Intermediate care – where are we now?

Danielle Harari

Two years on from the government's introduction of the Intermediate Care (IC) policy backed by a £150 million investment, it is timely for providers and policy makers to ask themselves this question. The conference audience consisted mainly of geriatricians and GPs with a scattering of nurses and health services managers, and judging from enthusiastic exchanges of views and experience there seemed to be as many different local IC schemes as there were delegates.

The Department of Health (DH) defines IC as a goal-driven, time-limited (six weeks) whole system multidisciplinary approach designed to promote independence by reducing avoidable admissions to hospital, facilitating discharges and reducing need for long-term placements. IC encompasses services such as rapid response and supported discharge teams, hospital-at-home, and nurse-led units in residential homes and community hospitals. Further government investment is planned to achieve 5,000 additional IC beds by March 2004, driven by the concept that IC will provide a solution to delayed discharges by bridging hospital and home for older people. Standard 3 of the National Service Framework for Older People (NSF-OP) sets out the agenda for the IC, and supports this concept[1]. Yet a recent national survey by Age Concern and the British Geriatric Society (BGS) of the current implementation of IC revealed fragmentation of local services, patient exclusions, and lack of specialist input[2]. Also highlighted was shifting of acute or rehabilitation beds to IC, and a general absence of clear accountability and any formal structure for monitoring progress against milestones.

The Department of Health view

Fifteen years ago IC was 'scrabbling for short-term moneys'. Then came the King's Fund Modern Age report, followed by the National Bed Inquiry (NBI) and NHS plan, which put IC firmly on the policy agenda. We are now entering a new phase where the crux is service delivery. Gareth Jones disagreed with the view that IC diverts patients away from specialist care; 'it is not about marginalising older people...but nor is it a "honey-pot" to fund all community-based services'. Targets are being met, and collectively people are being flexible and working across boundaries with local evidence of good practice and commitment to provide better services. However, coverage is patchy; in some areas people with dementia are being excluded, and medical assessment input may be suboptimal in others. Greater co-operation between organisations and agencies at operational level with real partnership working is needed to mainstream IC and to secure future investment. A recurrent theme was introduced in this conference – the need for evaluations of IC effectiveness at an individualised and system level.

Gareth Jones acknowledged the tension between politics and 'real life' sometimes leading to a push for solutions without a solid evidence base, but made a case for using intuition and judgement to move forward so that 'practice and evidence...are going along together'.

The academic geriatrician view

After this predominantly positive view, Professor Ray Tallis threw down the gauntlet, by stating that the IC field is largely evidence-free, and that this is worrying considering the number of patients and resources involved. While the NSF-OP is excellent in providing a comprehensive framework to drive forward health care in older people, he had serious concerns around Standard 3[1]. The NBI recommended that before pursuing implementation cost-effective-

Danielle Harari
FRCP, Clinical Senior Lecturer in Elderly Care, King's College London; Consultant Physician, Elderly Care Unit, Guy's and St Thomas' Hospital, London

Clin Med JRCPL 2002;**2**:477–9

This conference was held at the Royal College of Physicians on 22 May 2002

Conference programme

- **Current national picture**
  Mr Gareth Jones, Department of Health
- **Intermediate care: confusion and ageism**
  Professor Ray Tallis, Hope Hospital, Salford
- **The geriatrician in the community**
  Dr Chris Turnbull, Arrowe Park Hospital, Wirral
- **Partnerships between primary and secondary care**
  Dr Ian Donald, Gloucester Royal Hospital
- **Primary care and intermediate care**
  Dr John Glasspool, Victor Street Surgery, Southampton
- **An update on the research basis of nurse led units**
  Dr Peter Griffiths, King's College London
- **The single assessment process and intermediate care**
  Professor David Challis, University of Manchester
- **Views on intermediate care and summary of the day**
  Professor Cameron Swift, President, British Geriatrics Society

ness should be looked at, but politics intervened – the short timescale of the political cycle demands visible changes driving large scale reforms rather than incremental learning from pilot studies. Furthermore, the rationale behind IC development includes an ageist misunderstanding of the medical needs of older people – that nonspecific management is adequate, and illnesses are less complex. This is particularly the case for step-up care, which presents an increased barrier to older people's access to specialist services ('not evidence-based but prejudice-based'). Step-down care, on the other hand, may lead to earlier hospital discharges, though an older individual's preferences should be factored in. All of the 'new range of IC services' quoted in Standard 3[1] (with the possible exception of nurse-led wards) were already in existence, so is IC in essence a rebadging of old services, poorly evaluated, and given a new government gloss? The BGS survey shows a serious risk of shifting limited resources away from acute hospitals – the promise of a massive increase in staff in the community will be hard to achieve (the government promised 2,000 new GP appointees this year and to date just 18 are in post). Furthermore, making community hospitals safe for complex patients with extra staffing and equipment may lead to wasteful duplication of resources.

The community geriatrician view

In contrast, Dr Chris Turnbull described working service models for IC including nurse-led rapid response teams and step-down rehabilitation beds in residential homes for post-fracture and stroke patients. Hospital readmission, where needed for patients in these schemes, is facilitated by the community geriatrician working with GP colleagues. The role of the community geriatrician should include planning and developing an expanding range of community services, securing capital money for IC development, and setting up nursing home training schemes to promote procedural skills for taking care of feeding tubes and suprapubic catheters in order to avoid hospital admissions. A whole systems approach is required, consolidating partnerships between various IC schemes, primary care trusts (PCTs), ambulance service, and casualty department. IC development can be funded by partnership grants, joint investment funds, and ideally PCTs. Currently PCT views are variable. Some wish to develop their role using community hospitals or residential homes as bases alongside geriatrician outreach teams. Others, however, worry about transfer of acute care into the community and additional work for GPs. Looking to the future, each PCT should have a geriatrician with community sessions for IC and continuing care assessment; it should support specialist nurses and evolve a policy in the nursing home sector on issues such as prescribing, falls prevention, pressure sore prevention, continence, and acute problems.

The general practitioner view

Dr John Glasspool presented his and colleagues' views on IC 'as ordinary GPs'. To help avoid hospital admissions, GPs want direct admitting rights to a nurse-led unit for sub-acute cases (such as urinary tract and lower respiratory infections). Other key GP issues around IC are that they are poorly renumerated for medical cover, and that both accountability ('who is in charge?') and the channels of communication between primary and secondary care are often unclear. Manpower is also an issue for overworked GPs. However, he recognised that in order for IC to be effective, GPs need to be flexible, and have a more strategic vision with an understanding of how the system works.

Bridging the gap between primary and secondary care

Dr Ian Donald spoke about organising straightforward access to IC services, eg a single telephone number, and an arrangement enabling geriatricians to provide immediate advice to GPs. Partnership working reduces hospital admissions in heart failure, diabetes and Parkinson's disease. Preventive home visits for older people have been successful in Europe and USA; these are by intensive nurse-led teams, which are expensive but effective[3]. Data on early discharge schemes show no overall adverse impact on functional recovery. Furthermore a tendency toward heightened patient satisfaction is shown, but also increased stress on carers. The Leicester hospital-at-home scheme reduced length of stay with no increase in mortality or disability, though medical care was provided entirely by GPs so the partnership element was weak[4]. Community hospitals work best where partnership working is in evidence, such as daily care by GPs alongside consultant input to complex medical cases and discharge planning. There is no evidence that residential home-based IC has any advantages (although likely patient benefits include single rooms and a nicer environment). He concluded that ineffective IC often exists where consultants have played no part in its development or design, and play no part in its leadership, operation or governance, including evaluation and research.

Nurse-led units

The evidence around nurse-led units (NLUs), schemes which target patients with stable low-intensity medical needs, was summarised by Dr Peter Griffiths. Fears of diagnostic failures and inadequate treatment have not been confirmed by published research. However, neither has the early promise of NLUs, that therapeutic nursing tailored to the patient's need and protection from iatrogenic problems in acute hospital would lower death rates and functional dependence. Published data concern hospital-based NLUs, with none on community-based NLUs. While the quality of these trials is flawed, a meta-analysis showed no impact on increased costs, and a trend toward improved function[5]. Total inpatient stay in the NLU group was eight days longer, however, so improved function may simply relate to having more recovery time. Patients' attitudes to NLUs are variable, and dependent on many factors other than their placement. Among nursing staff, there is fear of losing acute skills, and a danger of drawing on acute staff. He concluded that on the basis of identifying the optimal patient group, ensuring an appropriate skill-mix and a well-resourced caring environ-

ment, NLUs are potentially a safe and effective model for IC, though evidence is sparse.

Evaluation – how to establish an evidence base for IC

All agreed that while rigorous evaluation of IC schemes is very important, data in the field are poor because such studies are very hard to do. Nevertheless, evaluation and research going beyond simple audit is the way to create resources. Where IC has been up and running for some time there is service level evidence of reduced demand for hospital admissions and long-term care placement – but are these data enough? This is a topic perhaps meriting a conference of its own, but some evaluation approaches were discussed: evaluating local schemes that are working well; examining the impact of IC in diagnosis-specific conditions (such as nurse-led management of deep vein thrombosis); assessing evidence for some components of IC schemes rather than the whole.

Randomised controlled trials (RCTs) remain optimal, but non-RCTs may be more practical in local settings. These, however, must be based on sound methodology to assess complex services, an area of evaluation which itself needs more methodological work. The challenge remains to answer the essential question, 'Is IC delivering better outcomes than the alternatives?' And finally, as an audience member pointed out, those who run IC services, like her, may have no time to either evaluate or publish.

Conclusions

Real and present concerns exist around lack of evaluation, service co-ordination, specialist input and resources. But IC is here to stay, and the challenge is to deliver the best care to older people in this setting. So what conclusions could be drawn about formulae for success? Effective joint working schemes, jointly owned from the start, plus solid links with other services and agencies were high on the list. A concern raised more than once, and left largely unanswered, was how to effectively engage social services in IC, and develop better working practices and routes of access across this crucial boundary. A valid system of identifying appropriate patients for IC is important. The need for more consultant involvement in IC was strongly advocated, though perhaps more so by secondary care providers than by GPs. The resource implications for the specialty are significant, particularly in view of geriatricians' increasing commitments to general internal medicine and specialties of their own. Training in IC (including spending time with GPs) also needs to be incorporated into specialist registrar modules. Use of single assessment was supported for standardisation of care, with triggers leading to guidelines and, more controversially, protocol-driven care pathways. Finally, the people factor cannot be ignored – success in IC schemes is often down to workers' enthusiasm and staying power, good team work, shared vision, and least transferable of all, a charismatic leader.

References

1 Department of Health. *National Service Framework for Older People*. London: DH, 2001.

2 A joint statement from Age Concern and the British Geriatrics Society. *Implementation of the national service framework and intermediate care seen from geriatricians' and older people's perspectives*. London: British Geriatrics Society, 2002.

3 Stuck AE, Egger M, Hammer A, Minder CE, Beck JC. Home visits to prevent nursing home admission and functional decline in elderly people: a systematic review and meta-regression analysis. *JAMA* 2002;**287**:1022–8.

4 Wilson A, Parker H, Wynn A *et al*. Randomised controlled trial of effectiveness of Leicester hospital at home scheme compared with hospital care. *BMJ* 1999;**319**:1542–46.

5 Griffiths P, Harris R, Richardson G, Hallett N, Heard S, Wilson-Barnett J. Substition of a nursing-led inpatient unit for acute services: randomised controlled trial of outcomes and cost of nursing-led intermediate care. *Age Ageing* 2001;**6**:483–8.