King's Fund

Intermediate Care

Shifting the Money

Andrea Steiner, Barbara Vaughan and
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Intermediate Care Series - Four

INTERMEDIATE CARE

Shifting the Money

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Section One: Introduction

Box 1.1

Highlights of this section

- Unless intermediate care can be defined, it cannot be commissioned.
- It is more helpful at this stage to be clear about local contextual needs than to seek an all-embracing universal definition.
- Those who work in the area of intermediate care no longer view their activities as sector-based.
- Obstacles to implementation (and funding) must be dealt with explicitly in order to ensure long-term sustainability.

This report, which focuses on the costs and financing of intermediate care services, is the fourth in a series of papers produced by the King's Fund. Previous work has provided a conceptual framework to clarify understanding of intermediate care and examined issues related to implementation and evaluation.[1,2,3]

In the last few years, intermediate care has burgeoned. In some localities, it has been part of a whole systems plan for health and social care.[4] More commonly, the services have been patchwork and piecemeal. Funding has tended to be patchwork and piecemeal as well, reflecting an opportunistic rather than a planned approach to meeting people's intermediate care needs. This has resulted in some negative ramifications in that providers, lacking any assurance that a service offered one season will be supported the next, have treated its evaluation as marginal. Without evaluation, however, there has sometimes been insufficient evidence to justify gap-filling transitional services as part of a usual package of care. Thus confusion continues and intermediate care remains controversial and experimental, even as those most involved

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

[2] 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.

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

[4] This has been the approach in Leeds, for example, where the Health Authority took a whole systems approach which was planned for several years before going live in April 1998.

report that, for them, the critical task is less the decision of whether to provide intermediate care than it is the challenge of securing longer-term support than has been available thus far.

To help break this pernicious cycle and consider the leap to more stable contract-based funding, the King's Fund convened a workshop to discuss the possibility of reconfiguring services to fulfill patients' transitional needs, with specific reference to financing. Called *"Disabling Perverse Incentives to Service Reconfiguration: Shifting the Money"*, the workshop focused on finding out what local providers and commissioners of health and social care have been able to achieve in terms of funding intermediate care, what they have wanted to do but been unable to because of difficulties with financial or contractual arrangements, what they have learned about costs and savings associated with intermediate care, and what the most creative solutions to common problems appear to be. In this report, we summarise the general proceedings of the day.

1.1 Revisiting definitions

Despite - or perhaps because of - the exuberant grass roots growth of intermediate care services in the UK, virtually all conferences, seminars, workshops and meetings on the subject begin with debates about definition. The term invites instant controversy. Is intermediate care an NHS flavour of the month, characterising services that have been part of the health care system for decades? Is it a cost-cutter's call for a return to the days before geriatricians became advocates for appropriate medical and rehabilitative care of the elderly, when the convention was inexpensive, unsophisticated and essentially non-therapeutic care of older people? Does it describe a pioneering model of nurse-led holistic care that nurtures and educates, a GP-led model of primary care that promotes continuity and prevents avoidable admissions to hospital, or a social services-led model of continuing care that emphasises short-term care plans, re-assessment and iterative goal-setting in order to improve or restore people's function and well-being?

Some proponents equate intermediate care with rehabilitation. Others argue instead that there is an important place for traditional nursing services such as wound dressing, pressure sore treatment or nutritional evaluation, and that intermediate care is the optimal setting for paying this sort of attention to patients. Still others maintain that most of what is called intermediate care is actually continuing care by another name. This is a perspective that treats intermediate care as a general but activist approach to

a range of fairly low-level needs, either pre- or post-acute, which could develop into urgent problems if left unattended.

There is probably no right or wrong to this, although the King's Fund has usefully argued that rebadging existing services without shifting the culture of service delivery threatens to sell the intermediate care concept short. The definition offered in previous documents is based on a reading of consensus and conflict in the literature and born of an interest in capturing what is distinctive about the philosophy of transitional care, as well as a desire not to duplicate existing ways of organising services. To reiterate, intermediate care is defined as a *function* concerned with *transition* from medical dependence to personal independence, focused on *restoration* of self-care abilities. It arises from a combination of medical and social needs and is aimed at those people who are physiologically stable following an acute episode of illness but who could improve the quality of their lives, increase their ability to live independently, or minimise their longer term dependence on health services through timely therapeutic input. Alternatively, it can be used to prevent inappropriate admission to acute hospital for people who have a short-term episode of ill health or a short-term need for social care rather than specialist medical intervention.

Typically, with intermediate care, a clear end goal is in sight. It is this which distinguishes it from convalescent or continuing care, even though the services offered, settings where care is received, and professionals who provide support will overlap and at times be identical. To some clinicians, such a distinction can seem academic. However, for commissioners, the distinction is essential because the planning and cost implications are entirely different.

At least in the short term, it is probably less important to share a definition nationally than to make explicit what the local operational definitions are. Clear definitions will facilitate contracting, system design, service delivery, and eventual judgments of cost-effectiveness. The key is this: ***If intermediate care cannot be described, it cannot be commissioned.***

1.2 Who this report is for

However readers may be defining intermediate care, it is assumed that many will have already identified their interest and want ideas about how to secure appropriate and sustained funding for it, despite resource and other constraints. We did not find simple solutions but did locate numerous examples of creativity and success. The report should also be useful to those less persuaded about the merits of the intermediate care

concept, but who want to understand more about the concrete issues involved in shifting the money.

1.3 What this report is *not*

What follows is not intended as a manual for costing intermediate care. We do offer some specific examples of detailed costings which were produced by commissioners or providers of particular services, but these are only intended to give a general feel for possible approaches. Nor is it a primer on economic evaluation. We will review the fundamentals of value for money, but are not specifically focused on discussing ways to fulfill that algorithm. Finally, it is not a review of systematically collected evidence on the costs and financing of intermediate care. Rather, the report collates the perceptions and best efforts of a select group of people who are in the vanguard of those commissioning, organising, and providing intermediate care.

1.4 Organisation of the report

The workshop was organised into four broad sections: (1) introductory presentations on value for money and the challenges to intermediate care associated with perverse financial incentives, followed by theme-setting and workshop discussions on (2) community/health perspectives, (3) the acute care perspective, and (4) the commissioning perspective. However, delegates rejected the distinctions. ***Those who work in the area of intermediate care no longer view their activities or their concerns as sector-based.*** This is an interesting finding in itself. In organising this report, then, we have taken their cue and arranged our summary according to the issues, incentives and potential resolutions in intermediate care provision.

Section Two discusses the issues and incentives that make it complicated to arrange financial support of intermediate care, whether for pump priming or in the longer term. Because reconfiguring services is at the heart of such arrangements, issues of power, professional culture and considerable administrative detail all come into play. These must be dealt with explicitly in order to ensure the best care for patients. It is hoped that what may seem like a litany of obstacles, or perverse incentives, will be used by readers to identify more precisely which financial or contracting issues they must tackle locally and nationally in order to implement a stable set of intermediate care services. Section Three focuses on the approaches used by some groups that have succeeded, at least temporarily, despite the barriers. It is here that good ideas, both broad-brush and specific, are presented.

We also provide two appendices. Appendix A very briefly summarises the basic state of knowledge regarding the costs of intermediate care, focused on Hospital at Home, early discharge and community management of stroke, early discharge and community management of frail elderly, and community hospitals. Appendix B lists the delegates to the King's Fund workshop that prompted this report, along with their affiliations. Speakers have been noted with an asterisk.

Section Two:
Issues and Incentives in Reconfiguring Services towards Intermediate Care

Box 2.1

Highlights of this section

- The national policy interest in integrating care makes it timely to consider a move from 'creative' funding options (e.g. Challenge funds, winter pressures monies, etc.) to mainstream sustainable funding for intermediate care.
- New arrangements will have to offer value for money, which goes beyond direct costing to comprise the concepts of economy, efficiency and effectiveness.
- When considering cost savings, there is a trade-off between 'keeping it simple' in order to make a clear comparison and taking a complex whole-systems approach in order to examine the knock-on effects of innovation. When considering value for money, it must be remembered that value may be understood in different ways by different people.
- Reconfiguration requires attention to both desired and unintended incentives that are built into any organisation or system of delivering care.
- At present, there are practices, polices and values embedded in the NHS that undermine the development of intermediate care. These include an institutionalised reluctance to admit to problems; the ambiguous impact of evolving purchasing arrangements; the diffuseness of targeted users across primary care practices and clinical directorates, which can make it difficult for physicians to feel the impact of intermediate care upon daily practice and hence become enthusiastic; the shift of responsibility but not always funding between acute and primary care; and the fact that economic benefits often accrue to a sector other than the funder of new intermediate care services, yet cross-sector budgets can be difficult to arrange.
- Poor understanding of the intermediate care concept or professional resistance to redistribution of resources can lead to inappropriate and therefore ineffective service developments.

Such barriers to implementation are better made explicit than left unacknowledged because it allows disincentives to be confronted and often overcome.

It is difficult to reconfigure health and social services. The fact that reconfiguration requires resources to be shifted away from some areas and towards others raises issues of power, professional culture, and a great deal of administrative detail. The alternative would be to add new resources, but at present there is neither the evidence base nor the political will for it. Even in light of the current injection of funding to the NHS, the King's Fund seminar participants were united in their view that if funds were not drawn from existing budgets, there would be no intermediate care. This means reconfiguration.

In recent years, intermediate care services have been provided flexibly and funded opportunistically. There now seems to be a clear national policy interest in integrating care,[5] and considerable regional interest in developing services more comprehensively and systematically. This would involve explicit contracts, be it within the health authority or primary care group (PCG) framework, and not the 'creative funding' approach so commonly used thus far. (See Box 2.2 for examples.) With explicit attention to integrated care, contracts could reflect a more rational link between budgets and service provision. This, in turn, could aid in both the implementation and the evaluation of services intended to create smooth transitions and to prevent avoidable problems for patients, whilst reducing inappropriate use of a health service under pressure.

2.1 Commissioning, reconfiguring, and the concept of value for money

According to Dimblebee, decisions to reconfigure or to introduce new services begin with examining their value for money (VFM). (See Box 2.3.) VFM is a product of three critical considerations: economy, efficiency and effectiveness. Most workshop delegates accepted VFM as a necessary if not sufficient criterion. However, many felt there was a gap between the rhetoric of VFM and reality. They argued that although the VFM algorithm may be accurate enough, there are difficulties with applying it, *as currently implemented*, to intermediate care. One problem is that most intermediate care projects are simply that: short-term projects implemented quickly. Economy, efficiency and effectiveness may all have been invoked in the process of accessing such funding, but there has rarely been enough time to attend to questions of maximising VFM. In many cases it is not even assessed retrospectively, at least not rigorously.

[5] NHS Executive. (1997) *The New NHS - Modern Dependable*. Cm3807. London: HMSO.

Box 2.2

The Quick Fix: 'Creative Funding' for Intermediate Care

Workshop delegates described how they had managed to support intermediate care services in their locality. One of the most common approaches was to take advantage of multiple pots of money; for example:

- Tomlinson funds
- Joint finance funding, such as strategic transfer grants (STGs) from health to social services
- Winter bed pressures monies
- Challenge Fund
- Health Authority support for a pilot

Delegates were unanimous in their frustration with certain implications of creative funding. Although the pots of money were highly valued, as was the flexibility with which they could be applied, the cobbling together of multiple short-term sources to create new services does not allow for planning, evaluation or longer-term implementation.

A second problem is that, from a contracts perspective, VFM is usually measured in terms of finished consultant episodes (FCEs); yet, by its nature, intermediate care does not lend itself to an episode framework.[6] One delegate suggested retaining the FCE currency in contracting, but double counting the early (i.e. acute) days of hospitalisation and single counting the later (i.e. intermediate care) days. However, another delegate familiar with health authorities that had followed this procedure - paying more for the first five days of hospitalisation than for the next five, and so on - reported that they had found it too crude an algorithm and had abandoned it.

Moreover, the 'economy' aspect of VFM must be given its full due. Efficiency and effectiveness are not enough. According to policies that promote VFM, services must be obtained as cheaply as possible. In intermediate care, the lower wages of therapists compared to consultants must be traded against the fact that rich, multiprofessional packages of care appear to be more effective than single-focus interventions in restoring patients to an independent state. Once the multiplications are completed,

[6] The FCE barrier has also slowed the introduction of stroke rehabilitation units into common practice, which is only slowly being overcome as the weight of good quality evidence makes it clear that such units are highly effective in improving patient outcomes.

Box 2.3

Value for Money

There are three critical components of value for money:

- **Economy** is about *'saving money'* - not necessarily by cutting back, but possibly by acquiring inputs more cheaply. In intermediate care, that could mean substituting less expensive (and perhaps less skilled) staff for more expensive staff, reducing the number of routine interventions, or shifting the care setting away from the acute hospital.

- **Efficiency** is about *'doing things right'* or doing the same thing better. Here the focus is about the balance between inputs and outputs. Can existing staff treat patients as successfully as usual but in fewer days? Alternatively, can less expensive staff do as well as their pricier colleagues, given current lengths of stay? Can GPs keep their patients out of hospital with a few judicious phone consultations or visits?

- **Effectiveness** is about *'doing the right things.'* The goal here is to have inputs and outputs targeted on appropriate outcomes, and to avoid perverse incentives that could divert efforts away from such targeting. If, for example, the goal is to intervene early enough with chronic care patients to avoid an incipient crisis, one wants neither to over-provide because a programme is 'in place' - and inappropriately turn the patient into a continuing care user - nor to neglect someone in need because GP, community trust and social services cannot agree on who is to be responsible.

(Adapted from Dimblebee, P. "Value for money", paper given at the King's Fund Intermediate Care Seminar, 28.1.98)

economy *per se* may be difficult to achieve without sacrificing quality and therefore effectiveness.

VFM is not the only rhetorical device in the intermediate care debate. Another question that should be fundamental has been made rhetorical by the economic climate. That question is whether the rationale for developing intermediate care is primarily to improve quality by integrating services, or primarily to find cheaper substitutes for existing approaches. The question *should* be fundamental because the answer will influence how effectiveness is defined and therefore how managers will organise the services. However, it may be virtually moot, because even those focused more on quality gains than on cost savings will still have to meet the economic criterion of VFM. The Labour government have introduced a number of measures to address these issues. Quality standards are now acknowledged to include clinical issues, and

the dual strategies of a National Institute of Clinical Effectiveness (NICE) to set standards and the introduction of clinical governance to ensure and improve standards at a local level may introduce active debate about values and goals. Whether these steps will suffice in a policy climate that also emphasises economy and efficiency remains to be seen.

2.2 Cost-effectiveness and knock-on effects

To gauge the cost-effectiveness and VFM of intermediate care, it must be compared to usual costs and outcomes. But which ones? Depending on the intervention, intermediate care costs might best be examined in relation to acute care or nursing home expenditures. Given that the hospital-based intermediate care units in development around the country are used in some cases as mini-rehabilitation units, in other cases as convalescence wards, and in still other cases as low-cost staging grounds for long-term care placement, it is not appropriate to judge the overall effectiveness of intermediate care in one fell swoop. The problem occurs with admission avoidance as well as post-acute schemes, in that intermediate care's costs could be identified in comparison to A&E, acute medical wards, community hospital or residential and nursing home care. Again, the costs will be very different; and so, therefore, will the savings. In intermediate care, it is crucial to identify the implicit comparator.

Moreover, any reconfiguration will have knock-on effects. At the acute level, both beds and staff must be found. For beds, it is sometimes possible to use unoccupied or threatened estate. But for staffing, nurses and therapists must be borrowed, moved or newly hired to form an intermediate care team. In primary care and social services too, professionals will have to be diverted from one set of tasks to another. This means that those who continue with their usual jobs will do so under altered circumstances. Such effects - upon those in traditional roles as well as those working in intermediate care - must be assessed in terms of workload, throughput, morale and effectiveness with patients.

Beyond the acute level, reconfiguration will have system-wide effects. For example, if budgets are moved from the secondary sector into the community, something achieved in hospital will almost certainly have to be sacrificed. On the other hand, intermediate care may introduce efficiencies in the areas of assessment, rehabilitation and discharge planning which will be felt system-wide, not as losses but as gains. In the social services sector, there is a great need for information about the effects of intermediate care, in that services could either increase or decrease demand for social care. Again,

much will depend upon the goal and definition of the particular intermediate care intervention.

Each of these issues is a potential morass, yet patient care depends on their being managed with open eyes. From a pragmatic perspective (see Section Three for examples) one must decide just how broad a view to take - for example, in attempting to establish knock-on effects - because the broader the view, the more difficult it will be to be confident that observed changes in practice or morale are actually due to the introduction of intermediate care. Other influences will also be having an effect. The temptation to keep it simple, however, must trade against the value of taking a whole systems approach to modifying health and social care in order to improve quality and maintain or reduce costs.

A final point to raise, before proceeding to an examination of incentives in intermediate care, is that perspective is all. The question of value must always imply a second query, "value to whom?" Is it good or bad to reduce the need for acute care? Does Social Services really want to share in intermediate care interventions for medically stable people when the provision of complex care packages to highly dependent individuals is itself problematic? As it is, the social care sector faces an ethical dilemma about improving the quality of assessment, for example, knowing that local authorities may not be able to deliver on what comprehensive assessments might indicate. Although it might compromise quality of the service, the incentive there would be to eschew state of the art needs assessment rather than face the consequences.

Already, it can be seen that some of the usual ways of doing business have inadvertently undermined the efforts of those who would increase continuity of care by attending to the intermediate care function. It is just these unintended incentives which need to be aired.

2.3 Perverse Incentives and Disincentives

It is a maxim of organisational and economic planning that systems use implicit and explicit incentives to produce desired effects. It is also understood that, inevitably, there will be unintended, or perverse, incentives to behave in less desirable ways. If these can be clearly identified, there may be scope to correct the system and to offer short-term rehabilitative or other transitional support more routinely, either to post-acute patients or to chronic and continuing care patients in short-term crisis. In what follows, we report on seminar participants' descriptions of those practices, policies and

values built into the NHS which have undermined the reconfiguration of services in the direction of transitional care.

The role of purchasing is increasingly ambiguous

Although some seminar participants disagreed, many commented that commissioning was not as powerful a tool as it was set up to be. "Trusts are making things even more territorial," one said, "and intermediate care should be about erasing territorial boundary lines." Another delegate complained about "all the sorts of vested interests against change" which made him relatively powerless as a commissioner of services. Numerous purchasers observed that their successes in "driving through change" had come about "opportunistically, not rationally or strategically." There was recognition that the dismantling of the market economy in health care and the advent of primary care groups (PCGs) would potentially alter the situation but participants tended to be cautious about their expectations.

The messenger always gets shot

Some participants noted that it is not in the culture to say "there's a problem, we aren't doing well." Obviously this is one perverse incentive which extends far beyond the promotion of intermediate care. As a potential remedy for persistent problems with transitions and continuity of care, however, intermediate care's development can easily be undermined by any organisationally reinforced reluctance to come forward when there is trouble; as is the case, for example, with rising readmissions, too many beds occupied by people with long stays, suboptimal rehabilitation, or inappropriate admissions to hospital. At the King's Fund workshop, there was a clear view that the perception of poor organisational performance could mean job loss for the manager in charge. Therefore, "you never acknowledge that there are serious problems."

The maintenance agenda crowds out the ability to focus on something new

Some seminar participants observed "a massive sea change in the last 18 months" such that health authorities were moving beyond their bias towards acute care. Others, however, were emphatic in their disagreement. They simply "didn't see a lot of that happening." A majority had the impression that in most health authorities and trusts, there have been few discussions of the complex issues relating to intermediate care because most time was spent "dealing with the budget deficit, or getting the three people waiting more than 18 months for surgery sorted." One delegate observed that "change in the NHS goes in steps, not along a curve" and another reported that a range of intermediate care services for children came only in response to the impending closure of the local paediatric hospital. The crisis-driven agenda of the NHS acts as a

perverse incentive to developing new approaches to care, particularly if they are complex to implement.

A diffuse user population makes it hard for any single sector to feel the positive impact

Because patients come to intermediate care in small numbers from any single place, it will be difficult to raise consciousness about its potential. This occurs from both sides of intermediate care. In the hospital, patients are referred from multiple wards. Much is required before beds can be moved or acute units shut down. (See Box 2.4) The incentive is to make modifications that will facilitate ward closures, but the broad-based character of intermediate care suggests such closures are either unlikely or will take a long time to achieve.

Box 2.4

How many intermediate care patients must be treated to allow acute wards to be closed?

It takes time and critical mass to make intermediate care cost-effective through service reconfiguration, specifically, through bed closures in acute care wards. Some participants claimed as well that, in order to observe their true effects, intermediate care services need to be costed over two or three years.

In Bedford & Shires Health Care Trust, it was found that cost savings could not be realised until at least 60 patients could receive intermediate care at any given time, and that an intermediate care 'caseload' of 120 patients would be needed to realise savings of 20 percent over conventional inpatient care. In West Herts, it was estimated that 700 patients per year (13-14 per week) would have to use the home support team in order to save enough hospital days to close 10 hospital beds and begin to release fixed costs. It would take 1700 cases per year, or 32 patients per week, to close a 26-bedded ward and yield significant net savings. In part this is because West Herts already has low average lengths of stay (mean = 7 days, with key diagnoses ranging from 6.3 days for stroke to 14.7 for fractured neck of femur). This is an important factor when projecting costs and savings, and implicitly supports the use of a whole-systems approach because it allows one to see the interplay between intermediate care and other services at the local level.

(With thanks to Margaret Stockham, East Berkshire Community Health NHS Trust, Nicola Bell, West Herts Community Trust, and Dr. Maria Cox, consultant geriatrician in West Hertfordshire.)

Equally, in the community, where primary care practices might collaborate to support a liaison team for early discharge and community-based follow-up, the number of intermediate care patients known to any single GP will necessarily be small. (See Box 2.5) The policy incentive is for GPs to create purchasing groups and leverage relatively

small investments to devise new and better ways of delivering health care. Presumably the new PCGs will incorporate such models into their commissioning strategies. But a service that is diffuse in its application is less likely to find product champions, as the jargon goes, because individual purchasers (i.e. GPs or their practices) may not be

Box 2.5

The primary care example: Sharing the service dilutes the benefit to individual GPs

In Enfield, a group of GP practices have joined forces, in the context of a Total Purchasing Pilot, to support a discharge team. The team handles approximately 30 patients per month, or 360 discharges per year. This is significant in the aggregate, and may be extremely useful. Still, in any single practice, the service benefits only about two patients per week. In the context of the thousands of patients who pass through a GP surgery or are supported by Social Services, its impact will hardly be felt at all - except by the patients themselves, of course, and their families.

(With thanks to Dr. Michael Gocman, New River Total Care Project, Enfield)

getting much from it – certainly not as much as if the entire benefit accrued to them directly. PCG purchasing for larger populations than multifunds or other locality commissioning groups can manage may offset this difficulty because the number of patients to benefit will be greater than before and the development of a new group unit may encourage doctors to take a broader view.[7] In the interim, however, even if intermediate care were popular and effective, it could be difficult for many individual GPs to become sufficiently engaged to promote it.

GPs have numerous disincentives to offering intermediate care

One of primary care's central characteristics is that it is longitudinal; that is, primary care professionals treat the same person over time. Another is that it is community-based. GPs should have an incentive, therefore, to manage their patients' sub-acute needs in the community, because it is they who know their patients best and in the community that they have the most control. In fact, however, GPs report that placing a patient in acute care costs less than giving them community-based intermediate care. It is hoped that such anomalies will be overcome with the new commissioning arrangements. Nevertheless, the current view is that "it costs the NHS more, but it doesn't cost us. So that's a perverse incentive."

[7] – PCGs are anticipated to cover some 100,000 people each.

An even more serious disincentive for GPs is that there is no standardised remuneration for intermediate care. Responsibility for intermediate care remains undefined; certainly it is not part of General Medical Services. The incentive is to reject anything new or extra, because there is no additional recompense to acknowledge any extra work taken on. If services are reconfigured to shift responsibility from the secondary to the primary care sector, then current remuneration practices will have to be adjusted. Within the primary care sector, if GPs devolve intermediate care responsibility to nurses or therapists, there may be remunerative implications for them to manage as well.

The acute sector may lose if intermediate care works

If the NHS seems to disadvantage those in the primary sector who provide intermediate care, the situation is potentially even worse for secondary care. It is not just a case of the acute sector's losses if post-acute care options are not cost-effective. More importantly, acute trusts are also vulnerable when intermediate care is at its most successful. After all, the goal of most intermediate care interventions is to avoid hospital admissions or to reduce patients' post-hospital dependency, including their need for outpatient follow-up. Put bluntly, that would translate to less income for hospitals.

In localities where demand definitely outstrips supply, freeing up resources would be an aid rather than a problem. But in increasingly competitive markets, the intermediate care substitution could potentially hurt hospitals. Resource shifts might benefit some sectors of the acute trust economy but would almost certainly be to the detriment of others. Moreover, until the new service had been in operation long enough to fully understand its best applications, it might be difficult to grasp which sector was which. It is not surprising, then, that many acute trusts have mixed feelings about supporting intermediate care.

Intermediate care does not lend itself to the clinical directorate structure

A related point is that intermediate care does not fit well with clinical directorates. Because it targets the medically stable, intermediate care is not diagnosis-driven so much as needs-driven. Therefore, it may be difficult to determine who should 'own' any new transitional care services. The extent of difficulty depends on the purpose of the intermediate care unit. For example, a post-surgical observation unit might be more readily supported than more general nurse-led units. This is particularly so if the nurse-

led units are used as a pressure valve for consultants hoping to transfer their so-called 'bed blockers', because such patients tend to be disowned.[8]

Hospital managers have an incentive to keep their medical staff happy. To vigorously support a service reconfiguration that is not particularly medical in focus - and which may be met by indifference (due to the diffuse impact), poor comprehension of its objective, or resistance (one participant noted that "consultants are very reluctant to let go... it's not a money thing") - would threaten existing arrangements. Most managers would not do so lightly. The tension between the intermediate care model and the existing structures of acute practice acts as another perverse incentive to development.

Payback often accrues to sectors other than the one investing

Judging from the workshop, there are mixed views as to which sector can benefit the most from intermediate care, but there is a shared view that the sector which funds a programme often is not the sector to realise the gains. As stated, GPs believe that their success with admission avoidance saves hospitals more than it does them, given that their benefit is spread whilst the hospital's reduced patient load is in the aggregate. On the other hand, acute trusts believe that their support of hospital-based nurse-led units may benefit social services more than it does them - again because of the diffuse effect on clinical directorates but an overall reduced need, long term, for continuing care.[9] If savings accrue to a sector other than the one paying for intermediate care, there is an argument that the sector which benefits should contribute to the intervention producing such benefits; yet this rarely happens. Until then, separate sectors of health and social care have a perverse incentive to withhold services that may benefit and satisfy patients, if the investors are not the ones to realise the returns.

Cross-sector funding is difficult to arrange

Both a cultural and administrative issue, cross-boundary funding lies at the heart of many intermediate care interventions. Probably primary, secondary and social care sectors should contribute collaboratively to the budget which supports the reconfiguration of care; yet it is anything but straightforward to arrange this. For one thing, the costings that would inform the development of joint budgets are awkward to

[8] As noted in Section One, this is possibly not the best use of intermediate care units; certainly it misses important aspects of the intermediate care philosophy. But pragmatism often obliterates philosophy, and in this context may result in post-acute units being supported on condition that they are used to unblock beds.

[9] How cogent this argument is, is not known. The evidence is not yet definitive, but the likelihood is that nurse-led units may increase the need for social services in the short term due to improved discharge packages. Longer term, they may well reduce the need for continuing care, but the cost-effectiveness analyses are not available.

acquire. Seminar participants questioned how to benchmark examples of good practice when costing mechanisms or record-keeping units differ, because the heart of benchmarking is comparison. They wanted to know how to determine the costs of domiciliary care from different sectors and how to reckon the likely new costs of domiciliary care under early discharge or preventive care programmes. They were not sure which overheads to include, when intermediate care will be only a small component of either sector's activities. Finally, some reported cross-sector differences in geographical boundaries of responsibility and the timing of budget cycles.

The differences are not only structural and administrative. Important decisions must be made regarding the basis on which to decide the questions just listed, and this in turn brings out the different philosophical foundations of health and social services. To offer a few concrete examples, the acute trusts need to align intermediate care services to particular diagnoses in order to cost them (for example, using DRGs) whereas social services reject that paradigm entirely. The medical sector is more used to operating in deficit than the social sector, for whom local accountability is extremely strong. Social services have maintained a policy for some time to restrict social care to the most dependent whereas hospitals and GPs must provide health care for all. This may be euphemistic, but it remains an essential tenet of NHS care.

In one small but telling example, the winter pressures money - which was so important to health care providers' efforts to implement transitional care arrangements - came at exactly the wrong time for social services. For that agency, the high-pressure period is not in the winter (when many people die) but in the summer, when mortality is lower, families go on holiday, and demand for continuing care is at its highest.

The fact that social services and health services have different cultures makes the drafting of appropriate contracts and the appropriate allocation of joint budgets extremely thorny issues that require considerable attention. These gulfs can seem daunting. In practice, primary care providers and purchasers seem to have had more success collaborating with social services to deliver intermediate care than they have had trying to work jointly with health care colleagues in the acute sector. The building vs. community mindset seems to be very powerful, and acts as a perverse incentive to developing boundary-crossing arrangements such as supported early discharge.

Poor understanding of the intermediate care concept can lead to inappropriate, ineffective services

Some of the cynicism about intermediate care pertains to its nomination as a quick-fix, cost-saving solution to a range of systemic problems with health care, and not to its possible therapeutic role. The incentive, then, is to use the rhetoric of intermediate care to keep community hospitals afloat, find a dumping ground for so-called difficult patients, rescue old estate, or devolve responsibility for patient care to ever lower - and less costly - levels of staff. This can be extremely problematic for intermediate care development.

If, for example, so-called intermediate care units are used as dumping grounds for difficult patients, it will be difficult to make either the quality or the cost argument. One delegate reported that patients admitted to the post-acute ward in her hospital were increasingly older, frailer and more severely ill; for example, requiring intravenous lines. These patients are poor candidates for rehabilitation. Further, they are at risk medically. To term such patients recipients of intermediate care is a cruel euphemism.

Similarly, workshop participants asserted that intermediate care requires high-grade nurses. In their experience, care assistants and lower-grade nurses work well as part of a team, but higher-grade positions need to be costed into any service plan. In the absence of well-trained leadership, there is a risk of unpleasant consequences for patients. Often, intermediate care candidates are elderly; as such, the diagnosis of their medical status is highly complex. (Even without comorbidity, older people's medical problems do not present in the same ways that younger people's do.)

As for the notion of using old estate by creating off-site post-acute care units, many delegates worried that it represented a return to old-style non-care of elderly or difficult patients. "In the acute setting," one person observed, "you are treated as somebody in care; once you move, you are out it." This can easily put patients at risk, and there was evidence at one hospital to suggest that patients in acute units had easier access to physiotherapy and other types of rehabilitative treatments than patients in nurse-led units.[10]

[10] Batehup, L. et al. (1998) *Outcomes-based evaluation of a nursing-led intermediate care unit.* Department of Nursing Studies, King's College London.

Resources for changing paradigms of care are extremely limited

Finally, it is worth raising an issue that is not so much a perverse incentive as a disincentive to developing intermediate care. It is 'change burnout.' At the seminar, it was widely acknowledged that intermediate care providers are trying to achieve something new. They intend to come closer to the goal of patient-centred care by moving both services and funds along the patient's personal continuum of care. This is a serious diversion from service-centred care. But the budgets available to educate people about intermediate care (paradigm and practice) are severely limited. The dedicated funds are not always available. Newman noted that health professionals were exhausted, and did not have a lot of energy left over for testing new ideas in patient care. [11] This is not to underestimate clinicians, but rather to acknowledge that such a climate works against innovation, even when new approaches are clearly needed.

2.4 Implications

The discussion in this chapter rehearses a range of difficulties relating to the mismatch between the NHS' incentive structure and optimal ways of organising intermediate care. Wearying as they may be to review - and familiar as well, because numerous themes are not unique to intermediate care but reflect inherent weaknesses in the system which have manifested in other areas of treatment or need - such difficulties are better made explicit than left unacknowledged.

There will always be perverse incentives in any system but, equally, there will usually be ways to move around them. Despite numerous barriers, many commissioners, managers and clinicians have been motivated to work with the existing incentive structure and introduce intermediate care. In the final section, we describe some of the ways they have succeeded.

[11] Newman, P. *"An acute care perspective"*, paper given at the King's Fund Intermediate Care Seminar, 28.1.98.

Section Three:
Disabling Perverse Incentives to the Financing of Intermediate Care

Box 3.1

Highlights of this section

- When organisations were faced with a problem for which they had to find a solution, they were able to move forward and overcome traditional sources of resistance.
- Given the will, it is clearly possible for health authorities and primary care groups to significantly change the allocation of resources across service categories.
- There are many examples of good practice that build upon cross-sector ways of delivering intermediate care services. Successful programmes rely upon such cross-sector co-design and multiprofessional involvement from the outset.
- General practitioners must be remunerated, at a realistic level, for their role in providing community-based intermediate care.
- Step costs may be a useful way to view the economics of innovation, because they account for start-up costs and can map the increments of implementation.
- At the heart of financing intermediate care must be local recognition of need and a collaborative approach to planning, assessment, delivery of services, and sharing costs and benefits.

Delegates had strong and sometimes divergent opinions about the best way to approach the financing and implementation of intermediate care. There did seem to be agreement, however, that intermediate care was ***"less about focusing on any one bit than on focusing on how the bits fit together"*** in order to fill desired functions. This observation could be the key to disabling an inappropriate incentive structure to meet patients' transitional care requirements.

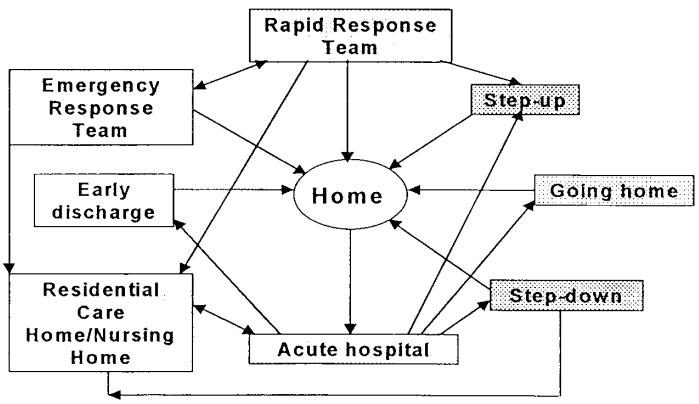
Despite structural difficulties, most workshop participants had succeeded in implementing programmes of intermediate care. This section describes some typical arrangements and, where evaluated, the degree of success various approaches have had with particular reference to costs. We also summarise participants' recommendations about making it work.

3.1 Seizing the opportunity

A number of delegates commented that their success began by acknowledging, or even taking pains to develop, a shared and urgent need to solve a problem such as blocked beds, fiscal deficits, or impenetrable cost inflation. Awareness of a problem can gradually (or sometimes quickly) turn into the impetus for change. In an atmosphere of concern, when an environmental change occurs such as the withdrawal of medical cover or the shutting of a local hospital, the natural professional resistances to change are overcome by the motivation to find solutions. As one person said, to the agreement of others in the room, "You are waiting for the gap and then, whap, there you go."

One example of opportunistic programme implementation is the Newcastle experience, where the health authority took a chance on transferring a large sum of money from the acute to the community health sector. In 1995, on the back of an acute care review, the Newcastle and North Tyneside Health Authority shifted £2 million in the form of a Primary Care Development Fund from acute to community health care budgets. Supported by Continuing Care Challenge funds and short-term winter pressures money, the health authority commissioned a wide range of intermediate care services including step-down and step-up facilities, rapid response to prevent avoidable admissions to hospital, early discharge programmes for stroke and orthopaedic patients, post-hospital domiciliary care, an elderly resource team and a community team for multiple sclerosis sufferers. As Figure 3.1 shows, this creates a complex network of services, with home at the centre.

Fig 3.1 Working with complexity: Intermediate Care in Newcastle



It was this health authority's recommendation - echoed by many at the seminar - to work with the complexity of intermediate care arrangements, rather than try to simplify them. Patients have multiple and varying needs, and in Newcastle the strategy has been to tailor as many services as possible to meet them.

The Newcastle services may or may not be cost-saving, although the per-patient estimates are positive. For example, in comparison to the £960 required per acute bed week, step-down care costs are £595 if an inpatient or £665 if in residential care. However, the elderly resource team requires investment of £250,000 per annum, and discovering the precise value for money of that and the other interventions has been difficult (see Box 3.2).

Box 3.2

A perspective on value for money in intermediate care

Iain Kitt, of Newcastle and North Tyneside Health Authority, was a proponent of what he humorously, but only partially with tongue in cheek, described as the 'smash and grab' approach to shifting the money. However, he warned of complexities in establishing value for money; for example:

- Are the intermediate care services substitutes or complements? None, he argued, were *pure* substitutes.
- What is the appropriate cost comparison, step-down facilities compared to acute care wards, or compared to enriched nursing home care, or to something else? The VFM determination will vary accordingly.
- Can you get the money apparently saved out, and back into the system? The most obvious example is being able to close a hospital ward, but it is virtually impossible to track service delivery through the system in order to establish firm enough links between patients, intermediate care, and acute length of stay to justify such a step.
- Who invests, and who benefits? Very little of the health authority money actually goes into primary care; most goes to support social services. Should social services be contributing to the cost of intermediate care, then?
- What is the longer term impact of intermediate care? It simply is not clear.

(With thanks to Iain Kitt, Newcastle & North Tyne Health Authority)

Despite uncertainty about cost-effectiveness, this example suggests the possibility that providers who are keen to develop intermediate care can use their health authority, in its role as advocate for health service users, to fight against the vested interests of narrow professional groups. If it wants, the health authority *can* shift the money. At the King's Fund workshop, several people observed that those who were currently

employed at health authorities seemed to have a new, non-acute perspective which could facilitate this sort of advocacy.

3.2 Working to fixed budgets, but in new ways

The Newcastle example is not the only instance of health authorities' taking advantage of a negative situation in order to support new developments. In 1995, the Liverpool Health Authority and the North Mersey Community Trust undertook a joint review of the inpatient facility at Sir Alfred Jones Memorial Hospital (SAJMH). They found that 90 percent of admissions did not require the level of nursing they received, and that the length of stay for patients over age 55 was far higher than the national average. Further, the highest number of admissions to the Royal Liverpool University Hospital came from the same part of the city where SAJMH was located.

Although it was evident that a change was needed, the health authority insisted that reconfigurations of care would have to take place within the hospital's existing operational budget of £783,000. Three options were considered: orthopaedic rehabilitation and clinical respite, stroke rehabilitation and clinical respite, and an intermediate care unit led by nurse practitioners to focus on meeting clinical needs that were likely to respond to intensive therapeutic nursing. The intermediate care unit was chosen in part because the providers felt it would encompass the other options as well. As developed, it used only £585,000 (75 percent) of the allotted budget. The unit was judged revenue-neutral; presumably, however, the remaining £200,000 was able to be spent elsewhere.

Services such as that offered in the Sir Alfred Jones Memorial Hospital have also been developed as an alternative use of estate in acute care settings. The impetus for these nurse-led in-patient services has usually come from severe pressure on acute beds, a shortage of junior doctors or recognition that intermediate care needs are not best met within an acute ward setting. While there are several studies under way,[12] cost information on these initiatives is not yet available and, although preliminary findings look encouraging, the jury is still out as far as definitive evidence is concerned.

3.3 Devolving purchasing from health authority to primary care

The Liverpool approach was community hospital-based. Another alternative is to focus on intermediate care services outside hospital walls. In Oxfordshire, the health authority elected to devolve the responsibility for purchasing community nursing to

[12] Homerton Hospital is currently analysing cost and outcomes data from a two year evaluation of a nurse-led intermediate care service. A multi method evaluation is also under way at the University of Southampton (Steiner et al., building on Walsh, Brooking and Pickering).

primary care providers. Funds for this purpose were given to all GPs, not just fundholders. Although not specifically focused on intermediate care - the purchased community nursing services included health visitors to support parenting and provide child protection, and continuing care delivered in concert with social services - the model offers some lessons for the development of community-led intermediate care. The health authority found that, initially, individual GPs were more likely to purchase nursing that was focused upon medical tasks than on broader services aimed at public health or supportive care. These aspects of community nursing were subsequently incorporated into the contracts negotiated by the health authority and primary care providers. If the model were applied to purchasing intermediate care, there might be a similar need for health authorities to negotiate the values and services desired for maximum effectiveness. GPs might then enjoy managing a flexible budget to best suit their patients' specific needs for transitional care. In this regard, Personal Medical Services (PMS) and PMS-plus pilots offer promise.

3.4 Extending the geriatrician's role and involving the GP

In a number of cases, health authorities and providers have collaborated to establish early discharge programmes. Two examples may be found within one health authority's catchment area, where early discharge programmes have developed according to different paths in neighbouring localities. The common ground is that both take a multidisciplinary approach, both employ generic workers, and in both areas, geriatricians play a significant role in determining strategy.

In one area, an elderly care team takes a needs-centred approach to identifying appropriate candidates for early discharge. Sensitive to the complexity of diagnosis and treatment of older patients, they may be cautious, even conservative, in their appraisals. For those patients who meet their criteria for early discharge, however, responsibility for post-acute care is transferred to their GPs. The programme operates only with participating primary care physicians - currently some 80 percent of the total who practice in the area - so that the GP is aware that the patient will need intermediate care and is prepared to provide it.

Nearby, geriatricians have developed an outreach approach that relies heavily on multidisciplinary assessment and generic health workers. The consultants make active use of care pathways and continue to take responsibility for patients after discharge to the community. This may allow for more confident transfer of patients to their homes. Ten nursing home beds have recently been acquired as well, and professionals in both

areas view the availability of a safe place for post-acute medical observation as an important aspect of the project.

The schemes have been financed by the health authority as three year pilots. One is in its final year; the other, beginning its second year. Currently, however, they are working to develop an integrated approach trust-wide. One of the "lessons learned" has been that GPs want to be engaged in co-design of intermediate care services from an early stage. Equally, other seminar participants noted that in areas where primary care took the lead, geriatric and other consultants need to be involved as fully as possible. With regard to cost-effectiveness, careful analysis of the projects indicated that a fairly high level of substitution (of community for acute care) was required before cost savings would be achieved.

Box 3.3

Costs of intermediate care: the Manchester experience

Costs are full year estimates (in UK pounds) based on actual expenditures.

Fixed costs	
GP lead (1 session/week)	6,480
2 G-grade nurse assessors	48,000
1 0.5 wte physiotherapist	13,000
1 0.5 wte occupational therapist	13,000
Total fixed costs	**£80,480 (p.a.)**
Variable costs	
GP inputs (3 visits + 1 admin payment @ 7 patients per week)	21,000
Social care (25 hours per week)	13,000
Agency nursing (5 hours per week)	3,900
Total variable costs	**£37,900 (p.a.)**

Total costs: £118,380 p.a.

To put this number in context, ward costs for 7 patients are estimated at £4,900 per week, or £254,800 per annum. However, the hospital is not sure whether cost savings have been achieved. The pressures of emergency admissions and waiting lists continue. There is disagreement as to whether the days saved through early discharge are the cheaper part of the hospital stay (because diagnostics and medical inputs are no longer needed) or not (because they represent the more labour-intensive part for nurses, medical and therapy staff). As for patient outcomes, without data to the contrary, they are assumed to be approximately equal under conventional and intermediate care.

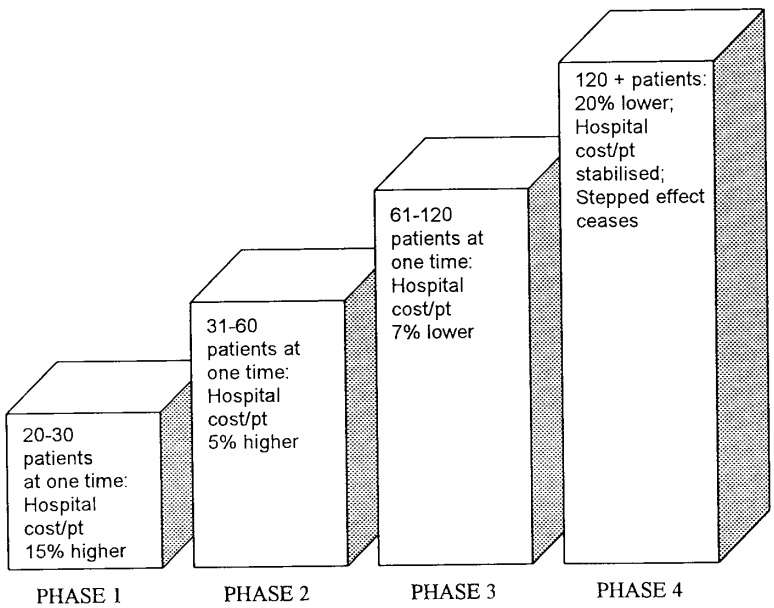
(With thanks to Jo Purcell, Manchester Health Authority)

3.5 Using multidisciplinary teams

Another variation on the early discharge theme is the Manchester programme. An intermediate care team has been funded from Continuing Care Challenge Fund monies which were made available to support health authorities in developing long- and short-term solutions to the dual pressures of high demand for continuing care and continually increasing emergency medical admissions.

Initially, the scheme used nursing homes as a transfer destination. Subsequently the beds became unavailable and the team found that a single transfer - to home - was preferable for patients in any event. Patients now have the support of GP supervision, G-grade nurse assessment, physiotherapy and occupational therapy. There is capacity to purchase social care support or agency nursing as required. There is also access to further GP contact if needed, with remuneration handled through a small fee for administration and telephone contact (£5 per patient) and a larger fee for call-outs (£17.50 per visit). This strategy was favoured by numerous seminar participants, who noted that with medically stable or physiologically predictable patients, call-out tended to be the exception rather than the rule.

Fig 3.2 Stepped cost model in Bedford and Shires



Once the programme was established, inputs were fully costed (see Box 3.3); however, comparative economic evaluation has not yet been completed. Initially, because the scheme was so new, neither providers nor commissioners could predict what the actual investment would have to be. They waited until they were confident that their estimates constituted reliable figures for the current level of activity. Several of the delegates supported this approach. One recommended that every effort be made to maintain the winter beds or other arrangements for as long as possible, in order to take advantage of the time it took to set it up - "you can't save money in one season" - and to measure costs throughout, so that the turning point could be mapped.

3.6 Finding the break-even point in providing post-acute care

In Bedford & Shires Health Care Trust, supported discharge programmes have gradually proved cost-effective, according to a stepped cost model. In the first phase, pump-priming was required because a service that treats 20-30 patients at a time cost about 15 percent more than conventional post-acute care in hospital. At the point that more than 60 patients can get intermediate care at any given time, the service begins to make savings. When the threshold of 120 patients is crossed, the service is considered both cost-stabilised and cost-saving, at 20 percent less than conventional inpatient care. (See Figure 3.2.)

Box 3.4

Intermediate care costs in Bedford

Variable and semi-fixed direct costs of intermediate care provision at home (average cost in pounds, per contact)

Referral made by general medical consultant	£5.78
Referral made by orthopaedic/surgical consultant	8.22
Referral made by primary care (for reasons other than terminal care)	6.33
Referral made (usually by primary care) for terminal care	11.32

These estimates average across all staff types and levels, and across all services provided. For context, district nursing costs are estimated to average £20 per contact.

Costs for people who would require long-term care placement if intermediate care were not available

For 6 weeks of continuing care £1800

Six weeks in residential or nursing home care in the area have been estimated to cost between £2250 and £2550.

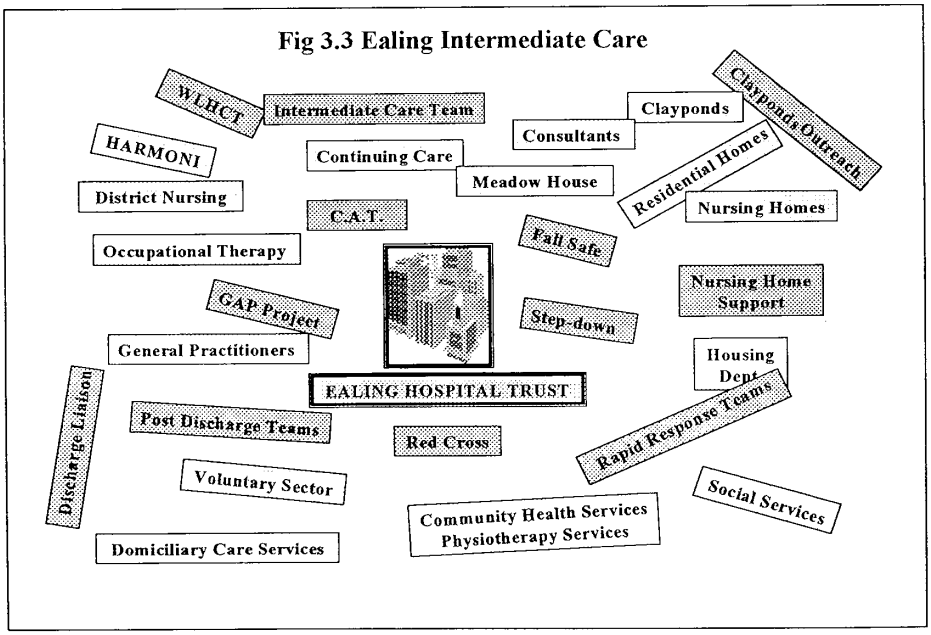
(With thanks to Margaret Stockham, East Berkshire Community Health NHS Trust)

The Bedford intermediate care model is based on the concept of "small wards without walls" throughout the local community. Because infrastructure costs are lower than in acute hospitals, the costs per case (or episode, or bed day) are less, although start-up costs must be taken into account. In addition, because it is an innovation, the service provides for flexibility, for "breaking the rules in ways they need to be broken." In practice, this has meant varying the professional skill mixes according to patients' needs (e.g. convalescent care vs. rehabilitation), using more part-time staff, varying between therapists, patient support workers and others on a case-by-case basis as appropriate. Bedford supports a phased development, in part to allow staffing capacity to grow incrementally rather than have intermediate care services displace something else of value. In such a context, the stepped cost model suits strategic development nicely. Regarding the costs of arranging professional contacts in the community, Box 3.4 offers details.

3.7 Jointly funding a health/social intermediate care service

The examples thus far have been based in the health sector. In Ealing, however, there has been an active collaboration between primary care (led by one local GP), social services (led by a full-time social services manager who supports the GP) and Ealing Hospital, where an intermediate care team, called the Community Assessment Team, is based. The interventions are dually focused to avoid inappropriate admissions to hospital and to facilitate discharge of older patients back to their homes.

Fig 3.3 Ealing Intermediate Care



At A&E, all borderline admissions are screened by the team, who use a core assessment tool jointly developed for use by GP, occupational therapy, district nursing and social services staff. The assessment team has resources to offer a wide array of community-based services if appropriate. (See Figure 3.3, and compare to Figure 3.1.) For older patients already in hospital, the team arranges for a district nurse to telephone these patients immediately upon their return home in order to assess their needs and visit those at greatest health or social risk. Finally, social work home care providers, who have been trained and are supervised by a hospital OT, provide basic rehabilitative care to patients in their homes, post-discharge.

The set of intermediate care services just described developed over a two-year period. Existing projects were streamlined into an integrated programme, and non-recurring funds were added from Tomlinson, joint finance and winter pressures monies. In this way, it was possible to leverage small bits of money into a coordinated approach. The 1998/99 service is now additionally supported with explicit contributions from both Social Services' STG monies[13] and Ealing Hospital's baseline funding.

Box 3.5

Collaboration in Ealing

Joe Gannon of Ealing Hospital writes in...

Health and social services relations in Ealing have come some way since 1993, when communication, all too often, took place through the local press. We now have a range of proven intermediate care services, aimed at preventing admission and enhancing discharge. Where social services and health staff are working in teams, to joint objectives, with aligned incentives and shared financial responsibility, the impact in genuinely startling to behold. We have learned how to work together in the patients' interests. We have made it our business to understand how the other works and each other's internal agendas. We have supported each other in our efforts to work differently.

Tracking savings across both sectors is essential, particularly ongoing social care costs. Identifying the recurrent from the non-recurrent, the social services from the health, is not easy. The presentation of timely, user friendly and integrated reported of financial and activity data from what are separate organisations and systems is now needed to support the service as it develops.

(Thanks also to Alan Clark, Greenford Social Services)

[13] These Strategic Transfer Grants are made annually, from health to social services. Traditionally intended to help with the funding of long-term residential care, more recently they have been used to help fund alternatives such as community-based intermediate care.

Savings realised as a result of the intermediate care service made such contributions feasible. At present, the team oversees a pooled budget of approximately £1 million (See Box 3.5).

3.8 Giving social services the lead: the preventive potential of early transfer to a residential rehabilitation unit

As a final example of progress made despite perverse incentives, we focus on a social services-led model of intermediate care designed to prevent long-term care placements. In Devon, the Social Services Inspectorate faced the bed-blocking problem proactively. They noted that too many older people remained in hospital because social services rosters were full. By the time case management services became available, many required long-term placement, and another round of waiting began. However, they questioned the inevitability of this progression, even as they sought to relieve the pressures of high demand. Their solution was to acquire the Outlands Rehabilitation Unit, an early discharge destination where the ethos is activist and the care takes a vigorously rehabilitative orientation.

A central feature of this intermediate care intervention is longitudinal assessment. Indeed, a number of seminar participants indicated that not only assessment, but re-assessment, lies at the heart of successful intermediate care. Intermediate care teams do best when they try to identify and work towards specific endpoints and - even more important - modify goals as the team discover that the patient is capable of more (or different) than initially anticipated. Admission to Outlands is contingent upon patients being highly motivated and desiring to return to their own homes. The unit estimates that, using this primary requirement for entry, some 20 percent of permanent admissions to residential care can be diverted. In the five years since its start, Outlands has had 838 admissions. Fully 78 percent of patients were discharged home within six weeks (see Box 3.6). A detailed review of a subsample of 35 such residents revealed that 48 percent required no supportive services whatsoever. A further 44 percent received no more than four hours of home care per week. Only 8 percent (2 patients) did not cope well at home and were in long-term residential care within three months of discharge. Although the numbers for such detailed review are small, they are suggestive of success for a transitional care model that places high value on rehabilitation.

Patients are charged £50 per week to be treated at Outlands. The weekly cost of care is £500. Still, because of the high proportion of patients who are restored to

independence, the programme translates to a £250,000 savings per annum for Devon County alone.

Box 3.6

Discharge destinations from Outlands Rehabilitation Unit

For the period 1 June 1992 through 31 May 1997.

Destination	Number of residents	% of residents
Home	**655**	**78.2**
Hospital readmission	54	6.4
Residential care home	65	7.8
Respite care	23	2.7
Nursing home	8	1.0
Hillside Centre (residential care for people with dementia)	7	0.8
Hospice	4	0.5
Deceased	**1**	**0.1**
Still on unit	21	2.5
Total	**838**	**100.0**

(With thanks to David Raw, Social Services Inspectorate)

3.9 Concluding advice

Despite a non-trivial set of barriers and disincentives, people have found ways to finance and implement a range of intermediate care interventions. Most report benefits, but not all have identified cost savings. It may be that the more aggressive the intervention, and the more serious the prevented outcome, the greater the financial benefit. Issues of capacity - how many patients can be treated, given constraints of staff, beds or money - have significant implications for realising cost savings as well. In these early days, it may be most important to renegotiate the incentive structure, at the same time working towards a successful enough service to allow for longer-term funding and more consistent savings. It is hoped that the ideas in this report will support such positive reconfigurations in patient care.

Appendix 1: Summary of Evidence on Costs of Intermediate Care

CLINICAL OUTCOMES AND SAFETY

Costs

1 Most of the economic evaluations are limited. They commonly omit costs outside of the health sector and costs to patients and informal carers.

2 Calculated savings in the acute hospital sector (e.g. costs per patients day) are not realised in practice without service reductions.

3 It is argued that HAH can release bed days for maintaining throughput and reducing waiting lists.[14]

Costs – Early discharge for selected elective procedures "Hospital at Home"

1 Several studies on hip fracture show short lengths of stay and lower costs for enhanced home care in comparison with hospital.[15,16,17]

2. There are lower direct costs of rehabilitative care despite higher readmission costs.

3. Some of the cost reductions related to transfer of care from formal to uncosted informal carers.[18,19]

Costs- Early discharge and Community Management of Stroke

1. Information on the cost effectiveness of rehabilitation is essential but lacking.

2. Well organised multidisciplinary care brings more rapid improvement, where this is provided seems less important.

3. More active approaches to rehabilitation leading to shorter stays may not reduce costs per case if more staff are ultimately required . Whether released beds represent a saving depends on how they are used.

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[14] Haggard L, Benjamin B.(1992) All Systems Go. *Health Service Journal*, 102: 24-5

[15] Hollingsworth et al. (1993) Cost analysis of early discharge after hip fracture. *British Medical Journal*, 307:903-6

[16] O'Caithan A. (1995) Evaluation of a hospital at home scheme for early idscharge of patients with fracture neck of femur. *Journal of Puclic Health Medicine*, 16:205-10

[17] Wilson AD et al. (1997) 'Hospital at Home' is as safe as hospital, cheaper and patients like it more; early results from an Rct. Society for Social Medicine.

[18] Steiner, A. (1997) *op. cit.*, footnote 1.

[19] Crown J, Newman J. Intermediate Care. A Literature Review for Anglia and Oxford Intermediate Care Project

Costs – Early Discharge and Community Management of Frail Elderly.

1. One large RCT reported substantial savings as a result of the subsequent reduction in readmission.[20,21]

2. The marlow EPICA Audit suggested that 15% of acute admissions could be saved at substantial costs savings.

COMMUNITY HOSPITALS

Costs

1 Few studies have examined in depth the costs of community hospitals compared to acute care and alternatives. Community hospitals are viewed by some as inefficient and costly.[23] Others state that they are cost effective[24] or that there is little evidence that they are not.[25]

2. Several studies indicate that although the cost per day may be less than in an acute hospital[26] the cost per stay is greater die to nursing costs and longer lengths of stay.[27]

3. At present low GP remuneration (bed fund) may be contribute to low running costs. Furthermore, with the advent of high grade nurse practitioners, future staff costs may rise.

4. In general, community hospitals are inefficient with low bed occupancy rates of around 60%. Where targets are s et occupancy rates have risen. Economics of scale demand a critical mass of at least 30 beds and sharing facilities with larger acute hospitals can help.

5. It has been argued that the comparatively high cost of capital investment in community hospitals could be usefully invested in directed services provision.[28]

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[20] Townsend J. et al. Reduction in hospital readmission stay of elderly patients by a community based hospital discharge scheme: randomised trial.*British Medical Journal.*

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6. Supply factors appear with hospital beds. Increased numbers result in increased total of admissions. Accessible beds may 'substitute' for more appropriate forms of home and community nursing and social support.

7. It is likely that community hospitals beds substitute for between 8%[29] and 17%[30] of acute hospital care.

With thanks to those who contributed to this appendix.

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Appendix 3: List of Participants

Jean Addison	Senior Social Worker, Watford General Hospital
Jane Barret	Institute of Public Health, Cambridge
Trish Bennet	Advanced Nurse Practitioner, Intermediate Care Unit, Sir Alfred Jones Memorial Hospital
Sally Brodhurst	Joint Elderly Commissioning, Oxfordshire Health Authority
Philip Burgess	Director of Operations, South Bedfordshire Community Health Care NHS Trust
Melody Carter	Care Management Facilitator, Southmead Health Services, Southmead Hospital, Bristol
Alan Clarke	Head of Adult Services Commission, Greenford Social Services
Paul Dimblebee	National Audit Office, London
Amanda Finch	Havering Hospitals Trust, Romford
Jon Ford	Head of Health Policy and Economics Research, B.M.A., London
Joe Gannon	General Manager Medicine and A & E, Ealing NHS Trust, Ealing Hospital
Deborah Glover	Project Officer, Nursing Developments, King's Fund
Michael Gocman	Chair, New River Total Care Project, Enfield
Linda Hanford	Project Manager, Intermediate Care, King's Fund
Ruth Harris	Senior Nurse (Research Project), Homerton Hospital NHS Trust
Tony Harrison	Fellow, Policy & Development, King's Fund
Tricia Hart	Director of Nursing, John Radcliffe Hospital
David Hewlitt	Branch Head, Department of Health, Wellington House, London
Alex Hoffman	Health Care Evaluation Unit, West Hertfordshire Community Trust
David Holmes	Section Head, Department of Health, Wellington House
Philip Housden	North Downs Community Health NHS Trust, Farnham Hospital
Mandy Hutchinson	Senior Policy Analyst, B.M.A., London
Iain Kitt	Assistant Director of Health Commissioning, Newcastle and North Tyneside Health Authorities
Ron Lee	Finance Director, Teddington Memorial Hospital NHS Trust
Debbie Lee	Senior Nursing Officer, Wellington House, Waterloo Road, London
Nick Mays	Director of Health Services Research, Policy Institute, King's Fund
Ann Netten	P.S.S.R.U., University of Kent, Canterbury
Penny Newman	Consultant in Public Health/Primary Care Havering Hospitals Trusts, Romford
Sue Pascoe	Project Nurse, Hillingdon T.P.P., Middlesex
Michelle Pilkington	Sister - Letchmore Ward, Watford General Hospital
Richard Poxton	Project Manager - Joint Commissioning, Community Care, King's Fund

David Raw	Inspector, Social Services Inspectorate, South and West Region
David Richards	Research and Development Manager, Leeds Community & Mental Health Trust
Janice Robinson	Programme Director, Community Care, King's Fund
Anne Rosbotham-Williams	Nurse Practitioner, Intermediate Care Unit, Sir Alfred Jones Memorial Hospital
Andrea Steiner	Institute for Health Policy Studies, University of Southampton
Tony Sterne	Hillingdon T.P.P., Care Point, Middlesex
Margaret Stockham	Deputy Chief Executive, Bedford and Shires Health and Care
Stuart Turnock	Project Manager – Health Studies, Audit Commission, London
Barbara Vaughan	Programme Director, Nursing Developments, King's Fund
Shirley Williams	Until recently - Chief Executive, Oxford Community Trust
Steve Williams	Cambridge and Huntingdon Health Authority, Fulbourn Hospital, Cambridge
Liz Wise	New River Total Care Project Manager, Enfield

Please note – participant details correct at the date of workshop, 28.1.98.