Intermediate care and diversity: principles and practice

The last few decades have seen a dramatic reduction in the number of hospital beds, despite the UK being an ageing society and the elderly being major users of hospital resources. The *National Beds Inquiry* (Department of Health, 2000a) and the British Geriatrics Society's (2001) bed-blocking surveys confirmed the lack of sufficient community alternatives to hospital care, inappropriate use of hospital beds, and delays in hospital discharges as key factors for the high numbers of people who stay in an acute hospital longer than is desirable. At the same time the expectations of patients and their families have risen, and it is therefore easy to understand how many medical departments struggle to cope with large numbers of sick older people.

A report by the Audit Commission (1997) disclosed how unplanned admissions of older people to hospital and, in turn, premature admission to long-term residential care could be reduced by an increase in investment for preventative and rehabilitative services.

It was precisely these demographic changes and economic necessity that motivated the Government's response to promulgate the increased use of non-acute beds for the care of older people. The *NHS Plan* (Department of Health, 2000b) called for health and local authorities to develop joint investment strategies to enable providers to make tangible progress in integrating therapeutic and financial intent. With an investment of over £500 million approximately 2300 intermediate care beds have been created, together with about 2700 non-residential intermediate care places. Around 134 000 extra people have been treated and therefore the system would appear to be on target for developing the capacity projected by the *National Service Framework for Older People* (Department of Health, 2001).

The definition of intermediate care has evolved over the years with much debate. Steiner (2001) recognizes consistent core elements such as the need for a holistic assessment at the point of entry, timely reassessment and flexible input from a multiprofessional team where the main interest is in maximizing patients' and families' access, comfort and control.

The main disagreements seem to be a lack of consensus on the appropriate users, goal setting and intensity of care. Stevenson and Spencer (2002) suggests that most authorities would agree that intermediate care is a short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute inpatient care, long-term residential care or continuing NHS inpatient care. At the British Medical Association (2003) conference on intermediate care Singh agreed with the aim of intermediate care to provide integrated services to promote faster recovery from illness preventing unnecessary acute hospital admissions, supporting timely discharge and maximizing independent living.

The principles that are already at work in existing intermediate care services in many parts of the UK include: person-centred care, joined-up care, timely access to multiprofessional care and promotion of health and active life. Older people must be treated with dignity and respect, regardless of age, on the basis of clinical need alone. We must encompass social and health care where older people are enabled to make choices about their own care. Partnership with older people and their carers is essential.

HOSPITAL AT HOME SCHEMES

Shepperd and Iliffe (2003) define hospital at home as a service that provides active treatment by health-care professionals, in the patient's home, of a condition that otherwise would require acute hospital inpatient care, always for a limited period and with the aim of preventing admission or facilitating early discharge.

Evidence from 16 randomized controlled trials suggests that early discharge schemes for patients recovering from elective surgery and elderly patients with a medical condition reduce length of stay and may have a place in reducing the pressure on acute hospital beds, although the cost-effectiveness remains uncertain. The evidence supporting hospital at home for patients recovering from a stroke is conflicting. There is some evidence that admission avoidance schemes may provide a less costly alternative to hospital care.

The views of the carers must be taken into account because of the increased carer burden when patients are cared for at home.

Future research will focus on admission avoidance schemes and the effect of early discharge hospital at home schemes.

COMMUNITY REHABILITATION TEAMS

Heseltine (2001) describes a general increase in community rehabilitation schemes to facilitate discharge from hospital, prevent hospital readmission and improve the mental and physical health of patients and their carers. To date only three randomized controlled trials have studied the principle of community rehabilitation as a general service provision for older people. Several smaller studies have evaluated very focussed aspects of community rehabilitation. Although this approach requires further evaluation it does appear to be successful and cost-effective.

NURSE-LED UNITS

According to Griffiths et al (2003) this model of care refers to inpatient intermediate care that substitutes for a period of acute hospital stay during the

predischarge stage. Patients neither require nor benefit from the full range of disciplines and facilities of the acute ward. Nursing is identified as the lead therapy and nurses replace the care management function of doctors.

The authors reviewed three randomized controlled studies comparing nurse-led units (NLUs) with usual care, and showed that outcomes were similar, with those allocated to the NLUs achieving the same level of independence and discharge destination, but staying longer (18 *vs* 11 days) than those remaining on the acute wards.

Cost-effectiveness of the NLU and more sensitive measures of functional status should be addressed by future studies before policy and national organizational support for such development can be given.

CULTURALLY SENSITIVE CARE

In relation to black and minority ethnic communities the difficulties of access and appropriate and responsive services have been well documented (Memon et al, 2001). The need to focus on achieving improvements in the building blocks of information and community engagement is the central theme of *Delivering Race Equality* (Department of Health, 2003). Singh et al (2002) stressed the importance of community participation and partnerships, and the need for commissioners and providers to raise the profile of ethnic health in their business and action plans.

With regards to planning and delivery of intermediate care services to ethnic minority older people it is important that there is a clear understanding of the communities and issues around access, services and suitable workforce, with action plans for delivering and monitoring outcomes. To understand communities it is essential to have detailed demographic and needs-related data, which are comprehensively collected and intelligently used. Ethnic minority individuals and the appropriate representative bodies must be encouraged to be involved throughout this process of review and development of local services.

It is of paramount importance that doctors acknowledge the different culture, languages and needs of the community when trying to encourage and facilitate access to information. In addition to facilitating access a commissioning strategy needs to be based on consultation and commissioners need to have a separate section on services for ethnic minority elderly within the commissioning arrangements and business development plans.

CONCLUSIONS

It is important to assess the quality of health care from the patient's perspective and there needs to be a clear recognition of the need to take account of, and respond to, the needs, views and rights of the diverse communities in society. Organizations which commission or provide intermediate care would be expected to incorporate due respect for this diversity in all they do and take appropriate account of dietary preferences, communication and preferred languages, religious practice, gender and other cultural norms.

Changes to the health improvement and health inspection mechanisms and the creation of the Commission for Healthcare Audit and Inspection must not lead to a gap in terms of role of inspection and quality assurance because of the previous overlap between health and social care for intermediate and continuing care.

Intermediate care is constructed from individual service components that form an integrated service. As with any other service for older people, intermediate care must provide timely access to person-centred, multiprofessional health and social care that should reduce the need for long-term care. Assessment for suitability of patients for this type of care is a precondition for reaching the required level of safety. **HM**

KEY POINTS

- Intermediate care aims to provide integrated services to promote faster recovery and maximize independent living.
- It is important to assess the quality of health care from the patient's perspective and services need to be appropriate and responsive to the needs of our diverse society.
- Organizations which commission or provide intermediate care should incorporate due respect for this diversity.
- Services must be person-centred and joined up with timely access to multiprofessional care.

I Singh/A Vilches
Consultant Physician/Specialist Registrar
Department of Medicine for the Elderly
East Lancashire Hospitals NHS Trust
Queen's Park Hospital
Blackburn BB2 3HH
RC Gupta
Consultant Physician
Lancashire Teaching Trust
Chorley PR7 1PP

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