nurses. As new roles develop and tasks are accepted which are beyond their normal scope of practice, there is ample room within their professional regulations to adjust. The onus is on the practitioner to give evidence of the manner in which competency to undertake a range of tasks or decisions pertinent to the needs of the client can be assured[8]. However, practitioners also have an accountability to their employers. Some are anxious about offering vicarious liability for both decision making and tasks beyond the usual scope of the occupational group concerned. Hence they may restrict creative developments which challenge traditional role boundaries arguing '... *this [the new task] will detract from basic nursing [physiotherapy, occupational therapy...*].'

A similar concern arises when services bridge between primary and secondary settings. Employment contracts usually lie at one or the other end of the continuum and, in a cost conscious era, there are times when restrictions have been placed on activities outside the normal boundaries of the employing Trust. Thus the provision of services which bridge between acute and primary care become difficult to sustain.

Despite these words of caution there are many examples of good practice where such concerns have been overcome. Assurance that both parties are aware of, and agree to, the range or responsibilities accepted by the nurses, the tasks they are undertaking, and the manner in which the service will be funded has eased the way forward.

2.2 The therapist's view

For therapists there is a very real concern that their voice will not be heard in debates about the future. Little mention was made of their contribution in the recent White Paper 'The new NHS - Modern Dependable'[9]. They face many of the same problems as nurses but are smaller in number. The playing field is also very uneven in relation to access to their services. As one participant suggested, while there may be a hue and cry about waiting lists for surgery who, in the public domain, has heard of the long waiting list to access the resource of a therapist (unless they have had a personal need!). It must be added that public

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[8] UKCC (1992) *The Scope of Professional Practice* London UKCC - this document was one of the most liberating directives from the United Kingdom Central Council for Nurses Midwives and Health Visitors (UKCC). In essence it allowed individual practitioners to identify the range of skills which they needed in order to be able to practice effectively. Provided that they can give evidence of the manner in which these skills have been acquired they are, from a professional stance, free to undertake a range of tasks which are deemed useful to their work. Unfortunately some employers, and some of the Royal Colleges, are less liberal in the manner in which they respond to role expansion and offer insurance cover.

[9] Department of Health (1997) *The New NHS – Modern –Dependable* London The Stationary Office

attention has been paid to some aspects of care supported by therapists, such as delays in assessment for, and provision of home adaptations[10], but the voice is often short lived and less well heard.

2.2.1 Registration

Therapists have only had a system of state registration, which can be taken as the kite mark of professionalism, since 1960 with the passing of the Professions Supplementary to Medicine Act. They are not, as yet, protected by the requirement of doctors for Continuing Medical Education (CME[11]) or Post Registration Education and Practice (PREP[12]) for nurses, which may put their continued learning at risk and place them in a vulnerable position. As with nurses they have an 'upward drift of skills' with many becoming highly specialised, creating an artificial gap in provision of 'basic care'. They are also seen to be '*leaking from the system*' as the jobs on offer within mainstream health or social care do not provide the clinical challenge or career opportunities commensurate with their skills.

A final concern of the therapists is that they are lagging in the world of research and development, partly through limited work to date and difficulty in securing funding. Again this concern is shared by nurses and general practitioners, relative to those conducting the narrower clinical research that lends itself more readily to biomedical research models. Gathering the evidence remains a significant challenge.

2.3 The medical view

One of the very real worries which doctors have expressed relates to their ongoing responsibility for care in a situation where patients may move out of their traditional 'patch'. Many hospital doctors have a concern that expertise to provide the medical care which has traditionally been offered in hospital is not available in a community setting, which may lead to a second rate service for patients. In particular they express anxiety that, if admitted to an intermediate care facility rather than acute care, patients may be deprived of expert assessment and access to specialist services and investigations. They see intermediate care as 'messy', not fitting into a neat linear pattern of services we have come to know, and hence difficult to navigate.

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[10] Age Concern England (1998) *Stuck on the waiting list*

[11] Royal College of Physicians and Surgeons of Edinburgh, Glasgow and London (1994) *Continuing medical Education for the Trained Physician*

[12] UKCC (1994) *The Future of Professional Practice : The Councils' Standards for Education and Practice following Registration* London UKCC

2.3.1 Workload

Another major issue which concerns many doctors relates to work-load. Is the hospital clinician being asked to do even more outreach work? Is the over-burdened GP being asked to undertake responsibility for yet another aspect of care? There was a mention of *'care dumping'* which had to be mitigated by ensuring that the GPs had some control over who could be received into a primary care-led intermediate services. It was also suggested that all some surgeons want is a 'take away' service. While this may sound flippant initially, a critical argument for intermediate care is that patients deserve the right service at the right time. Once the surgeon's work is done, they may be better served in a different clinical setting. This does not mean, however, that intermediate care services constitute a way out of an intolerable work load situation or as a 'warehouse provision' when waiting for alternative care. Some GPs remained concerned that surgeons were attracted to intermediate care for the wrong reasons.

2.3.2 Funding

Funding may also become an issue, particularly in the primary care setting where medical staff are reimbursed through independent contracts rather than being salaried[13]. Participants reported a variety of different financial packages that have been agreed at a local level with a combination of retainer and call out fees being negotiated. At the moment there is no favoured approach. There is, however, a strong suggestion that, since patients requiring intermediate care services tend to be medically stable, a low retainer and high call out fee would be the favoured economic choice. Some would go further and argue that the service is within the normal range of responsibility for general practitioners and does not require a separate funding arrangement.

2.4 A social services view

The impetus from social services has been driven by a number of inter-related factors. First, there is the increase in demand for community care services which itself is fuelled by a rise in public expectation and an increasing withdrawal from what has come to be considered as social care by health providers, particularly when considering an older population. Second, most social services departments have had to manage a diminishing budget whilst at the same time providing equity of funding between adult and child-care services and continuing to meet their statutory duties towards individuals. The lack of a systematic approach, not only within social services but also between social and health sectors, has resulted in reactive solutions being advanced that may solve an immediate difficulty in one part of the system but result in increased pressure in another. (See Box 2.2)

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[13] NHS Executive (1997) *Personal Medical Services Pilots under the NHS (Primary Care) Act 1997* Leeds NHS Executive

Box 2.2 Examples in practice

One recent example was the decision taken by a London Borough to control its spend on residential and nursing care placements by taking all decisions at a monthly panel. This effectively rationed the number of placements agreed; in addition it slowed the spending rate of the Local Authority so that they could use their limited budget to greater effect. However by solving its own problem the Local Authority increased the average length of stay in its local general hospital by 40%. Similarly a decision by a Health Authority to increase the average waiting time for elective surgery, in this instance hip replacement operations, had a severe impact on the Local Authority's domiciliary care budget.

2.4.1 Gains and losses

Social Services are starting to recognise both the benefit and the imperative to forge close working links with health care providers and commissioners[14], as without this strategic alliance no part of the whole system will cope. There are, of course, a number of fears including loss of independence; loss of political control; the culture of social care being subsumed within a health orientated culture; and marginalisation of the professional base. However the potential benefits of such an alliance are, as a result of many pilots funded by Tomlinson monies, Winter Pressure monies etc., starting to become much more apparent from the patient's or user's perspective, as well as in business terms.

2.5 Summary

In summary, it is widely acknowledged that tensions can be created within the boundaries of a single occupational group when change is proposed. Time and help are needed to gain confidence and trust in the work of colleagues as well as envisaging new working relations. There is no doubt that these changes can be achieved but a starting point which acknowledges the existence of potential challenges will help in sound planning for future developments.

[14] Department of Health (1998) Modernising Health and Social Services: National Priorities Guidance 1999/2000 – 2001/2002 Department of Health

Section Three: Inter disciplinary work

Box 3.1

Highlights of this section

- Ideological and practical concerns place interdisciplinary team working at the heart of developing intermediate care. However, even professionals who work side by side tend not to understand the knowledge base, goals and responsibilities of other occupational groups.

- In part this is owing to differences in how language is used. Certain words (like 'empowerment') attract loyalists and enemies. At other times the same words (like 'enablement' or 'episode of care') carry different meanings for different groups. The lesson is to listen carefully and not to assume understanding.

- Patients and clients are often painfully aware of the overlaps in professionals' functions, yet occupational groups remain reluctant to acknowledge duplications.

- Cross-skilling has both pros and cons but the consequences of *not* sharing skills can be serious for patients.

- Sharing leadership of the intermediate care team in a flexible way, determined on an individual basis according to patient need, may be considered. Traditionally admission and discharge rights to care, vested in medicine, have indicated leadership. The transitional recuperative nature of intermediate care may challenge this tradition, in both acute and primary care settings.

- There is a difference between guidelines (not a blue print) and protocols (which are meant to be adhered to). On the one hand protocols may mitigate error and safeguard against litigation; on the other hand they may limit the opportunity to exercise clinical judgement.

- Concerns that nurse-led units might isolate patients from skilled assessment and diagnosis may be unfounded, as nurses have long been used to alerting doctors to a change in condition. Equally, it may be appropriate to confer greater responsibility than in the past to those therapists and nurses with the skills required for rehabilitation.

- Equity of access to expertise and resources which have traditionally been based in acute care is important wherever intermediate care is delivered.

Interdisciplinary work is at the hub of this report, driven by an acknowledgement that it is only through combining the knowledge and skills of all team members that patients can access a comprehensive (or holistic) package of care which is sensitive to their needs. As ever more demands are made on resources it is critical that we make efficient use of what we do have, which can only be achieved through effective collaboration. However, while the ideology of interdisciplinary team working is well voiced and there are many excellent examples where such collaboration can be demonstrated, it must be acknowledged that the inter-relationships are complex, not always easy to achieve and may be restricted by traditional values, patterns of care, perceived roles and power bases. Variations in the professional education of different occupational groups has led to a situation where language is used in a different way; the manner in which we cope with uncertainty varies; power bases are uneven; and the way in which different occupational groups prioritise usually favours what they know best.

As was suggested at the seminar, professions may see new ways of working as a threat to traditional patterns, commenting *"We are engrained in the way we work and unwilling to look at alternatives."* Although this comment came from a doctor, it could equally well have applied to any of the occupational groups present. We aim here to highlight a broad range of issues which need to be considered when moving to new ways of working.

3.1 Knowing who does what

As one participant said *"There is a tremendous ignorance about what other members of the multi-disciplinary team do ... even if they spend most of their working day together."* However unintentional this may be, there is ample evidence that we all view the world from our own professional stance, an entirely understandable characteristic since this is where our greatest knowledge lies. Yet we have very limited insight into either the knowledge base or the goals of other occupational groups in health care. Hence there is a serious risk of duplication, over or under-use of skills, inappropriate referral or inadequate communication.

We are dealing with a situation which has partly arisen from the way in which we have segregated the development of both practitioners and services. For example few doctors are aware of what nurses can or cannot do within the confines of their professional regulations, nor do they understand the freedom they now have to develop skills appropriate to the needs of their patients[15]. At the same time, many nurses are unaware of the extent to which their own regulations allow them to develop skills and, more importantly, accept responsibility for their own actions. Even though there are many excellent local examples of

[15] SCOPE op cit

innovation[16] [17], time and tradition have led nurses along a cautious route, with a legacy where it is presumed by others that they are neither able, nor wish, to accept additional responsibility.

3.2 Language

Language is our most powerful tool for communication yet our different backgrounds lead us to *use* language in a different way. For example doctors pleaded with others to avoid the so-called 'put off' use of terms such as empowerment and enablement. Yet these were expressions with which members of other occupational groups at the seminar not only felt comfortable but to which they were committed. Maybe this is a further expression of the complexity of multi-professional work. Every occupational group develops a shorthand language of its own which is frequently incomprehensible to others. In many instances this language reflects the way in which the knowledge of the occupational group has been developed. Thus for doctors science has dominated, reflected in an ongoing use of the language of science and the use of scientific terms which remain opaque to many patients. For nurses much of their work is about helping people to regain self-care skills[18]. Thus empowerment is an everyday word, common to many, which has come to form part of their day to day language. Similarly enablement is a positive term in many health settings but for social workers caring for clients with substance abuse problems, it refers to the ways in which people help the 'addict' to maintain his or her habit.

This issue is exacerbated further by the introduction of management terms in health and of international differences in use of language. For example in the US an 'episode of care' refers to the whole chain of services throughout need, whereas in the UK it is commonly used to mean the exact opposite. Power relations can also be identified through varied use of language, demonstrated, as one participant suggested, by referring to patients as being '*under the doctor*'.

There is another even more critical message behind these comments. If we, as members of a range of different occupational groups working in the common field of health care, have trouble with varying use of language, it is even more complex for patients or clients, with a high risk of misunderstanding. The lesson reiterated throughout the day was to listen - to other professionals and to service users. While the words may be simple and overused it is

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[16] Read S (1996) *Catching the Tide : new voyages in nursing?* University of Sheffield ScHARR Occasional Paper no 1

[17] Touche Ross (1995) *Evaluation of nurse practitioner pilot projects* London NHS Executive South Thames

[18] Furlong S (1995) *Self-care : Application in practice* London King's Fund

evident that many feel that there are still important hurdles which must be overcome in order to move from confusing rhetoric to shared reality.

3.3 Overlap of function and issues of trust

It is often the patients who can point to overlap of function between occupational groups, the most frequent comments relating to variations in the information given, lack of integration of care or a need to keep repeating the same story for different people[19]. Practitioners remain reluctant to acknowledge such an overlap albeit between acute and primary care or health and social care[20]. There appear to be different views at operational, strategic and policy levels of what are core skills and functions shared among many groups, particularly physiotherapists, occupational therapists, social workers and nurses[21]. While at a local level trust and sharing may occur amongst teams, this is not readily reflected on a wider front. Thus mistrust develops 'in principle' although many practitioners know it to be misplaced.

Even though trust often does develop in an acute or primary care team, it is less easy to develop that same trust across traditional organisational boundaries. Thus the hospital team may display concern about the clinical competence of colleagues working in the community, whether in medical, nursing or therapists' roles, while community teams may express disquiet about hospital colleagues' awareness of the environment and social circumstances to which a patient will return. Indeed one suggestion was that hospital-led stroke teams could 'over rehabilitate' and hence raise unreal expectations of home life!

3.4 Integrating care

Another issue relates to the manner in which the services of each practitioner are integrated into a whole package of care. Without some degree of cross skilling concern was expressed that the endeavours of each team member may be less effective since they would not be reinforced by others. Thus the consequences of not cross skilling can be significant for patients. It can lead to a delay in access to the services of a therapist who may only be available intermittently. The value of the treatment offered by therapist may be lost if it is not reinforced in his/her absence and integrated into a whole pattern of care.

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[19] Wilson A (1994) *Being Heard : the report of a review committee on NHS complaints procedures* London Department of Health

[20] (1998) *Partnership in Action* This report stresses that 'sharing information between agencies to help enhance integrated services to individuals will be crucial to successful partnership between health and social services'.

[21] MacFarlane L, Lees P (1997) Barred facts *Health Services Journal* 107 26-29 This bar coding system is being developed to bring to light the type of actions which are carried out by different team members and potentially to identify any duplication of effort.

At the same time the concept of integrating care by integrating roles begs interesting questions about how scarce resources and skills may be best employed. At which point should the practitioner be directly 'giving care' and at which point could he or she be more effective by teaching the primary carer, whether a family member or a practitioner from another occupational group, to manage a specific aspect of care? Cross skilling could be seen as a way of streamlining care, solving some of the problems of multi-professional approaches to care and reducing the chance of patients receiving conflicting information. At present patients may have to relate to many different people, all of whom have an important contribution to make, but with the risk that it is the patient or carer who is left to put everything together in a whole package. Patients need help prioritising what matters most, and in linking the different options together. (See Box 3.2)

Box 3.2

The Pros and Cons of Skill Sharing

Advantages of skill sharing	Disadvantages of skill sharing
• Ensures continuity in the absence of the specialist. • Allows effective use of resources. • Prevents delay of access to some services. • Reinforces therapists' treatments by all team members. • Reduces the number of people to whom the patient must relate. • Enhances an holistic approach to meeting individual goals and care packages.	• Dilutes specialist skills. • Limits equity for patients in accessing specialist services for intensive, rather than usual, care. • Erodes professional identity

These comments in no way undervalue the specialist skills of different members of the multi-professional team. Rather they highlight the potential pitfalls we may have to address if more integrated pathways to care are not found. Serious questions must be raised about the way in which we have traditionally packaged care, related to the different occupational groups rather than the whole needs of the patient.

3.5 Who leads the team?

There has been a long standing presumption that the clinical team will be led by doctors [22], despite situations where clinical need is not pertinent to their expertise. There is also a genuine, though some would suggest unfounded, concern of doctors, managers and nurses that while tasks may be delegated, authority to manage care and hence responsibility cannot be referred to another occupational group within the health service. However some of the Primary Care Act Projects which are led by nurses offer an excellent example of just how well some of these initiatives can work[23]. Time and again a view was heard that we are frustrating practitioners within the confines of the team by not allowing them sufficient room to exercise clinical judgement and autonomy.

Intermediate care services bring to the surface issues which have long been the subject of debate[24]. The argument is simple. It has already been suggested that access to intermediate care is determined by medical stability or predictability, and that needs relate to regaining self care skills and the ability to manage personal health in order to prevent (where possible) further deterioration. The question then is who takes the lead? Should it be vested in the person who has the skills which are most appropriate to clinical need at that point in time? Whose skills relate most closely to need? What is the relationship between the range of occupational groups who may contribute to care? Where does overall responsibility lie?

3.5.1 Power of admission

One argument which has been rehearsed in relation to these questions is that the lead role lies with the person who holds power of access. Thus it is the practitioner who can accept a patient for admission to an intermediate care scheme, or refuse when the referral is not appropriate, who takes the lead. In practice this may well vary. For instance, in one current example[25] it is the nurse practitioners who can accept patients into their care in a community hospital, and when appropriate take responsibility for discharge home. Medical advice is sought when needed, as if in the patient's own home, and every encouragement is given to the nurse practitioners to exercise their clinical judgement autonomously. This arrangement reflects both the early and more recent work undertaken on nurse-led inpatient care[26],[27]. In another setting it is the GPs who negotiate with consultants on a one-to-one

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[22] Batchelor I, McFarlane J (1980) *Multi-disciplinary Clinical Teams* London King's Fund
[23] Gardner L (1998) Does nurse-led care mean second-class care *Nursing Times* 94(36) 50-51
[24] Batchelor and McFarlane op cit
[25] Sir Alfred Jones Memorial Hospital, Liverpool
[26] Pearson A, Punton S, Durant I (1992) *Nursing Beds : an Evaluation of the Effects of Therapeutic Nursing* London Scutari Press
[27] Griffiths P, Evans A (1995) *Evaluation of a Nursing-led In-patient Service: an interim report* London King's Fund

basis prior to agreeing to transfer a patient to an intermediate care setting with the GP in the lead. In yet another situation it is hospital outreach teams who retain responsibility during the period of transition, with consultants remaining at the helm. Thus, as can be seen, the simple question has multiple responses.

3.5.2 Breadth of knowledge

Leadership of course goes beyond admission and discharge rights, although power and locus of control are part of the story. Some participants (and others) have expressed a view that only medical education offers the breadth of knowledge to allow for recognition of the unusual, and hence the skill to identify the range of causes and treatment options. This is, of course, within a medical model of care. It does not always account for the psychosocial factors influencing health. Time and tradition have a part to play, but external factors are rapidly altering this scene. Increasingly the need for a multi-agency approach to health is acknowledged. Public health is now firmly on the agenda, with a growing agreement about the need to address the health of the nation from a multi-factorial perspective[28]. In addition an understanding of management, with its own specific body of knowledge, has a part to play though it is a perspective which is often neglected.

Finally within this section a question was raised about the role that patients and clients have to play in leadership. While there was a shared agreement that the voice of users must be heard, a lay participant at the seminar firmly expressed the perspective that this was a professional issue. His comment was "*Sort your own team out*". Such a view underlines a serious issue about whether the ideology of leadership being vested in patients for their own care is just an abdication of professional responsibility. There is, however, a more insidious concern about the manner in which the shift is managed from the traditional paternalistic relationship between the giver and receiver of care, and the partnership relationship encouraged by current policy[29].

3.6 Shifting Responsibility

With the development of intermediate care services the movement of a patient between acute, primary and social care shifts from the traditional pattern to which we have become accustomed. Hence it is critical that clear decisions are made about the manner in which responsibility for care is handled. Two main issues were discussed at the seminar. Firstly there is a need to clarify the point at which responsibility for medical care moves between the general practitioner and the hospital consultant. At the heart of this issue participants

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[28] Department of Health (1998) *Our Healthier Nation* London The Stationary Office
[29] Department of Health (1998) *Modernising Health and Social Services: National Priorities Guidance 1999/2000 – 2001/2002* Department of Health

stressed the need to ensure that channels of communication are clear. They also highlighted the need for flexible gatekeeping rights in case of atypical moments in a patient's progress. Thus, for example, if hospital cover is retained in the community, as it may be in some hospital-at-home schemes, then the people who are in ongoing contact with the patient (usually nurses and therapists) need to have rights to re-admission. However in some early discharge schemes, medical responsibility is transferred to the general practitioner without such rights. In order to avoid a feeling of being 'dumped on', some GPs have negotiated the right to refuse a patient's early discharge to the community if they do not feel able to manage the care required.

3.6.1 Shifting between occupational groups

The second area of debate about responsibility arose in relation to inpatient services, either in community hospitals or nurse-led in-patient facilities in acute settings, where nurses usually take the lead responsibility. For many this is a new way of working which may take time to develop, since formal acceptance of responsibility, and hence accountability, has not been widely exercised by occupational groups other than doctors in the past. Hence time and support are needed during a transition period, as is the opportunity for some further skills development.

3.7 Use of protocols and guidelines

Guidelines and protocols for care are widely employed in intermediate care services, particularly when some team members are making clinical decisions beyond their traditional scope of practice. Indeed there is a drive for this approach to care on many fronts as part of the central strategy for quality assurance[30], risk management and the enhanced use of evidence based practice. There is, however, a subtle but important difference between guidelines and protocols which could have important implications for practitioners. While guidelines are just what they say - that is, a guide to practice but not a blueprint, protocols are there to be adhered to. If there is any variance a strong case must be made for not following the recommended procedure. There is also an agreed wisdom that it would be the medical staff who would be held to answer for such variations.

While some may see protocols as a safeguard against error, a view was also expressed that their over use could lead to cookbook care, which may not be sensitive to individual need. Indeed one view expressed was that protocols could '*stifle clinical judgement*' and limit opportunity for patients' involvement in care planning. Others felt that protocols were a necessary prerequisite to audit and, in a society that is becoming more litigation minded,

[30] Department of Health (1998) *A First Class Service : Quality in the new NHS* London The Stationary Office

serious problems could arise if they are not in use. Hence the use of protocols remains controversial (See Box 3.3)

Box 3.3
The use of protocols

Advantages	Disadvantages
• Assurance of an agreed standard. • Safeguard against error. • A prerequisite for audit. • Transparency of decision making for the patient or client. • Protection in litigation cases.	• Fear of 'cookbook' practice. • Stifling of clinical judgement and innovation. • Potential delay in referral when deviation from expected pathways occurs. • Limited opportunity for patient involvement and choice.

This variation was clearly expressed by two alternative models of intermediate care which have been developed. In one instance the team have no protocols. They strongly argue that the manner in which they have developed their practice would have been hampered if they had relied, in the early stages of development, on the use of either guidelines or protocols. Instead they have developed a challenging health team where the multi-professional review of decision making not only gives those who are less used to relying on their own judgement the opportunity to do so, but also develops trust within the team and assurance of the competence of all members of the team. At the other end of this continuum some very well developed initiatives in intermediate care have placed considerable effort in the development of clear protocols, not only to safeguard the patients but also to ensure that agreed standards are maintained. The argument is ongoing and unresolved.

3.8 Equity of access to care

A major concern expressed by some participants was the manner in which equity of access to both clinical expertise and to specialist services could be assured. Many people who use intermediate care services are elderly, disabled or at a vulnerable stage of their lives, and a fear was expressed by some that these patients would be denied access to specialist services currently housed within the acute care sector. An alternative perspective, however, was that hospitals were '*not a safe place to be*' and only acceptable when there is no other option. Regardless of age, people differ vigorously on whether they perceive hospitals as places of

danger or safety when they are unwell. Thus the problem to be addressed was the manner in which access to specialist skills could be assured and the varying wishes of the population could, where possible, be accommodated.

3.8.1 Skilled assessment

The critical role of skilled assessment was a focus of discussion, particularly as it concerned elderly care. While many practitioners can, and do, relate to 'off your legs', an important question was raised about why that clinical state had arisen. The risk of missed diagnosis and the need to rule out any underlying pathology was strongly endorsed. The messages portrayed were twofold. First, from a medical stance, the need for joint planning between acute and primary care was stressed. Thus within, for example, a home based rapid response scheme, liaison with a consultant in elderly care to offer specialist assessment can be established from the outset and indeed good examples of co-operation of this kind were offered.

3.8.2 Shifting responsibility for assessment

The second arm of this debate relates to a situation where responsibility for care has been transferred to a member of another occupational group, most commonly to nurses who are managing either in-patient or home-based care. Fear was expressed that nurses may not have the diagnostic skills to identify potential or actual physiological difficulties at an early enough stage. One participant suggested a need to reconsider the basic curriculum of nurses, with a stronger emphasis on the underlying skills of diagnosis related to pathophysiology.

In practice such concerns do not seem to be well founded. Early reports from people who are running intermediate care schemes suggest that when patients become unwell it is most commonly because a further acute incident has occurred, which would have been the case in whatever setting they were being offered care. Furthermore, while the responsibility for diagnosis remains firmly in the hands of doctors, nurses have always been the ones who are at first hand to alert colleagues to a change in condition. There are also examples where additional skills training has been undertaken by nurses and therapists in areas such as chest percussion, in order that changes in clinical condition can be picked up at an early stage. There remains, however, a fundamental difference between recognising a change and diagnosing of the underlying cause. This emphasises a critical difference in the contribution of nurses and doctors.

A case was made for formally extending the range and breadth of responsibility of nurses and therapists involved in intermediate care. If the need for a service of this nature relates to

development of self care skills and independent living, then there is a logic in transferring responsibility to therapists and nurses who already have many of the required skills, As one general practitioner at the seminar said *"neither GPs or consultants know about rehab."* If we are to find safe, pragmatic ways of reducing the pressure on medical staff, enhancing the role of nurses and therapists, distributing the work load more evenly and ensuring services which are sensitive to patient need then these are options for serious consideration.

3.9 Summary

The starting point in shaping a team to offer intermediate care arises from careful consideration of the needs of the patients concerned. There are many examples where skills have been shared across traditional role boundaries without getting over-zealous about labels and 'turf', but there is a range of concerns which need to be addressed in development work of this nature.

A case was made by some participants to retain the clear distinctions of each of the occupational groups, with an argument that the skills and knowledge of each were needed. This opinion was coupled with a fear that overall shared responsibilities would blur each unique contribution. There was, however, a stronger message that there are core competencies which can readily be shared, with 'add ons' for both the specific professions and the specific needs of the clients.

For some this offers an exciting and interesting challenge for the future in considering the way in which the development and training of health care workers may be reconfigured, issues which will be briefly raised in Section Four.

Section four: Making it work

Box 4.1

Highlights of this Section

- Most successful intermediate care projects developed as local answers to local problems. Those able to clearly define their purpose, objectives, target population and planned intervention did best.

- The role of leaders with vision cannot be underestimated. They can hold tribalism at bay by keeping focused and understanding different stakeholders' concerns. But the charisma that can initiate a new programme must be complemented by skilled management to embed practice, even if the first leader moves on. It is important to help the range of affected parties to understand about intermediate care.

- Good communication is another key to success, which manifests in several ways
  - Health care professionals and the public need to know about the service
  - It is essential that information moves with the patient
  - Team members need to be informed of ways to access resources easily
  - Access routes to intermediate care from acute, primary and social services must be explicit

- The success of intermediate care rests on developing the confidence and competence of those who provide the service. Many successful teams are supported by generic workers, prepared with mulitprofessional training packages.

- The attraction of intermediate care is that it is so simple. But it requires addressing 'just about every interface there is.'

- Services need evaluation, not only to learn formative lessons about development but also to gauge effectiveness and the economic implications.

- Users' concerns must not be ignored. Intermediate care is an unknown quantity to most patients. They need to be reassured that it is not a lesser quality service, but purposefully targeted at a specific range of needs.

- So far intermediate care successes have been small scale and it has not been possible to fully assess the knock-on effects across the health service. But shifting services into ambulatory and other intermediate care structures would sharply alter the DGHs, PCGs, and professional workforce of the future. It is these issues which need further serious consideration.

That there are ways of developing intermediate care services which are creative, well managed and sensitive to local need is self-evident since there are so many examples of

good practice. In debate with those who have been able to shift traditional boundaries of both service configuration and roles, the elements which they have seen as essential to success are by no means new. Indeed they are classic to the management of change and, as was highlighted at the seminar, they bring to light "*the art of the possible*". Hence in this section many of the issues that were raised by participants will be familiar - the old adages of good management. Nevertheless there is a value in highlighting them here in relation to intermediate care, supported by participants' examples from practice.

4.1 The vision

Change without reason is rightly open to criticism, but in the case of developing intermediate care, participants were quite clear about the drivers that had led them to introduce a new service. The initiatives were most commonly seen as '*a way of finding local answers to local problems*' and responding to a recognised need or opportunity. The reasons were varied, ranging through the under-use of a local community hospital and hence its threat of closure; pressure on acute beds; silting up of social service facilities; a belief that it is clinically safer to get people out of hospital early; a response to winter beds monies; or a recognised gap in service provisions. Frequently it was a combination of two or more of these factors accompanied by either a pragmatic or financial '*window of opportunity.*'

4.1.1 Clarity of purpose

In many instances the development had to be 'marketed' to others on whom it may impact. Thus clarity of purpose was closely linked to the vision. Both seminar participants and others who have successfully implemented intermediate care are clearly able to define the rationale for the development; the target population for whom the service is being developed; what they are hoping to achieve; a time frame for access to the service and a description of what it will 'look like' in practice. While in many instances these factors have shifted in the light of time and experience, clarity of purpose at the outset was a common feature amongst participants.

4.2 Leadership and involvement

Often the 'vision' was the brainchild of an individual who was willing to take risks, had a clear purpose and the energy and drive to take things forward. While it was commonly agreed that strong leadership of this nature was critical, it was also critical that the project was skilfully managed. If plans to embed the new service in main line provision were not made, then a serious concern remained that the initiative would fold when the 'hero innovator' moved on. This risk was seen as even greater when the drive had come from

either non-medical or managerial sources as these roles are more transient than those of senior medical practitioners.

Whatever source the leadership came from, a critical function of the leader was seen as keeping 'tribalism' in check in order that new ways of working could be promoted which may be seen as threatening to some participants. As one participant admitted *"Yes, the children squabble ...so what [this is only to be expected] The issue is to be pragmatic and opportunistic and to be seen to recognise and respond to their needs."* There was also a view that it is the strength of leadership which can, in itself, help to make things happen through raising the interest of those concerned in order that they give of their best. A suggestion that the perceived success of some stroke units rested in the concern and interest of the team (rather than the measurable therapies) was voiced as an example of this kind of influence, which raises a major challenge to traditional approaches to evaluation.

4.2.1 Getting people on board

There is no doubt that a key feature to success has been early involvement of all concerned. Working out who may help or hinder the development and involving them from the outset was seen as essential. Key players had wide and varied backgrounds, encompassing people from acute and primary care, the health authority, medicine, nursing, social work and the therapies, community health councils, housing and any neighbouring service providers on whom the service may impact. Multi-agency planning and agreed project monitoring were seen as essential, as was a public agreement of the contribution which each participant would make. In some instances this has meant that more than one agency has had to be involved when, for example, the boundaries of health and social services are not coterminous. Similarly, when services may be funded from more than one budget, early involvement is essential.

While organisational issues are a critical feature in development, clinical concerns also need to be addressed from an early stage. For example a plea from the acute sector was for early involvement of geriatricians in order to ensure that older patients have access to specialist assessment. As already suggested, while 'off your legs' may be a commonly used term, the reason why that episode of ill health has occurred must be explored since it may be an avoidable feature for the future.

4.3 Communication

Whenever new organisational developments are discussed, the need for full communication is stressed. The introduction of intermediate care is no exception. Participants repeatedly

stressed the essential requirement for debate, involvement, sharing of ideas and an opportunity for everyone to express a view.

4.3.1 Spreading the word

Information related to organisational issues such as the purpose of the service, the way in which it is managed and the type of people who may benefit are required by a range of different people (see Box 4.2). Briefings to the division of medical consultants was suggested as one means of ensuring that they knew of the service but did not feel individually 'victimised' about reducing their bed numbers, since potential users of intermediate care come from many different clinical directorates. Nevertheless, as a cautionary note, longer term service reconfigurations may well have an impact on the shape of acute care services and clinical teams.

Box 4.2
Sharing information

Whom to tell (the stakeholders)	What to share
• The public who may be service users • Acute care teams (doctors, nurses • therapists and social workers • Primary care teams (as above) • Social services • Health authority managers • Accident and emergency teams • Bed managers • Community health councils • Housing and transport	• The purpose of the service • The potential client group • Where the service is offered • How it can be accessed • How it may impact on other parts of th service and on intra and inter professio issues

NB – the lists above are not exhaustive but need to be 'tailor made' locally

4.3.2 Information management

Several participants pointed out the essential need for information to move with the patient, in order that the person responsible for care is fully informed of previous needs and actions. Simple though this may sound, ensuring that it happens will mean sharing across traditional boundaries in a non-traditional way. One simple method is patient-held records, with an assurance that all team members sign up to, and use, the records. There may be a backup system for aspects of information that are confidential to one team member, whether counsellor, general practitioner or therapist, but most data can be accessed by all those

involved in care, including the patient. Routes of communication between acute, primary and social care also need to be clarified, as does the manner in which each team member can access other services. For example, in one early discharge scheme, medical and nursing aspects of care are co-ordinated from a community base but, with acknowledgement that expert support for therapists was not available in this setting, therapy team members are still linked to the hospital base. Thus there is assurance of access to expert support for all team members even though the sources may be different.

4.3.3 Accessing services

Another issue raised was how intermediate care services themselves could be accessed. Routes in may be from a range of different acute directorates, from an accident and emergency department or from primary care. Within one patch there may be more than one facility. Thus central co-ordination was seen as essential. A single phone line, and someone with a clear co-ordinating function who could 'make things happen' (often a nurse) was offered as an example of good practice.

4.4 Competency and training

Critical to the safe introduction of intermediate care services is the assurance of clinical competency. In line with the national recommendations[31] there was a view that national standards should be set which may offset the current dilemma of each occupational group considering the development and use of protocols, standards and care pathways from a separate stance. Standards were also seen by some, but not all, participants as a means of assuring safety and quality, especially when there was a shift in responsibility between either a consultant and a general practitioner or a nurse and a doctor (see section 3.6). It was stressed that, without the safeguard of a formal period of development to build confidence and trust in the team, there is a serious risk that errors may occur in practice.

Another point raised was that many people "*do not know what they know*". There was a suggestion that nurses, for example, needed support in building confidence in their own clinical judgement. Participants referred back to the old 'doctor-nurse game', highlighting the guiding hand of experienced nurses for junior doctors even though this was not formally acknowledged by either party[32].

Examples were given of formal skills training for nurses and therapists, particularly in expanding their assessment skills, in order that any change in clinical condition would be

[31] National Service Frameworks are one of the key recommendations in the DoH document *A First Class Service* op cit

[32] Stein L I, (1967) The Doctor-nurse Game *Arch Gen Psychiatry* 16 p 699-703

recognised at an early stage[33]. In the early stages this training was usually agreed at a local level between the occupational groups concerned. Sadly one example was given of non-involvement of the local academic institute who expressed a fear of liability for preparing people for tasks beyond the usual scope of the occupational group concerned. Evidently such concerns needed to be addressed if they are to be overcome.

4.4.1 Generic workers

Many of the teams who have successfully introduced intermediate care have spent time and effort in developing the role of the support workers usually from a generic stance. As one participant said of generic support workers "*...[they are] unqualified but not untrained*". Several examples were offered of training and development packages which involved a range of different occupational groups. Participants were also reminded not to forget podiatrists who could teach basic foot care, since 'bad feet' could have a major impact on mobility. Another example was of collaboration between health and social services, where home care staff were offered training by health care workers in order to develop more rounded skills[34]. The cynical view may be that this was a ploy to pave the way for health staff to withdraw their services, but to date there is no evidence that the cynicism is justified.

The attitude to development of generic workers was expressed as one of 'Why not?' rather than 'Why'. Thus the onus for those involved in preparing training packages has been to give clear reasons why a skill cannot be passed on to a generic worker. The impact on individuals of these types of development are also of interest, particularly in a time when it is difficult to recruit staff to health services. At a local level anecdotal information about the impact on the job satisfaction was expressed as "*...an enormous success...part of the team now.*" Another example is of 'mother and daughter pairs', where one satisfied family member has recruited another to the role.

4.4.2 Not for everyone

It must be noted that while many people thrive in an environment where they are able to exercise more discretion in decision-making, this is not universally the case. Examples were offered of some team members who were very angry over the developments and left or were redeployed. Both time and firm management were needed to ensue that the right team was in place. However it should be stressed that, in line with the Magnet Hospital

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[33] Evans A, Griffiths P (1994) *The Development of a Nursing-led In-patient Service* London King's Fund

[34] see also Partnership in Action

findings[35], examples were offered of high levels of motivation and minimal recruitment problems to these units, even in areas were there was a general shortage of staff.

4.4.3 Marketing

Even though we are shifting from a market economy in health care there is still an important need to ensure that both the general public and other health care workers are aware, and understand the purpose, of any new service. Misunderstanding can lead to fears of a second-class service, a cost-cutting activity, limited access to medical surveillance, or an unsafe, 'warehousing' service. The health service has been slow to involve the public in either its clinical or managerial decision-making. Involvement of local voluntary organisations, businesses and the media can all help to raise the profile and the understanding of a new type of service and hence gain confidence in its efficacy.

4.5 Implementation

For some involved with the introduction of intermediate care, time to plan may be seen as a luxury which they did not have - hence the critical need to share ideas and experience. One issue raised by several participants was getting the timing right and recognising the window of opportunity for development. Both generic and context specific issues were identified as the driving forces behind the introduction of intermediate care. Pressure on acute, primary and social services has already been discussed. In addition participants identified opportunistic funding, visionary leadership, willingness on behalf of managers and practitioners to take informed risks but also to compromise, and the energy to take action as positive forces.

4.5.1 Threats to success

Many seminar participants could also identify threats to the introduction of intermediate care. These are summarised in Box 4.3.

As many participants said, in introducing intermediate care just about every interface which exists has to be addressed including inter and intra-professional issues, lack of coterminous boundaries between health and social services, restricted sharing of budgets and a division between acute and primary care. It should, however, be stressed that all of these concerns have already been successfully circumnavigated somewhere in the country.

[35] Buchan J (1997) Magnet hospitals : what's the attraction? *Nursing Standard* 12 (7) 22-25

Box 4.3 Threats to success

- lack of time to plan alongside a full time day job
- tribalism and lack of trust within and between teams
- scepticism - it will never work
- poor information systems and hence restricted communication
- fragmented managerial relations and a reductionist division of labour
- divided loyalties - to professions and services
- closed funding arrangements
- too many projects with resultant rivalry rather than co-operation
- too many people with a vested interest wanting evaluation to suit their purpose
- strategic uncertainty and instability

(Adapted from seminar presentation 8-5-98 / Joe Gannon and Alan Clark)

4.5.2 Some lessons learned

As is always the way it is easy to be wise after the event and highlight what might have been handled in a different way. Differing experience however did lead to a mix of ideas about how best to proceed. For example, on the one hand, it was suggested that it is wise to start small and get sufficient evidence before proceeding on a larger scale. Alternatively a view was offered that the time for piloting had passed and it was more appropriate for intermediate care to become part of mainstream service provision. The importance of developing an open, flexible strategy which allows for quick response to shifting goal posts and can accommodate individual effort within an overall framework was stressed.

The need to keep things simple was also emphasised. As was said, *"It works because it is so simple."* However even simple solutions usually take much longer than anticipated to establish. It is important not to raise unrealistic expectations by underestimating the start-up time. In particular great importance was placed on staffing issues in terms of role development, team building, skills training and probably most importantly recognition of the need for a change in culture. As one participant said *"staffing issues are very time consuming ...[it feels like] two steps forward and one step back"*

Preventing trouble before it happens was another common theme. For example the development of a communication strategy was essential (see section 4.3). One part of this was a 'first day visit' after discharge by the GP or the intermediate care team leader to make sure that both the patient and the team were well informed of what to expect. Such visits

can potentially spot problems before they happen. Thinking ahead in terms of security of contracts, recruitment and training are also essential and schemes which do not invest in staff development are doomed to fail.

Budget issues were a further challenge to some participants which are discussed more fully elsewhere[36]. Suffice to say here that there was strong support for the principle of unified budgets in order to maximise use of resources and minimise duplication of effort.

4.6 Evaluation

If new teams and services are to be established and embedded in future service provision then finding out whether they work is a basic requirement. This topic is covered in detail elsewhere[37]. However, in this seminar participants again stressed the importance of establishing an evaluation strategy from the outset with shared agreement about what would constitute meaningful outcomes. There was general agreement that functional level evaluation alone was not enough but that effectiveness and economic aspects were also needed. However, with a note of caution, a view was also expressed that by the very nature of what we are examining we will never be able to get the degree of concrete evidence which would equate with more easily examined subject areas.

4.7 What of the user

This brief section deals with some of the concerns raised about users' views. They ranged through their need for information about what intermediate care is; the issue of choice and an assurance that intermediate care would not be used as an alternative to acute care should that be a more appropriate option; and the clinical efficacy. There were also questions raised about the risk of this type of care being seen as second best. While, from a professional stance, an argument can be developed to suggest that intermediate care is targeted at needs which are currently poorly addressed in health care services, unless they are acceptable to potential users their introduction must be questioned.

There was also a view that hospitals are feared by many and '*are not always a safe place to be*'. Hence the option of an alternative would be welcomed. Hospitals are, however, familiar while intermediate care services are not. Thus it is critical that patients enter intermediate care facilities with informed consent of purpose and goal. For many potential users of an intermediate care service and for those who offer the service, time may be needed in order to establish an effective way of working. The importance of ensuring that

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[36] Steiner A, Vaughan B, Hanford L (1998) *Intermediate Care : Shifting the money* London King's Fund

[37] Steiner A, Vaughan B, Hanford L (1998) *Intermediate Care : Approaches to evaluation* London King's Fund

the views of users are actively sought during these developmental stages was stressed, in order that they may inform a way forward.

4.8 Is it worth it?

There is a received wisdom that it is worth the effort involved to develop a strategy for intermediate care even though it is early in the day to offer definitive benefits. Nevertheless there was enthusiasm among participants of the perceived benefits which are summarised below. (Box 4.4)

Box 4.4 Benefits of intermediate care

- provides a more coherent service for the public
- reduces pressure on emergency hospital admissions
- reduces the scale of 'social problems' on acute wards
- minimises interruption to elective work
- strengthens links between health and social services
- allows more rational planning of domiciliary resources
- influences recruitment of staff and provides job satisfaction
- is valued by community teams and offers an interesting option for PCGs of the future
- encourages a flexible and creative style of team working

It is too early yet to have evidence of whether or not these benefits can become sufficiently wide spread to have a significant impact on the way in which health and social care are packaged for the future and there is an urgent need for rigorous research. Nevertheless there is a ground swell of interest which, in itself must raise questions about how to proceed.

4.9 Summary

While the concept of intermediate care is simple and logical it does have wide reaching implications which link to both current health care policy and options for future reconfigurations. There is already evidence that we misuse acute hospital beds, with a significant proportion of the occupants not needing access to the expensive range of services on offer, either because they are in the recovery stage from ill health or their condition does not require high tech intervention. There is a wide variation in clinical management of patients, which is being addressed under the auspices of clinical governance and there is lack of equity in both the range of services which can be accessed at a local level and the priorities which are set by commissioners.

The work which we have drawn on to inform this report offers some examples of different patterns of work. Yet it highlights the way in which the structures we currently work with put artificial barriers between acute, primary and social care, as they do between different members of the clinical team. The examples used have largely been at a pilot stage which, in terms of wider implications, may hide the knock-on effect for service reconfiguration and professional education. A pilot is fine as an isolated case, but in reality it is the tip of the iceberg and, as it stands, it is often insufficient to 'hurt' other parts of structure. Yet the volume of work which could fall into both intermediate and ambulatory care services will inevitably impact severely on the structure of the DGHs and PCGs of the future, the relation between health and social services, the shape of the workforce and their professional education. In a time when there are very real problems in funding of health care and recruitment into the service it may be opportune to be bold and take note of what has been achieved, somewhere throughout the country, in offering patient sensitive intermediate care services, and to raise wide spread debate about what the short and long term implications may be.

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Appendix 2: List of Participants

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