King's Fund

INTERMEDIATE CARE

A discussion paper arising from the King's Fund seminar held on 30th October 1996

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Published by
King's Fund publishing
11-13 Cavendish Square
London W1M 0AN

ISBN 1 85717 143 8

A CIP catalogue record for this book is available from the British Library.

Further copies of this report can be obtained from King's Fund Nursing Developments Programme. Telephone 0171 307 2760.

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A Discussion Paper

Introduction

It is widely recognised that there is a group of people who have health care needs which, while not requiring the facilities of the acute hospital sector, do demand considerable support to regain a maximum level of health. A number of different initiatives have been explored to meet this diverse group's needs, yet there is little agreement about what is meant by intermediate (or transitional) care; the needs and size of the potential target group who may benefit; the objectives of the care alternative; and the efficacy of the services.

For this reason, the King's Fund convened a half-day seminar to discuss the premises of intermediate care and debate some of the issues. Fifty people from throughout the health service participated (see Appendix 2). In what follows, the central issues are presented as a "debate on paper" which incorporates points raised by speakers and audience alike and, we hope, crystallises what was an open-ended discussion into a focused review of intermediate care's challenges and potential.

What (exactly) is intermediate care?

Although the term "intermediate care" is new to many, the concept will not be. Intermediate care may be best seen as a **function**, rather than a discrete set of services. That function is to facilitate transitions from medical dependence (experiencing oneself as a patient) to day-to-day independence (experiencing oneself as a person). It may also encompass the prevention of a transition in the opposite direction. The concepts of **transition** and **restoration** are central to intermediate care.

Although exceptions to the rule abound, several themes emerge in the literature on this subject and help to clarify the intermediate care function. First, the services are not primarily medical in nature; instead they focus on support, nurturing and education (often the domain of nursing). Second, patients are viewed holistically, so that both medical and social factors are included in diagnostic assessment of their needs and resources. Third, there is some element of "home" in the intermediate care model, ranging from delivery of care in the home to creation of hospital wards that look more like home than usual, emphasise self-care and welcome the on-site contributions of family or friends to an individual's recovery. Finally, there is the crucial notion of "in-between." Intermediate care is not intended to duplicate effective existing services, but to fill some of the gaps between secondary and primary, acute and chronic, or high- cost and rarely-offered services.

Summary Box

1. Intermediate care is a function concerned with transition from medical dependency to personal independence and restoration of self care abilities.

2. The need for intermediate care arises from a combination of medical and social factors occurring after physiological stability has been achieved (or when physiological breakdown is threatened) and when there is a clear end goal in sight of increasing independence and quality of life.

3. These needs follow on from medical diagnosis and are concerned with maximising self care ability in order to reduce longer term dependency.

4. The setting in which intermediate care can be offered may range from home to hospital but is of secondary importance provided that the function is clear.

Why consider intermediate care now?

Intermediate care is attracting attention because a number of factors have come together to create an environment characterised by both opportunity and urgency. Some factors are external to the NHS. For example, demographic transition (declining birth and death rates at once) continues to shift the UK age mix upward. Because older people tend to recover more slowly than younger people, increasing numbers of elderly may translate into increased demand for supportive transitional care. In addition, medical and engineering advances now enable people born with severe disabilities to survive into middle age and beyond, albeit with complex care needs. Technological advances also allow medically sophisticated care to be delivered in the home, sometimes self-administered by the patient, which makes home-based intermediate care options feasible.

NHS policy developments also encourage intermediate care developments. *A Primary Care-Led NHS* promotes shifting service delivery from the secondary to primary care sector. One speaker referred to the "increasingly sterile debate" about secondary/primary care shifts and referred to intermediate care as a possible "way into" activities that would reduce pressure in both sectors and improve overall service efficiency as well as acceptability to users. Other policies that implicitly promote intermediate care include the NHS and Community Care Act of 1990, the continuing care long-stay bed policy which sets stricter limits on defining appropriate candidates for such beds, and the recent *Priorities and Planning Guidance for the NHS: 1996/1997*, which stresses the importance of partnership across health and social care sectors and the need to integrate services to improve efficiency and minimise confusion for users.

Most important, however, are budget issues and new purchasing arrangements - from the provider/purchaser split to GP fundholding and the total purchasing pilots. Significant reductions in hospital funding may encourage acute trusts to seek alternatives to simply cutting back; reconfiguring and creative thinking are required. One participant referred to the "siege mentality" that besets secondary care providers, and pleaded for relief. At the same time, community hospital closures around the country have stimulated those still in existence to update their service mix in order to survive - in many cases, by offering day surgery units, increasing their rehabilitation functions, or providing respite and palliative care. There is real potential, then, for more care to be community-based.

Summary Box

1. Factors external to the NHS, such as demographic changes and technological changes, require and allow consideration of new ways of working.

2. Central policies encourage consideration of intermediate care as a possible way of dealing with the interface between acute, primary and social services.

3. Budgeting constraints require a stringent review of current services, opening up options for alternative (less costly) approaches.

What is the evidence on intermediate care?

The seminar began with the presentation of an overall conceptual framework and results of a literature review.[1] Two particular service models are emphasised in the literature: nurse-led in-patient care and post-hospital supported discharge schemes. In that context the community hospital was placed in the former category because it is a model of in-patient care.

American evidence from the 1970s indicated that patients admitted to an innovative therapeutic nursing unit - the Loeb Centre for Nursing and Rehabilitation - had fewer acute re-admissions, better function, better quality of life and higher satisfaction than patients receiving traditional treatment. The findings inspired various innovations in primary nursing and community care models in the UK, including a number of nursing development units which focused on meeting intermediate care needs. In a series of pilots and experiments, equivalent or better outcomes were reported for intermediate care, in one case including a mortality advantage. However, although these studies produced useful information about the

[1] Steiner, A. (1997) Intermediate Care: A Conceptual Framework and Review of the Literature, King's Fund, London

feasibility and dynamics of organising such units, their relevance from a population perspective was limited by methodology. Weaknesses included high attrition rates, lack of adjustment for (sometimes completely unmeasured) underlying differences between intervention and comparison group patients, and using project leaders as evaluators.

An alternate in-patient model was the Lambeth Community Care Centre (LCCC). LCCC evaluations reported equivalent lengths of stay and lower costs, compared to acute hospitalisation in the same geographical area; the length of stay observation most likely resulted from setting limits on the maximum days allowable. No data were available on the patient case mix in each setting; nor was there information about the different care models' relative effectiveness.

Regarding community hospitals, a well-designed study in the Oxford region found that community hospitals both substituted for and complemented secondary care. That is, in areas where community hospital care was available, acute hospital lengths of stay shortened significantly; however, total length of stay (acute plus community) increased, indicating GPs used community hospitals to admit patients who perhaps could have been treated at home or - alternatively - who would have remained at home without needed care were it not for the community hospital option.

In summary, the evidence indicates that nurse-led in-patient care can in fact be organised and does please and benefit some patients. Quality of care appears to be good. But it cannot yet be said - one way or another - how such care compares to conventional treatment in terms of clinical efficacy, cost-effectiveness or acceptability to users, carers and professionals.

In contrast to the qualitative nature of research on in-patient intermediate care, many supported early discharge programmes have been evaluated according to more quantitatively stringent designs, including randomised controlled studies and attention to outcomes. Evaluations can be categorised by target population, as follows:

In maternity, supported early discharge - even for special-care infants - has proved safe, cost-effective, and popular with users if targeted to a select subgroup of women who are at low risk medically, relatively well-educated, economically middle-class, and motivated to go home quickly.

In paediatrics - typically targeted to chronically or terminally ill children's bouts with fever or other acute episode - available studies report large cost savings with no damage to health outcomes. These studies are methodologically flawed in important ways (many used a before-and-after design that cannot account for changes in overall practice patterns, and some had attrition problems) but the magnitude of effect remains promising.

For adults undergoing minor surgery, the findings are mixed. Not only do they vary according to procedure, but even within procedures, evaluations report gains in one measure, losses in another - and do so inconsistently, precluding valid inference.

Finally, in elderly care, the best-designed studies produced either mixed results (differential patterns of advantage and disadvantage to conventional or intermediate care) or found no statistically significant differences in outcomes between post-acute options. These studies tended not to be specific about their target population, and often included both long-term care patients and patients with positive prognoses for a return to functional independence. Patients who could be demonstrated to benefit from supported discharge schemes were those at high risk of re-admission, non-institutionalised but with pre-morbid functional problems, and cognitively intact.

In summary, the qualitative research findings regarding intermediate care are promising but the policy (population-based) evidence is lacking. A clearly defined population group, effective statistical control for underlying differences between intervention and controls, independent evaluation, and attention to process, outcome and the links between them would aid evaluators in producing policy-relevant conclusions. It is recognised that randomised controlled trials are not necessarily appropriate designs in a developmental setting; hence explicit criteria for selection into an intermediate care programme and analytic strategies for case mix adjustment are all the more important.

Summary Box

1. The literature on intermediate care emphasises nurse-led in-patient units and post-hospital supported discharge schemes which range in orientation from medical to social and multi-professional.

2. Nursing unit evidence is mostly qualitative and suggests it is feasible and effective to introduce this type of intermediate care. However policy implications remain unclear owing to methodological difficulties of comparison with conventional approaches.

3. Supported discharge schemes can be cost effective with equal or improved patient outcomes, provided that interventions are targeted at patients with defined needs and good potential for recovery.

4. Clear specification of care components and service users is required to demonstrate effectiveness. The importance of this arises most evidently in evaluations of intermediate care for elderly people.

Points for Debate

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

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

Progressive patient care has been touted as the ideal for well over thirty years and more recently there has been a commitment to the provision of a seamless service. Numerous pilot studies and demonstration projects related to an intermediate care service - some of them with experimental designs - have reported benefits to patients and health care workers alike. Despite this, an intermediate care function has not been acknowledged in the NHS; nor have training and services been promoted to fulfil it. Why not?

In debate one speaker suggested the problem lies in an absence of clarity, in that professionals lack a shared interpretation of what intermediate care is - or could be. Specifically, is intermediate care most appropriately targeted to patients with good prospects for regaining their maximum health - the literature suggests effectiveness in this arena - or would it work better as a repository of bridging services that do not fit comfortably into current structures of care? For example, should it encompass respite care, hospital at home schemes which substitute one care setting for another or shifts in management of clinical problems such as deep vein thrombosis from an acute to a primary setting? Lack of clarity also means that evaluations can fail to demonstrate effectiveness - not because the interventions do not work, but because the service users are a mix of patients with potential to benefit and patients with poor prognoses (for example, nursing home residents with severe chronic care needs). Without a policy-relevant evidence base, purchasers may hesitate to support an explicit intermediate care strategy. Thus a strong plea was made to distinguish between intermediate and chronic care services.

Another perspective refers to the enormous complexity of intermediate care services. They tend to be multi-disciplinary, require early assessment, and cross boundaries between health and social services as well as between different professional specialities within each of those sectors. There are difficulties in managing this kind of work, such as how a common terminology (with common meaning) is to be achieved, where the locus of power would reside and who (or which sector) is to be held accountable for the care. One speaker noted that not only must intermediate care professionals help patients move from one state to another, they must themselves bridge backwards and forwards between an array of different boundaries as part of their routine practice which can be highly challenging. The complexity of this 'muddy' situation and the uncertainty it generates among those involved should not be underestimated. However some participants noted that increasing numbers of health and social care providers are gaining experience in this regard and have coined the term "boundroids" to describe themselves.

In a related observation, there were those who identified the stumbling block in terms of the threat that new models pose to established treatment patterns and existing power arrangements. Intermediate care was seen to challenge the biomedical (some said reductionist) approach to health. In addition, it was seen as a potential challenge to the social care sector - particularly if taken to include services designed to prevent transitions from home to either hospital or nursing home. Finally, the intermediate care model stresses partnerships between professionals and users - potentially quite different from traditional (some said paternalistic) approaches to communication and therapeutic strategies.

The last hypothesis was that intermediate care has not been taken up because it costs money. One participant commented that rather than treatment costs being distributed evenly across a patient's hospitalisation, they are highest in the initial days. Once a patient is stabilised, it costs no more to remain in an acute setting than a community one. Transfer - whether to a new ward or a new site - would constitute an additional cost. Moreover, intermediate care poses the danger of a woodworking effect, whereby people interested in such services virtually "come out of the woodwork" when the service becomes available. The increase in demand could be debilitating in a block purchasing environment. In response, other participants noted that quality, not costs, should be the central concern; that some intermediate care settings had been demonstrated to save money; and that, at a minimum, the assertion that intermediate care costs money was an empirical one that had not yet been resolved.

Summary Box

1. There is a variety of opinion about what intermediate care does, or does not, including. For example:

patients with good prospects for regaining maximum health **vs.** *those with a poor prognosis for recovery*

a specific targeted service **vs.** *a repository for bridging services or substitution for the setting in which services take place*

2. This lack of clarity has hampered effective evaluation

3. Intermediate care crosses traditional boundaries between acute, primary and social care as well as occupational groups and hence its introduction is very complex.

4. It potentially threatens traditional patterns of care since it overlaps with and bridges between medical and social health.

5. There is lack of information about cost implications and a variation of opinion about the relationship between cost and quality indicators.

Debate Point 2: **Is intermediate care a new layer in the system, or the glue that holds existing layers together?**

It has been noted that the term intermediate care implies a between-ness. This gives rise to a concern that intermediate care is meant to be a new layer in the health service, which alarmed many seminar participants on numerous grounds. Some claimed that inevitably a new layer of services would increase overall costs - if, for example, it entailed a new FCE. (It was argued in response that transfer to stroke or geriatric rehabilitation units also initiated second FCEs but were recognised as appropriate pathways of care.) Others observed that care teams in acute hospital wards would be deprived the satisfaction of seeing patients recover. If the recovery phase became the domain of a new team, it could prove socially destructive to a working group already coping with fragmentation and loss of traditional roles. In addition, it could harm quality of care, in that patients do not like being moved around. This perspective was questioned by others who believed not only that patients would be willing to move if the transfer improved treatment, but that the rehabilitative aspects of their care are at risk in an acute ward setting where medical emergencies, by their very nature, must take priority.

It was noted that managing the interface between secondary and primary care is difficult enough, without adding new boundaries within the system. In preference to conceiving of intermediate care as an additional layer, participants agreed that it should be embedded firmly within existing structures - be they primary care, secondary care, or community-based health and social services. One speaker suggested that rather than thinking about intermediate care in terms of layers, one could think in terms of integrated packages of care. Another asserted that in the wake of an explosion of medical knowledge and the development of highly efficient specialist services in response, patients are left to themselves to interpret multiple messages from different sources and reconstitute their lives in the light of complex and sometimes conflicting information. With its holistic focus, intermediate care can become the "glue" between high-tech treatments, by helping patients to integrate new inputs and return to their daily routines.

Summary Box

1. There is some concern that intermediate care would introduce a new 'layer' in the service but this perspective can be rejected in favour of it being integrated into current acute, primary and social services.

2. Similarly concern about excessive moves for patients can be countered by the benefits of providing a service specifically targeted at their needs rather than having to vie for attention in an environment which is, by necessity, dominated by acute medical emergencies.

3. In the wake of a high degree of specialisation in medical treatment intermediate care can provide the 'glue' in the service which helps patients integrate new levels of health into their day to day lives.

Debate Point 3: **Where is the proper locus of intermediate care?**

Despite the consensus that intermediate care should be embedded within existing structures, participants continued to debate which structures these should be. One speaker presented a developing approach - the Anglia & Oxford Intermediate Care Project - that takes a service perspective, viewing intermediate care as relating to the entire care system, from primary and secondary services to social care and housing policies. By examining care pathways for people with five tracer conditions (stroke, chest infection in elderly people, deep vein thrombosis, minor injury, and hip replacement), the project hopes to identify different localities, existing resources and areas appropriate for improvement.

In the main, however, there was a division between those whose starting point was secondary care - an initial acute hospitalisation - and those who began with community care and a commitment to keeping people in their own homes so far as possible. Each viewpoint gave rise to a different set of issues.

Regarding intermediate care services initiated by acute hospitalisation, participants focused on tangible issues to do with budgets (including fixed expenditures and block contract purchasing), varying admission/discharge incentives for health commissions and GP fund holders, and the threats and opportunities engendered by disinvestment. Some speakers felt strongly that there are benefits to remaining in hospital even after a medical crisis has passed, and that acute services can be reconfigured so that a portion of the existing estate is allocated to nurse-led units where patients' recovery-based needs for continuing therapeutic support (for example, wound care or rehabilitation) are managed. In opposition, other participants foresaw increased workload, higher stress levels and lower morale among nurses in non-intermediate care wards.

An example of hospital-based intermediate care is Cass Ward, a nurse-led unit in Homerton Hospital. The unit is open to medically stable patients who have significant nursing needs and are likely to respond to intensive therapy. Organisational and patient-level factors converged to make the innovative unit possible. First, the hospital was at a step-point for increasing its medical staff but lacked resources. Second, numerous audits had demonstrated that a significant portion of patients remained in acute beds inappropriately, awaiting discharge arrangements; at the same time, acutely ill patients needed those beds. Third, Homerton nurses had experience with innovative care and increased responsibility (for example, with a nurse-led primary care unit in A&E, night nurse practitioners, and other developments from clinical nurse specialists). Rather than feeling threatened, then, medical staff were pleased to reduce their burden of care and hospital management were relieved to open a new ward that would be less expensive than the normal medical model. This programme is currently the subject of a randomised control trial.

A completely different vision of intermediate care emerged from the community trust and community care participants. Such different world views led one participant to question the extent to which it helped or hindered the development of intermediate care to locate it in health care, the NHS, and nursing. Another participant made a strong plea to begin thinking about intermediate care from the premise that a person's "own bed" (at home) was best and that the objective of intermediate care services should be to capitalise on domicilary services to prevent hospital admissions or moves to residential care. In the same spirit, other community care specialists found the most meaning for intermediate care in terms of services targeted to people with severe illness, noting that the reality for such people had less to do with acute hospitalisations (and their aftermath) than with the challenges of living with uncertainty and frequent ups and downs.

Several speakers and participants raised the Lambeth Community Care Centre (LCCC) as a model of community-based intermediate care, one person reporting that it resulted from "lateral thinking" about patients' needs and how to configure services to meet them. It was noted, however, that entry into (and exit from) even an innovative unit can be complex. In the case of LCCC, GPs could block beds as readily as consultants can in acute care settings; similarly, nurse-led units usually set stringent admission criteria of their own.

An alternative model of community-based responsibility for intermediate care locates it in the primary care sector, with total purchasing pilots receiving particular attention. According to this model, GPs work with a primary care team that includes practice-attached community nurses and health visitors, counsellors and psychologists, a home care manager and social services staff, occupational therapists, a discharge liaison nurse and others. Leadership and team configuration is flexible depending on the patient's needs, and care can be either post- or pre-acute (i.e. preventive). The New River Total Care Project, described at the seminar, maintains GP beds in a community care centre; these are used to treat both acute illness (such as myocardial infarction) and relapsing chronic disability, provide rehabilitation, respite and terminal care, and function as an initial discharge destination for acute hospitals. The most significant expressed difficulty was the "artificial divide" between health and social services; however, the speaker emphasised that multi-disciplinary teams can work well in this approach. In addition, one participant questioned the capacity of a GP-led cottage hospital to provide the most up to date technologies in the case of myocardial infarction.

Another natural setting for intermediate care is the community hospital. In localities where they still exist, community hospitals hold a potentially critical place in any continuum of health and social services because they sit at the interfaces between secondary, primary, and social care. As an innovative example, the Oxfordshire Community Health NHS Trust recently developed a global strategic plan to meet intermediate care objectives across its 11 community hospitals. These serve seven NHS trusts and 88 primary health care teams, with a

roughly even distribution between acute and other admissions from the community and post-acute transfers from secondary care. Service delivery is meant to be nursing-led but not nursing-owned, in that nurses work in partnership with other disciplines. As with the GP beds, admission categories include acute medical care, rehabilitation, respite care, and terminal/palliative care. However, "care categories" are taken as more relevant. Oxfordshire's intermediate care philosophy was characterised as a "re-enablement focus" to be applied flexibly according to patients' needs.

In summary, the central debate around locus of care considers whether home- or hospital-based services are best. Implicitly, it considers whether intermediate care targets chronic care or transitional rehabilitation-style needs, or both. Emphasis on one category or the other gives rise to different sets of philosophical, operational, and training issues. Potentially, primary care or community hospital settings can be appropriate bases for organising services that extend in both directions - from or towards home. Alternatively, these models can combine with hospital- and home-based innovations to form a coherent intermediate care strategy at multiple service levels.

Summary Box

1. The setting in which intermediate care services arise is a contentious one which appears to be driven from either a community perspective, as a step up option, an acute perspective as a step down option or as an entire care system.

2. In any of these options there are financial disincentives related to contracting processes but the threats and opportunities engendered by disinvestment may encourage development in this area of care.

3. Examples of exploratory approaches/views being taken to intermediate care include:-

- A hospital based nurse led unit (currently being subjected to an RCT)

- The Lambeth Community Care Centre model of a community based in-patient and day care service

- A flexible multi-professional community team (within a primary care total purchasing practice) offering either pre or post acute care with access to community hospital beds

- Collaboration between acute and community Trusts to provide focused but flexible use of community hospitals with admission primarily related to care categories.

- A view that all developments should start from the premise that home care is best

- The use of 'tracer conditions' (at this stage primarily related to a medical diagnosis) to assess what is or could happen to patients and their service arrangements

Debate Point 4: **Does intermediate care pose a threat?**

Three areas of potential threat arose. First, the issue about locus of care is one of the most contentious, despite reiterations that patients (or clients) benefit, at least potentially, from different types of intermediate care. The problem appears to be that in a mixed group, concentration on any one sector leaves members of the other sectors on the margins, resulting in few points of common ground - even for debate. It is this perception of marginalisation that is most threatening, and which gives rise to complaints that the premises of the discussion - and of service planning - are misplaced. For the omitted group, they may be.

For example, the community care sector may view intermediate care services as a much needed addition to current chronic care options. Their central concern is that the debate is not compromised by equating intermediate care with hospital beds. In contrast, the acute care sector may view intermediate care as a substitute for current approaches to treatment. Its concern appears to be one of losing ground - be it beds, staff, or control. If that concern falls out of the debate, intermediate care may either become the exclusive domain of community care - missing at least some aspects of the original point of restoration and re-enablement - or hospital-based services will be planned naively and may fail for want of thoughtful management.

A second potential for threat is the shift in therapeutic model. The intermediate care philosophy places non-technical activities such as informing, encouraging and motivating patients on a par with specialised medical interventions. Although numerous seminar participants voiced strong support for acknowledging patients' transitional needs - including restoration of confidence - others reacted sceptically, not only to the cost-effectiveness but even to the appropriateness of allocating beds for this purpose. Because hospital-based intermediate care could equate with transferring responsibility from one professional group to another, its introduction would require careful organisation to avoid perceptions of threat.

Finally, one speaker noted that some nurses working in transitional care report considerable uncertainty and confusion. They must function in unfamiliar organisations, interact with unfamiliar professions, and create a professional identity because - to some extent - they no longer have a peer group. Their very service niche can threaten other long-established roles, power relations and even - in an economically constrained environment - jobs. On the other hand, several speakers and participants observed that the new class of "boundroids" found their work exciting, positively challenging, and highly meaningful; indeed, they felt they could not "go back."

Summary Box

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

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

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

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

Debate Point 5: **Who should lead care provision?**

One of the central issues regarding intermediate care is leadership and, implicitly, training. Who shall take the lead in organising and providing care?

One view raised was that medical, nursing and social work education each emphasise different types of knowledge about health and illness. Hence each leaves gaps in terms of the information and orientation required to meet patients' intermediate care needs proactively. It was proposed that occupational groups could be trained in intermediate care skills that matched their core competencies, with "top-up" supplements guided by local needs. Although a multi-professional approach to training was anticipated, the critical issue was to begin by examining well-defined client groups' clinical needs, identifying the skills required to meet them, and only then devising training opportunities to acquire the relevant skills. It was suggested that with their special training in the impact of illness on patients, nurses made natural candidates for learning to lead intermediate care teams.

Numerous participants called for joint education for care professionals and increased attention to wider organisational learning. Many asserted the need to break down territorial boundaries between health and social services, as well as other professional and organisational barriers. However some participants stressed instead the importance of preserving competencies unique to each discipline. Several people questioned whether 'nursing' must always be

delivered by nurses. Some suggested that clearer distinctions be drawn between tasks that are general care and tasks that are specifically nursing care but an alternative view was that breaking work down into tasks is not a helpful way of defining roles. More generally, some advised a focus on creating flexible social/health care teams which together possessed an appropriate skill mix rather than trying to embed all relevant skills in every care professional.

It was noted that many services which fit the function of intermediate care already exist, implying that the competencies and skills required to deliver such care have been identified. What is lacking are opportunities to disseminate the information. It was suggested that the Royal Colleges had an important role to play, particularly in terms of their influence on how doctors are trained. One perspective raised is that medical training is devoid of information about social services, which leaves a gap in doctors' competence to organise intermediate care. Another participant reported that in most chronic mental health and long-term care, services are already nurse- or therapist-led; on the whole, however, these are models of chronic rather than transitional care.

Summary Box

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

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

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

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

Debate Point 6: **Does intermediate care cost too much to be a realistic option?**

Some participants suggested that intermediate care has not become common currency in the NHS because it does not save money. One suggestion was that one care regime can cost less than another only if fewer inputs are invested. Where alternate models appear to bring large cost savings, the burden of care may simply be shifting; for example, hospital at home

schemes seem cost-saving because families and other informal carers substitute their time for elements of NHS labour. One speaker added that costing was not simply a matter of counting inputs but of valuing them. The bulk of proposed savings from intermediate care derives from shifting responsibility to a professional group that - for better or worse - receives lower wages.

The importance of payment systems, and especially of contracting units, was also raised. In the US, it was observed, payment on a per-day basis encourages alternate providers to offer specialised services - such as post-acute care for medically stable patients - at a lower price. The "reality of fixed expenditure" was identified as a barrier to developing intermediate care in the NHS. Further, where services are arranged through block purchasing contracts, providers face strong incentives to limit the number of users, not expand it. By contrast, more integrated purchasing/providing arrangements (such as GP fundholding) or private fee-for-service insurance plans are less vulnerable to those incentives.

As a possible way forward, one participant proposed that responsibility for health services be placed under local authority control. Such a move, it was argued, might stop territorial disputes between the health and social care sectors. Another proposal was to reshape services within the acute sector - not only to release funds for doing more work, but to reconfigure portions of the work itself (for example, creating options to reduce inappropriately long hospital stays for want of a suitable discharge arrangement). In this regard, some thought that closing hospitals - termed by several participants as appropriate disinvestment given current usage - could become pilot sites for intermediate care.

Finally, various participants advised promoting intermediate care on the basis of quality gains, not cost savings. Another emphasised the importance of maximising value, as opposed to minimising costs, and called for studies that identified which approaches were most cost-effective from the perspective of the patients receiving care. This requires examination not only of costs but outcomes.

Summary Box

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

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

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

What next? How to proceed

Even in the context of active debate on fundamental and second-order issues, seminar participants agreed on four points that should provide a way forward. The first was a basic affirmation that the transitional, restorative function of intermediate care is crucial to patient care. Hence it is appropriate for health and social care professionals - providers and purchasers alike - to arrange services in ways that will enable that function to be fulfilled.

Secondly, there are at present important contractual disincentives to providing intermediate care as easily as could be desired. Fixed expenditure budgets and block-contract purchasing work against flexible use of funding; they also make it more difficult to support gap-filling services which would presumably invite new demand. In the primary care sector, some total purchasing pilot sites as well as some GP fundholders are experimenting with practice-attached counsellors, health visitors, social service managers, and others in order to form a multi-disciplinary team capable of meeting intermediate (and other) patient care needs. However, as one participant commented, the difficulties in obtaining, for example, a social services budget breakdown at a practice level precluded any actual sharing of budgets. The best that could be done was to collaborate with a practice-associated social worker and "make care appear seamless" to patients. If the policies of integration are to be taken seriously, purchasers must re-examine payment incentives and their systems of contracting for services.

Thirdly, whether in the secondary, primary or community health care sectors, practitioners must develop the skills to work across health and social care boundaries. To this end, it will be critical to know beforehand that not only do common vocabularies carry different meanings but that there are complex cultural variations and understandings amongst health professionals. Developing good communications and - from that - care packages to suit patients' needs will require not only meeting and listening carefully, but also a willingness to clarify the assumptions that guide delivery of care. Achieving a common understanding however may be the key to effective team working and programme development. Embedded in the call for cross-boundary working is the important issue of training and competencies. Some joint education or, at a minimum, education of one professional group regarding the working premises of another will probably be required.

Finally, there was a call for pilot projects, experiments and evaluations to test the efficacy, cost-effectiveness and acceptability of various intermediate care options. The methods and feasibility of dissemination must figure prominently in the process, beginning with learning from existing and ongoing programmes. At this time, too little is known about whether a programme deemed successful at a local level can generalise to new localities and justify support at the public policy level. Practitioners need information, not rhetoric, for in the absence of information it is rhetoric that will dominate the debates - to the potential disadvantage of service users and carers.

Both service development and evaluation take time. To arrange them sequentially takes even longer. Thus two sorts of studies would be useful: case study-style research based on pilot/demonstration projects to inform development, and more narrowly defined quantitative assessments of costs and benefits relative to existing options. In the latter instance, a strong case can be made for starting with well-defined interventions targeted to a well-defined user population and careful case mix adjustment to justify cost-benefit comparisons between innovative and traditional care groups.

To conclude, there is both a need for and some opportunities to develop hospital- and community-based intermediate care. In conjunction with this, and if intermediate care is to become a recognised and routinely-met function of the NHS, attention must be paid to financial incentives, intersectoral working, and evaluation.

Summary Box

1. There is general agreement that the transitional restorative function of intermediate care is crucial to patient care.

2. There are important contractual disincentives to providing intermediate care which need to be addressed.

3. Practitioners in all sectors must learn to work across boundaries, with shared use of terms, clarification of assumptions, and willingness to develop cross-discipline competencies.

4. There is a call for pilot projects and evaluation, using both case study and quantitative approaches to assess intermediate care in relation to existing options.

5. A range of options in both community and acute care sectors should be incorporated into this work.

Appendix 1

INTERMEDIATE CARE SEMINAR, 30 October 1996 at the King's Fund

PROGRAMME

2.00 **Welcome and introduction**
Dr Robert Maxwell, Chief Executive, King's Fund

2.10 **Summary of literature review and conceptual framework**
Dr Andrea Steiner, Lecturer, Institute for Health Policy Studies, University of Southampton

discussion

2.40 **Raising the issues**

Cross boundary working
Dr Sue Dowling, Consultant/Senior Lecturer, Department of Social Medicine, University of Bristol

A Perspective from General Practice
Dr Michael Gocman, General Practitioner/Chairman, New River Total Purchasing Project

Roles for the future
Ms Barbara Vaughan, Programme Director, Nursing Developments, King's Fund

discussion

3.45 **Tea**

4.00 **Practice examples**

The Anglia and Oxford initiative
Mr Philip Hadridge, Service Development Manager, Anglia and Oxford NHS Executive

Nurse led in patient services at Homerton Hospital
Dr Shelley Heard, Post Graduate Dean, Thames Post Graduate Medical and Dental School (formerly Chief Executive, Homerton Hospital)

Ms Nancy Hallett, Director of Nursing, Homerton Hospital

Interface between acute and primary care
Mr Brendan McCormack, Fellow/Programme Manager, RCN Institute/Oxfordshire Community Trust

Ms Amanda Evans, Senior Nurse/Service Delivery Unit Manager, Acute General Medicine, Oxford Radcliffe Hospital

discussion

5.30 **Where now**
Dr Robert Maxwell, Chief Executive, King's Fund

6.00 **Drinks and canapés**

Appendix 2

Participant List

Mr Jonathan Asbridge, Nursing Director, Oxford Radcliffe Hospital
Dr Gifford Batsone, Director, Medical Development, King's Fund
Dr Peter Bourdillon, Senior Principal Medical Officer, Department of Health
Mr Seán Boyle, Research Manager, London Commission, King's Fund
Mrs Pat Cantrill, Assistant Chief Nursing Officer, Department of Health
Mr Andrew Clark, Head of Clinical Performance Improvement Unit/Consultant Surgeon, The Royal Sussex County Hospital
Mr Peter Coe, Chief Executive, East London & the City Health Authority
Mr Peter Coles, Chief Executive, Homerton Hospital NHS Trust
Surgeon Commander Richard Dale, Assistant Director, Audit Unit, Royal College of Surgeons
Dr Edward Dickinson, Associate Director, Research Unit, Royal College of Physicians
Dr Sue Dowling, Consultant Senior Lecturer, Department of Social Medicine, University of Bristol
Mrs Catherine Elcoat, Nursing Officer, Clinical Effectiveness, Department of Health
Professor Adrian Eddlestone, Dean of the Medical School, King's Healthcare
Dame Audrey Emerton, Chairman, Brighton Healthcare NHS Trust, Royal Sussex County Hospital
Mr William Erwin, Project Co-ordinator, New River Total Purchasing Project
Ms Amanda Evans, Senior Nurse/Service Delivery Unit Manager, Acute General Medicine, Oxford Radcliffe Hospital
Mrs Alison Forbes, Press and PR Manager, King's Fund
Dr Michael Gocman, General Practitioner/Chairman, New River Total Purchasing Project
Ms Pat Gordon, Director, Primary Health Care, King's Fund
Mr Peter Griffiths, Director, Management College, King's Fund
Mr Philip Hadridge, Service Development Manager, Anglia and Oxford NHS Executive
Ms Nancy Hallett, Director of Nursing, Homerton Hospital NHS Trust
Mr Anthony Harrison, Fellow in Health Policy Analysis, Policy Institute, King's Fund
Dr Shelley Heard, Post Graduate Dean, Thames Post Graduate Medical and Dental Education (formerly Chief Executive, Homerton Hospital NHS Trust)
Mr Stephen Hunt, Projects Director, Hinchingbrooke NHS Trust
Mr Anthony Hurrell, Manager, South Powys Purchasing Project
Mrs Elizabeth Jenkins, Assistant General Secretary, Royal College of Nursing
Dr Robert Maxwell, Secretary/Chief Executive, King's Fund
Mr Brendan McCormack, Fellow/Programme Manager, RCN Institute/Oxfordshire Community Trust
Mrs Catherine McLoughlin, Chairman, Bromley Healthcare
Ms Penny Newman, Fellow, Management College, King's Fund
Dr Paddy Phillips, May Reader, Nuffield Department of Medicine, John Radcliffe Hospital

Dr Diane Plamping, Fellow, Primary Health Care, King's Fund
Mr Richard Poxton, Project Manager, Joint Commissioning - Community Care, King's Fund
Professor Michael Pringle, Professor of General Practice/Head, The Department of General Practice, Queen's Medical Centre
Mrs Vivien Rhodes, Director of Nursing, Lewisham Hospital
Dr Kay Richmond, Principal Medical Officer, Welsh Office
Ms Emilie Roberts, Research Assistant, Policy Institute, King's Fund
Mrs Janice Robinson, Programme Director, Community Care, King's Fund
Ms Angela Sealy, Chairman, North & Mid Hampshire Health Authority
Mr Clive Smee, Chief Economic Adviser, Department of Health
Dr Andrea Steiner, Lecturer, Institute for Health Policy Studies, University of Southampton
Dr Robin Stott, Medical Director, Lewisham Hospital
Ms Sue Thomas, Community Health Adviser, Department of Nursing, Policy and Practice, Royal College of Nursing
Ms Barbara Vaughan, Programme Director, Nursing Developments, King's Fund
Mr Stuart Welling, Chief Executive, Brighton Healthcare NHS Trust, Royal Sussex County Hospital
Dr Peter West, Senior Lecturer in Health Economics, Department of Public Health Sciences, The United Medical and Dental School
Ms Gill Whittington, Strategy Director, Guys & St Thomas Hospital
Mr Ian Wylie, Head of Communications, King's Fund,
Mrs Judie Yung, Director of Performance Management, North Thames NHS Region