Medical aspects of intermediate care

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The term 'intermediate care' has become embedded in NHS terminology together with other widely used phrases such as 'whole systems approach' and 'modernisation', which on deeper enquiry appear to mean different things to different people. The impetus for a new type of service called 'intermediate care' in the late 1990s was given a very considerable boost following the consultation on the National Bed Inquiry,[1] and subsequent publication of the NHS Plan.[2] Nine hundred million pounds was apparently dedicated centrally to deliver a national programme in England.

A problem from the start has been that intermediate care has been seen as the solution to a number of different problems. A positive clinical view was of reinvestment in rehabilitation type services, particularly for older people, in a properly organised multidisciplinary environment, nearer to home, without the perceived dangers of prolonged district general hospital care. From a managerial perspective, such services were seen as an answer to the chronic NHS bed crisis and to ensure that the NHS Plan targets for elective surgery could be met. More recently, there has been a concentration on services around the time of hospital admission to try and support the four-hour transit time targets in A&E. Yet despite this investment there has been concern that for the first time since the inception of the NHS, lengths of stay are rising, particularly for older people. The reason(s) for this is not understood.[3]

Physicians have been somewhat ambivalent about intermediate care. In some parts of the country, community type services were planned which seemed to deliberately exclude hospital-based input, even geriatric medicine. In other parts of the country it proved difficult to get engagement of doctors from either primary or secondary care, and yet there are also areas where the opportunities have been genuinely embraced by health and social care communities, including primary and secondary care physicians, leading to successful local projects.[4] Certainly there has been very little secondary care input into intermediate care by other specialties apart from geriatric medicine, although intermediate care was never conceived as being solely an issue about older people.

Concern raised on publication of the Older Peoples National Service Framework[5] was that development of intermediate care reflected an ageist policy being pursued by central government.[6] The worry was that older people were being shunted into second rate under-resourced services and deprived of the resources and investigations available in district general hospitals. To protect against such criticism it would appear to have been important that any intermediate care scheme should have built in clinical governance arrangements from their inception. Such concerns derive from a long history of scandals in older people's care going back to the 1960s which led to the formation of the original Health Advisory Service. The current incarnation of Government inspection (The Commission for Health Improvement – CHI), recently published an investigation into the Gosport War Memorial Hospital.[7] Although the inpatient facilities were not formally called intermediate care, the type of slow stream rehabilitation environment partly run by primary care and partly run by secondary care, might, in other areas, be called an intermediate care scheme. Following a police referral, the Trust systems were found to have failed to ensure good quality patient care in this community hospital, including:

- a lack of thorough multidisciplinary total patient assessment to determine care needs on admission and
- the absence of adequate trustwide supervision of appraisal systems meaning that poor prescribing practice was not identified.

The heart of the problem appeared to be a failure of clinical governance systems. Such examples reinforce the views of those who are concerned about the care of older people in newly developed intermediate care schemes.

The Federation of the Royal College of Physicians of the United Kingdom has recently published a report of a working party on 'Medical aspects of intermediate care'.[8] The working party's remit was to review the current progress in delivering new intermediate care type services and to make recommendations from a medical perspective to ensure future progress in delivering effective national intermediate care type services.

The report sets out to try and address some of the practical problems encountered in the delivery of intermediate care. In particular, it:

- advises on the knowledge and skills required of

doctors, whether in primary or secondary care, who work in intermediate care type services

- suggests how this knowledge base can be achieved, including offering opportunities for career diversification and progress
- argues for a much greater emphasis on clinical governance in intermediate care type services and makes recommendations both at local and national level for those setting up such services.

The report makes it clear that although there are differences within the UK in terms of terminology, planning, framework and approaches to intermediate care, comprehensive assessment is essential and appropriate medical input is vital. It is hoped that the report will provide a clear medical steer to anyone setting up, developing or working in an intermediate care type service.

References

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