Intermediate care: private–public partnership

The NHS Plan (Department of Health, 2000a), unveiled in July last year, was a watershed for health and social care in the UK. The plan contained, among many other policies and promises, the announcement of a 'concordat' between the Government and the Independent Healthcare Association.

IDEOLOGICAL BARRIERS REMOVED

The concordat, which was duly signed and sealed on 31 October 2000, promised: 'no organisational or ideological barriers to the delivery of high quality healthcare free at the point of delivery to those who need it, when they need it.' In practical terms the independent sector has come in from the cold.

In direct contradiction of planning guidance issued by the former Secretary of State for Health Frank Dobson, in the autumn of 1997, the concordat encourages the NHS to work in partnership with the independent sector for the benefit of NHS patients. It focuses initially on three areas of joint working — elective care, critical care and intermediate care.

ENABLING FRAMEWORK

The concordat is a framework. It is not an exhaustive guide to partnership between the two sectors and it is not designed to negate any existing partnership arrangements. On elective care, however, it does provide three examples of how such partnership might be achieved:

1. Primary care group (PCG) or primary care trust (PCT) commissioning or renting accommodation from the independent sector with the service delivered by NHS consultants and other NHS staff under their NHS contract
2. An NHS trust 'sub-contracting' the provision of a service to the independent provider. In this case the NHS trust would be fulfilling its obligation under a service agreement with the PCG or PCT but would meet the cost of the sub-contracted service from the resources received from the PCG/PCT
3. PCGs or PCTs commissioning directly from an independent provider.

INTERMEDIATE CARE

In intermediate care too there is a range of commissioning routes available to facilitate partnerships. But what exactly is intermediate care — or more accurately what is intermediate care in today's policy context? Many health and social care professionals know what they think intermediate care is but what do the government and those driving intermediate care policy at the Department of Health think it is? Is it, for example, still what it was when the term first came into common usage a number of years ago — step-down hospital beds usually in a community hospital. Or, does intermediate care now describe a whole range of services, and indeed places, where care can be delivered.

In a speech on 2 February 2000 intermediate care was described by Secretary of State for Health, Alan Milburn as 'the bridge between hospital and home'. Since then the Department of Health have been working to define this bridge. The concordat gives us a clearer idea of what the government is looking for. It states:

> **'Intermediate care is a whole system approach to a range of multidisciplinary, multi-agency services designed to promote independence by:**
> **Reducing avoidable hospital admission**
> **Facilitating timely discharge from hospital**
> **Promoting effective rehabilitation**
> **Planning innovative new services in a non-hospital environment**
> **Minimising premature dependence on long-term care.'**
> **(Independent Healthcare Association/Department of Health, 1999)**

MULTIDISCIPLINARY INPUT

So essentially, intermediate care is a service not a bed. It is time-limited, with multidisciplinary input, the aim of which is to restore a person's confidence and independence to the degree where they can continue to live at home with minimum support.

Intermediate care is therefore a crucial part of the government's agenda of promoting care at home wherever possible and its determined focus on maintaining or returning people to independence. It is also essential to efforts to prevent a crisis in the NHS, particularly this winter. The National Beds Inquiry found evidence of significant inappropriate or avoidable use of acute hospital beds and in the case of older people specifically, that around 20% of bed days were probably unsuitable (Department of Health 2000b).

By encouraging and investing in intermediate care the Government hopes to see people discharged from hospital more quickly or, even better, prevent people being admitted to hospital in the first place. The spectre of older people on trolleys in accident and emergency and cancelled operations is something the government want to avoid at all costs.

THE INDEPENDENT SECTOR AND INTERMEDIATE CARE

But what can the independent sector offer the NHS in terms of support for intermediate care?

The independent sector is extremely diverse and has a wide range of services available to support the NHS. It is not, as some may think, just care homes, although there are around 15 000 nursing and residential care homes in the sector delivering 150 million bed nights of care a year. Day care services, home care and health-care-at-home services, assisted living, very sheltered housing and close care are all also available. And that is all in addition to the 10 500 beds that exist in the UK's 211 independent acute hospitals.

All these services mean that there is huge scope for independent sector involvement in intermediate care to provide:

- Recuperation
- Rehabilitation, for example after hip operations
- Respite care
- Direct admission from the community
- Rapid response.

Some critics of the sector have suggested that increased use of, in particular, nursing and residential homes for intermediate care would promote a culture of dependency rather than independence. This could not be farther from the truth with homes often the hub of community health activity and able to offer best value care that is local to communities, nurse led, ensures privacy and dignity in single rooms and reduces isolation and institutionalization.

CULTURAL CHANGES REQUIRED

While services and beds are clearly available in the independent sector and there is political will and new money behind partnerships in intermediate care, there are still problems to overcome and challenges to meet. One of the biggest will be the ability of the independent sector and the NHS to change their ways of working. Real partnerships will need individuals and organizations on both sides to break down barriers, think differently, end prejudices and build trust. But it can be done because there are many examples throughout the country where it is already being done.

But the concordat is just the beginning. Both the government and the Independent Healthcare Association are committed to continue working together to broaden the aims of the concordat and look at how the two sectors can continue to work together.

It is the responsibility of all those who work in health and social care in the UK to make the concordat and the prevailing spirit of partnership flourish for the benefit of patients. **HM**

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KEY POINTS

- The concordat between the government and the Independent Healthcare Association removes organizational and ideological barriers to the delivery of health care.
- An enabling framework, the concordat sets the tome for longer-term partnerships between the NHS and the independent sector.
- More detail about what constitutes intermediate care is called for.
- The independent sector delivers in excess of 150 million bed nights of care every year.
- Long-term partnerships between the NHS and the independent sector require cultural shifts from both.
- All of those who work in health and social care have a responsibility to make the concordat work for the benefit of patients.