Intermediate care in England: where next?

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Introduction

The announcement that the stipulated targets for intermediate care have been met marked the end of the beginning for this new type of community service in England [1]. The targets, which quantified people treated and places and beds available, have not been a popular indicator with service providers. They have proved difficult to collect, partly because of the potential for double counting of shared social and healthcare services and partly because of uncertainties in accounting for patients moving between different intermediate care services. Moreover, there has been considerable scope for simple re-badging of existing services as intermediate care. Nonetheless, this rapidly achieved landmark will be closely observed by healthcare planners internationally who are similarly wrestling solutions to demographic transitions, acute care demand and the burdens of chronic disease. It is therefore opportune to draw back and consider the reality of progress to date and reflect on the future of intermediate care.

Background

The roots of intermediate care lay in the recognition that acute hospital care was a blunt instrument for chronic disease management, that there was insufficient time available for the process of rehabilitation and functional recovery for older people and that community care as a patient experience in England was one of organised chaos. The concept of intermediate care was first signalled in the National Beds Enquiry [2] and became policy in the NHS Plan [3], and a rapid national dissemination was achieved through the National Service Framework for Older People [4]. Initial responses were mixed and included those of suspicion [5], a concern about the re-invention of workhouses [6] and a judgement that an evaluation was urgently needed [7]. There was much introspection over competing definitions and understandings of intermediate care. Indeed, the concept and its taxonomy continue to excite academic debate [8]. The national targets cleverly cut through much of this debate by imposing a highly practical definition for intermediate care [9] that, although in some respects restrictive, has allowed sufficient flexibility in interpretation to foster local innovation and service diversity [10]. At a time when the Department of Health has been concerned with local devolution of healthcare planning, with reluctance to issue central guidance, it is perhaps salutary that such a clear statement of what is, and is not, intermediate care has been so helpful. Few can doubt that the national targets have achieved their objective of a rapid expansion of intermediate care services, though the journey has been hard won [11] and general practitioner engagement remains weak [12].

What has intermediate care achieved?

The strategic aims of intermediate care were concisely stated: ‘... to promote faster recovery from illness and prevent unnecessary acute hospital admissions, support timely discharge and maximise independent living’ [4]. Thus, there was an expectation that general hospitals would become less hard pressed and that admissions to (expensive) institutional care might be avoided. The extent to which these aims have been achieved is unclear. Despite a specific obligation for primary care trusts to reduce acute admissions, general hospitals nationally continue to be hard pressed, and Department of Health episodes of care statistics reveal there has been a further 7.8% increase in acute admissions since intermediate care has been a healthcare policy. There has been greater apparent success with expediting
hospital discharges. Delayed discharges have fallen in the 3 years since 2001 from 6,419 to 2,619 [1]. Although it is likely that intermediate care has contributed to this welcome improvement in bed management, the issue is a complex one and includes other factors such as better co-ordination between health and social care following the introduction of the reimbursement policy [13]. The effects of reimbursement on the process of hospital discharge is illustrative that in a turbulent, constantly changing health and social care system, it is always going to be problematic to judge the success or otherwise of a national reform such as intermediate care. Nonetheless, three multi-site studies have concluded that local intermediate care services are often too small or too poorly organised to be effective [14] (M. Godfrey, personal communication; E. Regan, personal communication), and an evaluation of a well-resourced, city-wide service reported increased hospital use for a group of patients receiving intermediate care [15].

**Operational issues**

Despite the national targets, the optimum size for intermediate care services was left to local health and social care communities to resolve. With hindsight, a needs-based assessment for intermediate care might have been an essential first step. Indeed, needs assessment methods and results for whole system intermediate care services have only recently emerged, and a surprising finding has been the high percentage of 45% of inpatients in one healthcare system who fulfilled a locally agreed criteria for the intermediate care service [16]. Services with the capacity to support proportions of patients of this order imply a futility with what might be generously termed embryonic intermediate care. In this situation, some practical experience is achieved with inter-agency working, but the services are small scale and relatively invisible within the high-volume activity of mainstream older people’s services. But service size alone is unlikely to be the sole determinant of a successful intermediate care service. Common sense suggests that a reasonable service capacity is required, but increasing complexity and the wider engagement and integration of intermediate care are additional important attributes evident where intermediate care has matured from an embryonic to a larger scale service [14] (M. Godfrey, personal communication; E. Regan, personal communication). Unfortunately, too many of the larger scale services remain excessively fragmented—essentially a collection of different intermediate care services each with separate staff and separate entry criteria [14] (M. Godfrey, personal communication; E. Regan, personal communication). In this criterion-driven form of intermediate care, patients can be subjected to multiple assessments and many, particularly those with cognitive impairment, are excluded.

**Next steps**

The delivery of intermediate care in England needs strengthening. We suggest that a bolder version of intermediate care is needed—one that is more consistent with the needs of older people with chronic conditions, including cognitive impairment. The current perception of intermediate care as simply a new and discrete tier of community services is to miss its full potential [14]. It is useful to consider the underlying principles of intermediate care: multi-agency working; comprehensive, shared assessments and person-centred care based on an enabling (rehabilitation) approach. There is no fundamental reason why these good practice principles should be confined to intermediate care services. Rather, the policy of intermediate care could be viewed as a stepping stone, a practical mechanism, to introduce these important concepts as acceptable and routine new ways of supporting older people. In other words, intermediate care becomes an embedded function of the care delivered by those staff engaged in supporting older people in the community rather than as a service in its own right. Thus, the person may sometimes be receiving intermediate care according to our current understanding (e.g. care that avoids unnecessary time in hospital), and they may at other times be receiving ongoing care at home but delivered by the same people. Essentially, most of the community staff will be adopting a rehabilitation philosophy and incorporating the principles of intermediate care into their daily practice. The key to this approach is probably having a sufficiently large pool of well-trained and well-supported generic rehabilitation/care support staff, working as teams and under guidance from clinical managers, to provide the day-to-day support for people and thus deliver the continuity of care which service users, especially older people, value highly [18]. As with current intermediate care practice, it would be crucial for arrangements to be in place for quick access to medical assessment, for example from a general practitioner or geriatrician.

The future pattern of community care for older people could be one in which well-resourced health and social care locality teams are jointly commissioned by the local planning partners. Such teams could bring together a full range of professions and skills, generalists and specialists, underpinned by many trained rehabilitative support workers able to offer continuity of care and able to respond flexibly and quickly to change in needs of the most vulnerable older people. In this way, we could achieve a step change in community care for older individuals with intermediate care as currently conceived becoming an historical stepping stone.

**Key points**

- Intermediate care is a new national community care service in England designed to bridge the gap between hospital and home.
- The intermediate care planning targets for England have been met, but it is unclear whether the strategic aims for the service have been achieved.
- There is evidence that many intermediate care services are too small, inadequately targeted or insufficiently integrated to achieve a whole system change to the care for older people.
- Wider dissemination of the intermediate care function could be achieved by incorporating its principles
(multi-agency working; comprehensive assessment and enabling/rehabilitation approach) into service specifications for jointly commissioned local health and social services.

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Conflicts of interest

J.Y. and J.S. have been protagonists of intermediate care on the basis that community care for older people in England has been neglected. Our views about the future of intermediate care have arisen from the many visits we have made to intermediate care services and teams in England during the last 3 years as part of our work for the Department of Health and from educational workshops we have contributed to. J.S. is an associate member of the DH Health and Social Care Change Agent Team, and J.Y. is a professional adviser to the DH. Both have contributed to DH policy papers in this area. The views expressed here, however, are privately held.

References